THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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

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

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SC Court of Appeals

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

v.

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

RECORD ON APPEAL
VOLUME 2 OF 4

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1 iphone?
2 A: Correct.
3 Q: Okay. I don't have a new iphone with me, but
4 is the iphone bigger or smaller than this
5 pamphlet?
6 A: It's probably about the colored part of that
7 pamphlet.
8 Q: So you think the screen of the iphone is about
9 the colored part of this pamphlet?
10 A: Yeah. He had one of those big ones.
11 Q: I'm going to ask you to measure the diagonal of
12 the colored part of that pamphlet.
13 A: Okay. Seven and a quarter, seven and a half.
14 Q: Okay. So you think the screen on the iphone is
15 about, it was at least approximately that size,
16 seven and a half, seven and a quarter inches?
17 A: Approximately.
18 Q: Okay. Could have been a little smaller than
19 that?
20 A: Could have been.
21 Q: Okay. Do you have the new iphone by any
22 chance?
23 A: No. I got the antique model.
24 Q: And, you know, I'm getting older. I just got
25 bifocals about two years ago, but I noticed

1 that during the deposition you had some trouble
2 reading some of the print on some of the
3 reduced stock. Do you agree with that?
4 A: Yes, sir.
5 Q: How many times did you look at that video on
6 that screen that was on the new iphone, on Mr.
7 Stoller's iphone.
8 A: Once, maybe twice. I'm not sure. I think we
9 might have looked at it twice.
10 Q: Where were you physically located when you were
11 viewing the video?
12 A: We were in the back of the Emergency
13 Department. There's an area that sometimes
14 doesn't have any patients in it.
15 Q: Okay. Was there ambient noise around where you
16 were?
17 A: I don't think -- at the time there wasn't a lot
18 of patients back there. I don't think there
19 was any patients back there. It might have
20 been a staff member or two. I don't recall.
21 Q: Okay. Have you ever seen the video on a big
22 screen before?
23 A: During the deposition we watched it on a
24 computer screen I believe.
25 Q: And I understand that after you saw the video,

1 you never had any discussions with Mr.
2 Davenport about what you saw in the video, is
3 that correct?
4 A: Correct.
5 Q: Okay. You never initiated any type of
6 disciplinary action against Mr. Davenport?
7 A: No. After I saw the video, then we agreed to
8 send it on to DHEC and let them deal with it.
9 Q: And that was Mr. Stoller's idea. He said, I'm
10 going to send this onto DHEC. What do you
11 think of that?
12 A: Yes, sir.
13 Q: Okay. And you said, fine with me. Right?
14 A: Yes, sir.
15 Q: Now, part of these policies and procedure
16 manual or the protocol manual that's Exhibit 1,
17 if you'll pull that out again. Part of that
18 contains what are called clinical policies. Do
19 you recall we talked about those in your
20 deposition?
21 A: Yes, sir.
22 Q: And if you'll turn to page, it's Bates page
23 122.
24 A: Hospital diversion policy? Is that page 122?
25 Q: I'm sorry. 112. I misspoke. It's policy 22

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

1 order? I mean that's a mandatory ---
2 **MR. WICEVIC:** Your Honor ---
3 Q: --- term, isn't it?
4 **MR. WICEVIC:** --- I'm going to object. We've spoke
5 at this regarding this relevance issue at
6 length. Compliance with these disciplinary
7 polices are local, it's for Anderson County.
8 It's not significant to your decision, it's not
9 important for the Department to know whether or
10 not they complied with this particular
11 disciplinary policy. It does not relate to the
12 facts at issue in this matter. So I'd ask that
13 Mr. Rothstein be directed not to ask questions
14 concerning compliance with these disciplinary
15 policies.
16 **THE COURT:** Mr. Wicevic, I'm going to disagree.
17 It's relevant to me, so I'm going to allow the
18 question.
19 Q: And just for clarification, Dr. Kickham, that
20 document we're looking at is in the same
21 protocol book that we've been talking about
22 this whole hearing. Isn't that right?
23 A: Yes, sir.
24 Q: Okay. Did you follow the disciplinary
25 procedure set forth in this policy 22 with

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

1 Director, correct?
2 A: Correct.
3 Q: Okay. So that would require Mr. Davenport to
4 have been notified of the specific patient
5 issues that you and or Mr. Stoller had with
6 regard to his care, is that right?
7 A: Correct.
8 Q: Okay. And you never notified him specifically,
9 even what patient encounters you all were
10 investigating, did you?
11 A: We did not notify him in writing. We did it
12 verbally.
13 Q: So that was a violation of this procedure,
14 right?
15 A: Correct.
16 Q: All right. And then later in that item number
17 one, it gives you the authority to immediately
18 suspend a employee pending further
19 investigation, right?
20 A: Correct.
21 Q: Okay. And then you're supposed to provide
22 written notice to the employee within three
23 working days of the suspension, correct?
24 A: Correct.
25 Q: That wasn't done in this case either, was it?

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

1 you?
2 A: Other than the meeting we had right after the
3 first meeting?
4 Q: You're talking about the meeting at the
5 hospital ---
6 A: Yes, sir.
7 Q: --- before you went on duty Friday afternoon?
8 A: Right. Those were the only two meetings.
9 Q: Okay. Was that meeting pursuant to this
10 policy, or was that just a meeting you took at
11 Mr. Davenport's request?
12 A: Correct. It was ---
13 Q: The latter, right?
14 A: --- the latter.
15 Q: Now the next bullet says, after reviewing all
16 the information, the Medical Director will
17 issue a disposition of this matter. The
18 Medical Director may exercise one or more of
19 the following options, right?
20 A: Correct.
21 Q: And then there's I guess six, seven, eight
22 bullets of possible remed- -- or disciplinary
23 action that you can take, correct?
24 A: Correct.
25 Q: You could take no action and consider the

1 matter resolved. You can require remediation
2 training. What does that mean, remediation
3 training?
4 A: Additional courses like advanced cardiac life
5 support or trauma life support.
6 Q: More clinical type courses?
7 A: Correct.
8 Q: A clinical refresher?
9 A: Correct.
10 Q: Okay. Mr. Davenport didn't need any clinical
11 remediation training, did he?
12 A: Not in my opinion.
13 Q: Okay. So the disciplinary action you imposed
14 in terms of requiring him to take that PEPL
15 course was somewhere between no action and the
16 remediation piece. Isn't that right? Or the
17 clinical remediation training?
18 A: I'm not sure if it was between those or not.
19 But if it's going down the list -- I see what
20 you're saying. The list might be going in
21 order of seriousness or something.
22 Q: The last item on the list has revokation of
23 practice privileges.
24 A: Correct.
25 Q: That's pretty severe ---

1 A: Correct.
2 Q: --- punishment, right?
3 A: Right.
4 Q: And then you could also temporarily suspend the
5 privileges or suspend it for -- suspend
6 specific practice privileges. So if a
7 paramedic was having trouble with intubations,
8 you could say, I'm going to order you not to do
9 intubations until you get remedial training,
10 right?
11 A: Correct.
12 Q: That's what that refers to? So once you
13 announce your disposition then the paramedic or
14 EMT subject to the discipline is supposed to be
15 notified in writing that he may appeal to a
16 patient safety committee, right?
17 A: Correct.
18 Q: Okay. And you never gave Mr. Davenport the
19 opportunity to appeal to a patient safety
20 committee in this case, did you?
21 A: Correct.
22 Q: And under this policy you're supposed to be the
23 presiding officer of the patient safety
24 committee, right?
25 A: Correct.

1 Q: Okay. Have you ever in your 24 years at
2 Anderson County presided over a patient safety
3 committee meeting?
4 A: No.
5 Q: All right. I'm going to ask you to turn to the
6 next policy, number 23.
7 **MR. WICEVIC:** And, Your Honor, before we get
8 started, I'm going to make the same objection
9 of relevance concerning this medical error
10 reporting policy. Again, the QA process within
11 Anderson County is not relevant to the
12 Department's ultimate decision. You know, I
13 strongly believe that this case is about the
14 facts alleged against Mr. Davenport. Those
15 facts concern the March 19th, 2016 call. I
16 think whether this particular case or the cases
17 that were investigated by Anderson County went
18 through the medical error reporting policy is
19 not of significance to The Court.
20 **MR. ROTHSTEIN:** Your Honor, this is again another
21 one of these mandatory polices that's in the
22 protocols book. And, I mean, the fact that
23 they didn't bother to follow it, I think, is
24 relevant as to what the underlying motivation
25 for escalating this beyond, you know, Anderson

1 County was, sending this to DHEC.
2 **THE COURT:** I'm going to allow the question.
3 Q: Do you recognize, Dr. Kickham, do you recognize
4 -- I'm sorry, policy 23?
5 A: Yes, sir.
6 Q: And that sets forth sort of a philosophy of
7 quality assurance in reviewing potential medial
8 errors, right? Sort of in general.
9 A: Correct.
10 Q: And if you'll look the paragraph above the
11 bottom there where it says clinical review
12 process, you see that last heading at the
13 bottom?
14 A: Yes, sir.
15 Q: If you look at the paragraph immediately above
16 that states that, all Anderson County EMS
17 providers involved in reviewing errors and
18 evaluating care are committed to an educational
19 parentheses non-punitive approach to correcting
20 circumstances that lead to a medical error.
21 You believe that is an accurate reflection of
22 your policy for quality assurance and medical
23 error reporting in Anderson County?
24 A: Yes, sir.
25 Q: Okay. Do you know who Keith Eudy is?

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

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

1 Q: There were actually three cases in Mr. Eudy's
2 report. Would you consider the two cases from
3 February, the pediatric seizure patient and the
4 elderly man from the nursing home. Were you
5 familiar with those two cases?
6 A: Yes, sir.
7 Q: Okay. Would you consider those to be urgent
8 matters that needed to go outside the normal QA
9 process?
10 A: I think those could be handled more by the QI
11 officer in most cases.
12 Q: Okay. And the QI officer for Iva Rescue Squad
13 was a gentleman, or maybe still is, is a
14 gentleman named Craig Lawless. Isn't that
15 right?
16 A: Correct.
17 Q: Okay. And he's been there for a number of
18 years while under your medical control in that
19 regard?
20 A: Correct.
21 Q: Okay. And Mr. Lawless's job as the QI officer
22 is to look through patient care reports, to
23 check for compliance with the protocols, isn't
24 that right?
25 A: Correct.

1 Q: Okay. And if he see a deviation from what he
2 thinks is what's required by the protocols, he
3 flags it, or I think they call it a fallout.
4 Isn't that right?
5 A: Yes, sir.
6 Q: Okay. And then I think you said you have eight
7 or nine agencies under your umbrella?
8 A: Correct.
9 Q: Okay. Every other month, you meet together
10 with the QI officers from all those different
11 agencies and you talk about the fallout
12 reports, right?
13 A: Correct.
14 Q: Okay. And you'll look to see if there's any
15 trends or any remedial education that needs to
16 be done to address, sort of, patterns of the
17 fallouts, is that right?
18 A: Correct.
19 Q: And, you meet every other month, and I think
20 you testified in your deposition, correct me if
21 I'm wrong, that you meet on the odd numbered
22 months, is that right?
23 A: Correct.
24 Q: Okay. So it would be January and then skip
25 February, you meet in March, right?

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

1 investigate all questions regarding clinical
2 care issues. The process insures that Anderson
3 County EMS providers are aware of and can act
4 on current issues as they arise in order to
5 provide timely feedback, education, and track
6 clinical performance. Did I read that
7 correctly?
8 A: Yes, sir.
9 Q: Okay. So, did Mr. Davenport ever receive
10 timely feedback for the two cases that occurred
11 in February of 2016?
12 A: Not that I'm aware of.
13 Q: Did any of those -- well let me ask you this
14 way. To your knowledge, did Mr. Eudy's chart
15 review, was that ever discussed with Mr.
16 Davenport to your knowledge?
17 A: Not to my knowledge.
18 Q: Now, if you'll turn over to page 116, Bates
19 page 116. It describes the procedures in the
20 clinical review process, right?
21 A: Yes, sir.
22 Q: All right. First item on the list is contact
23 with the Anderson County EMS Director, okay?
24 Were you made aware, or did anyone make you
25 aware as the Anderson County EMS Director of

1 any suspected concerns about Mr. Davenport's
2 calls from February of 2016 prior to Mr.
3 Stoller bring it to your attention?
4 A: Prior to Mr. -- no.
5 Q: Okay. How did you find out about the issue
6 with the stabbing call? Was that from Mr.
7 Stoller or was that from some concerned person
8 following this ---
9 A: It was from Mr. Stoller. I think it was a
10 phone call. Yeah. It would have been a phone
11 call.
12 Q: All right. And again, you send this out to all
13 paramedics, QA officers, training officers
14 under your umbrella, right?
15 A: Yes, sir.
16 Q: So if they observe a problem with a patient
17 care issue, they know that they're supposed to
18 contact you as part of this clinical review
19 process, right?
20 A: Correct. I think it goes to Scott first and
21 then it comes to me based on number one, but
22 ...
23 Q: Okay. So was Scott your designee to receive
24 the complaints?
25 A: That's what it says under number one, contact

1 the county EMS Director. I'm thinking that's
2 supposed to be Scott. It doesn't come directly
3 to me.
4 Q: Okay. And item number two, set number two on
5 the next page says that all Anderson County EMS
6 provider management personnel are responsible
7 for notifying the Anderson County EMS Director
8 at anytime there's a question surrounding
9 medical care or decision making, right?
10 A: Correct.
11 Q: Thank you. How was included in that term,
12 Anderson County EMS providers management
13 personnel?
14 A: Tell me where the sentence is again.
15 Q: I'm sorry.
16 A: I lost you.
17 Q: Under item number two.
18 A: Okay.
19 Q: Are you on page 117?
20 A: Yes.
21 Q: Okay.
22 A: Anderson County providers management personnel
23 are responsible for notifying Anderson County
24 EMS Director anytime ...
25 Q: And I was asking who was included in Anderson

1 County EMS provider management personnel?
2 A: Well it's basically Mr. Stoller, Mr. Davenport,
3 Ms. Kaiser, and myself.
4 Q: Would it also include the Chiefs of the
5 different rescue squads and training officers
6 within the rescue squads that are under your
7 umbrella?
8 A: If it pertained to their rescue squad. Yes,
9 sir.
10 Q: And what about the QI, QA officers for each
11 rescue squad? Would those be considered
12 management personnel?
13 A: Correct.
14 Q: And so if they saw a problem, they have a duty
15 to at least notify you or Scott Stoller of the
16 problem, right?
17 A: Correct. The protocols -- like this page for
18 example has to apply to Medshore Ambulance
19 Service and each of the rescue squads. So that
20 hierarchy of management would be a little bit
21 different from Medshore for example versus Iva
22 Rescue Squad. But yes, I think that would
23 include those people.
24 Q: Okay. So once you get the complaint in, item
25 number three talks about investigating the

1 complaint, right?
2 A: Yes, sir.
3 Q: Okay. And the investigation is supposed to be
4 done by the Anderson County EMS Director?
5 A: Yes, sir.
6 Q: And that's Mr. Stoller, correct?
7 A: Yes, sir.
8 Q: Okay. And it lists a number of items that can
9 be considered in the investigation, right?
10 There's the review of the initial concerns or
11 questions, review of the patient care record,
12 review of the dispatch record, interview with
13 the crew involved, interview with other people
14 like bystanders, patient's family, hospital
15 staff, on down the line, right?
16 A: Correct.
17 Q: Okay. I think you testified about the
18 investigation, at least to the extent that you
19 were part of it, involved looking at two
20 things, right? You were sent the PCR, the
21 patient care reports ---
22 A: Correct.
23 Q: --- and you saw Kim Aiken's statement, right?
24 A: Correct.
25 Q: Ms. Aiken wasn't the crew member in the two

1 calls from February was she?
2 A: I'm not sure.
3 Q: Did you ever talk to a Jennifer Brickle as a
4 part of your investigation?
5 A: No, sir.
6 Q: Did you ever get any documents from Ms.
7 Brickle?
8 A: No, sir.
9 Q: Have you ever talked to a Tommy Miller about
10 any of the patients from February?
11 A: No, sir.
12 Q: Do you recall when you were discussing the case
13 with Mr. Davenport, seeing any statements from
14 Ms. Brickle or Mr. Miller?
15 A: No, sir.
16 Q: To your knowledge, did Mr. Stoller interview
17 any of the patient or family members involved
18 in any of these three incidents?
19 A: No, sir.
20 Q: Do you recall ever seeing as part of this
21 investigation, any records from the actual
22 hospital, either the Emergency Department or
23 the Operating Room regarding the stabbing
24 patient?
25 A: No, sir.

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

1 you had the necessary information to determine
2 whether Mr. Davenport's medical care was
3 appropriate?
4 A: Yes.
5 Q: Okay. You knew from the patient care report
6 that the patient's vital signs were stable,
7 right?
8 A: Correct.
9 Q: Okay. You knew that the pain level of the
10 patient was a four, correct?
11 A: Correct.
12 Q: You knew that the patient was reported to be in
13 mild distress, right?
14 A: Correct.
15 Q: Okay. You knew that the knife was still
16 impaled in the stomach of the patient, right?
17 A: Correct.
18 Q: Okay. You knew that the patient was ambulated
19 from the couch or inside the residence to the
20 ambulance?
21 A: I don't think I knew that part.
22 Q: Look at item 11b. That's the patient care
23 report that I think you testified ---
24 A: Yes, sir.
25 Q: --- you already had, right?

1 A: Yes, sir.
2 Q: Turn to the second page, the narrative.
3 A: Yes, sir.
4 Q: Third line down says, the knife was secured
5 with dressing and tape. Patient was then
6 assisted to unit and placed on stretcher. You
7 see that?
8 A: Yes, sir.
9 Q: Okay. When you saw, patient assisted to unit,
10 did you think he was walked to the stretcher?
11 A: At the time I did not think so. I probably did
12 -- it says it right here in black and white,
13 but I ---
14 Q: Okay. You also testified that you had seen Ms.
15 Aiken's statement at that meeting, right?
16 A: Yes.
17 Q: In fact, you think you met with Ms. Aiken
18 before you actually met with Mr. Davenport,
19 correct?
20 A: Yes. I believe that's true.
21 Q: Turn to Exhibit 4, which is Ms. Aiken's
22 statement.
23 A: Yes, sir.
24 Q: I'm looking down at the fourth line, at the end
25 of that line says, Medic Davenport placed

1 bandages to hold the knife in place, then I EMT
2 Aiken placed tape on the bandages. Medic
3 Davenport helped the patient walk to the
4 stretcher. You see that?
5 A: Yes.
6 Q: Okay. So you knew at the time you met with Mr.
7 Davenport that the patient was walked to the
8 stretcher?
9 A: Based on this -- you know, I didn't know -- I'm
10 just trying to think back in time that he was
11 actually walked out of the house to the unit.
12 It says in the report he was walked to the unit
13 and put on the stretcher, which I should have
14 read that more clearly. This says walked to
15 the stretcher. Stretcher could have been right
16 next to the patient. So he could have stood
17 him up and ... So I'm just saying if I knew
18 before the video, the video was more
19 informative.
20 Q: Okay.
21 A: Maybe I didn't ---
22 Q: You also knew at the time you met with Mr.
23 Davenport and Mr. Stoller on that Friday,
24 before you saw the video, you knew that Ms.
25 Aiken rode the call in as a BLS call, right?

1 A: Yes, sir.
2 Q: Okay. And after you had all that knowledge,
3 you said that Mr. Davenport shouldn't be
4 suspended any longer, right? You reinstated
5 his medical control, correct?
6 A: Correct.
7 Q: Okay. The only remediation that was ordered
8 was for him to take I think what they call
9 PEPL class, right? The ethics and leadership
10 class, correct?
11 A: And review the protocols and take a protocol
12 test.
13 Q: And take a protocol test, which Mr. Davenport
14 took within a day or two and passed it, right?
15 A: I'm sure he took it several times.
16 Q: So the only thing that changed in terms of the
17 video -- the video didn't affect Mr.
18 Davenport's medical care. It affected the
19 verbal interactions he had with the patient.
20 Isn't that right?
21 A: Correct.
22 Q: And I think you testified earlier you thought
23 that Mr. Davenport had committed abuse towards
24 this patient?
25 A: Verbal abuse. Yes, sir.

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

1 Q: Okay. Now would you agree with me that the
2 comment that Mr. Davenport made to that patient
3 was somewhat reassuring? For example, if you
4 said to somebody, oh my god you've got a knife
5 in your stomach, that would be a little
6 different reaction to the patient then say,
7 that was a pretty stupid thing to do. Did
8 anybody ever tell you you're an idiot? Right?
9 A: I think he used some reassuring words and
10 sentences reassuring him that he was going to
11 be okay.
12 Q: Okay. I mean he's joking with a patient about
13 that was an idiotic thing to do. That's
14 somewhat reassuring to the patient that the
15 patient is not, I mean it's not a serious --
16 the patient's not going die in the next 10 or
17 15 minutes, right?
18 A: Can you ask that question again?
19 Q: Yeah. You agree that could have a calming
20 effect on a patient if the medic is sort of
21 joking around.
22 A: If the medic is joking around, yes.
23 Q: Okay. And you never talked to the patient to
24 see how the patient interpreted that sort of
25 banter or comment from Mr. Davenport, did you?

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

1 Davenport of abuse, is there?
2 A: Correct.
3 Q: And under your policies, if a EMT witnesses
4 another EMT or paramedic abusing a patient,
5 they have a duty to report that, isn't that
6 right?
7 A: Correct.
8 Q: Ms. Davenport never reported Mr. Davenport --
9 Ms. Aiken never reported Mr. Davenport for
10 patient abuse, right?
11 A: Correct.
12 Q: Okay. Now the second part of the video
13 exchange if I'm remembering it correctly,
14 correct me if I'm wrong, but there's a question
15 I think the Police Officer may have asked the
16 patient why he, you know, was trying to kill
17 himself or always trying to harm himself. Do
18 you agree with that?
19 A: Yes, sir.
20 Q: Okay. And the patient said something to the
21 effect, I stabbed myself hoping I would bleed
22 out, right?
23 A: I can't remember exactly.
24 Q: Do you remember Mr. Davenport saying, well
25 that's not where your heart is? Remember that

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

1 that Mr. Davenport was suggesting a better way
2 for the patient to kill himself the next time
3 he attempted it, right?
4 A: I don't recall that.
5 Q: And then do you recall Mr. Davenport -- there's
6 a discussion about why the patient did that.
7 Why he would want to harm himself. You recall
8 that on the video?
9 A: Vaguely.
10 Q: Okay. And Mr. Davenport tried to reassure the
11 patient that, oh you don't have it so bad. I
12 stepped on a GD, goddamn IED in Afghanistan and
13 blew my nuts off, right? You remember that in
14 the video?
15 A: Portions of it.
16 Q: Okay. So Mr. Davenport was trying to tell the
17 patient, you know, things could be a lot worse.
18 I mean, trying to put some perspective to the
19 patient, right? That his problems may seem
20 minor compared to other people's problems,
21 right?
22 A: Yes, sir.
23 Q: Do you think that is an appropriate interaction
24 with a suicidal patient?
25 A: I think in general reassuring the patient can

1 be appropriate action.
2 Q: And then, did you notice the interaction from
3 the Police Officer in the video?
4 A: One of them I think I remember.
5 Q: And you recall the Police Officer saying, don't
6 make me be bad guy, to the patient. Do you
7 remember that?
8 A: Yes. I think that had to do with the
9 handcuffs.
10 Q: Almost like he's talking to a third grader,
11 right?
12 A: I didn't really interpret it that way.
13 Q: Okay. Do you think it's appropriate to
14 patronize or coddle a suicidal patient?
15 A: No.
16 Q: And then there was a discussion in the video
17 about the knife. Mr. Davenport told the
18 patient that he was going to have to go to the
19 OR to get the knife taken out. Do you recall
20 that?
21 A: Yes, sir.
22 Q: And the patient objected and said, you mean I
23 gotta go to the OR? You can't just pull the
24 knife out right here? You remember that?
25 A: Yes, sir.

1 Q: Okay. Mr. Davenport didn't pull the knife out,
2 did he?
3 A: No, sir.
4 Q: Okay. He said he had the skills to pull the
5 knife out, but he'd lose his job. Isn't that
6 right?
7 A: Correct.
8 Q: Okay. The most critical thing about this
9 patient when they arrived on the scene was
10 number one making sure the patient is not
11 hemorrhaging or bleeding out anywhere. Isn't
12 that right?
13 A: I don't know if that could be determined on the
14 scene.
15 Q: But that's an important consideration when you
16 come to a stabbing, one of the first, I guess
17 with a critical, what do you call it, critical
18 interventions is to make sure the patient is
19 not hemorrhaging?
20 A: You can't make sure that they're not
21 hemorrhaging. You can assess them for
22 hemorrhage and treat them appropriately. You
23 can assess for hemorrhaging, you can't make
24 sure they're not.
25 Q: Okay. The second thing is you want to make

1 sure that that -- you want to stabilize the
2 object in place, isn't that right?
3 A: I don't know if that'd be the second thing, but
4 it's one of the things.
5 Q: That's a pretty important thing to stabilize
6 that knife into place so it doesn't move,
7 correct?
8 A: Correct.
9 Q: Okay. And Mr. Davenport -- you still have that
10 Exhibit 25, the photograph? Looks like a
11 pretty good job of stabilizing that knife in
12 place?
13 A: Yes, sir.
14 Q: And did you ever talk to anyone at the ER about
15 how difficult it was for them to undo the
16 taping job that Mr. Davenport had done on this
17 patient to keep the knife in place?
18 A: No, sir.
19 Q: Okay. Looking at that photograph, do you have
20 any problems with the way that Mr. Davenport
21 stabilized that knife in place?
22 A: No, sir.
23 Q: And then the next thing that I recall seeing on
24 the video is Mr. Davenport says, okay we're
25 going to lift you up and walk you out to the

1 ambulance. You remember that?
2 A: Yes, sir.
3 Q: Okay. And you believe that that was
4 inappropriate care for Mr. Davenport to stand
5 the patient up and walk with assistance out to
6 the ambulance, right?
7 A: Yes, sir.
8 Q: Okay. Anytime you move this patient, there's
9 going to be some risk involved in the patient,
10 right?
11 A: Correct.
12 Q: Okay. And if you brought in a stair chair for
13 example, the patient's still going to have to
14 stand up off the couch to get onto the stair
15 chair, isn't that right?
16 A: Or you could pick him up.
17 Q: Okay. So you could either -- are you
18 suggesting that the medic should have picked
19 the patient up and moved him onto a stair
20 chair?
21 A: No. Put him on a stretcher.
22 Q: Okay. Do you know if that house -- you have
23 any paramedics that have ever been to that
24 house and taken the patient -- and brought the
25 stretcher into the house before?

1 A: I am not aware.
2 Q: Well let's get back to a stair chair a second.
3 So either have to lift the patient up to put
4 him into the stair chair, or he has to stand up
5 and get into the stair chair, right?
6 A: Correct.
7 Q: Okay. And then if you had the stair chair,
8 have you ever put a patient on a stair chair
9 before?
10 A: No.
11 Q: Okay. Have you ever seen the stair chair that
12 Iva Rescue Squad has?
13 A: I've seen stair chairs but I don't know if I've
14 seen their's or not.
15 Q: Okay. Are you aware that the stair chair has
16 straps that go across the body in an x shape
17 fashion to secure the patient into place?
18 A: I think that's standard. Yes, sir.
19 Q: Okay. And when you put a patient on a stair
20 chair, you want to make sure they're secured in
21 there pretty tight so they don't fall out of
22 the chair as they're ---
23 A: Right.
24 Q: --- bumping them down the stairs, right?
25 A: Correct.

1 Q: So you've got to crank down on the straps to
2 make sure the patient's secured into that
3 chair, isn't that right?
4 A: Yes, sir.
5 Q: So you don't know anything about where the
6 knife was in relation to where those straps
7 would have been coming across the body in a
8 stair chair, do you?
9 A: No, sir.
10 Q: Okay. And if you crank down on the straps too
11 hard, you could compress the patient's chest or
12 abdomen, isn't that right?
13 A: Correct.
14 Q: And that could actually push the knife further
15 down or further into the body cavity of the
16 patient, right?
17 A: I'm not so sure about that, but yes you could
18 tighten the straps down too tight.
19 Q: Okay. And I know you said you've never used
20 it. Have you ever seen anybody take a patient
21 out of his house on a stair chair?
22 A: I've seen videos.
23 Q: Okay. They kind of are on wheels and they bump
24 down the steps, isn't that right?
25 A: Correct.

1 Q: Okay. And that jostling motion could have an
2 affect on the position of that knife, right?
3 A: Correct.
4 Q: So you don't know whether the stair chair was
5 the safest way to get that patient out of the
6 house or walking the patient out of the house
7 was the safest way, do you?
8 A: No, sir.
9 Q: Okay. That's a judgement call that the
10 paramedic has to make on the scene, isn't that
11 right?
12 A: Yes, sir.
13 Q: There's nothing in the protocols that tells the
14 patient how to get this knife wound victim out
15 of the house, right?
16 A: Well the protocols say that the stretcher
17 should be brought in to the home and that the
18 patient should not be walked out.
19 Q: The protocols also say that they can deviate if
20 you can explain it and document it, right?
21 A: Correct.
22 Q: Okay. So the mere fact that Mr. Davenport
23 walked that patient out of the house is -- I
24 mean it violates the protocol in the sense that
25 he didn't bring the stretcher in, take the

1 patient out, but Mr. Davenport can explain it
2 and document it, it's okay, right? I mean you
3 never ordered Mr. Davenport, don't walk that
4 patient out of the house, right?
5 A: Well it's in the protocols not to walk the
6 patient out of the house.
7 Q: Now if the patient was on the stair chair, they
8 get out of the house, they get to the back of
9 the ambulance, how do you get from a stair
10 chair into the stretcher that you're
11 transporting to the hospital?
12 A: You'd put them next to each other and lift him
13 up or have him assist you over onto the
14 stretcher.
15 Q: Okay. So either the patient has to stand up
16 again, or be lifted and placed into the
17 stretcher, right?
18 A: They might not have to stand up, but they'd
19 have to assist themselves over onto the
20 stretcher or be assisted.
21 Q: Okay. Now was there anything wrong with Mr.
22 Davenport laying this patient down supine flat
23 on the stretcher?
24 A: I think in general you'd want to try and keep
25 him in the position that you found them in as

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

1 real safe to put him on his side, is it?
2 A: Correct.
3 Q: Okay. So this patient if he were taken out on
4 a spine board, would be in a supine position,
5 correct?
6 A: Correct.
7 Q: Okay. So there's nothing wrong with laying the
8 patient down flat in the supine position,
9 right?
10 A: Correct.
11 Q: Dr. Kickham, if you'll turn to page 43 of
12 Exhibit 1. That's the multiple trauma and
13 shock protocol. You see that? Are you on that
14 page 43?
15 A: Yes, sir.
16 Q: All right. And if a paramedic assess the
17 situation and determines there's multiple
18 trauma or shock, this protocol would apply.
19 Under management the paramedic is supposed to
20 initiate spinal immobilization, right?
21 A: Correct.
22 Q: Okay. And what's involved in spinal
23 immobilization?
24 A: Spinal immobilization is to try and transport
25 the patient on the long spine board to minimize

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

1 appropriate way to get the patient out of the
2 house, right?
3 A: I think prior encounters with the patient could
4 be taken into consideration in transporting the
5 patient, but I didn't see whether that was done
6 or not.
7 Q: Okay. Let me ask you to flip back a page to
8 trauma T- 1. It's on Bates page 42. This is
9 the general trauma protocol, right? I think
10 you testified earlier that you thought this was
11 applicable to Mr. Davenport's care of this
12 particular patient?
13 A: Yes, sir.
14 Q: Okay. And under critical trauma I think we
15 talked about the load and go situation earlier.
16 I'm not going to go back over that. Under
17 other trauma -- you see it half way down the
18 page, other trauma colon?
19 A: Yes, sir.
20 Q: It says all patients complaining of neck back
21 pain, or patients with a significant mechanism
22 of injury will receive full spinal
23 immobilization. You see that?
24 A: Yes, sir.
25 Q: Okay. So did you consider this a significant

1 mechanism of injury?
2 A: Yes, sir.
3 Q: Okay. Is a gunshot wound a significant
4 mechanism of injury?
5 A: Yes, sir.
6 Q: Okay. What if I shot my pinky off? You would
7 consider that to be trauma, right?
8 A: Correct.
9 Q: And that is a trauma with a significant
10 mechanism of injury, right?
11 A: Correct.
12 Q: Okay. Are you suggesting that if a patient
13 shoots their pinky off with a gun, that the
14 paramedic has to do the full spinal
15 immobilization on that patient?
16 A: I'm not sure I know how to answer that
17 question. Do I ... I think I know what you're
18 asking but ... Do they need full spinal
19 immobilization, no.
20 Q: Okay. But that's a trauma ---
21 A: Correct.
22 Q: --- with a significant mechanism of injury,
23 right
24 A: Correct.
25 Q: So if you took this policy literally, that

1 patient would need to have a full spinal
2 immobilization.
3 A: Correct.
4 Q: Okay. That doesn't make any sense, does it?
5 A: Correct.
6 Q: Okay. So that's an example of where a rigid
7 following of a protocol is nonsense, wouldn't
8 you agree with that?
9 A: That's where the education -- correct. It's
10 where the education, training, and experience
11 comes in.
12 Q: Okay. And you would agree with me that Mr.
13 Davenport has extensive medical education and
14 training, right?
15 A: Correct.
16 Q: Far surpasses the normal civilian paramedic?
17 A: Correct.
18 Q: And I think you also testified that this issue
19 of whether something's a critical case or
20 significant or major trauma, I think you said
21 it's sort of in the eye of the beholder. I
22 think you said that term severe trauma is a
23 generalization. Do you remember testifying
24 about that when Mr. Wicevic was asking you
25 questions?

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

1 defined in the policy, right? And you
2 testified that it's sort of in the eye of the
3 beholder. Is that a fair characterization?
4 A: Well there's parts of the policies that
5 delineate it and parts where there is judgement
6 call.
7 Q: Okay. And I think your testimony was
8 paramedics with their training and experience
9 know severe when they see it, right?
10 A: Correct.
11 Q: Okay. And in this case Mr. Davenport didn't
12 view this as a severe trauma, isn't that right?
13 A: Correct.
14 Q: Okay. He saw that the patient was stable based
15 on his assessment of the patient, right?
16 A: In his opinion, yes.
17 Q: Okay. The patient's vital signs that were
18 taken in the truck during the transport
19 appeared to be stable, correct?
20 A: Correct.
21 Q: Okay. The patient had an oxygen saturation
22 rate of 98 or 99 percent on the way to the
23 hospital, right?
24 A: Correct.
25 Q: Okay. In the picture you looked at earlier,

1 the patient's not blue or not pale. So it
2 looks like his respiration seems to be okay,
3 correct?
4 A: Correct.
5 Q: And so if Mr. Davenport made the medical
6 judgement that that's a stable patient, he just
7 has a knife in his stomach that's now been
8 secured into place, that's a judgement call for
9 Mr. Davenport to make based on his experience
10 and training, isn't that right?
11 A: Correct.
12 Q: And if Mr. Davenport determined that patient
13 was stable, that patient doesn't need
14 supplemental oxygen, right? No respiratory
15 distress?
16 A: No, sir.
17 Q: Okay. And that patient ---
18 A: I mean, no. That was a statement. It wasn't
19 really a question.
20 Q: Okay. The patient ---
21 A: So yes, the patient still needs oxygen, IV,
22 cardiac monitor, regardless of his assessment.
23 His assessment turned out to be correct, and
24 the patient was delivered to the Emergency
25 Department, and wheeled by myself, he looked

1 relatively stable. That doesn't negate the
2 fact that he could have changed his condition
3 on transport. So it doesn't negate the IV,
4 monitor, and oxygen.
5 Q: In a place I wrote down what constitutes a BLS
6 call versus what constitutes an ASL call. And
7 I think you gave some examples of BLS calls.
8 Let me see if I can find it. Minor laceration,
9 sprained ankle, and bee stings. Remember?
10 A: Well bee stings could be advanced call, so ...
11 There's not very many basic calls. But the
12 mechanism of injury could make it an advanced
13 call, so there is grey area there.
14 Q: Okay. In your opinion, most calls need to be
15 treated as ALS calls, is that ---
16 A: Correct.
17 Q: --- fair to say? Okay. I think you also said
18 if there's no immediate distress for the
19 patient, that can be considered a BLS call. If
20 the patient, no immediate distress, that can be
21 a BLS call, right?
22 A: It can be.
23 Q: Okay. And if it's a BLS call, the EMT basic
24 can ride in the back of the ambulance on the
25 way to the hospital, correct?

1 A: Correct.
2 Q: And if a paramedic starts the treatment on a
3 stable patient, under your policies, the
4 paramedic can transfer the care of that patient
5 to a BLS or EMT basic if the patient is stable
6 in the mind of the medic, is that right?
7 A: Correct.
8 Q: Let me ask you to turn to page 125 of Exhibit
9 1.
10 **THE COURT:** I'm sorry. What page are we going to
11 Mr. Rothstein?
12 **MR. ROTHSTEIN:** Sorry. 125, Your Honor.
13 **THE COURT:** 125, okay.
14 Q: This is the non-paramedic transport of patient
15 policy, correct?
16 A: Yes, sir.
17 Q: Okay. Forth bullet in this policy that's in
18 the protocols. It says second sentence, if the
19 technician determines that the patient is
20 stable and all patient care needs can be
21 managed by a lower level provider, patient care
22 can be transferred to a technician of lower
23 certification for care while en route to the
24 hospital. You see that?
25 A: Yes, sir.

1 Q: So your policy allows the technician or the
2 paramedic to determine that the patient is
3 stable on scene, right?
4 A: Correct.
5 Q: And if that determination is made, he can
6 transfer the care to a EMT basic or a lower
7 level provider without -- on the trip to the
8 hospital, right?
9 A: Yes, sir.
10 Q: Okay. And that's not abandonment of the
11 patient, is it? If they comply with that
12 policy?
13 A: If it's a basic call from the beginning, no.
14 Q: Okay. And if they're en route to the hospital
15 and a problem develops or complications
16 develops, the patient starts to decompensate,
17 and it now becomes something that's beyond the
18 capability of the EMT basic, at that point the
19 basic can say, he I need some help here, and
20 the medic can switch back, switch places, isn't
21 that right?
22 A: Yes, sir.
23 Q: Okay. And if the basic does not think, or is
24 uncomfortable riding the call, if they think
25 this is beyond my capability, the burden is on

1 the EMT basic to raise that to the paramedic,
2 isn't that right?
3 A: Yes.
4 Q: In fact, looking down further on Exhibit 1
5 policy 26, look down to the second to last
6 bullet. Paramedic must accompany the patient
7 to the hospital if the BLS crew or crew member
8 expressed any discomfort with assuming the care
9 for the patient, right?
10 A: Correct.
11 Q: So if Ms. Aiken said, James I don't feel
12 comfortable handling this patient. You know,
13 this is beyond my training. I want you to
14 handle it, Mr. Davenport should take over the
15 care of that patient, right?
16 A: Correct.
17 Q: And so this is regardless of whether or not the
18 paramedic believes any ALS procedures are
19 warranted, correct?
20 A: Yes.
21 Q: And it says, it is the obligation of the BLS
22 crew and or crew member to state that they are
23 not comfortable with managing this patient,
24 right?
25 A: Yes, sir.

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

1 I'm not doing anything for him, did you
2 interpret that by Mr. Davenport says, I'm done
3 with this guy. I'm not going to provide, I'm
4 refusing to provide care to this patient?
5 A: I didn't interpret him as refusing. I
6 interpreted it as I'm not going to do anything,
7 I'm not going to put an IV in him, I'm not
8 going to give him any pain medicine. Therefore
9 you can ride with him.
10 Q: Okay. And that was an accurate statement
11 right? Mr. Davenport didn't put an IV in the
12 patient, right?
13 A: Correct.
14 Q: And he didn't administer pain medication,
15 right?
16 A: Correct.
17 Q: And we already saw that the pain level was a
18 four, doesn't need pain mediation, right?
19 A: Well, maybe.
20 Q: And when you met with Ms. Aiken, did you ask
21 her how she interpreted Mr. Davenport's
22 statement, you know, I'm not going to do
23 anything for the patient?
24 A: No.
25 Q: Let me ask you to look at her statement,

1 Exhibit 4.
2 A: Okay.
3 Q: Look down about half way, let's see, the eighth
4 line down I think. Eight lines down. Sentence
5 starts, medic Davenport then stated that it was
6 a basic life support call and that I would be
7 fine, right?
8 A: That's what she has written. Yes, sir.
9 Q: Okay. So then she talks about Police Officers
10 that were there, and they got in the back of
11 the truck to take the photos. And then she
12 says, I then asked him again, would I be okay
13 to ride this call? Medic Davenport then stated
14 to me that he would not do anything more for
15 the patient than what I could do. Right?
16 A: That's what it says.
17 Q: Okay. So he's telling Ms. Aiken, you've got
18 this call. The patient's stable. It's BLS
19 call. You're okay to ride it. Isn't that
20 right?
21 A: Yes, sir.
22 Q: And Ms. Aiken didn't voice any objection after
23 that. She got in the back of the truck, and
24 they went to the hospital. Isn't that right?
25 A: As far as I know.

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

1 come back. Dr. Kickham, you're coming from
2 Anderson, correct?
3 **DR. KICKHAM:** Yes, ma'am.
4 **THE COURT:** I hate to have you come back. Is there
5 anyway you all can kind of shorten the balance
6 of your cross and your re-direct, so we can get
7 them and we can get him out of here?
8 **MR. ROTHSTEIN:** I'll try and finish it up quick.
9 Give me two minutes.
10 **THE COURT:** Okay. Very good.
11 Q: Dr. Kickham, were you aware that Ms. Aiken had
12 gotten in trouble before for riding in calls
13 that were beyond her certification or ALS level
14 calls?
15 A: Not to my memory.
16 Q: Were you ever contacted by anyone at DHEC about
17 this matter prior to your deposition being
18 taken?
19 A: I received a phone call from -- I can't
20 pronounce his name -- Vito's associate, and she
21 gave me the approximate dates of the hearing.
22 And then my other discussions with Vito.
23 Q: Okay. All your discussions with anyone at DHEC
24 have been with the lawyers, right?
25 A: Correct.

1 Q: Okay. You never talked to Mr. Naugler, the
2 investigator from DHEC?
3 A: No, sir.
4 Q: Okay. You never provided any information for
5 Mr. Naugler at DHEC?
6 A: No, sir.
7 Q: Did you ever speak to Mr. Wronski at DHEC?
8 A: No, sir.
9 Q: Did Mr. Wronski ever ask you for information
10 about the investigation with Mr. Davenport?
11 A: No, sir.
12 Q: Now after you met with Mr. Davenport, I think
13 it was that second meeting on Friday. I think
14 it was sometime right before you getting ready
15 to start work. You estimate it would be about
16 2:00, 2:30 in the afternoon?
17 A: Yes, sir.
18 Q: At that time, had you and Mr. Stoller decided
19 the appropriate punishment for Mr. Davenport's
20 matter?
21 A: I don't know if punishment's the right word,
22 but yes.
23 Q: Okay. His remediation had already been
24 announced?
25 A: Yes.

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

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

1 adverse patient outcome. Dr. Kickham has been
2 involved in cases that had very adverse
3 outcomes including death, and his license was
4 never affected.
5 **THE COURT:** I'm sorry. It has no relevance in this
6 matter. I'm sustaining Mr. Wicevic's
7 objection.
8 Q: Do you agree that paramedics have a very
9 stressful job?
10 A: Yes.
11 Q: Okay. And I think in your deposition we talked
12 about you thought that Mr. Davenport may have
13 been having a bad day from what you saw on the
14 video, isn't that right?
15 A: I don't remember stating that.
16 Q: Okay. You're aware that Mr. Davenport has a
17 through the knee amputation in his left leg?
18 A: Correct.
19 Q: Okay. And do you believe that the injuries he
20 suffered in combat are painful injuries?
21 A: Are or were?
22 Q: Currently are.
23 A: I'm not aware.
24 Q: Okay.
25 A: I don't know.

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

1 his outlook toward medicine, is that right?
2 And your answer was, yes. I think he had the
3 knowledge base. I know he has the knowledge
4 base. And he has the skill level. I'm sure
5 he's proven that over and over in his former
6 jobs, plus my discussions with him, he's very
7 knowledgeable. I think my thought is as
8 providers advance in their careers, it's very
9 easy, I hate this word, to get burned out. But
10 it's very easy to get burned out and not
11 provide optimal care. And it's not so much a
12 knowledge base as doing the right thing and
13 getting back on track. You see that?
14 A: Yes, sir.
15 Q: And then I asked you -- are you on the next
16 page, 153?
17 A: Yes, sir.
18 Q: Line ten, have you experienced or observed
19 providers such as the paramedics or EMT's or
20 emergency physicians exhibit signs of stress or
21 burn out? And you said, yes. Right?
22 A: Yes, sir.
23 Q: Okay. Did you do anything, like take Mr.
24 Davenport aside and say, James I saw this video
25 and you can't talk to patients like that. I

1 don't know if you were hurting or having a bad
2 day, but don't call patients idiots. Did you
3 ever take him aside and have a conversation
4 like that with him after you saw the video?
5 A: No, sir.
6 Q: Did you ever take any steps to determine
7 whether Mr. Davenport was suffering from some
8 type of either stress or depression or mental
9 health issue that might have affected his
10 interaction with patients?
11 A: No, sir.
12 Q: And you ever referred Mr. Davenport to the
13 employee assistance program at Anderson County
14 or asked him to have, like, a fitness for duty
15 evaluation done to see if he was suffering from
16 stress or some other mental health condition
17 that might have affected his interaction with
18 the patient on that day?
19 A: No, sir.
20 **MR. Rothstein:** I don't have any further questions,
21 Your Honor.
22 **THE COURT:** Okay.
23 **DR. KICKHAM - RE-DIRECT EXAMINATION BY MR. WICEVIC:**
24 Q: Dr. Kickham, still good to go?
25 A: Yeah.

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

1 indicates that, yeah, you can made deviations
2 from the protocols, you've just got to be able
3 to explain them and have it documented. Did
4 Mr. Davenport explain any deviations to you?
5 A: In our discussion verbally, he explained as
6 best he could why he did what he did.
7 Q: And what was that?
8 A: That he didn't think that the patient had the
9 potential for further harm or injury, and that
10 he had seen a lot of trauma in his career, and
11 this was minor.
12 Q: Now did he document the deviations?
13 A: Not on the patient care report.
14 Q: There's some talk about various terms within
15 the EMS industry, trauma, load and go. When a
16 new EMT comes aboard one of your services, is
17 there a requisite level of knowledge you expect
18 them to know and understand?
19 A: Yes.
20 Q: Okay. Would that knowledge contribute to their
21 understanding of trauma?
22 A: Yes.
23 Q: The word trauma. What about load and go?
24 A: I think that's a fairly common term they would
25 learn in school, in training and then in

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

1 refer to you. I believe it's Exhibit 26. I'm
2 not sure if it's up there.
3 A: Yes, sir.
4 Q: Do you recall the report?
5 A: I think we looked at it at the deposition.
6 Q: Do you recall whether or not you agreed with
7 that report?
8 A: I think in general I agreed with it.
9 Q: All right. QI reviews, are names discussed at
10 QI reviews, EMT names generally?
11 A: Generally, no.
12 Q: Okay. Let me ask you this, generally what has
13 greater minimization of movement, walking a
14 patient or using a carrying device?
15 A: I would say the carrying device would be less
16 movement.
17 Q: Okay.
18 **THE COURT:** Dr. Kickham, could you speak a little
19 louder.
20 **DR. KICKHAM:** I'm sorry, Your Honor.
21 A: I think the carrying device would be less
22 movement than walking the patient.
23 Q: I think Mr. Rothstein had some questions, and
24 I think it was focusing on this T-3 protocol.
25 He talked about hemorrhaging, and I believe you

1 said, you can't make sure they're not
2 hemorrhaging. I was just seeing if you had an
3 explanation of that statement.
4 A: Well with penetrating injury, you could be
5 bleeding inside the abdomen or peritoneal
6 cavity, and you might not know how much
7 bleeding you're having. So if someone's having
8 a lot of bleeding, their abdomen becomes
9 distended with the blood, and it can become
10 more obvious. But you have no way of knowing.
11 That's why the go to the Operating Room
12 emergently, and the wound gets explored, and
13 then they remove the knife in the Operating
14 Room.
15 Q: Was that a concern you had here?
16 A: Yes.
17 Q: Towards the end of your cross-examination with
18 Mr. Rothstein, I believe you acknowledged that
19 Mr. Davenport did not make the determination to
20 call a trauma alert. It's AnMed's
21 determination.
22 A: Yes.
23 Q: That being said, I believe during the video Mr.
24 Davenport acknowledged that this patient was
25 going to require to have surgery and go to the

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

1 A: Yes.
2 Q: Where would that be?
3 A: I believe it was in the ---
4 Q: I'm sorry?
5 A: It's not in here, so maybe it was after this --
6 it was probably on the next revision. So I
7 would say no.
8 Q: Okay. I think that's all I have. That's all
9 I have.
10 **MR. ROTHSTEIN:** Your Honor, can I ask two questions
11 on re-direct?
12 **THE COURT:** Very quickly.
13 **DR. KICKHAM - RECROSS-EXAMINATION BY MR. ROTHSTEIN:**
14 Q: Okay. Dr. Kickham, if you'll look at page 6 of
15 Exhibit 1, the intravenous access protocol.
16 A: Yes, sir.
17 Q: That protocol doesn't say every patient should
18 have an IV, does it?
19 A: No, sir.
20 Q: Okay. It actually says, assess patient for
21 indications, right?
22 A: Correct.
23 Q: And then if the paramedic determines that an IV
24 is appropriate, the standing order part under
25 management tells the paramedic what type of

1 fluid to administer to that patient, isn't that
2 right?
3 A: Correct.
4 Q: Okay. So Mr. Davenport by not ordering an IV
5 on this patient didn't violate a order to
6 provide normal saline to the trauma patient,
7 did he?
8 A: They're separate, but they are together. So if
9 you go to the IV protocol, it's got IV
10 intravenous fluids I believe.
11 Q: So the intravenous protocol is again, a flow
12 chart. If the paramedic says, IV not
13 warranted, he doesn't start an IV, right?
14 A: Correct.
15 Q: But if he starts an IV, your standing order
16 tells him what type of IV to administer, or
17 what type of fluid to administer to that
18 patient.
19 A: Well the converse is true as well. If the
20 patient needs fluid then he needs an IV.
21 Obviously can't get fluid without an IV.
22 Q: Are you suggesting this stabbing patient needed
23 fluid?
24 A: It turns out he did not need fluids, but the
25 potential for blood loss was there, so the

1 potential for administering fluid was there.
2 **MR. ROTHSTEIN:** I don't have any further questions,
3 Your Honor.
4 **THE COURT:** Okay. Dr. Kickham?
5 **DR. KICKHAM:** Yes, ma'am?
6 **THE COURT:** We are finished with you.
7 **DR. KICKHAM:** Thank you for not bringing me back
8 tomorrow. I appreciate it.
9 **THE COURT:** Well let me just make sure. Are you all
10 finished with Dr. Kickham?
11 **MR. ROTHSTEIN:** Yes, ma'am.
12 **MR. WICEVIC:** Yes, Your Honor.
13 **DR. KICKHAM:** I guess I was premature in that
14 statement, wasn't I? Sorry.
15 **THE COURT:** Yes. But you are excused. You don't
16 have to return.
17 **DR. KICKHAM:** Thank you.
18 **MR. ROTHSTEIN:** One house keeping matter, Your
19 Honor.
20 **THE COURT:** Uh-huh.
21 **MR. ROTHSTEIN:** Obviously we didn't make as much
22 progress today as we were hoping. We've got an
23 expert witness who's a trauma surgeon. He's
24 flying in tonight, and he has surgery on
25 Thursday morning.

1 **THE COURT:** Uh-huh.
2 **MR. ROTHSTEIN:** So I talked to Mr. Wicevic about
3 taking him out of order. I still hope that's
4 okay with you that if we do Dr. DeAngelo first
5 in the morning and then I get him back on the
6 road so he can catch his flight. That's ...
7 **THE COURT:** Okay. And also we missed part of
8 today's testimony. So what I wanted to do is
9 maybe start earlier in the morning. As opposed
10 to 10:00, start at 9:00 in the morning so that
11 we can try to get this wrapped up.
12 **MR. ROTHSTEIN:** I think that's a good idea.
13 **THE COURT:** Okay.
14 **(Whereupon, the hearing adjourned at 6:15 p.m. and**
15 **was reconvened on Wednesday, July, 26, 2017 at 9:08**
16 **a.m.)**
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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT
Docket No. 17-ALJ-07-0003-CC

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

ADMINISTRATIVE HEARING

****

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

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

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EXHIBITS

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

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

(The original exhibits were retained by Judge Robinson.)

STIPULATIONS

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

1 **THE COURT:** Good morning. And I am going to call
2 this hearing to order. We're at this point
3 taking witnesses out of order, or are we agreed
4 to begin with Mr. Wicevic?
5 **MR. ROTHSTEIN:** Yes, Your Honor. I discussed with
6 Mr. Wicevic about us putting our expert witness
7 on the stand.
8 **THE COURT:** Okay.
9 **MR. ROTHSTEIN:** As I mentioned, he's from
10 Philadelphia and he's scheduled for surgery
11 tomorrow.
12 **THE COURT:** Okay.
13 **MR. ROTHSTEIN:** So we'd like to get him back.
14 **THE COURT:** Okay. Is there anything we need to take
15 up prior, other than calling the witnesses out
16 of order?
17 **MR. ROTHSTEIN:** Just one matter, Your Honor.
18 Yesterday, it was kind of late in the day when
19 Dr. Kickham was on the stand. I started asking
20 him a line of questioning about a malpractice
21 claim that he was involved in. Mr. Wicevic
22 objected and Your Honor sustained the
23 objection. I'd like to proffer that testimony
24 just for the record as to what that testimony
25 would have been had Your Honor allowed that

1 like of questioning, just for the record.
2 **THE COURT:** Uh-huh.
3 **MR. ROTHSTEIN:** In 1999, Dr. Kickham had a medical
4 malpractice lawsuit brought against him. This
5 is a matter of public record in Anderson
6 County. That case was settled. It was a
7 wrongful death case. It was settled on a
8 confidential sentiment amount. It was approved
9 by The Court, but there's no discussion about
10 what the amount of payment was other than what
11 the approval of attorney's fees and cost were,
12 attorney's fees being a percentage one third
13 percentage. That case arose out of a gentleman
14 who slipped and fell on a dock, presented
15 himself to the emergency room. Dr. Kickham I
16 think was not the doctor taking care of the
17 patient initially. The patient came back about
18 two days later complaining of a headache. Dr.
19 Kickham did what's called a lumbar puncture,
20 and he performed a CT, which is an imaging
21 study that would show whether there's fluid in
22 the brain. Once the lumbar puncture was done
23 the fluid rapidly released through the hole
24 that was created by the lumbar puncture. The
25 patient's brain herniated and the patient

1 subsequently died about two or three days
2 later. And the point of that testimony was
3 that Dr. Kickham still had his active medical
4 license. He never had his medical license
5 revoked by the Board of Medical Examiners. And
6 I know that's a different licensing body than
7 DHEC. But the point I was going to ask Dr.
8 Kickham about was whether he believed it would
9 have been fair for DHEC to have pulled his
10 license for one occurrence of alleged
11 negligence. That's the proffer.
12 **THE COURT:** Thank you. Okay. Now at this point,
13 are you ready to call your witness, Mr.
14 Rothstein?
15 **MR. ROTHSTEIN:** Yes, Your Honor. We call to the
16 stand Frank DeAngelo.
17 **THE COURT:** Mr. Deangelo, is it doctor?
18 **DR. DEANGELO:** Yes.
19 **THE COURT:** Okay. Before taking your seat, face the
20 court reporter, raise your right hand, he will
21 swear you.
22 **DR. FRANK DEANGELO**, having been duly sworn, testifies
23 as follows:
24 **DR. DEANGELO - DIRECT EXAMINATION BY MR. ROTHSTEIN:**
25 Q: Good morning, sir. Would you please state your

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

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

1 you do your, I guess they call it post-graduate
2 medical education?
3 A: I did a year at Hahnemann and then that was
4 just an internship. And then for my full five
5 year general surgery residency I went to
6 Episcopal Hospital, also in Philadelphia.
7 Q: Okay. And what were the years of your
8 residency in general surgery?
9 A: 1991 to 1996.
10 Q: Okay. Did you have any fellowship after you
11 completed your general surgery residency?
12 A: Yes I did. I had a cardio-thoracic fellowship
13 at State University of New York in Brooklyn.
14 Q: Okay. And explain to The Court what a
15 fellowship is or how it differs from a
16 residency.
17 A: It's sort of a continuation of your residency.
18 You're still in training and closely supervised
19 by attending surgeons, but you're training in
20 a specific sub-specialty of surgery. In this
21 case it was cardio-thoracic.
22 Q: Is a fellowship required to be a board
23 certified physician or surgeon?
24 A: Yes.
25 Q: Okay.

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

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

1 don't have the ability to put someone on a
2 heart lung pump. The other difference between
3 -- there are several differences between level
4 one and level two. To be honest with you, I'm
5 not completely familiar with all of them. The
6 main thing is we don't have the ability to put
7 someone on a heart lung bypass. We also don't
8 have in-house neurosurgical residents. Two of
9 the most important requirements that I'm aware
10 of to be level one you have to have the ability
11 to put someone on a heart lung bypass machine,
12 you have to have a neurosurgical residency at
13 that hospital so that there are always
14 neurosurgical specialized physicians in the
15 hospital. I'm sorry, there's a third
16 requirement that I'm aware of, and that is you
17 have to have a pediatric ICU so that you can
18 take pediatric patients. And in our hospital
19 that's defined as patients under 15 years of
20 age. So we don't have any of those things, so
21 we're not level two. There may be other
22 differences between level one and level two.
23 Honestly I'm not familiar with them because I'm
24 not a department head.
25 Q: Okay. And I don't want to dwell on that too

1 much. Have you ever worked at a level one
2 trauma center in your career as a trauma
3 surgeon?
4 A: Yes. For four years at Cooper University
5 Hospital in Camden.
6 Q: In your employment as a trauma surgeon, do you
7 frequently interact with EMT's and paramedics?
8 A: Yes.
9 Q: How often would you say you interact with EMT's
10 and paramedics as part of your position?
11 A: Every day. Every day that I'm on call.
12 Q: Have you had occasion to observe the various
13 skill levels of certified nationally registered
14 paramedics?
15 A: Yes.
16 Q: Have you ever been a paramedic yourself?
17 A: No.
18 Q: Have you ever ridden any emergency calls with
19 a paramedic crew?
20 A: No.
21 Q: Have you ever served as a Medical Control
22 Physician for a rescue squad or ambulance or
23 sort of supervising EMT's and paramedics?
24 A: No.
25 Q: Have you ever treated trauma patients that have

1 been brought into the emergency department with
2 a penetrating knife wound or multiple knife
3 wounds?
4 A: Yes.
5 Q: Okay. How frequently would you say you see
6 knife wound patients in Atlantic City?
7 A: I would guess once a week.
8 Q: Have you ever treated a patient with a knife
9 wound where the knife is actually left in place
10 or reined in place when that patient was
11 brought to the emergency department?
12 A: Last time that I recall was several years ago
13 at Cooper.
14 Q: Have you ever treated patients with a knife
15 wound specifically to the abdomen?
16 A: Yes.
17 Q: Have you ever treated patients with other types
18 of penetrating wounds to the abdomen caused by
19 other mechanisms of injury?
20 A: Yes.
21 Q: Could you give The Court some examples of other
22 penetrating type injuries to the abdomen that
23 you've worked on?
24 A: The other big category is gunshot wounds.
25 Q: Have you ever had any experience in treating

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

1 **MR. WICEVIC:** Your Honor, if I could voir dire Dr.
2 DeAngelo.
3 **THE COURT:** Yes.
4 **DR. DEANGELO - VOIR DIRE BY MR. WICEVIC:**
5 Q: Dr. DeAngelo, first of all, my name's Vito
6 Wicevic, I represent the DHEC. I introduced
7 myself a little bit earlier. I just a have a
8 couple questions about your resume and your
9 involvement in surgery. And some of these
10 might just be mistakes. I was doing a Google
11 search and following up with various licensing
12 bodies you listed on your resume. And again,
13 you said this CV is up to date, correct.
14 A: Yes.
15 Q: Do you currently have licensor with
16 Pennsylvania?
17 A: It's on hold. I have renewed it. They now
18 require that you do an online CME and three
19 credits on, I believe it's recognizing child
20 abuse. I did the online CME, but somehow it
21 didn't cross over to Pennsylvania. CME's are
22 sitting on my desk and I haven't had time to
23 work it out. So yes, my Pennsylvania license
24 is on hold.
25 Q: Okay. And CME is just like continuing

1 education?
2 A: Yes, yes.
3 Q: Okay. New York, it appeared -- and again I'm
4 just operating off of my search on the New York
5 Public Health website, that you're no longer
6 licensed in New York. Is that correct?
7 A: To my knowledge I am unless the renewal came to
8 my house and I haven't seen it yet.
9 Q: Okay. Pennsylvania, it appeared that your
10 license expired at the end of 2016?
11 A: Yes. I renewed it, but as I said, it's on
12 hold.
13 Q: Okay.
14 A: I paid the fee and so on.
15 Q: Okay. And New Jersey, is it correct you
16 renewed this past June?
17 A: Yes, yes.
18 Q: Okay. And, question. Throughout your military
19 experience, have you maintained your licensor
20 in these various states?
21 A: For the most part, yes.
22 Q: And can you explain that?
23 A: During my time in the military -- when I joined
24 the military I was only licensed in
25 Pennsylvania. Later on I became licensed in in

1 New York. Later after that I became licensed
2 in New Jersey. So I can't say that the whole
3 time that I was in the military that I was
4 licensed in all those states. But ---
5 Q: Okay.
6 A: --- when I first joined I was only licensed in
7 Pennsylvania because I was in medical school
8 when I first joined.
9 Q: Okay. One other thing about your certification
10 and licensor. You're listed as a diplomat of
11 the American Board of Surgery.
12 A: Yes.
13 Q: And again, this might just be an online
14 mistake, but it appeared when I did a search of
15 American Board of Surgeries certificate look
16 up, your name wasn't listed. Are you currently
17 certified?
18 A: Yes. I'm board certified in general surgery
19 and trauma critical care.
20 Q: Okay. Now have you had any malpractice or
21 negligence verdicts against you?
22 A: I have, to my knowledge, I have not. I've been
23 deposed about three times in my career, and in
24 all cases I never heard anything else about it.
25 Q: Okay.

1 A: And I was told that I had been released from
2 the case.
3 Q: Okay. So there was no settlements?
4 A: No. I've never been informed of any money
5 that's been paid out in my name.
6 Q: Okay. Any disciplinary action by your previous
7 employers, hospitals?
8 A: No.
9 Q: The military?
10 A: No.
11 Q: I wouldn't think. Looks like you're a Colonel.
12 You also talked about your specialization
13 surgery. Now you specialize in thoracic
14 surgery, is that correct?
15 A: I trained in cardio-thoracic but I haven't
16 completed the board certification.
17 Q: Okay.
18 A: I don't practice it. I practice trauma
19 surgery.
20 Q: Okay. And thoracic surgery, that means the
21 injury is somewhere between the -- the surgery
22 is somewhere between the neck and the abdomen?
23 A: Yes. Cardio-thoracic is everything in the
24 chest.
25 Q: Okay. Am I correct that emergency medicine and

1 trauma surgery are -- I mean, they're related
2 but they're separate, correct?
3 A: Yes.
4 Q: Okay. And the emergency department is to
5 stabilize and cure the patient, is that
6 correct?
7 A: Yes.
8 Q: And then if they require surgery ---
9 **MR. ROTHSTEIN:** Your Honor, this is getting beyond
10 voir dire. I mean I think voir dire is limited
11 to the credentials and qualifications of the
12 expert witness. I have not moved to have Dr.
13 DeAngelo qualified as an emergency room
14 physician or an emergency department physician.
15 I think Mr. Wicevic's getting a little far off.
16 **MR. WICEVIC:** Well, Your Honor, my basis for that
17 line of questioning was that there was
18 reference through the direct about his relation
19 to civilian paramedics, civilian EMT's. This
20 case is about civilian EMT's, emergency
21 medicine. So I was pointing out the
22 distinction between that and the relevancy of
23 -- I mean this case isn't about inappropriate
24 traumatic or trauma care, trauma surgery. This
25 is about the care of an EMT. So my questioning

1 was directed at showing the ---
2 **THE COURT:** Mr. Wicevic, you can proceed with your
3 questioning.
4 Q: So, Dr. DeAngelo, am I correct that emergency
5 room and the OR, the Operating Room, they're
6 distinct parts of the hospital, is that
7 correct?
8 A: Yes.
9 Q: And how often is a paramedic in the Operating
10 Room?
11 A: Not very often.
12 Q: Okay. And that's generally where you're at,
13 correct? The Operating Room?
14 A: Not all the time. I'd say maybe 40 percent of
15 the time. The rest of the time in the trauma
16 bay.
17 Q: Okay. And the trauma bay is kind of where you
18 learn if someone is going to require some kind
19 of trauma surgery?
20 A: Yes.
21 Q: Okay. And you have general communications with
22 the ER doctor and ER staff, correct?
23 A: Yes.
24 Q: Okay. So I mean the contacts with EMT's
25 generally pretty limited?

1 A: Well, when a patient ---
2 **THE COURT:** Mr. Wicevic, you're getting into a line
3 of questioning that's ---
4 **MR. WICEVIC:** More cross?
5 **THE COURT:** Yeah. That goes more into cross.
6 **MR. WICEVIC:** Okay. There's no further questions,
7 Your Honor.
8 **THE COURT:** Okay. Now, Mr. Rothstein, you're
9 seeking to have this witness ---
10 **MR. ROTHSTEIN:** Qualified as an expert witness in
11 the area of general principles of trauma
12 surgery as well as the area of diagnosing and
13 treating patients with penetrating knife wounds
14 to the abdomen.
15 **THE COURT:** Based upon his training and the
16 experience that I've heard, I think that he's
17 qualified in those areas.
18 **MR. ROTHSTEIN:** Thank you, Your Honor.
19 **THE COURT:** And I will allow him to testify as an
20 expert.
21 **DR. DEANGELO - DIRECT EXAMINATION BY MR. ROTHSTEIN**
22 **(CONT.):**
23 Q: Dr. DeAngelo, have you had a chance to review
24 some of the medical records relating to the
25 self inflicted stabbing incident in Iva, South

1 Carolina on March 19th, 2016, where Mr. James
2 Davenport responded to a 9-1-1 call as a
3 paramedic?
4 A: Yes.
5 Q: Have you reviewed other documents other than
6 the medical records from the hospital? Have
7 you reviewed other documents relating to this
8 call?
9 A: I saw the body cam footage.
10 Q: Okay. Have you seen the patient care report
11 that was prepared by the civilian EMT crew?
12 A: I saw the chart when the patient came into the
13 ER.
14 Q: Is that notebook still up there? I'm going to
15 ask you to look at Exhibit 11b.
16 A: Okay. I did see this.
17 Q: Okay. And can, for the record, you identify
18 what Exhibit 11b is?
19 A: this is the records kept by the ambulance crew.
20 Q: Okay. And I think you mentioned you viewed the
21 body worn camera video footage taken by an Iva
22 police officer who was on the scene at that
23 incident?
24 A: Yes.
25 Q: Okay. Now I'd like to turn your attention to

1 that specific report that you were just looking
2 at. Can you tell from looking at the patient
3 care report whether or not the patient was
4 stable from the time Mr. Davenport and his
5 partner arrived on the scene until they
6 delivered the patient to the ED at AnMed
7 hospital?
8 A: Yes, I can tell.
9 Q: Okay. And do you have an opinion to a
10 reasonable degree of medical certainty about
11 whether that particular patient was stable
12 during that time period?
13 A: Yes, I would say stable.
14 Q: Okay. What were the patient's vital signs en
15 route to the hospital as reported in that
16 patient care report?
17 A: A blood pressure of 129 over 83, and a second
18 blood pressure of 128 over 88, with a pulse of
19 88 on both those blood pressures.
20 Q: Okay. Are the blood pressures and pulses
21 within normal limits for a stable patient?
22 A: Yes.
23 Q: And do you recall when you looked at the
24 medical records from the AnMed hospital, were
25 the patient's vital signs similar once he

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

1 of this patient from the scene to the hospital?
2 A: No.
3 Q: Do you have an opinion to a reasonable degree
4 of medical certainty about whether this patient
5 needed supplemental oxygen during the pre-
6 hospital care?
7 A: My opinion is he didn't need it.
8 Q: What is that opinion based on?
9 A: The fact that he's 98 percent on what we say
10 room air. In other words he's breathing air is
11 98 percent which is a completely normal
12 saturation.
13 Q: Do you know whether this patient received
14 supplemental oxygen after the ambulance crew
15 dropped him off at the ED?
16 A: I don't know.
17 Q: Do you have an opinion -- or let me ask you
18 this. When you were viewing the body cam video
19 footage, did you have an opportunity to observe
20 the patient, see the color of his skin and
21 listen to the tone of his voice?
22 A: I probably couldn't see the color of his skin
23 too well on the body cam, but I could observe
24 his face and his -- I could get a good idea of
25 how he looked.

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

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

1 you, they won't let you put it in and so forth.
2 I think that since his vital signs are stable,
3 you know, you weight the benefits versus the
4 risks. I don't think -- in my opinion is it
5 was a good judgement call to forego IV's and
6 just get him to the hospital.
7 Q: And I've had IV's before. I imagine the --
8 just for the record, an IV involves sticking a
9 needle through somebody's skin and into a vein?
10 A: Yes.
11 Q: Can that be a painful procedure?
12 A: Yes.
13 Q: Okay. And have you had experience or observed
14 a patient that being stuck with an IV, sort of
15 pulled away from it for flinched?
16 A: Yes.
17 Q: Is that a potentially dangerous situation where
18 you have a patient with a knife impaled in
19 their belly?
20 A: Yes. You don't want them to really make any
21 sudden movements.
22 Q: Do you have an opinion to a reasonable degree
23 of medical certainty about whether this
24 particular patient needed any type of
25 medication during the pre-hospital setting?

1 A: I would say he didn't need anything.
2 Q: Do patients with mild distress typically need
3 pain medication?
4 A: No.
5 Q: Do patients with a pain assessment of four out
6 of ten generally need pain medication to be
7 administered by a paramedic?
8 A: No.
9 Q: If this particular patient had nicked his small
10 bowel when the knife went in and caused some
11 type of potential infection. Is there any
12 medication that the paramedic could administer
13 to treat that condition?
14 A: No.
15 Q: How does that type of a condition need to be
16 treated?
17 A: The patient needs to go to surgery.
18 Q: Okay. Can a patient with a knife impaled in
19 his abdomen still be considered a stable
20 patient?
21 A: Yes.
22 Q: Now if you'll look back at Exhibit 25, does
23 that patient appear to be in pain?
24 A: No.
25 Q: Okay. I'm sure you have patients or observe

1 patients come to the ED a lot that are
2 complaining of pain and are either drug seeking
3 or sort of faking pain, is that right?
4 A: Yes.
5 Q: And do you have any sort of telltale signs
6 about when you see a patient laying on a
7 stretcher whether he's truly in pain or not?
8 A: They would have their ankles crossed.
9 Q: Okay. Does this patient in photograph 25
10 appear to be fairly relaxed?
11 A: Yeah. He has his hands resting on his abdomen
12 across -- not so much across, but sort of just
13 holding them. He even looks relaxed.
14 Q: Let me show you another photograph.
15 **MR. ROTHSTEIN:** Let me see the stack.
16 Q: I'm going to show you what's been marked, it
17 was actually introduced as Exhibit 24. And
18 I'll represent to you that's a close up of the
19 same patient that was in Exhibit 25. I know
20 you can't see his face but ...
21 A: Yes.
22 Q: Now focusing on the stabilization or the
23 dressing around the knife, does that appear to
24 be appropriately stabilized in place?
25 A: Yes.

1 Q: What do you believe was the most important sort
2 of critical component or the first thing that
3 needed to be done when emergency crew came to
4 this scene and saw a patient with a knife
5 impaled in his belly?
6 A: Most important thing would be -- my opinion
7 would be the most important thing would be to
8 get him into the ambulance and to the hospital.
9 Q: Is it important to keep the knife from moving
10 any further?
11 A: Yes.
12 Q: Okay. What would happen if the EMT just pulled
13 the knife out of the patient's abdomen? Or
14 what could happen?
15 A: If the knife was sitting in an organ or a
16 structure such as the aorta or the spleen that
17 had the potential to bleed a lot, the feeling
18 to my knowledge is that with the knife sitting
19 in there, it may actually have penetrated that
20 structure. The fact that it's still in there
21 is keeping that structure from just, you know,
22 bleeding explosively. So it's felt that the
23 knife should be left in place until the patient
24 gets to the hospital. And even then, to my
25 knowledge, these type of injuries the knife is

1 not taken out until you're actually in the
2 Operating Room in case removing the knife
3 causes some change structurally inside, such as
4 the patient suddenly starts to bleed a lot.
5 You're in the Operating Room, you can take care
6 of it.
7 Q: If an EMS crew in Atlantic City delivered a
8 patient with a similar self inflicted stabbing
9 wound to the trauma bay that you work at in the
10 condition that this patient appears to have
11 been left at AnMed in South Carolina, would you
12 think that the paramedic crew had done their
13 job appropriately?
14 A: Yes.
15 Q: Now you mentioned the body cam video. In your
16 observations of Mr. Davenport's interactions
17 with this stabbing patient, did you see
18 anything in the footage to support an
19 accusation that Mr. Davenport treated this
20 patient below the standard of care?
21 A: No.
22 Q: In your experience with trauma patients,
23 specifically with those with impaled objects in
24 their abdomen that had been stabilized first,
25 is allowing such a patient to walk at his own

1 pace with assistance for a short distance an
2 unreasonably dangerous manner of moving that
3 patient?
4 A: Can you say that again please?
5 Q: Yeah. That was a long one. In your experience
6 with trauma patients, specifically those with
7 impaled objects in their abdomen that have been
8 stabilized, is allowing that patient to walk
9 with slight assistance under their own power
10 from the scene to the ambulance an unreasonably
11 dangerous risk?
12 A: In this case I would say no because I know from
13 discussions that the patient was known to the
14 EMS services, he was known to have psychiatric
15 history, and he may not have liked being laid
16 down on the stretcher and might have put up a
17 fuss. So in that case I think having him
18 slowly walk out of the house with support,
19 supporting him as he slowly walks out of the
20 house down the steps I think is very acceptable
21 in order to keep him from making any jerky or
22 sudden movements. And then I know that when
23 they got him into the ambulance they then laid
24 him down. I think all of that is sound
25 judgement in my opinion.

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

1 Q: Okay. How long have you been a Colonel?
2 A: I actually don't remember. I think it's about
3 two years.
4 Q: I think it may be on your CV.
5 A: Yeah.
6 Q: Are you familiar with the United States Army
7 Special Forces or Green Berets?
8 A: Yes.
9 Q: Okay. Have you ever worked with any United
10 States Army Special Forces groups?
11 A: Yes.
12 Q: Are you familiar with the training that Special
13 Forces Medics receive?
14 A: Yes.
15 Q: Can you describe sort of generally the training
16 that Special Forces Medics have to undergo
17 before they actually become Special Forces
18 Medics, or 18-Deltas?
19 A: Yes. They undergo, I think about a year long
20 instruction in which they learn the basic
21 physiology and then they advance to learn about
22 pharmacy and medications. They get a lot of
23 instruction in surgical technique. I think
24 more so than most other branches of the
25 military. They can do a lot of surgical

1 procedures independently. Many other
2 practitioners don't. They get instructions on
3 placing chest tubes, on intubating patients, on
4 doing surgical airways, on doing suturing, and
5 amputations, completions of amputations. They
6 go through a long medical course in order to
7 become Special Forces Medic or an 18-Delta as
8 they're called. And then after that they have
9 to maintain their qualifications through
10 regularly attending a course in combat trauma
11 management which I assist in. They also do
12 rotations in local ER's and trauma centers.
13 They do several training events every year in
14 order to maintain their proficiency.
15 Q: How does the training that an SF Medic
16 receives, or the education in anatomy and
17 physiology compare to say your training for
18 medical school?
19 A: It's very close to what we receive.
20 Q: And you mention these various rotations. How
21 do those rotations that Special Forces Medics
22 go through as part of their training compare to
23 say an internship or a first year out of
24 medical school?
25 A: I would say a Special Forces Medic is easily

1 the equivalent of a civilian, what we call a
2 physician's assistant. And the experience
3 Special Forces Medic, just in my opinion, this
4 is just my opinion, can be as well trained and
5 experienced as a surgical intern.
6 Q: How does the skill set and scope of practice of
7 a Special Forces Medic compare to other types
8 of medical professionals in the civilian world?
9 I think you mentioned a physician's assistant.
10 A: Yes. A physician's assistant can do surgical
11 procedures, but directly under, you know in a
12 civilian hospital and a physician has to always
13 be supervising them. A Special Forces Medic is
14 trained to do surgical procedures such as chest
15 tubes, surgical airways, and amputations. That
16 medic is trained to do those procedures
17 independently because obviously if you're
18 deployed in a austere hostile environment,
19 there's not going to be a physician nearby to
20 supervise you. You have to be trained to do it
21 on your own.
22 Q: Are Special Forces Medics trained on critical
23 thinking skills?
24 A: Yes.
25 Q: Are Special Forces Medics trained on patient

1 assessments?
2 A: Yes.
3 Q: Are you aware of sort of the wash out rate is
4 in training to become a Special Forces Medic?
5 A: I can't give you a number, but -- I can't give
6 you a number. But I would think that it's
7 pretty high?
8 Q: You think it's higher than a general surgery
9 residency?
10 A: Yes.
11 Q: Can one make it thought the Special Forces
12 training and become a Special Forces Medic or
13 an 18-Delta without possessing substantial
14 skill in critical thinking and patient
15 assessment?
16 A: No.
17 Q: How do you know James Davenport?
18 A: We've served together in the 20th Group for a
19 couple years.
20 Q: Okay. And what is the 20th Group?
21 A: The 20th Special Forces Group is one of two
22 National Guard Special Forces Groups. 19th and
23 20th Group.
24 Q: And what is the sort of the mission of the 20th
25 Group generally?

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

1 A: No. I would have no issue.
2 Q: Do you believe that Mr. Davenport is a
3 compassionate health care provider?
4 A: Yes.
5 Q: Have you ever witnessed Mr. Davenport provide
6 medical care to people that he was not
7 particularly fond of?
8 A: I don't think that he really dislikes anyone.
9 Q: Are you aware of Special Forces Medics,
10 including Mr. Davenport, providing medical
11 attention to enemy combatants in hostile ---
12 A: Yes.
13 Q: --- territory?
14 A: Yes. I am aware of that.
15 Q: Do you believe that Mr. Davenport is a
16 dedicated medic?
17 A: Yes.
18 **MR. ROTHSTEIN:** I don't have any further questions,
19 Your Honor.
20 **THE COURT:** Okay. Mr. Wicevic.
21 **MR. WICEVIC:** Thank you, Your Honor.
22 **DR. DEANGELO - CROSS-EXAMINATION BY MR. WICEVIC:**
23 Q: Okay. Dr. DeAngelo, how were you retained to
24 be an expert in this matter?
25 A: I am friends with James Davenport.

1 Q: Okay. Are you being compensated for this
2 testimony?
3 A: No.
4 Q: No? I think you mentioned there were -- you
5 are in the National Guard with Mr. Davenport --
6 -
7 A: Yes.
8 Q: --- and have been deployed at the same time.
9 What about Mr. Leo Deason? Any relationship
10 with him? Do you know who Leo Deason is?
11 A: No.
12 Q: Okay. Is it accurate to say that you and Mr.
13 Davenport maintain a friendship?
14 A: Yes.
15 Q: Do you communicate often?
16 A: Yes.
17 Q: About how often?
18 A: About once a month.
19 Q: Okay.
20 A: At most once a month. Sometimes more. I'm
21 sorry.
22 Q: Sure. Do you ever visit Mr. Davenport?
23 A: No.
24 Q: Have you met Mr. Davenport's family?
25 A: No.

1 Q: Okay. You mentioned you were deployed at the
2 same time, but in a different battalion? I'm
3 not sure if I'm using the ---
4 A: Well when you're deployed, especially in
5 Special Forces you spread out throughout the
6 country. So I can't say that I actually was
7 side by side with James.
8 Q: You testified that you worked with the Special
9 Forces Medics ---
10 A: Yes.
11 Q: --- on a regular basis?
12 A: Yes.
13 Q: Now while serving in the military, you develop
14 close bonds with your fellow service members,
15 correct?
16 A: Yes.
17 Q: That' especially true if you're begin deployed?
18 A: Yes.
19 Q: Okay. You become almost like family?
20 A: Yes.
21 Q: Now you did some equivalence to a Special
22 Forces Medic to a physician's assistant and
23 surgical intern. Now you understand that when
24 you come back to The States there's licensor
25 for such professions, correct?

1 A: Yes.
2 Q: Okay. Now I understand you're very familiar
3 with the practice of trauma surgery and various
4 wounds. But you're not familiar with general
5 EMS practice, civilian EMS practice, correct?
6 A: No.
7 Q: Okay. Now your work on this case, about how
8 many hours do you think you've taken in
9 reviewing this matter?
10 A: I'm going to say five hours.
11 Q: Okay. You read the patient care reports, you
12 reviewed the body cam footage?
13 A: Yes.
14 Q: The medical records?
15 A: Yes.
16 Q: Did you review the witness statement?
17 A: Witness statement? I'd have to say no.
18 Q: Okay. And I imagine you consulted with Mr.
19 Davenport, correct?
20 A: Yes.
21 Q: Okay. And just to clarify again, you mentioned
22 that you're not familiar with generally
23 accepted emergency medical treatment standards,
24 is that correct?
25 A: I'm not a paramedic. I don't supervise

1 paramedics. But I do, you know -- our patients
2 get brought to us by paramedics, so I do have
3 some contact with them.
4 Q: Okay. I mean do you review reports from
5 paramedics?
6 A: I don't -- I review them because they become
7 part of my patient's charts, but I don't review
8 them in the respect that I look at them to see
9 if they -- that I evaluate them and decide
10 whether anything was done right or wrong.
11 Q: Right. Well that's important, right? I mean
12 you're looking for full documentation of the
13 continuum of care?
14 A: Yes.
15 Q: So any kind of care provided by an EMT, you'd
16 expect that to be documented, correct?
17 A: Yes.
18 Q: Okay. So, I mean, generally your testimony
19 here is limited to medical judgement of this
20 particular injury of the patient, correct?
21 A: Yes.
22 Q: Again, you're not testifying about -- you're
23 not familiar with civilian paramedicine?
24 A: No
25 Q: All right. You've never practiced here in

1 South Carolina as a physician, correct?
2 A: No.
3 Q: You never practiced as a Medical Control
4 Physician?
5 A: No, I haven't.
6 Q: Are you aware of the types of orders and
7 protocols that Med. Control Physician has for
8 the paramedics?
9 A: No.
10 Q: Okay. Do you know what the National Registry
11 of EMT's is?
12 A: Yes.
13 Q: Okay. Is it your understanding that that's the
14 accrediting body?
15 A: Yes.
16 Q: Okay. And you're mostly familiar, based upon
17 experience, with the Special Forces Medics,
18 correct?
19 A: Yes.
20 Q: And I think you mentioned in your direct
21 testimony that Special Forces Paramedics have
22 much more skills than civilian paramedics. Is
23 that correct?
24 A: Yes.
25 Q: They receive much more training and education?

1 A: Yes.
2 Q: And they see some pretty gruesome injuries in
3 the battlefield, correct?
4 A: Yes.
5 Q: Okay. And they're often left on their own to
6 treat those types of injuries, correct?
7 A: Yes.
8 Q: I mean, you even said they're akin to a
9 physician's assistant, and that would be in
10 respect to their decision making authority?
11 A: Their level of training, their skill level with
12 procedures they can do.
13 Q: Would you say the decision making authority for
14 a Special Forces Medic because of the
15 environment and the injuries that they
16 confront, I mean they have pretty much
17 unlimited discretion?
18 A: I wouldn't -- I'm uncomfortable with the word
19 unlimited. But they do have a lot of
20 desecration to make their own decision. They
21 kind of have to.
22 Q: Check the injury, assess the environment, and
23 they make their own decisions based upon their
24 training and education?
25 A: Yes.

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

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

1 ports and that was it. The patient, as far as
2 I know the patient went home the next day.
3 Q: Dr. DeAngelo, so the patient didn't have any
4 intra-abdominal injury, but the knife did
5 penetrate the peritoneum ---
6 A: Yes.
7 Q: --- is that correct?
8 A: Yes.
9 Q: And that's the -- is it I guess the membrane or
10 the cavity?
11 A: It's a thin tissue like a skin that surrounds
12 all the contents of your abdomen. It's like a
13 skin. It protects the abdominal contents.
14 It's very highly innervated. That's why as
15 soon as the knife hits the peritoneum, these
16 patients will stop at that point.
17 Q: You said it was very painful to have this kind
18 of puncture?
19 A: Yes.
20 Q: Did you see how the patient characterized this
21 patient in the emergency department records?
22 A: Yes, I did. But I have to find that.
23 Q: Well let me refer you. It's Exhibit 7, or
24 excuse me 6 in the DHEC ---
25 **MR. ROTHSTEIN:** Your Honor, I'm going to object to

1 this exhibit. This exhibit's not in evidence
2 and I think what Mr. Wicevic is getting ready
3 to ask would be double or triple heresay.
4 **MR. WICEVIC:** Well I do have an affidavit record
5 custodian for this, and I was planning on
6 getting it into evidence. That being said,
7 experts can rely on heresay. He relied on this
8 document in his review of this case. So I
9 think it's well within my authority to question
10 him.
11 **MR. ROTHSTEIN:** Well the fact that he relied on it
12 doesn't mean it's admissible into evidence.
13 And the records custodian affidavit is not the
14 ER physician that makes the statements that are
15 in those records. Mr. Wicevic may have gotten
16 past the first layer of heresay in terms of
17 this was a business record of AnMed, but he
18 can't get past the second layer of heresay,
19 which is the statements that the doctor made in
20 the report itself. And, Your Honor, this is
21 getting back to the issue of DHEC doing no
22 investigation. They didn't talk to the
23 emergency room doctor, they didn't talk to the
24 surgeon in this case, they only got these
25 emergency room records and the OR records on a

1 subpoena that was issued in June of this year,
2 about a month ago. And so, I object to this
3 document actually coming into evidence.
4 **MR. WICEVIC:** Well, Your Honor, he just laid out a
5 number of his alleged issues with this. Like
6 I said, I was going to offer this into evidence
7 during our case through one of DHEC's
8 witnesses. They did obtain this during our
9 investigation. We issued a subpoena and
10 obtained it that way in order to establish a
11 chain of custody. We have an affidavit record
12 custodian. I think the business records
13 exception applies directly here. These are
14 observations and diagnoses and conditions that
15 the emergency room physician who signed off on
16 this as well as the emergency room nurse who
17 also signed off on it observed. So I think it
18 would fit within the business records
19 exception. Again, my purposes of questioning
20 Dr. DeAngelo was because he relied on this
21 medical record.
22 **THE COURT:** Now is this the medical record that your
23 witness has seen before?
24 **MR. ROTHSTEIN:** He's reviewed it before, Your Honor,
25 but that still doesn't address the rule.

1 Evidentiary rule says that expert witnesses can
2 rely on things that are not admissible into
3 evidence. And the fact that he looked at it or
4 reviewed it does not make that document
5 admissible as a document here. And the fact
6 that it might be a business record and that Mr.
7 Wicevic might have an affidavit from the AnMed
8 person saying, this is a business record only
9 gets past the first layer of heresay. Your
10 Honor probably recalls from evidence in law
11 school, if you have multiple layers of heresay,
12 every layer of heresay has to have an
13 exception, and the doctor's statements -- this
14 is not the patient asking the doctor something.
15 A statement made for purposed of medical
16 treatment is an exception to heresay rule. But
17 what the doctor writes or what the nurse writes
18 in the note about his or her own observations
19 is heresay. And, Your Honor, I had no
20 opportunity to cross-examen the emergency room
21 doctor here. I had no opportunity to cross-
22 examine the nurse, and that's the whole point
23 of heresay is it's unreliable and it's
24 inadmissible in a proceeding like this.
25 **MR. WICEVIC:** Well, Your Honor, I haven't even moved

1 to admit it at this point. I was asking Dr.
2 DeAngelo about it 'cause it's something he
3 relied in providing his testimony. Mr.
4 Rothstein referred to the medical record a
5 number of times in his direct testimony. I
6 mean he asked him what kinds of surgery he had,
7 so I think it's fully within my authority to
8 question him.
9 **THE COURT:** Okay. So this is not a document that
10 you at this point, you're not offering ---
11 **MR. WICEVIC:** That's correct.
12 **THE COURT:** --- it for evidence?
13 **MR. WICEVIC:** That's correct.
14 **THE COURT:** Just asking him to refer to a document
15 that he reviewed in preparing for is testimony?
16 **MR. WICEVIC:** He testified that he reviewed it.
17 Yes, Your Honor.
18 **THE COURT:** I'm going to allow him to refer to it.
19 **MR. WICEVIC:** Thank you, Your Honor.
20 **THE COURT:** And you can refer to it in your
21 questioning.
22 Q: Dr. DeAngelo, according to the medical record,
23 what was this particular patient's pain level
24 on admission?
25 A: Can I look at it 'cause I don't have it?

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

1 Mr. Davenport's in the ambulance bay waiting
2 for his partner to come out from dropping off
3 the patient, they move the patient from the
4 ambulance stretcher to the gurney and they drop
5 the patient or they hit the knife accidentally,
6 and we're talking about the emergency
7 department crew, or if they go to take off the
8 bandaging that Mr. Davenport put on, and they
9 cause the patient some pain by ripping some
10 skin or some hair out of his stomach, his pain
11 level may change from a four to a higher level
12 of pain. But that has nothing to do with Mr.
13 Davenport's level of care that was administered
14 to this patient in the pre-hospital setting.
15 It also doesn't show that the patient was
16 decompensating or that he was going into shock.
17 I mean it just shows that he's experiencing a
18 higher level of pain than he told the EMT's
19 that he was experiencing on the trip to the
20 hospital. It's completely irrelevant, Your
21 Honor.
22 **THE COURT:** I'm not sustaining, but I'm overruling
23 the objection. Excuse me. I'm overruling the
24 objecting. I'm going to allow you to question
25 him.

1 **MR. WICEVIC:** Thank you, Your Honor.
2 Q: Dr. DeAngelo, is Exhibit 6, do you have Exhibit
3 6? It's been tabbed out. Can you identify
4 this document?
5 A: This is ED physician record.
6 Q: And is this the document that you reviewed in
7 your preparation for this case?
8 A: Yes. I have seen this.
9 Q: Okay. And on the first page ---
10 A: Uh-huh.
11 Q: --- towards the bottom there's a vital sign
12 box.
13 A: Yes.
14 Q: What was the pain scale of the patient?
15 A: Pain scale here's nine out of ten.
16 Q: Okay. So you talked about the knife penetrated
17 the peritoneum?
18 A: Yes.
19 Q: Now also at this hospital, isn't it correct
20 that their staff established these IV's? You
21 can turn to the next one.
22 A: I'm not sure where it says ... Yes. It says
23 here, yes. They did establish IV's at the
24 hospital.
25 Q: Okay. And they administered a 1,000 milliliter

1 bolus of normal saline solution, is that
2 correct?
3 A: Yes.
4 Q: Okay. And tell The Court what normal saline
5 solution's for.
6 A: It's a salt solution that's used to expand the
7 blood volume and to maintain the blood
8 pressure.
9 Q: Okay. And it appears that according to this
10 page 2 of Exhibit 6 ---
11 A: Yes.
12 Q: --- it was scheduled at 2157? Is that the
13 scheduled date and time? Is that what that
14 column refers to?
15 A: Schedule date time. I assume so. I'm not
16 really sure what the ---
17 Q: Are you familiar with these types of ---
18 A: No. Our hospital doesn't use that term. But,
19 you know, my guess common sense is, yes.
20 Schedule date and time.
21 Q: Okay.
22 A: That's probably what it means.
23 Q: And if you turn back to the previous page, it
24 looks like they arrived at 2154. Is that
25 correct?

1 A: Yes.
2 Q: And that was a 1,000 milliliter bolus of normal
3 saline solution. Was there another IV? It
4 looks like ertapenem was established or ---
5 A: They gave antibiotics.
6 Q: Okay. And again, that was scheduled at 2206?
7 A: Yes.
8 Q: Okay. Are you familiar with trauma alerts?
9 A: Trauma alerts?
10 Q: Yes, sir. Do you know what a trauma alert is?
11 A: Trauma alert is an activation of the trauma
12 team by the paramedics.
13 Q: Okay.
14 A: They call ahead and say, we're bringing this
15 patient and we want him to be a trauma alert.
16 Q: Okay. And when did that occur for this? It
17 looks like 2155? If you look back on that page
18 2, a little bit above the IV discussion.
19 A: Yes. Scheduled date and time, 2155.
20 Q: Okay. And it appears the patient was out of
21 the emergency room in less that 30 minutes. Is
22 that correct?
23 A: Yes. I'm pretty sure.
24 Q: I mean that's common for a trauma patient,
25 correct?

1 A: Yes.
2 Q: Okay. 'Cause time is of the essence in caring
3 for such a patient?
4 A: Yes.
5 Q: Have you ever heard of the golden hour?
6 A: Yes.
7 Q: And that's the principle that time is of the
8 essence and you need to get that patient to the
9 Operating Room and cared for?
10 A: Yes.
11 Q: Okay. Now is it your position that this
12 patient was hemodynamically stable throughout
13 Mr. Davenport's care?
14 A: Yes.
15 Q: Now isn't it correct that he did present with
16 the possibility to decompensate?
17 A: Yes.
18 Q: I mean the nature of his injury created that
19 possibility?
20 A: Yes.
21 Q: Okay. It's also correct that this injury could
22 have involved multiple systems?
23 A: From the location of the knife and the fact
24 that he's comfortable and his vital signs are
25 stable, there is the possibility, but it's not

1 a high probability that anything vital was hit.
2 Q: Yes, sir. Well you don't know how long that
3 knife is, correct?
4 A: No.
5 Q: I mean there's no way to know the length of the
6 knife until you get it out during surgery,
7 correct?
8 A: Not when you first encounter the patient, you
9 don't know.
10 Q: And is there a reasonable way to know the path
11 of the knife?
12 A: You can't be sure of it. But you have a good
13 idea from the way it's sitting in his body what
14 the path was.
15 Q: Okay.
16 A: But you can't really know for sure until you
17 take him to the Operating Room what the path
18 was.
19 Q: And there's no way to know with certainty at
20 the scene of the accident whether the organs
21 were actually punctured, correct?
22 A: I'll say, yeah, you're correct. You don't have
23 any certainty. But, you know, you have
24 probabilities.
25 Q: Okay. And I think you talked about this

1 patient in question, that he had a psycho-
2 social history, correct?
3 A: Yes.
4 Q: He had a history of attempted suicides?
5 A: Yes.
6 Q: Overdosed, were you aware of that?
7 A: No, I wasn't.
8 Q: Okay. Were you aware that he had a self
9 inflicted gunshot wound?
10 A: No. I don't recall that, but I was told that
11 he had done a similar -- stabbed himself
12 previously.
13 Q: Okay. And you talked about patients with these
14 psychiatric conditions requiring some special
15 attention, correct?
16 A: Yes.
17 Q: You'd agree that they need a supportive
18 approach, is that fair?
19 A: Yes. Yes.
20 Q: Okay. Now, a principle of, I guess medicine in
21 general, is to prevent the preventable. Is
22 that fair?
23 A: Yes.
24 Q: Okay. Is it your position that the only time
25 a patient should have an IV is when he or she

1 is hemodynamically unstable or when they need
2 medications?
3 A: Can you repeat that?
4 Q: Under what circumstances should a patient
5 receive an IV?
6 A: It's my opinion -- again we said I'm not a
7 paramedic, but in my opinion, you would put an
8 IV if you need to give them a medication or if
9 their vital signs are unstable. Those are two
10 things that come immediately to my mind.
11 Q: Is that even if you know they're going to get
12 an IV at some point for surgery?
13 A: Can you say that one more time?
14 Q: Let me back up a little bit. If you're having
15 surgery, are you going to require an IV?
16 A: Yes.
17 Q: Okay. So it makes sense if you're going to
18 require an IV for surgery, why not establish
19 it, correct?
20 A: You mean -- I don't want to put words in your
21 mouth. Are you trying to ask me why not
22 establish it as soon as possible, like in the
23 field?
24 Q: Would that be appropriate?
25 A: I would say the patient doesn't need it in the

1 field. You shouldn't establish it at that
2 time.
3 Q: So when would a patient need it, need an IV?
4 A: When they're going to go to the OR they'll do
5 it either in the ER or they'll actually do it
6 when they get to the OR.
7 Q: Okay. So ---
8 A: This is just my opinion, but in surgery in
9 general we don't consider IV's that are placed
10 in the field -- I'm not a nurse either but,
11 IV's that are placed in the field, once the
12 patient has stabilized and out of surgery and
13 all that, the nurses kind of take that out as
14 soon as they can 'cause that IV was put in on
15 the roadside somewhere. We don't consider it
16 as clean as one put in in the ER or the OR.
17 Q: So the only times in which a, you believe, an
18 IV should be established is when there's some
19 kind of hemodynamic instability?
20 A: Yeah. If his blood pressure is very low and
21 you got to get it up somehow, put an IV in and
22 give him a liter of normal saline. Or if the
23 patient is unconscious and he's not breathing,
24 he has some sort of an injury, usually a head
25 injury, that's causing him to shut down his

1 normal reflex to breath, and you're going to
2 need to intubate him, and in order to intubate
3 somebody you need to give them drugs, you give
4 them muscle relaxers. He'd need an IV to
5 intubate. Those are just two examples that come
6 immediately to my head. Those are, you know --
7 that's when you'd put an IV.
8 Q: Now when you become hemodynamically unstable,
9 you start to lose access to establish an IV.
10 Is that correct?
11 A: I'm not really sure what you're asking.
12 Q: As you become hemodynamically unstable ---
13 A: You mean as your blood pressure drops?
14 Q: Yes, sir. Doesn't it became more difficult to
15 establish an IV?
16 A: Yes, it does.
17 Q: Okay. Now taking the approach of waiting for
18 that instability to establish an IV, that
19 wouldn't be using an abundance of caution,
20 correct?
21 A: I would say -- the answer is yes. But your
22 judgement comes into play. As we discussed
23 before, this particular patient -- the
24 judgement and I agree with it, was that that it
25 would be better not to get him agitated with an

1 IV that he didn't need at that moment. All
2 though when a patient becomes unstable and you
3 have their blood pressure starts to fall, it's
4 more difficult to put an IV, but a good
5 paramedic will get an IV even if their blood
6 pressure is very low.
7 Q: Do you understand that an EMT basic rode this
8 call in?
9 A: Yes.
10 Q: Do you understand that an EMT basic is not
11 certified to establish an IV?
12 A: Yes.
13 Q: Would that raise concerns?
14 A: No because, again, because the patient was
15 stable, and also wasn't the paramedic very
16 close by? Again, I don't ride ambulances, but
17 I think the paramedic was driving the
18 ambulance.
19 Q: That's correct.
20 A: Yeah.
21 Q: But you acknowledge that somebody's blood
22 pressure, particular with this type of trauma,
23 could drop rapidly?
24 A: Yes.
25 Q: And critical trauma would include this type of

1 penetrating abdominal injury, correct?
2 A: Yes.
3 Q: Okay. Now are you familiar the ACS's committee
4 on trauma advanced trauma life support?
5 A: Yes.
6 Q: Okay. Is that a course?
7 A: Yes. I have to be certified in that for my
8 job.
9 Q: Let me hand you this treatise. Now can you
10 identify this, Dr. DeAngelo?
11 A: Yeah. It's the ATLS manual.
12 Q: Okay. And you said you were certified by the
13 American College of Surgeons. Is that correct?
14 A: Yes.
15 Q: Is this kind of the go to guide for trauma
16 care?
17 A: Yes.
18 **MR. ROTHSTEIN:** Your Honor, I object to this
19 document. There's no evidence that this
20 applies to paramedics. I mean this is -- I
21 mean the cover of it has people with surgical
22 masks on. This is the American College of
23 Surgeons. This is not relevant to the standard
24 of care of a pre-hospital provider, even a
25 nationally registered paramedic.

1 **MR. Wicevic:** Well he talked -- I mean he's not a
2 paramedic and he's providing testimony about
3 his observations and opinions on this matter.
4 Dr. DeAngelo can testify about whether he
5 agrees with this. I think there's some vital
6 points in here that are inconsistent with his
7 testimony in Mr. Davenport's case. And we
8 don't -- he hasn't testified to anything
9 regarding this particular treatise not being
10 applicable to EMT's. That's something that Mr.
11 Rothstein purported.
12 **THE COURT:** Your claim is this treatise applies to
13 paramedics?
14 **MR. WICEVIC:** My understanding is it's used for all
15 types of providers. It's developed by the
16 American College of Surgeons but that doesn't
17 mean it's only for surgeons or physicians. I
18 can ask him to explain -- I can ask Dr.
19 DeAngelo to explain what this is for and who
20 takes the ATLS courses.
21 **THE COURT:** Okay. I'm going to let you get into it.
22 And just hold Mr. Rothstein's objection in
23 abeyance for the time being.
24 **MR. WICEVIC:** Yes, Your Honor.
25 Q: Dr. DeAngelo, what types of providers attend

1 the ATLS courses?
2 A: Physicians.
3 Q: Is it limited to physicians?
4 A: I think PA's have. I honestly am not sure.
5 Q: So you're testimony is pre-hospital providers,
6 EMT's do not attend this?
7 A: No. I believe there's a specific course for
8 them. Again, this is out of my lane because
9 I'm not a paramedic. But I believe there's
10 something called PHTLS, pre-hospital ATLS that
11 the paramedics attend.
12 Q: Okay.
13 A: This manual tells you what to do once they come
14 through your door.
15 Q: Okay. But again, all of your expert testimony
16 is based upon your understanding of that point
17 inside the door, correct?
18 A: Yes.
19 Q: Inside the hospital door?
20 A: Yes.
21 Q: You have no experience with pre-hospital
22 medicine?
23 A: No.
24 Q: Okay.
25 **MR. WICEVIC:** I'll move on, Your Honor.

1 Q: Now Mr. Davenport's behavior and verbal
2 interactions, would you characterize him as
3 being rude or unprofessional in your review of
4 the body cam footage?
5 A: No.
6 Q: No? Not intimidating?
7 A: No.
8 Q: Would it raise a concern with you if you
9 witnessed a coworker acting in a similar
10 manner?
11 A: No.
12 Q: You've never spoken to a patient like that,
13 have you?
14 A: No.
15 Q: Would you agree that's a way to gain the
16 confidence of a particular patient?
17 A: Can you say the question again?
18 Q: Sure. Mr. Davenport's interactions with this
19 particular patient, would you see that as an
20 effective way to gain that patient's
21 confidence?
22 A: From watching the body cam, I think his -- the
23 way he conducted himself was fine. I think it
24 was okay.
25 Q: So if you saw this in a hospital you won't

1 report it?
2 A: I can't answer that.
3 Q: Why is that?
4 A: I'm not sure what to say. But from looking at
5 the body cam I think his demeanor conveyed
6 concern for the patient.
7 Q: Okay. So it wasn't calming for him, was it?
8 A: Huh?
9 Q: Was it calming to the patient, were Mr.
10 Davenport's interactions calming to the
11 patient?
12 A: I think they were.
13 **MR. ROTHSTEIN:** Your Honor, I think you'd have to
14 ask the patient that. Was it calming to the
15 patient? That's something only the patient
16 could answer, and they haven't asked the
17 patient that.
18 **MR. WICEVIC:** I think he can observe. Is
19 observations ---
20 **THE COURT:** I'm going to allow you to ask the
21 question. The objection is overruled.
22 Q: Dr. DeAngelo, did Mr. Davenport's affect to
23 this patient appear to calm him?
24 A: Yes. Yes.
25 Q: Okay.

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

1 abdomen include the stomach, the spleen, colon,
2 and potentially diaphragm, is that correct?
3 A: Spleen and diaphragm I'm not sure are in the
4 area where the knife is.
5 Q: Okay. So that would leave the stomach and
6 colon?
7 A: Yes. And small bowel.
8 Q: And small bowel?
9 A: Yeah.
10 Q: Would puncture to one of those organs cause
11 serious physical harm?
12 A: You would require surgery for it, so yes. But
13 it wouldn't make your vital signs unstable.
14 Q: Okay. And, I mean, moving a patient with an
15 impaled object would cause some level of
16 movement, correct?
17 A: You mean moving them -- how do you mean ---
18 Q: Well, ambulating them. Walking them.
19 A: You know, yes. But I think in this case it was
20 a good judgement call.
21 Q: Now you're not familiar with various carrying
22 devices used by EMT's, correct?
23 A: I've seen them as they come through as they're
24 brought in by the paramedics, but I don't use
25 them.

1 Q: Okay. Now by walking this patient, isn't it
2 correct that there was a possibility for
3 further injury?
4 A: Yes. But there's a possibility for further
5 injury pretty much any way you move them.
6 Q: Right. It's about minimizing that?
7 A: Yes. Yes. It's a judgement call.
8 Q: And that's particularly -- you know, this
9 minimization of movement is particularly
10 important for penetrating stab wounds, correct?
11 A: Yes.
12 Q: That are in close proximity to organs such as
13 the stomach, colon, small bowel?
14 A: Yes.
15 Q: And you don't regularly see patients with
16 impaled objects walking from the ER to the OR.
17 Is that correct?
18 A: No.
19 Q: A few more questions. Oxygen, can oxygen be
20 used to assist with a patient's pain?
21 A: To assist with pain? No.
22 Q: No? That's not one of the uses?
23 A: No.
24 Q: Okay. That's all the questions I have for you,
25 Dr. DeAngelo. Thank you.

1 A: Okay.

2 **DR. DEANGELO - RE-DIRECT EXAMINATION BY MR.**

3 **ROTHSTEIN:**

4 Q: Just a couple of follow up questions. Getting

5 to that last point. Mr. Wicevic asked if

6 you've ever seen a patient walk from the ER to

7 the OR. Have you ever seen any patient walk

8 into the OR?

9 A: A patient for an elective surgery, say a hernia

10 repair will walk to the OR.

11 Q: Okay. In the trauma bay, have you ever seen a

12 patient walk from the ambulance or the

13 emergency department into the OR?

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

15 Q: Is your personal relationship with Mr.

16 Davenport affect your professional opinions

17 that you've rendered in this case in any way?

18 A: I'm trying to give an unprejudiced opinion, but

19 does it affect me in some ways, probably, yes.

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

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

22 Q: Can you think of anyone in the Special Forces

23 that has had more experience observing Mr.

24 Davenport's skill level, training, and

25 experience than yourself?

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

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

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

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

1 record?
2 A: It says, wound abdominal wall left upper
3 quadrant open without penetration into
4 peritoneal cavity unspecified.
5 Q: Okay. What does that without penetration refer
6 to in that diagnosis?
7 A: That says that whoever wrote this diagnosis
8 felt that it did not penetrate into the
9 peritoneal cavity.
10 Q: If that knife penetrated into the peritoneal
11 cavity say 40 or 45 minutes prior to the
12 patient arriving at the emergency department,
13 what would the condition of the patient's
14 abdomen likely be?
15 A: He'd have a lot more pain. He wouldn't look as
16 comfortable as he does here.
17 Q: If you palpated that patient's stomach, what
18 would you likely ---
19 A: He would have -- if you pushed on his abdomen
20 you would hurt him.
21 Q: Okay. If he had significant bleeding inside of
22 his abdominal cavity, what would the stomach
23 feel like upon palpation?
24 A: He would have pain because blood irritates the
25 abdominal cavity. It hurts.

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

1 right hand and he will swear you.
2 **HARRY DEAN DOUGLAS**, having been duly sworn, testifies
3 as follows:
4 **MR. DOUGLAS - DIRECT EXAMINATION BY MR. WICEVIC:**
5 Q: Well good morning, Mr. Douglas. We've met on
6 a couple of cases now. My name is Peter
7 Wicevic and I represent DHEC. Can you please
8 state your full name for the record, please.
9 A: Harry Dean Douglas.
10 Q: Okay. I'm gonna hand you a document, Mr.
11 Douglas. Look on Exhibit 27 for DHEC. Can you
12 identify Exhibit 27?
13 **(Petitioner's Exhibit Number 27 was marked for**
14 **identification purposes.)**
15 A: Yes, it my curriculum vitae.
16 Q: Okay. And Mr. Douglas, can you tell us about
17 your education beginning with high school?
18 A: I graduated high school from Northern Durham
19 High School in Durham, North Carolina. I went
20 to Western Carolina University in Cullowhee,
21 North Carolina. Received my Bachelors Degree
22 in Emergency Medical Care and then attended
23 Medical University of South Carolina where I
24 received my Master of Health Administration in
25 1994.

1 Q: Okay. Let's back up a little bit to the
2 Western Carolina.
3 A: Uh-huh.
4 Q: When did you graduate from Western Carolina?
5 A: Sorry, in 1986.
6 Q: Okay. And what type of degree was that?
7 A: Emergency Medical Care.
8 Q: Was it a Bachelors Degree?
9 A: Bachelors Degree.
10 Q: Okay. And can you tell the Court about the
11 curriculum for that particular degree?
12 A: The curriculum itself is based on the national
13 standard for paramedic curriculum. It's just
14 expanded a bit. There are additional courses,
15 of course. There's general electives and
16 English and math and that kind of thing that
17 goes along with Bachelors Degrees. But the
18 paramedic portion of it, the core curriculum
19 follows the national standard curriculum but,
20 like I said, is expanded. It goes deeper into
21 each subject.
22 Q: Okay. So can you name some of the subjects?
23 A: Medical emergencies, traumatic emergencies,
24 like that kind of thing. Assessment ...
25 Q: Okay.

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

1 Q: Right, that's what I meant. Thank you for
2 clarifying that. Certification for an EMT, it
3 looked like from your CV you were certified as
4 a Basic in '83. Explain your time as an EMT
5 Basic.
6 A: All right. That was part of the Western
7 Carolina paramedic program. That was, I
8 believe, our sophomore year. We take the EMT
9 class, become certified as an EMT and that
10 allows us to perform as a paramedic student.
11 Also gives us a certification and so I worked
12 summers and weekends and holidays as an EMT at
13 home in Durham.
14 Q: Okay. And then from there were did you go in
15 terms of your certification as an EMT provider?
16 A: At that point you have options. You can pursue
17 the -- at the time -- actually there were
18 several options at the time. In North
19 Carolina, there were -- do you want me to go
20 into each state or just stick with national ---
21 Q: Just your ---
22 A: national ---
23 Q: experience and your education.
24 A: Okay. In my experience, I choose to go
25 straight from EMT to paramedic. So I did not

1 pursue the intermediate stage of certification
2 but instead went straight through as a
3 paramedic.
4 Q: Okay. When did you obtain your paramedic
5 certificate?
6 A: In 1986, just after graduation.
7 Q: And for what states?
8 A: I got my North Carolina paramedic as well as
9 national registry paramedic and then South
10 Carolina paramedic as well.
11 Q: Okay. And then where did you go from there.
12 Where did you begin your career?
13 A: I came to Greenville right after graduation as
14 soon as I was nationally registered and started
15 working in Greenville County, South Carolina.
16 Q: What made you come to Greenville?
17 A: At the time in 1986, Greenville County EMS
18 pretty much led the country in EMS. They were
19 an industry leader. Very well know throughout
20 the EMS industry. Very aggressive, aggressive
21 EMS service provided some of the best care in
22 the nation.
23 Q: What do you mean aggressive?
24 A: Aggressive as far as doing things nobody else
25 was doing at the time.

1 Q: Okay.
2 A: They were leading the industry. They were on
3 the forefront of EMS.
4 Q: Okay. Has DHEC taken any enforcements against
5 your certificate?
6 A: No, sir.
7 Q: Okay. Has any of the licensing agencies?
8 A: No, sir.
9 Q: Okay. Let's talk about your employment, and I
10 know you mentioned some about Greenville
11 County, and let's start about, 'cause it
12 appears you have been practicing as an EMT and
13 then you also have an education, kind of,
14 career. Let's start with your practicing as an
15 EMT. You began in Greenville County?
16 A: Yes, sir.
17 Q: And what ---
18 A: As a paramedic in Greenville County, yes.
19 Q: Okay. And what was your role as paramedic?
20 A: Providing care to the ill and injured citizens
21 and visitors of Greenville County.
22 Q: And how long did you do that?
23 A: Well so as a paramedic, I moved up in the
24 system so I was always a paramedic but then as
25 a paramedic I took on additional administrative

1 responsibilities and some training
2 responsibilities as well but continued to be a
3 practicing paramedic. So I did that for 21
4 years there at Greenville County.
5 Q: Okay. And I see you were also the COO, Chief
6 Operations Officer?
7 A: Yes, sir.
8 Q: What were your responsibilities as a COO?
9 A: I oversaw the daily operation.
10 Q: And how big was Greenville County at the time
11 as far as ...
12 A: We had approximately 150 employees or so, full-
13 time employees.
14 Q: And then where did you go?
15 A: I went to Medshore for a brief period and then
16 to Pickens County EMS full-time and remained
17 there part-time and continue to work there
18 part-time. And then moved into education and
19 have been in education since that point.
20 Q: Okay.
21 A: And continue to work in the field at Pickens
22 County EMS.
23 Q: About how often do you get in the field?
24 A: Not as often as I would like to, but generally
25 one to two half shifts a month.

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

1 didn't get formally involved in education until
2 I left Pickens County EMS for a full-time
3 position at Greenville Technical College.
4 Q: Okay. Now I think you made the distinction
5 between the education you provide to the
6 providers of a service and then the education
7 you provide at training institutions or
8 universities.
9 A: Right.
10 Q: Can you explain that distinction for the Court?
11 A: At the institutions that's primary education.
12 That's someone who is first time, their seeking
13 that paramedic education. Persons who are
14 working in the field of EMS, either as EMT's or
15 paramedics are required to attend ongoing
16 education and continued education and so
17 training personnel within a service would
18 provide that continued education at Greenville
19 Technical College and then where I am now at
20 the USC School of Medicine and Greenville
21 Health System, we provide primary education.
22 We also assist with some continuing education
23 as well, but my primary responsibilities are
24 primary education.
25 Q: Okay. So what types of courses do you teach at

1 Greenville Tech?
2 A: I just started back there part-time. When I
3 was there full-time, is that what you're
4 referring to?
5 Q: Sure.
6 A: When I was there full-time, I did my primary
7 responsibility when I was at Greenville
8 Technical College full-time was clinical
9 coordination. So I taught some of the
10 clinical, I attended clinical with the
11 paramedics students in the emergency
12 departments and then coordinated all that. But
13 also taught as well, usually most of the time,
14 in the final semester of their training. And
15 that's, kind of, the bringing it all together
16 semester. And we provide what we call all the
17 alphabet classes, all the -- you've heard
18 reference to PHTLS, a Pre-hospital Trauma Life
19 Support. There's an American Heart Association
20 Advanced Cardiac Life Support. We provide all
21 of those courses in that final semester. So I
22 was rather busy during that semester as well.
23 Q: Okay. And you also worked at T-2 Trauma
24 Training. What is that?
25 A: That was some time ago before, and you would

1 probably have to be in EMS to understand PCCC.
2 It's a tactical combat casualty care. Before
3 tactical combat casualty care was really a
4 thing, it was actually, kind of, invented by
5 the military but before it was a formal course,
6 there was a gentleman out of Virginia, a former
7 Seal, Navy Seal, who contracted with the Navy
8 to provide training to, not to corpsman, but to
9 Seabees and just everybody but the corpsman
10 basically for how to handle life saving
11 emergencies. And so I helped teach that with
12 him and several other people as well. So we
13 provided that training for the Navy.
14 Q: Okay.
15 A: Then it became a formal course and I don't know
16 if the name was trade marked but we quit
17 offering it.
18 Q: Okay. Are your teaching responsibilities with
19 USC School of Medicine Greenville similar to
20 what you've explained with Greenville Tech
21 teaching roles?
22 A: More or less, only at the EMT level. We do not
23 provide paramedic level training, at the USC
24 School of Medicine or with the Greenville
25 Health System. We provide EMT level training

1 for the first year medical students. We remain
2 involved in their education throughout the four
3 years. We teach them ACLS, the American, I'm
4 sorry, the Advanced Cardiac Life Support. We
5 also assist with some of their skills in
6 preparing them for the things that we're most
7 familiar with.
8 Q: Okay. And that's a good point. So Greenville
9 Tech has all different levels of EMT
10 certificate, certification training?
11 A: Well they do. EMT and paramedic.
12 Q: Okay.
13 A: Most, I think I'm pretty safe in saying this,
14 most educational institutions do not provide
15 the intermediate level. It's not a popular
16 certification and it frankly, it's redundant.
17 So ...
18 Q: Okay.
19 A: There's not a lot of calls for it.
20 Q: Either through your teaching responsibilities
21 and your care providing responsibilities, have
22 you been sued for negligence or malpractice or
23 ---
24 A: No, sir.
25 Q: Professional memberships, and that begins on

1 the second page. Can you explain to the Court
2 your various professional memberships?
3 A: I'm with National Association of Emergency
4 Medical Technicians. My membership there
5 affords me, or has afforded me, the opportunity
6 to serve as our state's advocacy coordinator.
7 I honestly could not tell you how I stepped
8 into that position. I just happened to be in
9 the right place at the right time, I think,
10 many years ago. And I have served in that
11 position for several years and, kind of,
12 coordinate or promote legislation within our
13 state at the national level. I'm also a member
14 of the advocacy oversight committee and that
15 oversees all of the other state advocacy
16 coordinators. I was on the membership
17 committee for several years and was involved in
18 actively seeking members and coming up with
19 ways to promote membership and designed the
20 challenge coin and things like that. With the
21 National Association of EMS Educators, which is
22 a fairly large and active association that
23 provides education for educators. It's a very
24 strong educational program and actually counts
25 in our state toward the basic educator course

1 in order to get your instructor certification.
2 I'm with the South Carolina EMS training
3 committee, which meets monthly and, kind of,
4 provides input and recommendations for various
5 issues regarding training and certification
6 throughout the state. South Carolina EMS
7 Association, I am a non-voting member but I
8 attend some meetings, not all meetings, but the
9 South Carolina EMS Association is made up of
10 really anybody, there aren't any restrictions
11 about who can belong to that association. But
12 the goal of the EMS Association is obviously to
13 promote the needs and welfare of EMS throughout
14 the state. Through my association with the
15 National Association of EMT, it makes sense to
16 belong to the state association as well. I was
17 on the Upstate EMS Counsel Board of Directors
18 for a long time, was the Chair for 11 years.
19 Q: What is the Upstate EMS Counsel?
20 A: Upstate EMS Counsel is one of the -- the State
21 of South Carolina is divided into four regional
22 counsels. And the four regions provide -- have
23 a regional counsel that provide paramedic,
24 certified paramedic education for those
25 counties within that region. It is not --

1 there are additionally -- in addition to that,
2 there are some college programs, like
3 Greenville Technical College, for example, that
4 falls within the Upstate region but the Upstate
5 Regional Counsel provides paramedic training
6 that does not come with a college degree.
7 Q: Okay.
8 A: It is accredited. They are associated with a
9 university but they do not provide college
10 credit.
11 Q: Okay. So moving on to your licenses and
12 certifications.
13 A: Yes, sir.
14 Q: What's your -- third one down, the name N-A-E-M
15 ---
16 A: NAEMSE, that's the, you know, they have
17 acronyms. NAEMSE is the National Association
18 of EMS Educators that I mentioned in
19 professional memberships.
20 Q: And what do you have to do to obtain those, I
21 guess, instructor certifications?
22 A: Each of those instructor certifications comes
23 after successfully passing a rather difficult
24 exam following a 40-hour course.
25 Q: Okay. And when did you obtain that?

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

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

1 Q: Okay.
2 A: No, sir.
3 Q: Okay. Honors and awards, are most of these
4 honors and awards, you know, awards that you
5 based upon your, I guess, general service to
6 the public?
7 A: Yes, sir.
8 Q: As a paramedic?
9 A: Kind of all combined as a paramedic, I also --
10 I'm very active in various honor guards with
11 regard to police, fire and EMS.
12 Q: Okay.
13 A: I attend a lot of funerals.
14 Q: And then your scholarly activity, publications,
15 presentations ---
16 A: Yes, sir.
17 Q: Any particular area of concentration for these
18 matters?
19 A: No, sir. Not particularly, most of them were
20 tied to one class or another. They were class
21 projects, not especially.
22 Q: Okay. All right. Your Honor, the department
23 would like to move this Exhibit 27, Mr.
24 Douglas' CV into evidence.
25 **MR. ROTHSTEIN:** No objection, Your Honor.

1 **THE COURT:** It's admitted.
2 **(Petitioner's Exhibit Number 27 was admitted into**
3 **evidence.)**
4 **MR. WICEVIC:** Thank you. And Your Honor, pursuant
5 to Rule 702, I am tendering Mr. Douglas as an
6 expert in the fields of pre-hospital medical
7 care and education.
8 **MR. DOUGLAS - VOIR DIRE BY MR. ROTHSTEIN:**
9 **MR. ROTHSTEIN:** Your Honor, I would like to Voir
10 Dire the witness just briefly. Mr. Douglas, I
11 think you testified that you currently work at
12 Pickens, is that right?
13 A: Yes, sir, part-time.
14 Q: Part-time? And you said, one to two and a half
15 shifts per month, is that right?
16 A: Yes, sir. Yes, sir.
17 Q: So you currently work in the field 12-24 hours
18 a month? Does that sound about right?
19 A: That's about right.
20 Q: How many calls would you say you ran on average
21 when you worked as the COO for Greenville
22 County EMS?
23 A: Quite a lot. A lot more than I do now. In
24 what period of time?
25 Q: I guess any. You were there for a long time as

1 the COO, isn't that right?
2 A: Yes, sir.
3 Q: Okay. And was that primarily an administrative
4 role?
5 A: It was daily operations, so I was heavily
6 involved in the operations every day.
7 Q: Were you routinely assigned to work shifts ---
8 A: No, sir.
9 Q: --- as a paramedic?
10 A: No, sir.
11 Q: And how often would you actually work on a
12 truck as a paramedic, clinically paramedic?
13 A: At that point, I was not working on a truck
14 often. I did run a lot of call though.
15 Q: And you're talking about a quick response
16 vehicle ---
17 A: Yes, sir.
18 Q: --- like an QRV?
19 A: Yes, sir. I had my own response vehicle, so.
20 I ended up running a lot of the -- a lot of
21 calls. But it was part of my responsibilities
22 as the operations officer.
23 Q: Now as I understand your CV, your training as
24 an EMS bachelors training was in 1986?
25 A: Yes, sir.

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

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

1 **MR. WICEVIC:** And Your Honor, he has 31 years --
2 over 34 years between being an EMT and a
3 paramedic. Yeah, he's held other
4 responsibilities but he's continuously been in
5 the field whether it's part-time or full-time.
6 He does simulations as part of his education
7 responsibilities. I think he's well capable
8 and well qualified, experienced and skilled to
9 be an expert in pre-hospital care.
10 **THE COURT:** I'm qualifying him as an expert.
11 **MR. WICEVIC:** Thank you, Your Honor.
12 **MR. DOUGLAS - DIRECT EXAMINATION BY MR. WICEVIC**
13 **(CONT.):**
14 Q: All right, Mr. Douglas, when did the Department
15 contact you regarding retaining you as an
16 expert?
17 A: I believe that would have been Thursday.
18 Q: And what were you provided as part of your
19 review of this matter?
20 A: Not this particular notebook but a similar
21 notebook.
22 Q: And you're referring to DHEC's proposed trial
23 exhibits?
24 A: Yes, sir.
25 Q: Okay. Do you know Mr. Davenport?

1 A: No, sir.
2 Q: How much time did you spend reviewing this
3 matter?
4 A: At this point, approximately 60 hours.
5 Q: 60 hours?
6 A: Yes, sir.
7 Q: Okay. Have you been in attendance this
8 evening?
9 A: Yes, sir.
10 Q: How did you become aware of the Department's
11 decision to revoke Mr. Davenport's paramedic
12 certificate?
13 A: Subsequent to being asked on Thursday to
14 certify as a witness.
15 Q: Okay. Do you know Scott Stoller?
16 A: I do.
17 Q: Okay. How do you know him?
18 A: Scott worked at Greenville County EMS at the
19 same time I did. We've never worked together.
20 We've never worked on the same shift. I known
21 him for many years.
22 Q: Okay. Other than previously working for
23 Medshore, do you have any other connections to
24 Anderson County?
25 A: No, sir.

1 Q: Do you know Arnold Alier ---
2 A: I'm sorry. I did work for Belton EMS part-time
3 early, early in my career.
4 Q: Okay. Do you know Arnold Alier?
5 A: I do.
6 Q: Who's he?
7 A: Dr. Alier is the bow-tie.
8 Q: Okay and ---
9 A: Asked me, how do I know him?
10 Q: Is he a DHEC staff person?
11 A: Yes, he's the Director of EMS for the state,
12 I'm sorry.
13 Q: And how do you know Dr. Alier?
14 A: Again, he worked at Greenville County EMS the
15 same time I did. I don't recall -- I don't
16 know that we ever worked the same shift
17 together. I know we have worked a couple of
18 shifts together. I don't think we were ever
19 assigned to the same shift.
20 Q: Okay. Do you know Mr. Wronski?
21 A: Yes.
22 Q: How do you know Mr. Wronski?
23 A: Just through his association with DHEC.
24 Q: No friendship?
25 A: No, sir.

1 Q: Okay. Protocols and order of compliance and
2 standards of care. In your education of EMT's,
3 how do you educate providing protocol and order
4 of compliance?
5 A: From the very beginning of EMT education, EMT's
6 are taught that basically everything the do
7 falls under medical control. So there's the
8 scope, there's a national curriculum which
9 teaches a wide variety of skills and knowledge
10 and then the state may pair that down some. So
11 the state tells you what out of what the
12 national curriculum teaches, the state tells
13 you what you can do according to the state.
14 And then the service wherever you work has a
15 medical control physician and then that
16 physician takes the state list and can pair
17 that down and can dictate what you can or can
18 not do ultimately.
19 Q: Okay. Would you consider compliance with
20 protocols a kin to monkey medicine, cookbook
21 medicine?
22 A: No. I mean, it depends on how the protocols or
23 standing orders are written, of course. But
24 no, generally not. Generally speaking, there's
25 plenty of room for thought. So, no I would

1 not.
2 Q: Are there terms used in protocols that you get
3 an understanding through education?
4 A: I'm not sure where you are going with that.
5 Q: Are there -- is terminology within protocols
6 something that you have learn --
7 A: Yes. Yes.
8 Q: Okay. Could you explain?
9 A: Give me a term to explain.
10 Q: Trauma.
11 A: Okay. So everything depends on your reference.
12 The term trauma when you're talking about the
13 difference between trauma and medical,
14 anything, any insult to the body is trauma.
15 Meaning, if I pull a hair follicle out, that's
16 a trauma. So then, when you talk about
17 significant trauma, or critical trauma, then
18 there are qualifiers. That's a more defined
19 area of trauma.
20 Q: Okay.
21 A: So there's trauma and then there's trauma.
22 Q: So, I mean, you said protocol compliance isn't
23 kin to monkey medicine. Explain the decisions
24 EMT's have to make in the course of their care.
25 A: I mean, there are an infinite number of

1 decisions they have to make. I mean, there are
2 safety decisions, there are patient care
3 decisions, there are transport decisions, there
4 are -- I mean, everything is a decision. And
5 you follow certain decision trees and you have
6 to insert some level of knowledge into that
7 tree and decide which path to go down.
8 Q: Okay. Are you familiar with generally accepted
9 standards of care for EMT's?
10 A: Yes.
11 Q: Is that what you teach at your training
12 institutions?
13 A: Yes.
14 Q: Under generally accepted EMS practices, when is
15 it appropriate for an EMT to deviate from an
16 order of protocol?
17 A: There certainly are times when one may need to
18 either expand upon a protocol or deviate. I
19 mean, basically with EMS, if you can imagine
20 it, it can happen. So there may be times where
21 you may need to give an increased amount of
22 medication that goes beyond what has been
23 prescribed by standing order or protocol.
24 There may be times where you need to withhold
25 a medication. There are just a, like I said,

1 an infinite number of possibilities.
2 Q: What are some of the guiding principles behind
3 pre-hospital care?
4 A: There are many. Do no harm, of course, is the
5 probably the most referred to, most well known.
6 Q: I mean, what are the goals does EMT and the
7 pre-hospital care.
8 A: Well the goals of EMS -- EMS is a very rapidly
9 expanding field. I'll try to keep this geared
10 toward this case, but the goal of a pre-
11 hospital 9-1-1 provider is to, not only get the
12 patient to the hospital, sometimes it's to make
13 the patient better. Certainly to not make them
14 any worse and to protect the patient. To be
15 the patient advocate. To protect oneself and
16 ones partner, many goals. And to protect the
17 public as well.
18 Q: Okay. So this patient in question, based upon
19 your review and using those generally accepted
20 EMS standards, how would you characterize the
21 injuries of this patient?
22 A: I would say that would be a significant trauma.
23 Q: Okay. And why?
24 A: Because he had what was reported to be a seven
25 inch blade within his belly.

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

1 We don't have x-ray, we don't have CT, we don't
2 have a lot of those things. At this point, we
3 don't have ultrasound on an ambulance. Given
4 ultrasound or some of the other testing modes,
5 we may be able to rule out some things. Until
6 that point, we have what we call a differential
7 diagnosis. And we have to go with what the
8 worst possible outcome and we have to assume
9 the worse.
10 Q: I'm sorry. What's a differential diagnosis?
11 A: It's basically a list of what could be wrong.
12 Q: Okay.
13 A: Yeah.
14 Q: Okay. So this particular patient in question,
15 protocol, how would you characterize the status
16 of this patient?
17 A: Stable.
18 Q: Okay. And what do you mean stable?
19 A: He appears to be alert. He appears to be
20 oriented. I will say that as far as mentation
21 goes, he is alert and oriented and therefore
22 stable, but he does appear to be -- I think
23 it's worthy to note ---
24 **MR. ROTHSTEIN:** Your Honor, I'm gonna object to this
25 speculation. I mean, he said the patient was

1 alert and oriented. Now he's getting into
2 speculation about whether the patient has some
3 sort of diminished mental capacity or is -- I
4 think that's improper.
5 **MR. DOUGLAS:** I didn't even say that.
6 **THE COURT:** Mr. Douglas, let your -- your attorney
7 will respond to ---
8 **MR. DOUGLAS:** Sorry. My apologizes.
9 **MR. WICEVIC:** I don't think he was finished with his
10 answer. I'm not sure what he was going to say.
11 **THE COURT:** Let's let him finish. I wasn't sure
12 what he was going to say either so at this
13 point I'm overruling your objection.
14 **MR. DOUGLAS:** What I was going to say was, he --
15 there appears to be some sort of developmental
16 disability or something. He appears to be
17 somewhat obtundent, however he appears to be
18 alert. He ---
19 **MR. ROTHSTEIN:** Your Honor, that's ---
20 **MR. DOUGLAS:** --- appears to be oriented to person,
21 place and time.
22 **MR. ROTHSTEIN:** Your Honor, that's not what I'm
23 objecting to. It's his speculation that
24 there's some sort of developmental disability.
25 This patient -- he's not qualified to make that

1 type of assessment. He's not been qualified as
2 an expert to make that type of assessment and
3 he's only seen the patient through a video. I
4 just -- I think that's complete speculation.
5 **MR. WICEVIC:** I don't think he was diagnosing him,
6 he was just making an observation based upon
7 his review of the video and that's what EMT's
8 do.
9 **THE COURT:** I understand that but Mr. Rothstein's
10 objection ...
11 **MR. WICEVIC:** We'll move on.
12 **THE COURT:** Yeah. I am sustaining his objection. I
13 don't think he's qualified to make that
14 observation.
15 **MR. WICEVIC:** Sure.
16 Q: Okay Mr. Douglas, where was this injury?
17 A: Left, upper quadrant of the abdomen.
18 Q: Now what organs are near that left upper
19 quadrant of the abdomen?
20 A: Contained within left upper quadrant would be
21 the spleen, part of the liver, the stomach.
22 Those are the organs that what additionally, in
23 addition to that, there's a great deal of
24 vasculature. There are a lot of vessels within
25 the belly. The lumbar vessels come around the

1 gut. There are splenic vessels. There are a
2 lot of vessels within the abdomen.
3 Q: When you're sitting down, are your organs in a
4 different place than if you were standing up
5 like me?
6 A: All right. So everything within the abdominal
7 cavity is, kind of, suspended. It's not firmly
8 rooted in place, and it moves. A good example
9 of that is the reason we don't do what was
10 called -- when we use to lift the feet of the
11 backboard in a patient that was going into
12 shock in order to shunt all of the blood into
13 the core of the body. And one of the reasons
14 we don't do that anymore is because, research
15 found that the organs would lay upon the
16 diaphragm in that position and would restrict
17 the motion of the diaphragm and breathing. So
18 I say that to exemplify that the organs are not
19 firmly rooted. They do move when we move.
20 Q: Okay. And if these organs that you mentioned
21 were punctured, would that cause some kind of
22 significant injury to the patient?
23 A: Yes.
24 Q: Death possibly?
25 A: Possibly. Depending on the organ, of course.

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

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

1 make that determination?
2 A: It's based on my experience. It's based on my
3 education. It's also based on every resource
4 available.
5 Q: Okay.
6 A: Every generally accepted practice.
7 Q: I mean, do all trauma patients require ALS
8 care?
9 A: No. Most do not.
10 Q: Okay. Well let's move on with this case. I
11 mean, what were your general concerns as far as
12 meeting that generally accepted EMS care in
13 this particular matter?
14 A: I had concerns about the affect ---
15 Q: Okay.
16 A: --- toward the patient.
17 Q: Well do the generally accepted standards of
18 care prescribe anything regarding the providers
19 affect?
20 A: Yes. Yes. Affect has become, unlike when I
21 was in school, -- when I was in school 30 years
22 ago, there was no mention of affect other than
23 treat people kindly. Affect has become a large
24 part of the education. We now educate by the
25 principles of education and the principles of

1 education provide us with three domains of
2 learning. They are cognitive, which is the
3 knowledge base. Psychomotor, which is the
4 skills. And then, affective, which is probably
5 the most difficult to teach, the most difficult
6 to assess but perhaps the most important skill
7 that we have.
8 Q: Why is it so important?
9 A: Well for one thing, it's the one that we use
10 the most. It's the one that allows us to enter
11 a patient's home, to capture the trust of a
12 patient. It's vitally important.
13 Q: Did Mr. Davenport meet this standard of care
14 regarding professional affect?
15 A: No, sir.
16 Q: Why?
17 A: His affect was not acceptable.
18 Q: Okay.
19 A: The statements that were made were derogatory
20 and just not acceptable.
21 Q: Did you see dangers in failing to meet that
22 standard?
23 A: Dangers in what way?
24 Q: Patient safety, health dangers.
25 A: I don't know. I don't know the patient. The

1 patient did not respond to the remarks so I
2 don't know.
3 Q: Okay.
4 A: I really can't respond to that. I wasn't
5 there. I can't really -- my expertise extend
6 to that. I don't know.
7 Q: Okay. Would you consider this patient abuse?
8 A: Yes.
9 Q: Would that be something that would be
10 reportable to ---
11 A: Well yes.
12 Q: Okay. What other concerns with this particular
13 call? We've talked about affect.
14 A: I guess the failure to appreciate the potential
15 for the patient to become unstable at any given
16 time. And then to not get ahead of that as has
17 been discussed previously. Once a patient, not
18 he, but once a patient's blood pressure begins
19 to drop, you loose your opportunity to achieve
20 IV access and thereby losing your opportunity
21 to provide fluids that could expand the volume
22 and at least keep a somewhat of a blood
23 pressure until we get to the hospital and get
24 them into the surgical suite.
25 Q: Were there any concerns with the assessment?

1 You can start from the beginning in terms of
2 the assessment?
3 A: Yeah. So where the knife was, there was a
4 potential for it to have perforated the
5 diaphragm. The diaphragm moves while we
6 breathe and it's a dome shaped muscle. A
7 sheet of muscle that separates the chest cavity
8 from the abdominal cavity and as we breathe, it
9 flattens and comes down into the abdominal
10 cavity. Depending on where he was in his
11 breathing pattern when he inserted this knife,
12 it could easily have perforated the diaphragm.
13 So I would like to have seen lung sounds
14 assessed. Not I would like to, lung sounds
15 should have been assessed.
16 Q: Okay.
17 A: I would like to have seen abdominal sounds
18 assessed. Not belly sounds but to listen for
19 air movement in the belly. That would not be
20 required. That would not be a critical fail on
21 a check-off but that certainly would be a good
22 idea. That's all of the essential ...
23 Q: How would you take those?
24 A: Stethoscope.
25 Q: Okay. And would those be generally accepted

1 EMS standards per ---
2 A: Yes.
3 Q: Can you explain then, I guess, the assessment
4 continuum. I understand there are differences
5 between initial primary assessment all the way
6 to ongoing assessments. Could you explain that
7 to the Court?
8 A: Sure. So primary assessment is at the first
9 encounter with the patient you -- as you
10 approach the patient you form a general
11 impression and then the intention of the
12 primary assessment is to identify any life
13 threatening conditions. So you would evaluate
14 the airway, determine if the airway is patent
15 or not, is open or not and then determine the
16 quality of the breathing, whether the breathing
17 was sufficient or not. Whether it was of a
18 sufficient rate and of a sufficient quality,
19 meaning the rise and fall of the chest and
20 generally lung sounds to make sure that both
21 sides are inflating equally. And then
22 circulation so we would check a pulse to make
23 sure the pulse was within a normal range. At
24 that point you don't necessarily have to have
25 a number, it just either to fast or to slow or

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

1 respirations and the patient condition
2 generally.
3 Q: What are the documentation parameters with
4 regards to these various assessments?
5 A: Document all of them.
6 Q: Okay. Talk about the initial primary, I mean,
7 explain the importance of or the level of
8 detail that's required by the generally
9 accepted standards.
10 A: I'm not sure what you're asking.
11 Q: What level of detail is required when you're
12 doing an initial primary assessment?
13 A: Okay. So like I said as far as the primary
14 assessment, the specific number of a pulse and
15 a respiratory rate is not necessary. It's
16 just, is the pulse adequate. Is the
17 respiration rate adequate. So one would
18 estimate that and that is absolutely
19 acceptable.
20 Q: Okay. Still a documentation requirement?
21 A: Yes.
22 Q: Okay. And explain the purpose of documentation
23 for the various assessments.
24 A: It's for the continuum of care so that once we
25 get to the next level, they know what EMS has

1 done. They know what was done in the pre-
2 hospital environment and can continue that
3 care.
4 Q: Any other concerns with the assessments in this
5 matter?
6 A: I don't think so.
7 Q: Okay. So they do the assessment, did some
8 bandaging of the wound, any concerns with the
9 ambulation of the patient?
10 A: Yes.
11 Q: What were they?
12 A: As I said earlier, the organs in the body can
13 move when we move. The appropriate way to move
14 him would be to keep him in a seated position,
15 whatever that took. Stair chair would have
16 been the ideal piece of equipment but there are
17 plenty other ways to move him and keep him in
18 a seated position. He appeared to be fairly
19 comfortable in the seated position. He did
20 not, from what I could gather, he did not
21 appear to be in significant pain until he stood
22 up and then he obviously winced with pain.
23 Q: Okay. Explain the generally accepted standards
24 in the EMS community for ambulation.
25 A: So there are few absolutes but -- well I

1 shouldn't say -- this isn't an absolute, there
2 are a few exceptions to this rule but just
3 about everybody gets the stretcher. Every
4 patient deserves a stretcher. If the patient
5 meets you as you're walking towards the house
6 and they're coming out of the house walking
7 toward you, it's a little different story but
8 generally speaking, when you're in a house or
9 residence or a building or any distance away
10 from the unit, pretty much everybody gets the
11 stretcher.
12 Q: Did Mr. Davenport meet this standard?
13 A: Certainly.
14 Q: Did he meet the standard?
15 A: Certainly, yes.
16 Q: Mr. Davenport ---
17 A: Oh, I'm sorry. I thought you were talking
18 about the patient. No.
19 Q: Okay. We talked about the dangers of
20 ambulation, what other kind of carrying
21 devices, I know you mentioned stair chair, are
22 there any other acceptable carrying devices?
23 A: Sure. The backboard has been mentioned. So to
24 clarify, if I might, the long spine board is a
25 useful tool just for patient movement. It is

1 not absolutely necessary to immobilize ones
2 spine every time you put somebody on a spine
3 board. We frequently use the long spine board
4 just to move someone from point A to point B.
5 If I was going -- I think if the long spine
6 board were to be used in this case, you would
7 have to be very careful to use a lot of
8 something, padding, behind him to keep him in
9 a seated position. I would not -- it would not
10 be prudent to lay him supine.
11 Q: From your review, were there any obstacles to
12 using any of those carrying devices?
13 A: I did not see any. It's really difficult to
14 tell in the video but I did not see any.
15 Q: Did you review the photos?
16 A: Yes.
17 Q: Okay. Do those indicate any obstacles?
18 A: Not that I could see.
19 Q: Do you want to allow the patient to have a
20 relative position of comfort?
21 A: Can I go back just a little bit?
22 Q: Sure.
23 A: Those aren't the only two ways to move a
24 patient, short of the stretcher. I mean, there
25 are improvised methods to move a patient. A

1 kitchen chair, a table, chair and table. Just
2 take the chair, move the patient to the chair
3 and carry the chair. There have been some
4 concerns expressed with the strapping on the
5 KED. There are alternate methods to strap a
6 KED going across as opposed to crossing. A
7 sheet, just a simple sheet can be placed under
8 the patient and carried in a seated position.
9 And then there's a carry, just a simple carry
10 under the knees, under the arms and just to
11 carry them in a seated position. So that there
12 are a number of ways to move a patient from
13 point A to point B in a seated position without
14 having him walk.
15 Q: I think you said, KED. Were you meaning stair
16 chair when you were talking about the straps?
17 A: Yes, I'm sorry.
18 Q: What's a KED?
19 A: I'm sorry. I KED has no relevance in this.
20 Q: Okay.
21 A: My apologies.
22 Q: Sure.
23 A: My intent was the stair chair, sorry.
24 Q: Is it important to allow the patient to
25 maintain some position of comfort in transport?

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

1 IV-O2 monitor. Everybody got oxygen. If a
2 little bit of oxygen was good, a lot of oxygen
3 was better. We have since learned that is not
4 the case, especially with certain situations
5 like cerebral vascular accidents or strokes.
6 We've learned that to much oxygen with a stroke
7 can be a bad thing. To much oxygen in a
8 cardiac event, a myocardial infarction, can be
9 a bad thing. To much oxygen with a traumatic
10 brain injury can be a bad thing. That is the
11 extent of the research thus far. In a case
12 where you're talking about the shock, nothing
13 has -- there is no evidence linking oxygen
14 administration to poor outcomes in cases of
15 shock or potential shock. However, I will say
16 many services standards are going to the oxygen
17 saturation level as the indicator for the need
18 for oxygen.
19 Q: Okay.
20 A: So, there's that.
21 Q: Well thank you for clarifying me. Did you see
22 this as a concern, the failure to administer
23 oxygen in this matter?
24 A: I would say a concern, yes. A requirement, no.
25 Q: Okay. Would it be more characterized as a best

1 practice?
2 A: Yes.
3 Q: Okay. You've spoken some about the lack of IV
4 access. Do the generally accepted standards of
5 care for EMT's prescribe IV access for this
6 particular ---
7 A: Yes.
8 Q: --- type of patient?
9 A: Yes.
10 Q: Okay.
11 A: IV access, understanding that does not
12 necessarily imply the administration of fluids.
13 Q: Okay. I think you've explained that. What's
14 an EMT's thought process as far as making that
15 determination?
16 A: I'm sorry, what?
17 Q: What's an EMT's thought process as far as
18 making that determination of whether you need
19 IV access or you don't need IV access?
20 A: And you're referring to EMT as the EMT or
21 paramedic?
22 Q: Paramedic. Because obviously an EMT basic ---
23 A: Yeah, okay. Again, it goes to the potential.
24 It goes to the potential and in getting ahead
25 of the shock. Because once -- the goal is to

1 prevent shock. Once his blood pressure begins
2 to fall, which could be the first indicator.
3 Not likely, but it could be, then it's to late
4 and you've lost your vasculature and especially
5 that's why it's vitally important to have a
6 well trained paramedic assessing the patient
7 constantly that would pick up on those small
8 signs that a relatively inexperienced EMT might
9 not pick up on.
10 Q: What's a saline mock?
11 A: It's basically the way to start an IV without
12 administering fluids.
13 Q: Would that be appropriate in this case?
14 A: Yes.
15 Q: Can you explain the concept of a load and go?
16 A: Load and go is, kind of, it's a slang term but
17 it's in many of the textbooks. But it's --
18 load and go is where you find a patient who is
19 either decompensating or common slang is
20 crashing, or about to or potentially could. It
21 would fall under the critical category and
22 there's nothing that we in the pre-hospital
23 environment can do to help them except get them
24 to definitive care.
25 Q: I know you mentioned critical trauma as an

1 indicator for load and go. Are there other,
2 kind of, indicators that were justified having
3 this load and go approach?
4 A: Not as it relates to this call. I mean ---
5 Q: Okay.
6 A: --- unsafe scenes.
7 Q: Okay. Just jumping back a little bit, what's
8 permissive hypotension?
9 A: Permissive hypotension, it goes by several
10 different names but the thought process behind
11 permissive hypotension is that when a patient
12 is in shock as opposed to bringing the blood
13 pressure back to normal, you want to bring it
14 back to less than normal. There are many
15 reasons behind it and gets deep but essentially
16 you don't want to fill the container up all the
17 way because the container has a leak in it and
18 you don't want to increase the pressure. It
19 does a lot of things, it hampers the body's
20 ability to clot. The volume that you're
21 putting in there, the fluid that you're putting
22 in there doesn't transport oxygen. It's just
23 a filler to create pressure so permissive
24 hypotension just means that you're limiting the
25 amount of fluid to a less than normal blood

1 pressure.
2 Q: Is there a conscience on this permissive
3 hypotension?
4 A: There is not. It was introduced some time ago.
5 It was introduced several years ago and I mean,
6 it's, kind of, -- a lot of people know about
7 it. I mean, it's fairly well known it just
8 hasn't really caught traction among trauma
9 surgeons, which is who pushes it, so. There
10 have been several research studies done on it
11 that the two biggest research studies that were
12 done were flawed. They were known to be
13 flawed, so.
14 **MR. ROTHSTEIN:** Your Honor, I'm not trying to be
15 difficult but permissive hypotension has
16 nothing to do with this case and I know we're
17 getting close to lunch. I don't think this is
18 relevant to anything.
19 **MR. WICEVIC:** I believe it was one of their theories
20 about not having the IV access, so that's why
21 I brought it up. Mr. Douglas ---
22 **THE COURT:** It has very limited ---
23 **MR. WICEVIC:** Okay.
24 **THE COURT:** Yeah. So, let's move on.
25 Q: Speaking of the IV topic, are there any

1 antibiotics that the paramedic can administer?
2 A: Yes.
3 Q: What would they be?
4 A: Yes, in South Carolina paramedics can
5 administer antibiotics. It would not be
6 germane to this case.
7 Q: Okay. Applicability of trauma protocols. Did
8 you feel they were applicable to this
9 particular man?
10 A: Yes.
11 Q: Okay. Why is that?
12 A: They are within generally accepted practice.
13 Q: Okay. And was the injury in question, patient
14 in question, did he present conditions that
15 would warrant compliance with those protocols
16 and orders?
17 A: Yes.
18 Q: And we talked about trauma and your
19 determination of critical trauma. Any concerns
20 with the EMT riding the call?
21 A: Yes.
22 Q: What are they?
23 A: That patient should have had an IV so it should
24 have had a paramedic tending and should have
25 had an ongoing advanced assessment looking for

1 those small signs. I would have like to have
2 seen a very experienced paramedic that would
3 catch those signs.
4 Q: Are there any, kind of, generally accepted EMS
5 standards about who was to ride a call?
6 A: Yes. Anytime there is an advanced life support
7 skill, the paramedic has to be in attendance.
8 Q: Okay. Aside from establishing the IV and the
9 reassessments, I think that you spoke about,
10 are there any other ALS requirements,
11 procedures that should have been performed for
12 this patient?
13 A: Requirements, no.
14 Q: Okay. So kind of a converse question I asked
15 earlier, I mean, under these generally accepted
16 standards, the only circumstances under which
17 an EMT basic can ride is when the patient
18 requires BLS care?
19 A: Yes.
20 Q: Okay. If you had this body cam footage to show
21 in your classes, how would you use it?
22 A: Of course, if I could redact all the faces, it
23 would be -- you could apply this -- it's
24 applicable to many different chapters of the
25 EMT text, starting very early with patient

1 lifting and moving. This is a good way not to
2 do it. Communication, therapeutic
3 communication. There are two different
4 chapters. There's communication and then
5 there's therapeutic communication. How to talk
6 to a patient. Again, affect is a very
7 important part of education now. So it would
8 be again, proportionally a negative example.
9 It would apply to, of course, the abdominal
10 trauma section as well. It's a very good
11 example of a potentially unstable stab wound,
12 yeah. Abdominal impalement.
13 Q: Any other concerns or conclusions regarding
14 your review of this particular case?
15 A: No, sir.
16 Q: That's all I have. Please answer any questions
17 Mr. Rothstein has.
18 **MR. ROTHSTEIN:** It will be a while, Your Honor. Can
19 we break for lunch?
20 **THE COURT:** Okay. Well it's afternoon so we'll take
21 a one hour break so we should reconvene -- my
22 watch says it's 15 after 12:00 now, so why
23 don't we reconvene at a quarter after 1:00.
24 **MR. WICEVIC:** Sounds good. Thank you.
25 **(Off the record from 12:15 p.m. until 1:26 p.m.)**

1 **THE COURT:** Mr. Rothstein.
2 **MR. ROTHSTEIN:** Thank you, Your Honor.
3 **MR. DOUGLAS - CROSS-EXAMINATION BY MR. ROTHSTEIN:**
4 Q: Mr. Douglas ---
5 A: Yes, sir.
6 Q: I'm David Rothstein. You and I have not met or
7 had the pleasure to meet. It's nice to see you
8 this afternoon. Have you been at the hearing
9 the whole week?
10 A: Yes, sir.
11 Q: I'm sorry?
12 A: Yes, sir.
13 Q: Okay. So you were here yesterday when Keith
14 Eudy testified?
15 A: Yes, sir.
16 Q: Okay. And it's almost like Greenville County
17 EMS home week, wasn't it?
18 A: It's a small world, small EMS industry.
19 Q: Mr. Eudy was here, you were here, Dr. Alier was
20 here, and Scott Stoller was mentioned but he
21 wasn't actually visible here. Y'all all sort
22 of work together back in the day in Greenville
23 County EMS, right?
24 A: I'm trying to think if we were all there at --
25 I believe we were all there at the same time,

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

1 care of pre-hospital casualties or patients.
2 Wouldn't you agree with that?
3 A: Yes, sir.
4 Q: Okay. The one thing that hasn't changed since
5 you were here, or since you went through your
6 paramedic training, is the definition of the
7 word protocol. I think you talked about it as
8 sort of a decision tree, right?
9 A: Yes, sir.
10 Q: Have you seen the protocols referred to as
11 algorithms before, a flow chart?
12 A: Yes, sir. Sometimes the terms become blurry.
13 A lot of the terms are used interchangeable, so
14 yeah. People use different terms for them.
15 Q: Okay. Has the definition of the term protocol
16 changed in the last 30 years? At least that
17 term as you understand it, paramedics?
18 A: No, sir.
19 Q: Okay. What about the term physician order, or
20 the phrase physician order? Do you understand
21 what that means?
22 A: Yes, sir.
23 Q: Has that changed at all in the last, I mean in
24 the time you went to paramedic school until
25 today?

1 A: No, sir.
2 Q: Okay. I'm kind of a visual learner, so I put
3 a little -- I don't know if you were taught
4 like I was in science. This is called a Venn
5 diagram. You seen those before?
6 A: Yes, sir.
7 Q: Okay. And I want you to see, I've drawn a big
8 green circle here. And I'm just going to put
9 protocol, okay? All right. So that's, in a
10 visual sense that's sort of the scope of what
11 either a paramedic can do or what an EMT basic
12 can do, or what an EMT intermediate can do is
13 spelled out sort of in the protocols that are
14 handed out by each rescue squad or whoever the
15 Medical Control Physician is, right?
16 A: Yes, sir. It's basically if then statement.
17 If certain criteria are met, then one should
18 fill in the blank. And then it depends on what
19 fill in the blank ---
20 Q: Okay.
21 A: --- is to what lies after that. And if it's
22 will or shall, then that must be followed. If
23 it's may or consider then there are things to
24 consider or things to think about. So it
25 depends on how it's written.

1 Q: Okay. Now the smaller circle I have down here
2 to the bottom right, I'm going to use that to
3 represent orders, physician orders, okay?
4 A: Uh-huh.
5 Q: And the reason I have it in red is because you
6 can't violate a physician order. You
7 understand that?
8 A: Sure.
9 Q: You agree with that?
10 A: Sure. An order implies there's a prescriptive
11 authority to it.
12 Q: Okay.
13 A: Yes, sir.
14 Q: And you see how I've drawn a little bit of
15 overlap here? I've got some of the red is
16 overlapping with the green.
17 A: Right.
18 Q: Some of the red is outside of the green, right?
19 A: Yes, sir. I assume you mean that that is
20 because some protocols have prescriptive
21 authority by being signed by a physician.
22 Q: Okay. I'm going to put an SO inside this
23 little overlap
24 A: Uh-huh.
25 Q: For standing order, okay? Do you agree with me

1 that within protocols, there are standing
2 orders sometimes?
3 A: Yes, sir.
4 Q: Okay. But there are sometimes when a paramedic
5 encounters a situation that's outside of the
6 protocols and has to call for online medical
7 control, right? So they call say the ER doctor
8 on duty and say, hey how do I handle this, or
9 you know this patient took pain medication this
10 morning when they woke up and I don't know how
11 much to give her now.
12 A: Yes, sir.
13 Q: So that's called a -- what do you call that?
14 Online medical control?
15 A: Yes, sir.
16 Q: Okay. So I'm going to put OL here for online.
17 And the reason it's outside the protocols,
18 again, is 'cause the protocols or the standing
19 orders don't tell you what to you, you have to
20 go and get online medical control, right?
21 A: Yes, sir.
22 Q: Okay. Would you agree with me that that's a
23 fair representation of sort of -- I mean, I
24 know it's a little rudimentary, but would you
25 agree with me that that's sort of a fair

1 representation of the relationship between
2 protocols and physician orders?
3 A: More or less. Again, the terms sometimes are
4 used interchangeable. For example, CMS, the
5 Center for Medicare Services uses them
6 interchangeably. They see no difference
7 between the term protocol, or physician's
8 orders, or order sets, or several other terms
9 that are used. So there are times where the
10 terms are interchangeable.
11 Q: Okay. Well there are certain times when
12 they're not interchangeable, right? So let me
13 give you an example.
14 A: Right. If a protocol does not have a
15 physician's signature, then it does not have
16 prescriptive authority.
17 Q: Okay. Let me ask you this. Have you seen --
18 did you review the Anderson County protocols as
19 part of your 60 hours or so of getting ready
20 for this case?
21 A: Yes, sir.
22 Q: Did you read the introductory paragraph that
23 said these are guidelines?
24 A: Yes, sir.
25 Q: Okay. You understand that guidelines are

1 different than orders?
2 A: Yes, sir.
3 Q: Okay. So, did you also see in the introductory
4 where it says that if you deviate from the
5 protocols, you have to be able to explain why
6 you deviated and you have to potentially
7 document at some point why you deviated? Do
8 you agree with that?
9 A: Say that again.
10 Q: In the introductory -- if you want to look at
11 it, it's Exhibit 1.
12 A: Right. Introduction? Okay.
13 Q: Yeah. And it says -- I'll point you to the
14 exact paragraph, give me a second.
15 A: The third paragraph, is that the one you're
16 referring to?
17 Q: Well we'll get to that third paragraph in a
18 second. Let me ask you to skip down to the
19 fifth paragraph.
20 A: Okay.
21 Q: The last sentence in that paragraph says ---
22 A: Yes, sir.
23 Q: --- all providers are responsible for their own
24 individual actions with regards to protocol
25 compliance, right?

1 A: That is what it says.
2 Q: Okay. And then the sentence goes on, it says,
3 and any deviation from the standards stated
4 herein, meaning in the protocols, must be
5 documented and explained, right?
6 A: That is what it says.
7 Q: So that introduction says paramedics and EMT's
8 can deviate from the protocols as long as they
9 can explain why they did what they did, right?
10 A: I will not try to interpret the procedures and
11 protocols.
12 Q: Okay. Now what about physician orders. As a
13 paramedic are you allowed to disregard a
14 physician order?
15 A: No, sir.
16 Q: Okay. So ---
17 A: Not without permission of course.
18 Q: Okay. So if there's a standing order and
19 unless you get permission from the online
20 medical control to change the standing order,
21 you have to comply with the physician order,
22 right?
23 A: That is correct.
24 Q: Okay. And if you disregard a physician order
25 as a paramedic, that's a bit problem, isn't it?

1 A: Yes, sir.
2 Q: Because, you know, your supervisor is that
3 medical control physician and the emergency
4 doctor in the ER right?
5 A: Yes, sir.
6 Q: And if they're telling you to do something,
7 either through standing orders or online, and
8 you disregard it, you're operating outside of
9 this -- I mean, you're way out here
10 (indicating) somewhere, right?
11 A: It's called practicing medicine.
12 Q: Okay. Now a lot of your testimony you talked
13 about the -- I think you talked about a lot of
14 your determinations were based on the
15 physician's report, I mean the patient's report
16 in the stabbing that the knife blade was seven
17 inches long. Do you recall that?
18 A: It was not just the patient's report. By all
19 accounts the knife was -- I heard two numbers.
20 I heard six and seven. So six to seven. And
21 given six and seven I would go with the
22 longest, so seven inches long.
23 Q: Do you recall in the -- you watched the video,
24 right?
25 A: Yes, sir.

1 Q: How many times did you watch the video?
2 A: I don't know. Five, six, seven.
3 Q: Okay. Do you remember toward the end of the
4 video when the Officer Burns with the camera
5 comes in and he says, how long was the knife
6 blade. Do you remember that conversation?
7 A: Yes, sir.
8 Q: And the patient said, oh about seven inches
9 long, and he held his hand up like that?
10 A: I recall it more like (indicating).
11 Q: You think it was like that (indicating)?
12 A: I remember him doing this (indicating), but
13 again, I'm not going to -- again, given any
14 numbers or any estimation, I'm going with the
15 greater estimation.
16 Q: I'll show you the Exhibit 23. Do you recognize
17 Exhibit 23?
18 A: Yes, sir.
19 Q: Okay. There's a bit of handle of the knife
20 sticking out.
21 A: Yes, sir.
22 Q: How big would you say the handle of that knife
23 is?
24 A: I honestly could not estimate that.
25 Q: Maybe four or five inches? I mean you've seen

1 a ---
2 A: I would not venture to estimate that.
3 Q: How big would you say it is?
4 A: I would not venture to estimate that based on
5 this photograph.
6 Q: It's hard to estimate the size of something
7 sometimes and be accurate, would you agree with
8 that?
9 A: Certainly from this photograph, yes.
10 Q: Okay. But if that knife was seven inches long
11 -- I'm going to hold it right there
12 (indicating). That's the blade.
13 A: Uh-huh.
14 Q: A lot of your opinions are based on the fact
15 that that whole blade is inside that patient's
16 body, right?
17 A: Yes, sir.
18 Q: And then that handle looks like it's -- well
19 you estimate it. If I'm holding a knife, it's
20 about there (indicating)? Would you agree with
21 that?
22 A: If you're asking ---
23 Q: That look like ---
24 A: --- if you're asking me if ---
25 Q: --- about the size of the handle ---

1 A: --- that extends beyond ---
2 Q: --- if this is the blade?
3 A: --- seven inches, then the answer is that
4 appears to be correct.
5 Q: Okay. So I'm now down at 11 and a half inches,
6 you see that?
7 A: Okay.
8 Q: You ever seen a steak knife that big?
9 A: I don't know.
10 Q: You also mentioned that you had some concerns
11 about the knife possibly hitting the diaphragm
12 I think. You recall testifying about that?
13 A: Potentially, yes.
14 Q: Okay. If that knife hit the diaphragm, what's
15 that going to cause in a patient?
16 A: Well it depends. It depends on how badly, if
17 it perforated the diaphragm it could cause a
18 rupture of the diaphragm, if it punctured the
19 lung it could cause air to enter the abdominal
20 cavity. It could cause bowel or organ to enter
21 the lung space. I mean it just depends on how
22 badly it was perforated. Or it could be very
23 minimal. It just, you know, it just depends.
24 Again, all of my testimony has been based on
25 the potential for the injury. And given the

1 potential, I can't say to what extent the
2 injury might have occurred.
3 Q: Okay. Well let's just assume for a second that
4 that patient had that knife in and it hit the
5 diaphragm. What exactly is the diaphragm.
6 A: It is a muscle.
7 Q: Okay. And the muscle that controls the
8 breathing in your lungs, right?
9 A: Yes, sir.
10 Q: I get this backwards a lot. When you inhale --
11 --
12 A: It seems converse. It goes against logic. But
13 as you inhale, the diaphragm contracts meaning
14 it flattens, and then as you exhale it relaxes
15 and comes back into a dome.
16 Q: Okay. So if that knife was inside the -- was
17 in the diaphragm, every time you breathed in
18 and that collapsed, and every time you breathed
19 out it expanded, you would expect to see that
20 knife kind of move up and down every time you
21 breath. Would you agree with that?
22 A: I do not actually. If that had happened, what
23 I would have expected is for the knife to have
24 perforated the diaphragm and the diaphragm come
25 away from the knife.

1 Q: All right.
2 A: Most likely. Especially if he was still
3 holding onto the knife.
4 Q: Okay. If that happened, that patient probably
5 would be in some respiratory distress. If that
6 knife perforated the diaphragm, that patient
7 would probably have some breathing problems.
8 Would you agree with that?
9 A: Potentially. Again depending on the extent of
10 the injury.
11 Q: Okay. And the patient might have even a
12 collapsed lung if he hit the diaphragm. Do you
13 agree with that?
14 A: Yes.
15 Q: Okay.
16 A: Potentially.
17 Q: I mean is that something that's pretty easy to
18 tell if a patient's having breathing difficulty
19 when you walk into a scene. I mean I'm sure as
20 a paramedic, you've seen patients that have had
21 respiratory distress ---
22 A: Sure.
23 Q: --- right?
24 A: Sure. And there again. It depends on many
25 variables here. It depends on the extent of

1 the injury. It also depends on how long it had
2 been since the injury occurred. So the lung
3 space would fill with air with every breath,
4 but then depending on the size of the injury
5 how much air would enter that lung space with
6 each breath. So it may develop over ten
7 minutes, it may develop over two hours. It
8 just depends on the extent of the injury.
9 Q: Well the patient had been sitting there for 20
10 minutes before the EMT's arrived, actually
11 before he even called 9-1-1. And there was
12 some perforation of the diaphragm, you would
13 expect it to manifest itself in 20 minutes or
14 so, wouldn't you? At least to some degree?
15 A: Not necessarily to the point of being visual,
16 no. Not necessarily. Again, it's all based on
17 potential.
18 Q: Okay. Well I think you testified earlier that
19 you don't believe this patient needed
20 supplemental oxygen. I think we had a
21 discussion about too much oxygen can be a bad
22 thing.
23 A: Right. I believe I stated that I felt it was
24 best practiced to place the patient on oxygen,
25 but I felt like it was not required.

1 Q: Okay.
2 A: I felt like it was not --- I'll leave at that.
3 Q: Okay. Where on this diagram is the term best
4 practice show up?
5 A: You didn't write it up there.
6 Q: Okay. Would it be like somewhere up here?
7 A: I don't know that best practice applies to your
8 diagram.
9 Q: Okay. Is best practice something that's beyond
10 the protocols?
11 A: No, sir. Best practice is what should be done,
12 what -- it's not necessarily a critical point.
13 But it's probably a good idea.
14 Q: It's not the same thing as a standard of care.
15 Do you agree with that? Is that fair?
16 A: That's fair. Yes.
17 Q: Okay. So if you don't comply with the best
18 practice, you're not operating below the
19 standard of care?
20 A: Right.
21 Q: Do I understand that?
22 A: Right.
23 Q: Okay.
24 A: That was my implication with it was not
25 required. Had it been required it would have

1 been standard of care.
2 Q: Okay. So I think Mr. Wicevic asked you, sort
3 of, what kind -- and I guess you did a fair
4 amount of analysis in this case. You actually
5 looked at this case for, I think you said 60
6 hours?
7 A: Yeah. It's hard to sleep at night.
8 Q: Okay. Does that include the time you've been
9 in the courtroom this week, the 60 hours?
10 A: Some.
11 Q: How much of the time are you including in the
12 time you've been in court?
13 A: In the 60 hours?
14 Q: In the 60 hours?
15 A: Oh, I don't know. Probably six or so.
16 Q: Okay. So you got 54 hours until the case
17 started, I mean the hearing started at 1:00 --
18 when did it start? 1:00 o'clock on Monday?
19 A: Right. So probably -- what's today?
20 Q: Today's Wednesday I believe.
21 A: All right. So probably six hours yesterday,
22 probably -- let's see, how long were we in here
23 yesterday?
24 Q: Well we -- it was my fault. I broke the
25 courtroom.

1 A: I'm sorry.
2 Q: So we were here from about 1:00 o'clock to
3 maybe 6:30.
4 A: A couple hours yesterday, a couple hours
5 Monday. So a couple hours each day was spent
6 doing research within the courtroom
7 Q: And if I understood your testimony correctly,
8 you first became aware of this case last
9 Thursday?
10 A: That's correct.
11 Q: Okay. How did you become aware of the case?
12 A: My boss and I were at the State Training
13 Committee Meeting Thursday, and Mr. Wronski
14 came in and said he needed to speak to us
15 afterward. And after the meeting we met him
16 outside, and he said that he needed an expert
17 witness. And I told him that we had just
18 started our medical school class like the day
19 before that, and that we just didn't have the
20 time. And then my boss told Mr. Wronski he
21 could free me up for the week, so ...
22 Q: Now your boss, who is your boss?
23 A: Phil Head.
24 Q: What is his position?
25 A: He's a program manager for the division of pre-

1 hospital medicine.
2 Q: At the Greenville Health System?
3 A: Greenville Health system. Yes, sir.
4 Q: Is that a licensed EMT or paramedic provider?
5 A: Can you clarify the question?
6 Q: Well do they actually run ambulances out of
7 Greenville Health System?
8 A: Yes, sir.
9 Q: Okay. So that's a licensed facility by DHEC
10 Bureau of EMS and Trauma, is that right?
11 A: The Greenville Health System has an ambulance
12 service, yes.
13 Q: And my point is that's licensed through DHEC,
14 right?
15 A: Yes.
16 Q: Through the division that Mr. Wronski is over
17 at DHEC?
18 A: Yes, sir.
19 Q: Okay. And if you were to lose your license,
20 just hypothetically, you couldn't operate an
21 ambulance service at Greenville Health System,
22 correct?
23 A: I have nothing to do with the ambulance
24 service. I don't know.
25 Q: No, I'm just saying Mr. Head does though,

1 right? Your supervisor?
2 A: No.
3 Q: No, he doesn't?
4 A: No.
5 Q: What is his ---
6 A: We're the education department.
7 Q: Okay.
8 A: We have nothing to do with the ambulance
9 service.
10 Q: All right. Fair enough.
11 A: I'm sorry. I'm sorry if that was misleading.
12 Q: So I think Mr. Wicevic asked you if you were
13 running this call, or what criticisms you had
14 of Mr. Davenport. And we'll talk about the
15 language and interaction with the patient. But
16 from a medical clinical standpoint, you said
17 your only -- the only thing you would have done
18 differently from a medical standpoint is
19 started an IV, right?
20 A: Not exactly what I said, but what I said was --
21 -
22 Q: Established, I'm sorry. Established an IV.
23 A: No. I would have done several things
24 differently. What I said was, as far as
25 generally accepted practice, the standard of

1 care would have required an IV. Other than
2 that, as far as the care, which would have, of
3 course required a paramedic in the back of the
4 ambulance, lung sounds would have been
5 required. I believe that was it ...
6 Q: Okay. So you wouldn't have ---
7 A: If I recall.
8 Q: --- put this patient on a heart monitor?
9 A: I would have.
10 Q: You would have?
11 A: Yes, sir.
12 Q: Well you didn't mention that in your testimony
13 earlier. You said IV was what you would have
14 done.
15 A: I don't recall being asked what I would have
16 done. But what I recall being asked was what
17 standard was or what would have been generally
18 accepted practice.
19 Q: Would putting this patient on a heart monitor
20 been part of the standard practice for this
21 patient?
22 A: No.
23 Q: I mean, what's a heart monitor going to show
24 you?
25 A: Right. So, the reason I would have put the

1 patient on a heart monitor is exactly the same
2 reason that the EMT that was in the back ended
3 up using it in the end anyway. It would not be
4 necessarily to interpret the cardiac rhythm.
5 I would have looked at it just to see if there
6 was anything going on. But it's to listen to
7 the heart rate rather than having to feel the
8 pulse constantly you can -- there's an audible
9 signal there, so you can listen to the heart
10 rate. So if the heart rate increases, then
11 it's a good indication that the patient may be
12 going into shock. There are conditions where
13 the patient could go into shock without having
14 the heart rate increase. But having the heart
15 rate increase would be an alert.
16 Q: Are you familiar with the device -- was it LIFE
17 Pack 15?
18 A: Yes, sir.
19 Q: Okay. And tell The Court what a LIFE Pack 15
20 is.
21 A: It's a cardiac monitor that does many more
22 things. It monitors blood pressure, depending
23 on what additional additives you put on it it
24 can monitor oxygen saturation. It can do, it's
25 called catonography. It can measure the amount

1 of carbon dioxide that you breath out. What
2 else. It's a defibrillator, so much akin to
3 the public that uses an AED, and automatic
4 external defibrillator, it has a manual
5 defibrillator as well as a pace maker. And
6 depending, again it's an option, it may also
7 monitor depending on if you purchase it, it may
8 monitor CPR while you're doing CPR. It may
9 monitor the quality of the CPR while you're
10 doing it.
11 Q: It measures pulse, doesn't it?
12 A: It does a lot of things.
13 Q: It measures pulse?
14 A: So it gives you a tracing of the heart beat.
15 It does 12 lead EKG as well. So yes, it
16 measures pulse as well. Pulse and the heart
17 rhythm.
18 Q: Is the use of the Life Pack 15 a skill that
19 only a paramedic can perform?
20 A: The use of it is ---
21 Q: In terms of vital signs, measuring, I mean
22 seeing the blip on the screen and what the
23 patient's heart rate ---
24 A: The EMT can do that.
25 Q: Okay. And you mentioned that it has a

1 defibrillator. Is that also called an AED. Is
2 that what you called it?
3 A: It has an AE- -- well I don't know if the Life
4 Pack 15 has an AED mode. My service uses a
5 different monitor. But I don't know if that
6 one has an AED mode. Some monitors have a
7 manual mode and an AED, an automatic mode. An
8 automatic mode, an EMT may administer the shock
9 through the AED, but not manually.
10 Q: I've seen those new defibrillators popping up
11 in public places all over the ---
12 A: Right.
13 Q: --- world. I mean that saves people's lives,
14 right?
15 A: Yes, sir.
16 Q: And it doesn't take a paramedic certificate to
17 operate one of those devices to save someone's
18 life, right?
19 A: That's correct.
20 Q: Okay. Some first responders who are not even
21 EMT's are trained on how to use that type of --
22 -
23 A: The general public is trained.
24 Q: Okay. So we have Ms. Aiken in the back with
25 the blood pressure being monitored by the Life

1 Pack 15 pulse.
2 A: Yes, sir.
3 Q: Respiratory rate and what's the pulse ox. Does
4 that also show sometimes the pulse?
5 A: Yes, sir.
6 Q: Okay. And looking at -- you've seen the run
7 report I assume in your 60 some hours of
8 looking at this case, right? If you'll turn to
9 Exhibit, I think it's 11b in that notebook.
10 A: Okay.
11 Q: You agree that the vital signs that Ms. Aiken
12 recorded on this first page kind of about in
13 the middle showed blood pressure, pulse, and
14 respiratory rate within the normal limits?
15 A: Yes, sir.
16 Q: Okay. And it also showed an SPO2 or an oxygen
17 saturation of either 98 or 99 percent for this
18 patient, right?
19 A: Yes, sir.
20 Q: On the way to the hospital?
21 A: Yes, sir.
22 Q: Is that also within normal limits?
23 A: Yes, sir.
24 Q: Okay. Given that O2 saturation, does that
25 patient need oxygen?

1 A: Like I said earlier, no.
2 Q: Okay. And did you look at the emergency room
3 record as part of your review of the case?
4 A: I did.
5 Q: Okay. Did you see whether they have the
6 patient any supplemental oxygen once the
7 doctors and nurses at AnMed took over the care
8 of this patient?
9 A: I don't recall, but I'll take your word for it.
10 Q: What is the abbreviation RA mean when it's
11 talking about oxygen.
12 A: Room air.
13 Q: Okay. So the emergency department notes that
14 RA. That means the patient is just breathing
15 the same air that everybody else is breathing,
16 right? No supplemental oxygen?
17 A: I believe that is correct. I don't know what
18 abbreviations the hospital uses. I believe it
19 is room air.
20 Q: Okay.
21 A: But that is -- I'm not certain of that.
22 Q: In your training you've never seen the
23 abbreviation RA refer to room air?
24 A: I use the abbreviation in EMS for room air.
25 But you're supposed to use organizationally

1 approved abbreviations. So ...
2 Q: Don't know whether ---
3 A: And different organizations have different
4 approved abbreviations. So my assumption is
5 that it is room air.
6 Q: Okay. You don't know what AnMed's ---
7 A: Right.
8 Q: --- routine abbreviations are, is that fair?
9 A: Yes, sir.
10 Q: Okay. The other thing that's listed on the
11 vital signs is a pain score of four. You see
12 that a little further to the right?
13 A: Yes, sir.
14 Q: Okay. If the patient reports they've got a
15 four out of a ten on the pain scale even
16 considering they have a knife in their belly,
17 does that person need pain medication in your
18 experience?
19 A: Pain medication is truly a judgement call. And
20 I'm -- and as well, pain estimation is very
21 much a judgement call. When I teach pain
22 estimation, I always teach to use two
23 estimations. That is one, the patient's, and
24 two the practitioner's. And especially in this
25 case, considering the patient has well

1 documented psychiatric history as well as
2 anything else that might be going on, I don't
3 know that I would trust the pain evaluation as
4 far, you know -- it's really just a very broad
5 estimation. But again, personally I'm pretty
6 stingy when it comes to pain medication.
7 Q: So if you were making this judgement call, and
8 by the way, if this is a judgement call, we're
9 talking about being up here (indicating) in the
10 Venn diagram ---
11 A: Right.
12 Q: --- right? We're not down in the red ---
13 A: Yes, sir.
14 Q: --- we're in the green.
15 A: And additionally, I would have started -- and
16 I understand what the physician said earlier,
17 but it has been documented, well documented
18 that oxygen has at least some pain relief
19 properties. I would have started with that.
20 Maybe it helps, maybe it doesn't. I don't
21 know. But ---
22 Q: Is your testimony that oxygen is a form of pain
23 relief?
24 A: It is well documented that oxygen has pain
25 relieving qualities.

1 Q: Well, you mentioned about this pain score, you
2 wouldn't necessarily trust what the patient
3 said in terms of -- I mean 'cause a lot of
4 times patients will inflate their pain to get
5 drugs, isn't that right?
6 A: Right. Considering the psychiatric history --
7 I mean like I said, it's a judgement call. And
8 additionally, you can, even in the video, there
9 are -- it varies. There are points where the
10 patient appears to be in significant amount of
11 pain. And then when he relaxes, when he's not
12 moving, he does not appear to be in pain at
13 all. The picture I think you're about to show
14 me probably shows him to not be in any pain at
15 all. But when he stands, he appears to be in
16 a great deal of pain. When he sits he appears
17 to be in a great deal of pain. And then when
18 he is places supine he appears to be in a great
19 deal of pain. Beyond that ---
20 Q: I'm going to show you Exhibit 21 that's been in
21 evidence. Do you see that patient in a supine
22 position?
23 A: Yes, sir.
24 Q: Doesn't appear to be in a lot of pain in that
25 position or in that picture, does he?

1 A: I could not estimate his pain level based on
2 this picture.
3 Q: Okay. A lot of times when people are in pain,
4 do they kind of grimace or tighten their facial
5 expressions?
6 A: A lot of times, yes.
7 Q: Okay. And that patient looks like he's kind of
8 relaxed. I mean he's laying back. He's got
9 his hands ---
10 A: I would say that he is not grimacing.
11 Q: Okay. So in your exercise of judgement, you
12 would not give this patient pain medication,
13 right?
14 A: I don't know. It depends on -- I don't know.
15 Q: Okay. You have to ---
16 A: Again, it's a judgement call. And without more
17 information than I have currently, I would not
18 want to make that judgement.
19 Q: I think you and I are on the same wavelength on
20 that. I agree that there are a lot of things
21 that you, as a paramedic, have to be on the
22 scene experiencing the same thing that that
23 medic sees in order to judge what that medic
24 does, right?
25 A: In this case, yes.

1 Q: You also, I think you talked about moving this
2 patient. I mean the patient has to be moved
3 out of the house, right?
4 A: Of course.
5 Q: Okay. I mean you can't -- a surgical team
6 can't come into the trailer and perform surgery
7 while he's sitting half reclined on the couch,
8 right?
9 A: Right.
10 Q: So there's got to be some movement of this
11 patient, right?
12 A: Yes, sir.
13 Q: And anytime you move a patient, there's some
14 risk involved, you agree with that?
15 A: Sure.
16 Q: Especially a patient with a knife stuck in his
17 belly, right?
18 A: Yes, sir.
19 Q: Even if that knife is bandaged into place the
20 best anybody could ever bandage a knife in
21 place, there's still a possibility that if you
22 move that patient and something happens to the
23 knife, you could further injure the inside of
24 that guy, right?
25 A: You are precisely correct.

1 Q: Okay. So you're faced with kind of a tough
2 situation. The protocols don't address how to
3 get this patient out of the house, do they?
4 A: They do not.
5 Q: Okay. And what the protocols actually say is
6 don't ambulate the patient to the ambulance,
7 right?
8 A: Yes, sir.
9 Q: And in your mind that means what, bring the
10 stretcher to the patient and then take the
11 stretcher back to the ambulance?
12 A: Again, I'm not here to interpret the protocols.
13 The protocols say do not ambulate the patient.
14 Generally accepted practice would be to use
15 some other alternative method.
16 Q: Okay. So, you worked for Dr. Kickham before,
17 right? I mean he was a Med. Control Physician
18 over Medshore when you worked at Medshore,
19 correct?
20 A: Yes, sir.
21 Q: Did you run calls at Medshore or was that more
22 of a training administrative type job?
23 A: No, I was on an ambulance.
24 Q: Do you know how long Dr. Kickham's had a policy
25 that says, don't ambulate a patient?

1 A: I have no idea.
2 Q: Okay. Is that a protocol or is that an order?
3 A: I would have to look at it. If it's signed by
4 him then that would give it prescriptive
5 authority making it an order. Regardless of
6 the title that would give it prescriptive
7 authority.
8 Q: Okay. If you're on the scene trying to comply
9 with that directive, don't ambulate the
10 patient, how are you going to get that patient
11 out of the house?
12 A: My first alternative, plan A, would be with a
13 stair chair.
14 Q: Okay. And correct me if I'm wrong. A stair
15 chair, I mean it's like a seat with wheels on
16 the bottom that you can bump up and down the
17 steps and strap the patient in securely, right?
18 A: Yes, sir. And I don't know what model Iva,
19 Iva?
20 Q: Iva.
21 A: Iva Rescue Squad has. There are different
22 models, there are different manufacturers.
23 Q: Were you here for Ms. Aiken's testimony?
24 A: Yes, sir.
25 Q: She's Iva Rescue Squad, right?

1 A: I believe so, yes.
2 Q: She talked about the stair chair having straps
3 that go across.
4 A: right.
5 Q: You have any reason to dispute that's the chair
6 that Iva Rescue Squad uses?
7 A: No, sir.
8 Q: Okay.
9 A: But that's not where I was going, but okay. Go
10 ahead.
11 Q: Okay. Yeah. I'm sorry, but ---
12 A: That's okay.
13 Q: --- I'm going to -- okay. So the stair chair
14 has some concerns with it as well, wouldn't you
15 agree with that? How do you get the patient
16 from the couch to the stair chair?
17 A: From a seated position. You take him from a
18 seated position and move him onto the stair
19 chair.
20 Q: Who does that?
21 A: Any number of people. The EMT and the
22 paramedic. If you need to solicit assistance
23 from, I believe there was another Rescue Squad
24 member there as well, or generally speaking,
25 law enforcement is pretty good help. There

1 were at least four people on that scene. There
2 were plenty of people.
3 Q: So you've got the patient sitting here on the
4 couch, like this, right?
5 A: Yes, sir.
6 Q: And you bring the stair chair in and you say,
7 okay we're going to move you from the couch to
8 the stair chair, okay? As the medic in charge
9 of the scene, tell me what you're going to tell
10 everybody in that room to do to get that
11 patient from the couch to the stair chair.
12 A: Okay. So I'm going to sit the stair chair
13 right at your knee, I guess either side would
14 work. I'm going to get on that side and I'm
15 going to take you by the shoulders. I want
16 somebody to get under your knees, I want
17 somebody to get on the other side ---
18 Q: Are you going to get behind me and grab my
19 shoulders?
20 A: No, sir. I'm going to be on the side.
21 Q: Okay. You're going to be on my left side?
22 A: Yes, sir.
23 Q: Okay.
24 A: And I'm going to on my count, on the count of
25 three, we're going to move you in increments

1 several inches at a time, and we are slowly
2 we're going to move you this way, this way,
3 this way, this way (indicating), and we're
4 going to slide you right onto the stair chair.
5 The stair chair would be right about the height
6 of the couch. And we'd slide you right onto
7 the chair.
8 Q: Well, if you're standing here to my left and
9 the stair chair's a little in front of you, how
10 are you going to get the body around you and
11 into the stair chair?
12 A: I'm going to serve as the back of that couch.
13 I'm going to move you right into me, so your
14 back is going to be against me, and I'm going
15 to move you right onto the stair chair.
16 Q: Okay. And how many other people are you
17 working with?
18 A: This may be difficult to visualize having never
19 done it before. But I can assure you, I mean
20 I've done this hundreds of times.
21 Q: Okay. How many people are you going to have
22 helping you move that patient?
23 A: At least one other. I'll take two more if we
24 have them.
25 Q: Okay. And the more people you have involved I

1 moving that patient, the harder it is to make
2 sure everybody's moving at the exact same time,
3 isn't that right?
4 A: Again, that's why there's one person who does
5 the count, and everybody moves on one count.
6 That is, again, generally accepted practice
7 that happens every day in EMS.
8 Q: Now, what happens if somebody slips or stumbles
9 or drops the patient? Let's say I'm holding
10 the knee and I drop the knee. Is that a
11 problem?
12 A: Of course. That would be unexpected. That
13 would be -- yes.
14 Q: Okay. What if I drop the patient, the patient
15 falls, knife hits him in the chest off the
16 couch, and it goes into his aorta? That guy's
17 dead, isn't he?
18 A: Sure.
19 Q: You can't get that patient out of the house to
20 the ambulance before he bleeds to death, right?
21 A: That is correct. He would be no deader than if
22 he were to fall forward while ambulating and
23 have the same thing happen.
24 Q: Okay. There's a lot of risk in getting this
25 patient out of the house. I mean that's a

1 sticky wicket, isn't it?
2 A: Sure. There's risk anytime you move a patient.
3 Q: Okay. Now you said that preferably you'd want
4 that patient to remain in the seated position
5 throughout the whole moving process, right?
6 A: Yes, sir.
7 Q: And I think you mentioned something about
8 possibly you could use a back board or a spine
9 board, long spine board?
10 A: It would not be ideal, but it would probably be
11 my plan D or E.
12 Q: Okay. And so your plan D or E where you're
13 going to put the strap the patient's legs to
14 the spine board?
15 A: I would probably -- were I to use a spine
16 board, I would strap him across his waist ---
17 Q: Okay.
18 A: Similar to a two point seat belt.
19 Q: Okay. What would you do with the upper part of
20 the body? I think you said something about
21 putting a pad on ---
22 A: Yeah ---
23 Q: --- the back.
24 A: --- somehow I'd have to use whatever was
25 available to have something to prop him

1 against.
2 Q: Okay. How are you going to secure either the
3 thing you're propping him up against to the
4 patient, and or how are you going to secure
5 that to the back board?
6 A: However necessary, tape, straps, by whatever
7 means necessary.
8 Q: Okay. Where in the protocols does it say to
9 use ---
10 A: It doesn't.
11 Q: --- spine board, tape, and some sort of pillow
12 type object to prop the ---
13 A: As you stated ---
14 Q: --- patient up?
15 A: --- earlier, it doesn't tell you in protocol
16 how to move someone to the ambulance.
17 Q: Okay. You ---
18 A: It says don't ambulate.
19 Q: --- also suggested -- I think you also
20 suggested maybe they could just get a chair
21 from the kitchen and use as sort of a ---
22 A: That is one method to use improvised -- an
23 improvised method to move a patient. Yes.
24 Q: What if you're picking that patient up, you
25 don't know it, it's not your chair, the chair's

1 got a crack in it. You lift the patient up and
2 ---
3 A: Right.
4 Q: --- the chair breaks and the patient falls out
5 on the floor?
6 A: We can what if this all day long.
7 Q: I agree. Fair enough. Bottom line is the way
8 Mr. Davenport got that patient out of the
9 house, he did it in a safe manner at the end of
10 the day, right? The patient got up ---
11 A: Are you asking my opinion?
12 Q: Yeah.
13 A: In my opinion that was not safe, no.
14 Q: Okay. Tell me what you think is a safer way to
15 get that patient out of the house.
16 A: In a seated position.
17 Q: Okay. What if the stair chair straps interfere
18 with the position of the knife, and you can't
19 use the stair chair? What are you going to do?
20 A: Then you alter the strapping method.
21 Q: Of the stair chair?
22 A: Yes, sir.
23 Q: And when you, let's say you do get the patient
24 strapped, and you got to put the patient in
25 pretty tight so eh doesn't fall out of the

1 stair chair, right?
2 A: You're asking me to quantify tight, but yes.
3 Q: Okay. 'Cause if you don't put him in tight,
4 and you start going down the stairs, he could
5 fall out of the stair chair, right?
6 A: Right.
7 Q: Okay.
8 A: Which is why you put the strap over the more
9 stable portions of the body, the shoulder
10 girdle, the pelvic girdle, not over the abdomen
11 itself.
12 Q: Okay. Have you ever ridden on a stair chair?
13 A: Yes, sir.
14 Q: Okay. Have you ever gotten the sensation that,
15 you know, you were going to fall out of the
16 thing?
17 A: Occasionally.
18 Q: Okay. If this patient were walking or being
19 bumped down the stair chair, and he's, oh I'm
20 falling, and he reached for the rail for
21 example. He could hit that knife couldn't he,
22 when he does that?
23 A: Again, you keep saying if, if, if. Yes.
24 Q: Mr. Wicevic said if, if, if a lot.
25 A: Okay. But if, then yes. I mean if he fell

1 forward while walking, the same thing would
2 happen.
3 Q: You also said I think, that you as a paramedic
4 would want to be the back of that couch right?
5 So you'd be kind of behind the patient?
6 A: It is general accepted practice that whoever is
7 at the head of the patient and that person
8 would be at the head, is the one that directs
9 the movement. So, the most experienced person
10 would be calling the shots.
11 Q: Okay. So again, visual learner. So I'm
12 sitting here on the couch ---
13 A: Yes, sir.
14 Q: And you're going to take the back position.
15 You want to be behind me or do you want to be
16 ---
17 A: No. As I said earlier, I would be to your
18 side.
19 Q: Okay. Do you know how wide that couch was?
20 A: It appeared to be pretty wide.
21 Q: Okay. So if he's sitting in the middle of the
22 couch, and you've got to be to the side of him,
23 I mean there could be one and a half, two feet
24 between you and the patient, right?
25 A: I'm not getting where you're coming from.

1 Q: Why don't you lift the couch up and take the
2 whole damn couch out? Excuse my ...
3 A: Because it would be impractical.
4 Q: You know if that couch would fit through the
5 door ---
6 A: I don't know.
7 Q: --- of that trailer? Would it be appropriate
8 to bring the whole stretcher inside the house,
9 up the stairs?
10 A: Yes.
11 Q: Okay. Are you aware of any standards that say
12 you should never bring a stretcher up and down
13 stairs?
14 A: There's usually -- there are some services will
15 define that. Usually there's a cap or a limit
16 on the number of stairs that they want you to
17 climb. So, it depends on the number that's set
18 by the department.
19 Q: Okay.
20 A: You know, I don't know see anything in the
21 protocols for Anderson County, and I don't know
22 if Iva Rescue Squad has one specific to them.
23 I don't know.
24 Q: Now I think Mr. Wicevic asked you whether you'd
25 consider this particular patient a critical

1 trauma.
2 A: Yes, sir.
3 Q: Do you recall that?
4 A: Yes, sir.
5 Q: And I think you also said something about
6 there's a potential for this patient to go into
7 shock, right?
8 A: Yes, sir.
9 Q: And do you agree with me that was a pretty
10 significant mechanism of injury?
11 A: It is a significant mechanism of injury, yes.
12 Q: Okay. Have you reviewed the Anderson County
13 protocol to see what's required with a critical
14 trauma significant mechanism of injury?
15 A: I looked through the protocols briefly assuming
16 that my testimony was more based on my opinion
17 rather than on the protocols themselves.
18 Q: Okay. Would it surprise you to know that the
19 way you described how you would treat the
20 patient would violate the protocols in Anderson
21 County?
22 A: Yes, sir.
23 Q: Okay. I'm going to ask you to look in the
24 notebook you got there, Exhibit 1. And there's
25 some little numbers on the bottom right-hand

1 corner. Those are called Bates numbers. If
2 you'll turn to page 42. Actually before we get
3 to 42 let's go to 43. Would you agree that T-
4 3, the multiple trauma shock protocol applies
5 to this situation?
6 A: In so much as there were multiple body systems
7 involved. Or that there was a potential for
8 shock. I haven't read the policy for that
9 purpose, so I'm looking at it now.
10 Q: You recall Dr. Kickham testifying yesterday
11 that he thought T-3 applied in this situation?
12 A: I don't remember his testimony specifically,
13 no.
14 Q: I'll give you a second to look at that.
15 A: Okay. So what was your question again?
16 Q: My question is do you believe that T-3 applied
17 in this situation, multi system shock protocol?
18 A: I would not apply T-3. I would not have done
19 anything to this patient based on T-3. How's
20 that? Is that a fair statement?
21 Q: Okay. If you took that position as a medic on
22 this call, you would have violated what Dr.
23 Kickham said was applicable here, right?
24 A: I don't think so.
25 Q: Okay. 'Cause I thought there was a long

1 discussion yesterday with Mr. Wicevic and Dr.
2 Kickham about whether this patient met this
3 criteria for a T-3.
4 A: Well again, I'm not here to debate the
5 protocols. I'm here to establish standard of
6 care and education. So ---
7 Q: Would you agree with me that it's ---
8 A: I don't work in Anderson. I have read through
9 these. I am not expert in Anderson County
10 policy. Ask me anything you want about Pickens
11 County policy. But I'm not expert in Anderson
12 County policy or procedure.
13 Q: All right ---
14 A: Although, understand, when the procedures and
15 protocols are written like they are, you don't
16 have to apply every procedure to a patient.
17 For example, if I want to start an IV on a
18 patient, all I need to do is fine one procedure
19 that allows me to start an IV on a patient.
20 Q: Okay. You agree with me the blind adherence to
21 a protocol can lead to bad medicine. Would you
22 agree with that?
23 A: I think doing anything in EMS blind is -- yes.
24 Q: Okay. And would you agree with me that at
25 least on your review of this T-3 protocol, you

1 got some -- there's some ambiguity about
2 whether this particular protocol applies,
3 right?
4 A: Yes, sir.
5 Q: Okay.
6 A: If the man that wrote it says so then, yes.
7 Q: All right. Turn back to 42.
8 A: Yes, sir.
9 Q: You believe that the general trauma standard or
10 the general trauma protocol applied to this
11 situation?
12 A: Yes.
13 Q: Okay. No question this was a trauma, that a
14 knife to the belly was a trauma.
15 A: Yes, sir.
16 Q: You defined a trauma could even be pulling a
17 hair out ---
18 A: Yes, sir.
19 Q: --- of your ---
20 A: I was trying to figure out how you were
21 tricking me.
22 Q: I'm not trying to trick you. Okay, so you
23 agree that it's a trauma.
24 A: Yes, sir.
25 Q: I think you said it, in your mind, it's a

1 critical trauma or a serious trauma or major
2 trauma?
3 A: By national standard, that's a critical trauma.
4 Q: Even if the patient's perfectly stable?
5 A: Yes, sir. Penetrating abdominal trauma, or
6 penetrating trauma to the torso without
7 qualifier.
8 Q: What do you mean without qualifier?
9 A: It doesn't matter how long the blade is, it
10 doesn't matter if they're stable or unstable.
11 It's still a critical patient. Now them being
12 unstable, being hemodynamically compromised
13 changes what you do to them. It's still a
14 critical patient regardless.
15 Q: Well you would agree with me under the
16 protocols that one, you've got a trauma, and
17 two you have a significant mechanism of injury,
18 right?
19 A: Yes, sir.
20 Q: Okay. So if we go to the protocol to match up
21 the flow chart on T-1 under other trauma, we
22 have a trauma, we have a significant mechanism
23 of injury, right? Look down about half way
24 down the page, you see other trauma and there's
25 a colon? The first bullet says, all patients

1 complaining of neck or back pain or patients
2 with a significant mechanism of injury, right?
3 A: Yes, sir. And again -- yes, sir. Go ahead.
4 Sorry.
5 Q: Then it continues with, will receive full
6 spinal immobilization, right?
7 A: Yes, sir.
8 Q: Okay. So if you didn't put a c-collar on this
9 patient, bring the back board in, strap him
10 down to the back board, that would be a
11 violation of the protocol, wouldn't it?
12 A: No. No, sir. So going to your phrase about
13 following something blindly, I agree you have
14 to read into this. Mechanism of injury, when
15 you refer to a mechanism of injury, it refers
16 to -- there's not one single mechanism of
17 injury. The mechanism of injury is what
18 happened to the patient, what caused the
19 injury. So, in this line, patients complaining
20 of neck or back pain, patients with significant
21 mechanism of injury, the reference is a
22 significant mechanism of injury to indicate
23 neck or back pain. So it's referring to
24 automobile accidents or something that would
25 cause neck or back pain. It is not referring

1 to, as you alluded to yesterday, a gunshot
2 wound to the finger or -- which would be a
3 mechanism of injury. The gunshot wound is a
4 mechanism of injury. A gunshot wound to a
5 finger is not necessarily a significant
6 mechanism of injury.
7 Q: That's something you have to rely on the
8 paramedic's training and experience, right?
9 A: As far as the significance?
10 Q: Yes.
11 A: Yes, sir. It goes to training and education as
12 well as to some degree of experience. It has
13 to do with kinematics or the study of the
14 transfer of energy.
15 Q: I'm going to ask you to look at GP-3. It's on
16 page 6 of that exhibit. It's called the
17 intravenous access protocol. You see that?
18 A: Yes, sir.
19 Q: Okay. Now the first, under patient assessment,
20 the first thing it says is it says, assess
21 patient for indication's, right? You see where
22 I'm talking about?
23 A: Yes, sir.
24 Q: That's the first, sort of, in the decision
25 tree, that would be your first intersection

1 where you need to make a decision. I'm
2 assessing this patient. Does he need IV, does
3 he not need IV, right?
4 A: Yes, sir.
5 Q: Okay. So with this patient you made the
6 decision he needs IV, right?
7 A: Yes, sir.
8 Q: So then you go down to the protocol. And that
9 first step is part of the protocol, right? And
10 then look down under management. You see under
11 paramedic management?
12 A: Yes, sir.
13 Q: So that's where we're getting into orders,
14 right? So if you made the decision to
15 administer IV to this patient, then you drop
16 down to the order, you see the distinction
17 between that -- this is a good example of a
18 protocol that has an order in it, right? A
19 standing order?
20 A: Okay.
21 Q: And the standing order tells you that if you
22 have a trauma patient, you're supposed to use
23 the largest catheter possible, two sites
24 preferred, and use y blood sets. Do you see
25 where I'm talking about? It's under normal

1 saline.
2 A: I see use y blood sets, but I don't see where
3 it says to do that if it's a trauma patient.
4 Q: Okay. Trauma patient is listed under normal
5 saline, do you see?
6 A: Okay. Yes.
7 Q: Do you read that protocol to say that if you
8 have a trauma patient, if you made the decision
9 that patient needs an IV, you do normal saline,
10 right?
11 A: Again, I would not -- I do not consider myself
12 an expert with Anderson County protocol. And
13 it does not expressly state that. There is
14 some ambiguity, and I would not venture to
15 guess that.
16 Q: Okay. If you were on the scene and you saw
17 some ambiguity, you would call the medical
18 control and say, I'm not sure how to handle
19 this. I got a trauma patient, I'm putting an
20 IV in. I'm not sure whether it applies or not.
21 Can you tell me what I need to do.
22 A: What I'm saying is I don't see -- there's a
23 list there. I don't imply that it tells me
24 that a trauma patient gets a y blood set.
25 Q: What else could it mean?

1 A: It's a list. I don't know.
2 Q: You said that you would put in a saline lock on
3 that patient, right? Or a ---
4 A: That would be appropriate, yes.
5 Q: Okay. Where does it say that if you made the
6 decision tree that you're going to do an IV,
7 and you got a trauma patient, where does it say
8 it's okay to put a saline lock in?
9 A: The paramedic or EMT. I mean under this
10 protocol it gives the paramedic or intermediate
11 can establish an IV access in any patient not
12 specifically addressed. I don't see that it
13 specifically addressed in here, and that's
14 where -- if I was working under this protocol
15 not knowing them intimately, that's where I
16 would hang my hat. But again, I am not expert
17 on Anderson County protocol.
18 Q: Okay. Well let me ask you this. If you give
19 ---
20 A: Let me rephrase that. My knowledge of Anderson
21 County protocol is limited.
22 Q: Okay. Fair enough. If you put a saline lock
23 in this patient, I mean you wouldn't give this
24 patient saline. If this were your patient, you
25 wouldn't give this patient saline on the way to

1 the hospital?
2 A: It would be appropriate to have fluid hanging
3 at a keep open rate. That would be
4 appropriate. It would not be appropriate to
5 load them with fluid at that point.
6 Q: If the patient's got uncontrolled bleeding in
7 the abdomen, and you can't compress that -- you
8 can't like turn a tourniquet on it or ---
9 A: Yes, sir.
10 Q: --- put pressure on it, right?
11 A: Yes, sir.
12 Q: If the blood vessels are, what's the term,
13 tamponaded?
14 A: Yes, sir.
15 Q: If the blood vessels are tamponaded and the
16 bleeding is temporarily halted, if you fill
17 that patient full of fluid ---
18 A: Right.
19 Q: --- you could mess up the clotting factors in
20 the blood, right?
21 A: Right. I don't think I can revisit what I said
22 earlier, but yes. It would increase the
23 pressure within the vessels and could
24 potentially disrupt the clotting process or
25 break loose ---

1 Q: Kind of blow the clot out, right?
2 A: Sure. Yes.
3 Q: And then all you've got is a belly full of
4 blood with some salt water mixed into it,
5 right? Is that helpful to the patient?
6 A: No.
7 Q: Okay. So you personally would not apply saline
8 in this other than maybe at a keep open rate?
9 A: Right. That would be the generally accepted
10 practice and standard of care.
11 Q: Okay. What's involved, if you're not going to
12 hand a bag of fluid, you're just going to put
13 a saline lock in this patient, tell me what's
14 involved in at least starting that saline lock.
15 A: The act of starting the IV and the act of
16 decannulation of the vein is the same. It's
17 just there's a small short tube that is filled
18 with saline that attaches to the hub of the
19 catheter.
20 Q: Okay.
21 A: And it's capped on one end as opposed to if you
22 are hanging -- I'm trying not to use industry
23 lingo. If you were to have a bag of normal
24 saline, it would have a longer tube with a stop
25 cock or an adjustment valve that would allow

1 the flow of fluid.
2 Q: What's on the business end of that device?
3 A: That goes into the hub?
4 Q: No, into the body. What goes into the body?
5 A: The IV cannula, the IV catheter.
6 Q: And how do you start that into the vein?
7 A: With a needle.
8 Q: Okay. How big is that needle?
9 A: It varies.
10 Q: Okay. If you had to estimate the length of
11 that needle, is it a seven inch needle that you
12 put in there?
13 A: No, sir. And again, the length of the needles
14 vary as well. It depends on purchase
15 practices. But they're usually anywhere from
16 inch and a quarter to two, two and a half.
17 Q: Okay. Have you ever had an IV started on you
18 personally?
19 A: Yes, sir.
20 Q: Okay. Is there some pain involved when that
21 needle goes into the vein?
22 A: Minimal.
23 Q: Okay. What if the patient was deathly afraid
24 of needles and he sees you opening up and
25 you're getting ready to stick him in the arm

1 with a needle? Have you ever had a patient
2 balk at receiving an IV before?
3 A: Have I ever, yes. I have never encountered
4 that that I haven't been able to overcome.
5 Q: Okay. And what are your available techniques
6 for overcoming that. You know, if somebody
7 says, don't stick me with that needle, what are
8 your available techniques to sort of solve that
9 situation.
10 A: Therapeutic communication.
11 Q: Okay. What if that doesn't work?
12 A: If they absolutely refuse then you can't start
13 an IV. That would be battery.
14 Q: Okay. So you have to get the consent of the
15 patient before you start the IV?
16 A: Yes, sir.
17 Q: Okay. So if you say to this gentleman, I'm
18 getting ready to stick you with a needle, and
19 he says, no you're not. You can't stick him
20 with a needle, right?
21 A: That's correct.
22 Q: Okay. What if the patient's a schizophrenic?
23 Does that matter?
24 A: As far as if they refuse it or what?
25 Q: Well yeah. If they refuse the IV and they're

1 schizophrenic. Is that a concern to you?
2 A: A concern, yes. It depends. It depends on the
3 patient's condition, it depends on their --
4 infinite number of variables there.
5 Q: Okay. Have you ever had a patient say, okay go
6 ahead and give me an IV, and then as the needle
7 gets ready to go into the skin they say, no
8 don't do it, and move in kind of like a
9 reflexive action. Try and stop you from doing
10 it?
11 A: I've had them move. I don't know that I've
12 ever had them tell me to stop in the middle of
13 the ---
14 Q: Okay. If the patient moves like that suddenly
15 with a knife in their chest, that could be a
16 problem, couldn't it?
17 A: Sure it could.
18 Q: Okay. So there's a risk involved in starting
19 an IV just to start an IV, I mean a port, just
20 to leave it open, right?
21 A: Can you say that again?
22 Q: I mean there's a risk involved in starting an
23 IV just to have a cap so if the patient someday
24 needed or sometime needed fluids it'd be
25 available to you. You agree there's a risk

1 involved in that?
2 A: I would restate that. I would say that there
3 is a risk involved in starting an IV. There is
4 always a risk involved in starting an IV. And
5 I would further add that the risk in starting
6 the IV is outweighed by the potential for the
7 patient to decompensate in this case.
8 Q: Are you charging DHEC for your time in
9 reviewing this case and testimony today?
10 A: Yes, sir.
11 Q: I'm sorry?
12 A: Yes, sir.
13 Q: Okay. You charge them by the hour?
14 A: Obviously not for all of it.
15 Q: You charge them by the hour?
16 A: For some if it, yes.
17 Q: Okay. How much of it are you charging them
18 for?
19 A: Ten hours I believe.
20 Q: Okay. What's your hourly rate?
21 A: $250.00 an hour I believe for review.
22 Q: So you're charging DHEC $2,500.00 for this
23 case?
24 A: I believe that's correct.
25 Q: For ten hours of time?

1 A: I believe that's correct.
2 Q: Okay. So the other 50 hours that you spent
3 getting ready for today and the, I don't know
4 how long we've been here today, six hours or so
5 that you've been here today, you're just giving
6 ---
7 A: Well there's a different charge for testifying.
8 But ...
9 Q: How much is the testifying charge?
10 A: It's a little embarrassing. To be honest with
11 you, I don't remember.
12 Q: Okay. Higher that 250 an hour?
13 A: Yes. I don't remember what it is.
14 Q: How much does a Pickens County -- how much do
15 you charge them, or how much do they pay you
16 for your time as a part time paramedic?
17 A: I don't know ---
18 **MR. WICEVIC:** Your Honor, I'm going to object.
19 What's it matter his pay part time job? I'm
20 not sure how that relates to his testimony.
21 **MR. ROTHSTEIN:** I imagine he makes about maybe 30,
22 $35.00 an hour as a paramedic.
23 Q: Does that sound about right?
24 **THE COURT:** It's not relevant.
25 A: Closer to half.

1 Q: Is that an overestimation of what you make?
2 A: Yeah.
3 Q: So you're charging DHEC more than ten times
4 your normal rate than you'd run a paramedic
5 call to review this case. Is that right?
6 A: Yes, sir.
7 Q: Okay.
8 A: Based on industry standards.
9 Q: Who did you speak with from DHEC about this
10 matter on -- let's say you talked to Wronski at
11 some meeting Thursday afternoon, right?
12 A: Yes, sir.
13 Q: Now what time did that meeting end?
14 A: It would have been right at lunch time, so
15 around noon.
16 Q: Have you spoken with anyone else at DHEC other
17 than Mr. Wronski about this case?
18 A: Can you qualify that? I mean in here, yes.
19 Q: About the substance of your testimony?
20 A: No. Well, Mr. last name who I can't pronounce.
21 I'm sorry.
22 Q: Vito.
23 A: Sorry.
24 Q: You've spoken with Vito?
25 A: Yes, sir.

1 Q: Okay. Anyone else at DHEC other than Wronski
2 and Mr. Wicevic?
3 A: No, sir.
4 Q: Now what did Mr. Wronski tell you about the
5 case?
6 A: Virtually nothing. He said that, what he told
7 us, because at the time Phil was standing
8 there, Phil Head, Mr. Head. He said that there
9 was a case that was initiated at some point
10 before and that the other party had called an
11 expert witness, and so now he had an
12 opportunity to call an expert witness, and it
13 was very last minute. And then that was the
14 extent of it. There was virtually nothing
15 else.
16 Q: And he offered you $2,500.00, and you said I'll
17 take it. Is that right?
18 A: Not at that point. No.
19 Q: When did you discuss what your charges would be
20 for that type of testimony?
21 A: After I viewed the video and made sure that I
22 did not know anybody that was involved in it,
23 and I told him I would do it. And then we
24 talked about the money.
25 Q: When did you tell him you would do it?

1 A: That would have been Thursday afternoon.
2 Q: You don't remember about what time it was?
3 A: No.
4 Q: Okay. So between the time the meeting broke up
5 around noon, spoke to Mr. Wronski, you reviewed
6 the video, got back with Mr. Wronski, and said
7 I'll do it. Is that a fair characterization of
8 what happened?
9 A: Yes, sir.
10 Q: How did you get the video?
11 A: Okay. I stand corrected. Thank you. I
12 apologize. It was Friday morning. It was
13 Friday morning. Ryan was in Greenville and
14 brought the book that, one of these books, and
15 handed it off to me. I was actually on the
16 phone with Mr. Wronski at the time. So I said
17 not one word to Ryan. He handed me the book,
18 and I waved and went back into my office. So
19 it was Friday. I apologize for that.
20 Q: So it wasn't Thursday it was Friday?
21 A: Yes, sir. I misspoke.
22 Q: All right. So where was the meeting that you
23 were at with Mr. Wronski?
24 A: That was here in Columbia.
25 Q: Here in Columbia?

1 A: Yes, sir. That was Thursday.
2 Q: Okay. I'm getting a little confused.
3 A: I apologize for that. I misspoke.
4 Q: Okay. So Thursday said we may need you to be
5 an expert. You didn't do anything on Thursday
6 in terms of looking at documents or ---
7 A: Right.
8 Q: Friday's the first time you ever laid eyes or
9 heard about this case, right?
10 A: Right.
11 Q: What time did the gentleman from DHEC drop off
12 the notebook?
13 A: It was early to midmorning I believe.
14 Q: So you look at the video, call Mr. Wronski up
15 and said I'll take it. I'll do this case for
16 you, is that right?
17 A: Yes, sir.
18 Q: Okay. How many times have you viewed the
19 video?
20 A: As I said earlier, it's probably five or six or
21 seven. I don't have a precise number. Also,
22 my estimation of 60 hours again was an
23 estimation. I don't know exactly the number of
24 hours. I stopped keeping track after two days
25 ago.

1 Q: Okay, so if you estimated 60 hours minus the
2 six I think you said, we're at 54 hours from
3 Friday a little before noon or right around
4 2:00 when you called Mr. Wronski until Monday
5 you spent 56 hours on the case?
6 A: I had spent a lot of time. I don't know.
7 Q: I'd venture to say you spent more time over the
8 weekend preparing for the case than I did if
9 you spent that much time on the case.
10 A: I have spent a great deal of time.
11 Q: What is it about -- I mean what have you been
12 looking at for 56 hours in connection with this
13 case?
14 A: Everything I can find.
15 Q: Did you read any of the depositions?
16 A: Yes, sir.
17 Q: Okay. Whose depositions did you read?
18 A: Everything that was in this book. I take that
19 back. I don't think it was a deposition that
20 was in this book. It was the -- I forget what
21 it's called. The IRC. Is that what it's
22 called? The IRC?
23 Q: Let me make sure I'm clear. Everything you
24 reviewed is in the notebook that's in front of
25 you?

1 A: I honestly haven't looked through this
2 notebook. But I got a notebook that is similar
3 to this. So ...
4 Q: Let me ask it this way, did you look at
5 anything other than that notebook in preparing
6 for your testimony today?
7 A: Sure.
8 Q: What else did you look at besides that
9 notebook?
10 A: Textbooks, research, a lot of research.
11 Q: Research about what?
12 A: Everything that's mentioned.
13 Q: Okay. Have you ever served in the military?
14 I didn't see that on your CV?
15 A: No.
16 Q: Okay. Are you familiar with the training that
17 Special Forces medics receive?
18 A: Somewhat. Not as much the initial training.
19 Where I teach at the University of South
20 Carolina School of Medicine, we host a course
21 for Special Forces medics from all branches,
22 not just Army, but all branches that's kind of
23 an extended care course. Physician lead. I
24 don't teach in the class. I don't think I'm
25 qualified to teach in that class. But it's an

1 extended care course taught by our physicians.
2 But I assist with the class. And so I'm
3 somewhat familiar with some of their training.
4 But as far as their primary education, no I'm
5 not.
6 Q: And I noticed in your resume there was
7 something about some courses you taught up in
8 Virginia for a contractor for the military, is
9 that right?
10 A: Yes, sir. That was the tactical combat
11 casualty care.
12 Q: I think you said you teach that to CV's. What
13 is a CV?
14 A: CB?
15 Q: CB.
16 A: Navy, they build stuff, build bridges and
17 stuff.
18 Q: I think you testified you don't ---
19 A: I mean that was one of the groups we talked to.
20 Q: Corpsmen. I think your testimony you don't
21 teach corpsmen. What does that mean?
22 A: That class -- I apologize if that was
23 confusing. That class is not designed for
24 medical personnel. It's a course much like
25 TECC, which is the tactical emergency casualty

1 care course is now, which I know if you're not
2 in EMS, you have no idea what I'm saying. But
3 it's a course that's designed for non-medical
4 personnel that teaches some very simple life
5 saving procedures like tourniquet application,
6 chest seals, like covering holes in the chest,
7 things like that.
8 Q: What do you do to keep up your knowledge and
9 skills in pre-hospital care? I know you
10 testified earlier about it's a rapidly evolving
11 field. What do you do to keep up your
12 knowledge and skills?
13 A: So you alluded to that earlier. As far as my
14 qualifications, I can say that as an educator,
15 I feel infinitely better prepared as far as
16 keeping up with the rapidly changing pace of
17 EMS, and the changing research and all that
18 that goes into it. Much more so than when I
19 was on an ambulance full time. That doesn't
20 mean I feel like I'm a better paramedic, but it
21 feels like I'm much more able to keep up with
22 the changes. I teach paramedics, I teach
23 EMT's, I teach critical care. I'm constantly
24 pushing my own knowledge. Last year I
25 completed the flight paramedic course and exam.

1 I'm not a flight paramedic. I have not served
2 as a flight paramedic, but I'm a certified
3 flight paramedic only because I needed new
4 information. I needed more knowledge. So I'm
5 pushing myself with knowledge, I took and
6 passed the community paramedic course a year or
7 two ago. Again, that's an expanded scope, kind
8 of beyond paramedic. And so now I'm teaching
9 those critical care courses as well. So
10 there's that. Because of my position with the
11 hospital and with the school of medicine I have
12 unbelievable resources available to me. As far
13 as research, I mean we have an entire research
14 department. So I'm constantly in the books,
15 constantly renewing. Every time I do a lecture
16 on whatever topic it is, I prepare for that by
17 looking up the most current research.
18 Q: And that's keeping up with cutting edge stuff's
19 important in ---
20 A: Right.
21 Q: --- providing good quality medicine, isn't that
22 right?
23 A: Yes, sir.
24 Q: Would you agree with me that outmoded treatment
25 protocols can lead to bad medicine?

1 A: Yes, sir.
2 Q: And I think you also used the phrase err on the
3 side of caution. Do you remember using that
4 phrase in your testimony with Mr. Wicevic?
5 A: Yes, sir.
6 Q: Okay. Doesn't that practice erring on the side
7 of caution presume that you're going to make an
8 error?
9 A: No, sir. It's err, not error.
10 Q: Err ---
11 A: Err.
12 Q: --- meaning to err, meaning to commit an error?
13 A: No, sir.
14 Q: Is it A-I-R or E-R-R?
15 A: I'm going to fall to the side of caution. I'm
16 going to ensure that given a risk of or a
17 potential, that I'm going to explore that
18 potential.
19 Q: Okay. And I -- we may be talking past each
20 other, but the word err, is that E-R-R or A-I-
21 R?
22 A: I'm not making an error. It is not a mistake.
23 Q: No. Listen to my question. When you say err
24 on the side of caution, are you saying err A-I-
25 R like breath air?

1 A: It is E-R-R.
2 Q: Or E-R-R?
3 A: it's E-R-R.
4 Q: Okay. And do you know what the word err means?
5 A: Yes, sir.
6 Q: It means to make a mistake, right?
7 A: Yes, sir.
8 Q: Okay. So why not just treat the patient for
9 what the patient needs rather than erring when
10 treating the patient?
11 A: Because the patient has a potential need, and
12 I'm treating based on the potential need.
13 Q: Okay. What is needs ---
14 A: Not only am I treating based on the potential
15 need, that is the standard of care.
16 Q: You used the phrase either needs based medicine
17 or evidence based medicine. What does that
18 mean?
19 A: The entire EMS industry is getting on board
20 with the rest of the medical industry. We're
21 a little late and we are moving towards
22 evidence based medicine. There's not as much
23 research in EMS as there is in the rest of
24 medicine. Frankly there aren't as many
25 educated EMS personnel as there are in other

1 forms of medicine. So it takes education in
2 order to do research. So ---
3 Q: Let me just ask you this ---
4 A: --- evidence based medicine requires us to do
5 research to prove that what we are doing is
6 working.
7 Q: Okay. And let me just paraphrase my
8 understanding. Either needs based medicine or
9 evidence based medicine, you treat the patient
10 according to what the patient -- you assess the
11 patient's needs to be or what the evidence is
12 at the call. That's not right?
13 A: No, sir. Evidence based medicine refers to
14 doing what is best for the patient's outcome.
15 It's based on patient outcome. It's strictly
16 based on patient outcome. What is the ultimate
17 outcome. And that's what evidence based
18 medicine looks at.
19 Q: Let me ask you this. I think one of your, sort
20 of -- I guess when you viewed the video one of
21 your concerns when viewing the video was the
22 language and the demeanor. I think you called
23 if affect that ---
24 A: Yes, sir.
25 Q: --- Mr. Davenport displayed, right?

1 A: Yes, sir.
2 Q: And what specifically about the video is
3 inappropriate in your mind? Is it the first
4 interaction where Mr. Davenport says to the
5 gentleman, did anybody ever tell you you're an
6 idiot?
7 A: That was the first one, yes.
8 Q: Okay. And did you see in the video that Mr.
9 Davenport was kind of smiling at the guy?
10 A: I did not see that. And I have looked at it
11 specifically for that, and I do not see a
12 smile.
13 Q: Did you look at the video on an iphone or did
14 you look at it on a big screen?
15 A: I looked at it on a screen about this size
16 (indicating).
17 Q: You recall Mr. Davenport's partner at the time,
18 the very beginning of the video when the EMT's
19 first get to the house, the partner Ms. Aiken
20 says, what'd you do now Johnny. You remember
21 hearing that?
22 A: I believe I remember what did you do Johnny.
23 I don't remember the specific wording, but
24 something like that, yes.
25 Q: Okay. Now yesterday, again I apologize to

1 everybody for breaking the courtroom. So we
2 come back at 1:00 o'clock, and Judge Robinson
3 says to me something about, Mr. Rothstein, you
4 didn't touch anything did you? She was sort of
5 joking with me. If she came out and said to
6 me, Mr. Rothstein did anybody ever tell you
7 you're an idiot, well you're being called one
8 now. Okay. I mean would you view that in sort
9 of a joking manner?
10 A: That would have made me very uncomfortable.
11 Q: Would you have thought that was abuse of me?
12 A: That would have made me very uncomfortable.
13 Q: You got to know the relationship between the
14 person who's making the statement and the
15 person who's hearing the statement before you
16 can tell whether it's offensive or not, right?
17 Do you agree with that?
18 A: Depending on the statements, to some degree,
19 yes.
20 Q: Okay. So like, if I said -- my brother falls
21 down from doing something stupid, and I say,
22 well that was a bonehead move. Bet you won't
23 do that again. Is that a denigrating or
24 disparaging comment to him in your opinion?
25 A: And this is who, your brother?

1 Q: Brother.
2 A: Your brother, no. But there's not a patient
3 clinician relationship there.
4 Q: In your experience in emergency medicine about
5 30 something years, right? Have you ever heard
6 an EMT or paramedic say something, that if you
7 just took out of context you'd think man that
8 would be offensive for somebody to hear it.
9 But in the context of your comradery in the EMT
10 profession, or whatever, you've heard some
11 inappropriate things said?
12 A: An EMT to an EMT?
13 Q: Or an EMT to a law enforcement officer, or and
14 EMT to a patient?
15 A: Yes.
16 Q: Okay.
17 A: But again, there's not a clinician patient
18 relationship even.
19 Q: So you really in order to know if something's
20 received as offensive, you need to talk to the
21 person who heard it and say, did you have a
22 problem with the way that was conveyed to you,
23 or did you have a problem with ---
24 A: When there's a clinician patient relationship,
25 the dynamics change all together. That's not

1 a friendly relationship, that's not a buddy,
2 that's a professional relationship.
3 Q: And do you think that was abuse what you saw on
4 the video?
5 A: Yes, sir. Let me rephrase that. I thought it
6 was abusive.
7 Q: Okay. And I actually wrote this down. Mr.
8 Wicevic was talking. You said, I don't know
9 the patient. I don't know this patient, right?
10 A: Yes, sir.
11 Q: Okay. So you don't know whether Mr. Davenport
12 had seen this patient around the town of Iva
13 since he'd been a paramedic?
14 A: No, sir.
15 Q: Okay. I think you also said I wasn't there,
16 right?
17 A: Yes, sir.
18 **MR. ROTHSTEIN:** I don't have any further questions,
19 Your Honor. Thank you.
20 **THE COURT:** Mr. Wicevic, before you get into
21 redirect, we're going to take a ten minute
22 break.
23 **MR. WICEVIC:** Yes, Your Honor.
24 **(Off the record from 2:53 p.m. until 3:18 p.m.)**
25 **THE COURT:** Okay. We're calling hearing back to

1 order. Mr. Wicevic, you ready?
2 **MR. WICEVIC:** Yes, Your Honor.
3 **THE COURT:** Okay.
4 **MR. DOUGLAS - RE-DIRECT EXAMINATION BY MR. WICEVIC:**
5 Q: Just a few follow up questions, Mr. Douglas.
6 There was some discussion about the potential
7 of hitting the diaphragm. How would you have
8 checked to see if there was some kind of injury
9 to the diaphragm?
10 A: By listening to lung sounds to see that they
11 were equal on both sides, and by listening to
12 the abdomen to see if you could hear gurgling
13 or lung sounds in the belly.
14 Q: From your review of this matter, did you see
15 anything that indicated Mr. Davenport checked
16 for lung sounds?
17 A: I did not. I did not witness a lung sound
18 assessment, no.
19 Q: There was a lot of discussion about the stair
20 chair, Mr. Rothstein got in the chair. How do
21 EMT's once they get a patient in the stair
22 chair, move the stair chair?
23 A: So this chair is on wheels but there is also a
24 track on the back of the chair that is friction
25 based, and the track travels down a stairway

1 and evenly distributes the weight across the
2 ledge of the stairs to reduce the movement.
3 There's no bumping, it's just a straight
4 travel.
5 Q: Okay. Is it a team effort to use the ---
6 A: Oh, yes.
7 Q: Okay. How many people do you need?
8 A: Two. At least two. Two is sufficient.
9 Q: Okay. And just to clarify, your testimony
10 during direct concerned the generally accepted
11 standards of care in the EMS. They were not
12 talking about the compliance with orders and
13 protocols?
14 A: That's correct.
15 Q: Okay.
16 **MR. WICEVIC:** That's all I have for him. Thank you,
17 Mr. Douglas.
18 **THE COURT:** Thank you, Mr. Douglas.
19 **MR. DOUGLAS:** Thank you.
20 **MR. WICEVIC:** All right. The Department's next
21 witness is Dr. Edgar Deschamps.
22 **THE COURT:** Dr. Deschamps, if you'll face the court
23 reporter, raise your right hand, he'll swear
24 you.
25 **DR. EDGAR DESCHAMPS,** having been duly sworn,

1 testifies as follows:
2 **THE COURT:** Mr. Wicevic, how many additional
3 witnesses do you have after this witness?
4 **MR. WICEVIC:** Dr. Deschamps and then Mr. Wronski,
5 and that's DHEC's case.
6 **THE COURT:** All right. One second. Mr. Rothstein,
7 how many witnesses are you calling?
8 **MR. ROTHSTEIN:** Your Honor, we can kind of shorten
9 it up a little bit. I think that some of the
10 witnesses that we have are -- I'll certainly
11 try and cut out some of the redundancy. Mr.
12 Davenport's going to testify, we have Sheilah
13 Kaiser the training officer, Craig Lawless, I
14 was going to call Dr. Alier and Mr. Naugler.
15 And we have Leo Deason, another expert witness
16 on paramedic, and we have two gentlemen here
17 from Mr. Davenport's Special Forces team. I
18 think only one of them really needs to testify.
19 **THE COURT:** Okay. If we continue to go at this
20 rate, we'll be here into next week. Go ahead.
21 **DR. DESCHAMPS - DIRECT EXAMINATION BY MR. WICEVIC:**
22 Q: Dr. Deschamps, could you state your name for
23 the record please?
24 A: Sure, it's Edgar Green Deschamps. D-E-S-C-H-A-
25 M-P-S.

1 Q: You have an exhibit packet up there in front of
2 you?
3 A: I have this proposed trial exhibits.
4 Q: For DHEC.
5 A: Yes, sir.
6 Q: Can you turn to tab 12 please?
7 A: Correct.
8 Q: Can you identify this document please?
9 A: This is a curriculum vitae for me.
10 Q: Okay, is it up to date?
11 A: I believe it's currently up to date. Let's
12 see. It was revised last year. I don't think
13 that there was any significant change.
14 Q: Okay. Can you explain to the court your
15 education.
16 A: I attended the University of South Carolina
17 here in Columbia for my undergraduate degree
18 where I received a degree in biology with a
19 cognate in math and chemistry. And that was
20 from '78 to '82, and then attended -- I'm
21 sorry, '75 to '78, and then attended the
22 University of South Carolina School of Medicine
23 '78 to '82 here in Columbia, where I received
24 Doctor of Medicine. And then attended what's
25 called a categorical internal medicine

1 residency at the VA Hospital and Palmetto
2 Health Richland here in Columbia, from 1982
3 through 1985 and received my medical licensor.
4 Q: Okay. You licensed in other states?
5 A: No.
6 Q: Any disciplinary action against your license --
7 -
8 A: No.
9 Q: --- in South Carolina? Could you explain your
10 employment from graduation until now?
11 A: Could I explain my ---
12 Q: Employment jobs.
13 A: Employment, okay. When I finished my residency,
14 I went back to my home town Bishopville, which
15 was in 1985, and I practiced there with my
16 partner John Pate until about mid 2003. At
17 which point I came over to Columbia and joined
18 a group of physicians, two of whom were in my
19 medical school class. It's the Columbia
20 Medical Group, and I have been employed there
21 since June of 2003 here in Columbia. I also
22 did work at Palmetto Baptist Emergency
23 Department as an Emergency Room physician from
24 1999 to 2012. And starting in about 2012 I
25 have worked in addition to my private practice

1 as a hospitalist for a group here called the
2 Landmark Medical Group, and continue to do so.
3 Q: Any professional organizations that you're
4 apart of?
5 A: Yes. I'm a member of the American College of
6 Physicians, American College of Emergency
7 Physicians, The National Association of EMS
8 Physicians, and National Association of State
9 EMS Officials. Those are the big ones.
10 Q: Okay. Can you explain to The Court your role
11 as a State Medical Control Physician? Let's
12 begin, when did you begin in that role?
13 A: As State Medical Director?
14 Q: Yes, sir.
15 A: That started in '95. Prior to that I was
16 associated with DHEC from 1985 on to 1995 as a
17 Regional Medical Director. And so in that
18 capacity we served on the Medical Control
19 Committee and the EMS Advisory Council. In
20 1995, I was asked by the Department to take
21 over as State Medical Director, and I've served
22 in that position from '95 until currently.
23 Q: Okay. You mentioned a few committees there.
24 The Med. Control Committee. What's their
25 roles?

1 A: The Medical Control Committee is a sub-
2 committee, a standing sub-committee of the EMS
3 Advisory Council and it's role is comprised of
4 11 physicians of varying specialties including
5 surgery, internal medicine, emergency medicine,
6 pediatrics, and their role is to recommend to
7 the Department the scope of practice and
8 appropriate medical care for pre-hospital EMS
9 in South Carolina.
10 Q: Okay. And is the EMS Advisory Council just
11 kind of a broader advisory body?
12 A: It is. It is comprised not only of members of
13 the Medical Control Committee, but also of EMS
14 agency Directors, EMS trainers, EMS medical
15 Directors, so it's a much broader composite.
16 And that council is defined in legislation.
17 Q: You mentioned the Trauma Advisory Council?
18 A: Correct.
19 Q: What is that?
20 A: The Trauma Advisory Council is also an advisory
21 council for the Department, also defined in
22 regulation and statute, comprised of members
23 from medical control, trauma surgeons from all
24 verified level trauma hospitals in South
25 Carolina, trauma nurse coordinators, rehab

1 therapists and so forth. And it's purpose is
2 to define appropriate trauma care, both pre-
3 hospital, but also at the hospital level. And
4 through that committee we verify and designate
5 hospitals as trauma centers and their level
6 within South Carolina.
7 Q: Okay. Have you served as a Medical Control
8 Physician for any of licensed South Carolina
9 EMS services?
10 A: Yes. I served for a couple. I served for the
11 Bishopville Rescue Squad from 1985 until about
12 2003. During that time the Bishopville Rescue
13 Squad was actually folded into what was
14 developed as Lee County EMS. So I served as
15 that Medical Director. I served as Medical
16 Director for Sumter County EMS for a while, and
17 then there have been a couple of other places,
18 Lynchburg EMS for a while, and a couple of
19 other places that have needed some coverage,
20 and I stepped in to help.
21 Q: Okay.
22 **MR. WICEVIC:** Your Honor, the Department would like
23 to admit Exhibit 12 into evidence please?
24 **MR. ROTHSTEIN:** No objections to the CV, Your Honor.
25 **THE COURT:** And also at this point I feel I do need

1 to disclose that looking at his CV I realize
2 that he practices with my primary care
3 physician. They're at the same medical
4 practice. That doesn't impede my ability to be
5 fair and impartial, but I wanted to disclose
6 that to you all.
7 **MR. ROTHSTEIN:** If you're fine with it, Your Honor,
8 I'm fine with it.
9 **MR. WICEVIC:** Yes, ma'am. Okay, Exhibit 12's
10 admitted?
11 **THE COURT:** Yes. It's admitted.
12 **(Petitioner's Exhibit Number 12 was admitted into**
13 **evidence.)**
14 **MR. WICEVIC:** Thank you, Your Honor.
15 Q: Dr. Deschamps, how many times have you given
16 expert testimony in the area of emergency
17 medicine?
18 A: In the ALJ setting?
19 Q: Any setting.
20 A: Any setting? I've served as expert witness on
21 multiple med-mal cases. I've done, I think for
22 the Department, I've had one other ALJ many
23 years ago that I participated in.
24 Q: Was it the Stuart Platt case?
25 A: Yes.

1 Q: Okay. What about being qualified as an expert
2 in internal medicine? Have you been qualified
3 in that regard?
4 A: I have.
5 Q: Okay. Can you explain to The Court what
6 internal medicine is?
7 A: Internal Medicine is basically defined as the
8 medicine for adults. You can break down the
9 global picture of medicine into medicine and
10 surgery, surgery having to do with operative
11 techniques, medicine having to do with the care
12 of patients non-operatively. And within
13 medicine there are things like pediatrics,
14 obstetrics, gynecology, and internal medicine.
15 Internal medicine has to do with the care of
16 the adult patient generally accepted to be 16
17 to 18 and greater.
18 Q: And what about emergency medicine?
19 A: I did emergency medicine for years when I was
20 back in Lee County. I was an Emergency Room
21 physician there. And then served at Palmetto
22 Health Baptist's emergency Department. I'm
23 technically able to be grandfathered in as a
24 fellow of the American College of Emergency
25 Physicians. I've just never done that, I've

1 never taken that certification. But basically
2 that has to do with care of persons who present
3 with emergency medical or traumatic injuries.
4 **MR. WICEVIC:** All right, Your Honor. The Department
5 would like to tender Dr. Deschamps as an expert
6 in both emergency medicine and internal
7 medicine.
8 **MR. ROTHSTEIN:** Your Honor, I do want to voir dire
9 the witness, but I think a qualification in
10 internal medicine would be irrelevant to this
11 case. I mean there's no -- it's not a medical
12 malpractice case. There's no issue about
13 whether my client complied with the standards
14 of care of an internal medicine doctor. So
15 I've got two parts to the objection. I mean
16 one is internal medicine's irrelevant, and I
17 would like to voir dire him on emergency.
18 **THE COURT:** Okay. Mr. Wicevic, why are you
19 including the internal medicine?
20 **MR. WICEVIC:** That is an area of his expertise. If
21 he used that area if his expertise in his
22 review of this matter, I think he should be
23 able to give an opinion on it.
24 **THE COURT:** The issue in this case is solely has to
25 do with the emergency care.

1 **MR. WICEVIC:** They had a trauma surgeon. Trauma is
2 distinct from emergency medicine. I made an
3 objection to that. I think if Dr. Deschamps
4 used his expertise in internal medicine in
5 reviewing this -- I understand the majority of
6 his testimony will concern his expertise in
7 emergency medicine. I'm just saying if he had
8 to use his expertise, skills, knowledge,
9 education in reviewing this with regards to
10 internal medicine, he should be able to offer
11 that testimony.
12 **THE COURT:** Okay. I'll give that some thought. Mr.
13 Rothstein, go ahead and ask your questions.
14 **DR. DESCHAMPS - VOIR DIRE BY MR. ROTHSTEIN:**
15 Q: Dr. Deschamps, you're an internal medicine
16 doctor, right?
17 A: That is correct.
18 Q: Sometimes that's referred to as a generalist?
19 A: No.
20 Q: No? It's not a specialist, right?
21 A: Yes.
22 Q: It is a specialist?
23 A: Yes. Internal medicine is considered a
24 specialty. There are other sub-specialties to
25 internal medicine such as gastroenterology or

1 neurology.
2 Q: Okay. You're not focused on any of those sub-
3 specialties?
4 A: I do not do sub-specialty work.
5 Q: Okay. And you did, looks like, a three year
6 residency after medical school?
7 A: Correct.
8 Q: Okay. Is that the shortest residency of any of
9 the specialties in medicine?
10 A: It's the standard internal medicine residency.
11 Q: My question is is that the shortest residency
12 that you can have to become a practicing board
13 certified physician?
14 A: No.
15 Q: What's shorter than a three year ---
16 A: General practice.
17 Q: Okay. You don't have any type of fellowship or
18 residency training in emergency medicine or
19 trauma, do you, other than maybe the first year
20 rotation of your internship?
21 A: Not formal training in an academic setting.
22 Q: Okay. And I noticed you're board certified
23 only in internal medicine, is that right?
24 A: That is correct.
25 Q: Okay. Even though you said you could be

1 grandfathered in somehow to something else,
2 you're not board certified in anything but
3 internal medicine?
4 A: That is correct.
5 Q: You've never been a fellow of the American
6 College of Emergency Physicians have you?
7 A: No.
8 Q: Okay. So when you listed your membership in
9 your CV to that professional group, that would
10 be like me joining the South Carolina trial
11 workers, right? There's no -- you don't have
12 to prove yourself to become a member of that,
13 right?
14 A: No. You don't have to take a boarded test,
15 correct.
16 Q: You just apply and pay some money?
17 A: And attend the meetings, things of that nature,
18 yes.
19 Q: And you've never been board certified in any
20 type of surgery, have you?
21 A: Not in a sub-specialty of surgery, no.
22 Q: Okay. Never been board certified in trauma
23 surgery by the American Board of Surgery?
24 A: No.
25 Q: Have you ever been licensed as a paramedic or

1 an EMT?
2 A: Yes.
3 Q: When were you licensed as a paramedic or EMT?
4 A: Back in the '70's. '75, 6, somewhere in that
5 range up through '82 or '83.
6 Q: Okay. When you were receiving your training,
7 do you recall that mantra O2, IV, and monitor?
8 A: I've heard that, yes.
9 Q: Okay. You ever served in the military?
10 A: No.
11 Q: I beg your pardon?
12 A: No, sir.
13 Q: Okay. Are you familiar with the medical
14 training that Special Forces Medics receive?
15 A: Not in specifics. Just in generalizations.
16 Q: And in looking at your CV, I don't see that
17 you've offered any scholarly publications or
18 given any type of presentations on emergency
19 medicine or trauma, have you?
20 A: No.
21 Q: Would you have had the skill set necessary to
22 remove that knife in the emergency department?
23 A: No. That knife should have been removed in the
24 OR.
25 Q: Okay. Would you have had the skill set to

1 remove that knife in the OR?
2 A: No. I would not do that.
3 **MR. ROTHSTEIN:** Your Honor, I object to this witness
4 being qualified as an expert in anything
5 frankly. He's certainly not qualified as
6 emergency medicine. He's not received any
7 specialized training in emergency medicine.
8 And I don't think he meets the qualifications
9 to be an expert witness.
10 **THE COURT:** Okay.
11 **MR. WICEVIC:** Your Honor, if I may?
12 **THE COURT:** Yes.
13 **MR. WICEVIC:** He has significant employment in
14 Emergency Rooms. He has significant
15 participation in various committees that
16 surround Emergency Room practice in EMS. I
17 think he's wholly qualified to be an expert in
18 emergency medicine.
19 **THE COURT:** Okay.
20 **MR. WICEVIC:** He's been qualified in several other
21 proceedings.
22 **THE COURT:** No. I agree that he does meet the
23 qualifications to be qualified as an expert in
24 emergency medicine, but you're also requesting
25 that he be qualified as expert in internal

1 medicine made by his training and
2 credentialing. He is qualified but I'm just
3 wondering the reason for it. But I find that
4 he is qualified to testify as an expert in
5 internal medicine.
6 **MR. WICEVIC:** And, Your Honor, I will keep Dr.
7 Deschamps' testimony as closely related to this
8 matter as possible.
9 **THE COURT:** Okay. Because that's what I'm thinking,
10 that he is only going to be rendering expert
11 opinions in the area of emergency.
12 **MR. WICEVIC:** Related to this ---
13 **THE COURT:** Yeah.
14 **MR. WICEVIC:** Yes, ma'am. All right.
15 **DR. DESCHAMPS - DIRECT EXAMINATION BY MR. WICEVIC**
16 **(CONT.):**
17 Q: Dr. Deschamps, you were involved factually with
18 this matter, is that correct?
19 A: Yes, sir. I was.
20 Q: Okay. So let's get to your factual involvement
21 first. Before we do that, I'm sorry, can you
22 explain some basic pre-hospital emergency
23 medical principles that are particularly
24 applicable to this matter?
25 A: Yeah. There are several. One is basic

1 medicine concept which is primum non nocere,
2 first do no harm. The second is to be
3 respectful and care for the patient in a
4 respectful manner, and the third is to think
5 ahead of the game and figure on potential
6 problems you may have, and manage for those.
7 Q: Okay. Factual involvement. Did you have any
8 involvement in this matter prior to the case
9 going to the Investigative Review Committee,
10 the IRC?
11 A: Other than I was informed of it and was asked
12 if this should be reviewed.
13 Q: Okay. Did you provide any kind of guidance?
14 A: I said based on what I was told in a summary
15 aspect, that yes it should be.
16 Q: Do you provide recommendation and guidance to
17 staff?
18 A: Correct. That's part of my requirements under
19 the statute is to provide that.
20 Q: Okay. And you mentioned the statute the State
21 Med. Control Physician is a defined physician
22 in the EMS act, is that correct?
23 A: Correct. 4161.
24 Q: Yeah. 4461.
25 A: 4461.

1 Q: And it outlines a number of responsibilities
2 for you?
3 A: Correct.
4 Q: Can you explain those responsibilities?
5 A: Basically my job is to provide medical
6 expertise and counsel to the Department in the
7 aspect of emergency medical care pre-hospital
8 in so much as to recommend medications,
9 procedures, protocols, and the extent for the
10 scope of the practice in the pre-hospital
11 setting. In addition, I'm obliged to review
12 cases that may come up and offer the Department
13 recommendations for remediations, punitive
14 actions that would occur based upon complaints
15 and investigations. So those are the big areas
16 that we cover.
17 Q: Okay. So you get the case, you recommend
18 review by the IRC. What is the IRC?
19 A: The IRC is also defined in regulation, and it
20 is the Investigative Review Committee which is
21 comprised of the State Medical Director, at
22 least one other emergency physician, a minimum
23 of two paramedic trained personnel, and other
24 personnel such as service Directors. The goal
25 being to fairly and blindly review a case to

1 make recommendations. The IRC has restrictions
2 in that no member who serves on the IRC can
3 participate in a case of a person that they
4 know or within the region from which they come.
5 So if a person is in the low country -- if a
6 case comes from the low country, no participant
7 in the IRC may be from the defined low country
8 area or if they know that person.
9 Q: So you try to recuse when there's some kind of
10 bias?
11 A: Correct.
12 Q: Okay. What did the IRC consider in review of
13 this Mr. Davenport matter?
14 A: The materials?
15 Q: Yes, sir.
16 A: Is that what you're asking? The IRC looked at
17 the information provided by the investigator
18 from DHEC, which included statements, medical
19 records, a video, I believe those were the
20 things we had at that point.
21 Q: I'm sorry, did you say the patient care report?
22 A: Correct. Yeah, medical records including the
23 patient care report. Yes.
24 Q: Okay. Can you explain the general procedure
25 with IRC as far as presenting cases?

1 A: Basically it is not a, what would be considered
2 judicial proceeding. We don't swear witnesses
3 in. We basically have the investigators come
4 in, present the information to the members of
5 the committee that they have gleaned, then we
6 ask the persons who are the subject of the
7 investigation to attend and make statements and
8 answer questions if they wish to do so.
9 Q: Okay. Was Mr. Davenport asked questions or did
10 he otherwise participate in this IRC?
11 A: He did. Both Mr. Davenport and Mr. Rothstein
12 were there, and were allowed to speak, to
13 answer questions, and to offer any information
14 that they wish to provide to us.
15 Q: Okay. How many IRC matters have you been
16 involved with?
17 A: It's hard to say. A lot of our investigations
18 as previously mentioned are resolved with
19 consent orders or with remediation. Maybe a
20 couple a year. It seems like they kind of run
21 in groups. We may go a year with none, and
22 then a year that we've got several.
23 Q: Have there been IRC's where there's been
24 recommendations of no disciplinary action?
25 A: Yes.

1 Q: Okay. What were the recommendations for this
2 matter?
3 A: From the IRC?
4 Q: Yes, sir.
5 A: The IRC made the recommendation to the
6 Department, and I'll have to read I tot be 100
7 percent sure that I ---
8 **MR. ROTHSTEIN:** Your Honor, I'm going to object to
9 this. This is, number one, heresay. Number
10 two, it's irrelevant. And number three, this
11 is a de novo hearing. The law does not allow
12 you to give any type of deference to what
13 happened below. So I would object to the
14 recommendations and decisions the IRC is
15 admissible to evidence.
16 **MR. WICEVIC:** Well, Your Honor, I can ask him if
17 he's aware of the recommendations of the IRC
18 and his involvement in relaying those
19 recommendations. Regarding the relevance, I
20 think the recommendations of the committee full
21 of unbiased, you know, various professionals
22 around the State in this industry are certainly
23 helpful in you making your decision.
24 **MR. ROTHSTEIN:** Your Honor, I've got a real problem
25 with him representing to The Court this is an

1 unbiased panel. The IRC meeting was lead by
2 Mr. Wronski. The meeting was chaired by Dr.
3 Deschamps. When Dr. Deschamps said that we
4 were allowed to provide everything at the
5 hearing that we needed, that's not accurate.
6 He refused to accept the grievance material
7 that Mr. Davenport provided. We also didn't
8 have an opportunity to participate in the first
9 half of the IRC meeting. We were sat in a room
10 on a different floor than the IRC meeting. So
11 Mr. Wronski described the IRC meeting as sort
12 of like a Grand Jury. Again, the decisions of
13 that body are not relevant to this case. And
14 the recommendations of the body are heresay.
15 **THE COURT:** I agree.
16 **MR. WICEVIC:** Okay. I'll move on.
17 **THE COURT:** Yes. Okay. The objection is sustained.
18 Q: All right. We talked about your factual
19 involvement. Did it end right there after the
20 IRC until this contested case came up and we
21 contacted you?
22 A: Yes. To the best of my knowledge.
23 Q: Okay. In your expert opinion were Dr.
24 Kickham's various orders and protocols
25 appropriate, I mean medically appropriate?

1 A: Yes, they were.
2 Q: Now were they appropriate as far as the level
3 of EMT certifications and the corresponding
4 skills that those EMT's can perform?
5 A: As far as I can see, yes.
6 Q: Okay. You mentioned the State protocols
7 earlier. Can you explain to The Court what
8 State protocols are?
9 A: The Medical Control Committee develops for the
10 State a set of protocols very similar to what
11 you've seen in general aspects. They are
12 different in format. And these are consensus
13 documents developed by members of the medical
14 control, which again include emergency
15 physicians, pediatricians, and trauma surgeons,
16 as well as internists, and are felt to be
17 appropriate practice within the scope of
18 practice for paramedics and all levels of
19 medics within South Carolina. We revised these
20 recently and sent them out to the field. They
21 are not mandatory -- in general they are not
22 mandatory. There are a couple of the protocols
23 that we do require as mandatory protocols
24 within our State list. But generally we set
25 these protocols as ceiling protocols, meaning

1 that the local EMS agency has the ability to do
2 anything up to the levels we have specified,
3 but may not proceed beyond those levels. So we
4 set what South Carolina's maximum scope of
5 practice is for the basic, the maximum scope of
6 practice for the intermediate, and the maximum
7 scope of practice for the paramedic. So a
8 local service may unitize a protocol up to
9 those maximums but may not exceed it.
10 Similarly they may downgrade the protocols and
11 not utilize those protocols, or may elect to
12 not utilize some procedure, or medication, or
13 whatever within the protocol.
14 Q: Okay. Can you explain to The Court the
15 distinctions between protocols and orders?
16 A: Okay. Protocols as has been stated before are
17 representations for algorithmic or guideline
18 processes on how to manage a given medical
19 situation. And these protocols represent what
20 is generally accepted as best practices and or
21 standards of care. Within the protocols you
22 may have directives to various levels of
23 certification by a physician which constitutes
24 standing orders. For example, within a
25 protocol it may say, open the airway. That's

1 part of the protocol. And in another place it
2 may say, intubate the patient. That is a
3 standing order. In this situation, intubate,
4 okay?
5 Q: Okay. Would you characterize the practice of
6 civilian paramedicine and pre-hospital care as
7 cookbook medicine?
8 A: No.
9 Q: Okay. Why is that?
10 A: Because it requires thought and integration of
11 knowledge, and knowledge of how to integrate
12 multiple protocols within a given scenario.
13 They're very -- in fact I don't know of any
14 scenarios where they are a strictly single
15 protocol based scenario where you've got just
16 a plain common garden variety heart attack.
17 Usually they are protocols that involve airway,
18 or shock, or cardiac arrest, or ventricular
19 fibrillation. So you're proceeding down one
20 protocol and may shift completely out of that
21 protocol to another protocol, follow that
22 protocol down, and then shift back into the
23 first. And this may occur multiple times. So
24 there's nothing cookbook about it. You got to
25 be able to think ahead and know where you may

1 have to deviate from one protocol into another.
2 Q: And deviate, do you mean move from?
3 A: Yeah.
4 Q: Okay.
5 A: Right.
6 Q: Okay. Before we get into the protocols and
7 orders, what did you review as part of the
8 expert opinion you're offering today?
9 A: I reviewed the documents that were provided by
10 the Department, which included the patient care
11 records, the hospital medical records,
12 Emergency Department records and operative
13 record, multiple depositions and a video that
14 we've seen earlier.
15 Q: Okay. I mean, did you determine whether any
16 protocols or orders were violated by Mr.
17 Davenport?
18 A: Yes.
19 Q: Okay. Well you're familiar with this patient,
20 what would the first protocol you look to be
21 this universal patient care protocol?
22 A: That's generally the best place to start with
23 protocols because it applies to all patients.
24 Q: Okay. Well let's turn to that. It's Exhibit
25 1, Bates page 15.

1 A: Stand by just a minute.
2 Q: And I apologize for the small type.
3 A: It's all right. I have glasses.
4 Q: Good.
5 A: Bates page 15 you said?
6 Q: Yes, sir.
7 A: All right. Go ahead.
8 Q: can you identify this?
9 A: This is listed as universal patient care
10 protocol general procedures for Anderson County
11 EMS, signed by Thomas Kickham DO dated 9/5/13.
12 Q: Okay. And is that in accordance with the State
13 protocols? Is GP-18 in accordance with the
14 State protocols?
15 A: Right. Yes. It does not exceed the State
16 protocols and generally follows in another
17 method of presentation than the current State
18 protocols.
19 Q: Okay. Did you see any concern with violations
20 of this particular protocol?
21 A: Well sure. I mean there are a couple here.
22 For example under management, bring equipment
23 to the patient's side, demonstrate
24 professionalism and courtesy, initial -- I
25 wouldn't ding initial assessment particularly

1 bad. And then those are the biggest ones that
2 I see there.
3 Q: Okay. Well are any of these an order?
4 A: An order? Yeah. For example, bring all
5 equipment to a patient's side. That is a
6 definitive statement. Do this.
7 Q: Okay.
8 A: Okay? It's not a consider or think about.
9 It's a definitive declarative statement. Bring
10 equipment.
11 Q: Okay.
12 A: So that would be considered a standing order.
13 Vital signs would be considered a standing
14 order that you would want to obtain. Now they
15 are apart of the protocol, but they are
16 directives to the medics in following of these.
17 Q: Okay. So you said bring all equipment to
18 patient's side.
19 A: Correct.
20 Q: Which equipment was lacking?
21 A: Well I didn't see stretcher or a carrying
22 device.
23 Q: Okay.
24 A: I didn't see oxygen. It may or may not have
25 been there. It's not important whether it gets

1 used. If it is needed, it needs to be there.
2 Q: Okay. You talked about demonstrate
3 professionalism and courtesy.
4 A: Well that was a big area, yes ---
5 Q: Okay.
6 A: --- that was deficient.
7 Q: And can you explain what your concern was with
8 that?
9 A: Well I think it's fairly straight forward and
10 simple. You just have to look at the video.
11 You do not approach a patient in that fashion.
12 That's just not acceptable.
13 Q: How might that affect patient care?
14 A: Well it could very easily initiate an
15 adversarial relationship right off the bat, and
16 what you're after is a comradery with the
17 patient. You want to demonstrate compassion to
18 the patient. You want the patient to feel
19 comfortable with you. You want the patient to
20 feel reliant upon you, and that he can rely
21 upon what you recommend doing.
22 Q: Okay.
23 A: He or she.
24 Q: Any other concerns with this particular GP-18
25 and compliance?

1 A: Not particularly.
2 Q: Okay. Let's skip back one.
3 A: Okay.
4 Q: GP-16, patient safety protocol.
5 A: All right.
6 Q: Any concerns with compliance with that
7 protocol? And let me back up a little bit.
8 A: Okay.
9 Q: Is it applicable?
10 A: The patient safety protocol? Well, sure. I
11 mean you always want to make sure that
12 everything you do allows for patient safety.
13 Q: Okay. And is this acceptable in terms of
14 compliance with the State protocols?
15 A: Correct. It is.
16 Q: Okay. And do you have any concerns with Mr.
17 Davenport violating this protocol?
18 A: I'm just looking. I don't see any large areas
19 there where I'm particularly concerned. One
20 thing that would concern me, and it would fall
21 under this generally is that the patient for a
22 period of time was left unmonitored so to speak
23 in the back of the ambulance once they were
24 moved from the house out. Along with that in
25 patient safety protocol, the safety also

1 includes not making something worse, and
2 ambulating the patient would violate maybe the
3 spirit of this.
4 Q: Well let me ask you to look at the bullet
5 points under paramedic. Does it state anything
6 regarding ambulations?
7 **MR. ROTHSTEIN:** Your Honor, he's leading the
8 witness. I'm trying to be somewhat patient,
9 but he's leading the witness to exactly what --
10 he's just having him read off a bullet point.
11 That's just nothing more than Mr. Wicevic
12 testifying.
13 **MR. WICEVIC:** I'll try not to, Your Honor.
14 **THE COURT:** Okay.
15 Q: I think it might be the small text.
16 A: Yeah. It is and trying to get through them
17 all.
18 Q: Take your time.
19 A: But particularly, you know, you've got to
20 transport all patients on appropriate carrying
21 devices, not done. That's under the EMT
22 paramedic. Ensure that all patient restraints
23 are utilized on each carrying device. Well no
24 carrying device, you can't do that. Both
25 personnel should maintain control of the

1 stretcher at all times. Well didn't get used
2 until at the ambulance. Stretchers and other
3 equipments. So those are the big ones that I
4 would say there.
5 Q: Okay. Let's turn to page 16.
6 A: Okay.
7 Q: GP-19.
8 A: Okay.
9 Q: Can you identify that?
10 A: This is the adult assessment protocol for Dr.
11 Kickham.
12 Q: Okay. And I assume this is an adult patient,
13 it would be applicable.
14 A: Yeah.
15 Q: Did you have any concerns with violations of
16 this protocol?
17 A: Well I did not see a focused history and
18 physical based on the patient's Chief
19 complaint. There was parts of that done, but
20 certainly not an adequate one. Assess the need
21 for critical interventions. And then it states
22 that if none are anticipated, downgrade -- well
23 certainly critical interventions could be
24 anticipated in this situation. Perform
25 secondary examination was not done at the

1 facility, or at the residence. But that's
2 acceptable. Maintain ongoing assessment
3 throughout the transport appears to have been
4 done.
5 Q: Okay.
6 A: And then the documentation of findings and
7 information associated with assessment and
8 performed procedures, certainly there was no
9 that I saw, no documentation of the original
10 in-home evaluation.
11 Q: Are you speaking about Mr. Davenport's
12 evaluation?
13 A: That's who I saw do what was done on the video.
14 Q: Okay. And those various procedures you just
15 mentioned, would those be considered protocols
16 or orders?
17 A: That does kind of overlap. I would -- and the
18 way these are written, it's not clear where one
19 stops and where another one starts. But I
20 would say, for example, perform a focused
21 history and physical based on patient's Chief
22 complaint. To me that would be an order. It's
23 a declarative statement, do this. So that's a
24 directive from the physician. So sometimes I
25 think we make too much of is this a protocol or

1 is this an order. There are times when it's
2 very clear, give them medicine, give x amount
3 of a medicine. That's clearly a standing
4 order. But if you say take the stretcher to
5 the bedside, that's an order but it falls
6 within the protocol. So it's kind of wishy
7 washy.
8 Q: Okay. Well I don't think I asked you about the
9 orders for the patient safety protocol, GP-16.
10 If you move back to page 14 very quickly. And
11 you talked about these various procedures that
12 you felt were applicable. Would they be
13 considered orders?
14 A: Under GP-16 you said?
15 Q: Yes, sir.
16 A: Yeah. I would say that these are orders. But
17 again, it's often not clear which one becomes
18 an order and which one becomes part of the
19 protocol. But regardless, you're supposed to
20 follow the document. And so whether you
21 violate the standing order or violate the
22 protocol, it's not necessarily a difference in
23 our eyes.
24 Q: And you said these. Are you referring to the
25 ambulation and the carrying device directives?

1 A: Correct. I mean I would consider that a
2 physician order. You don't ambulate the
3 patient, you do bring the stretcher to the
4 bedside.
5 Q: Okay. You've done, I think these are kind of
6 the overlapping initial kind of assessment
7 protocols ---
8 A: Right.
9 Q: --- and orders. Where do you go from there?
10 A: Well you go where the patient will lead you.
11 In this case this patient was obviously a multi
12 trauma patient. Penetrating abdominal wound.
13 So you would go to a protocol that fits that.
14 Now that may be several protocols. There was
15 no obvious indication of an airway difficulty,
16 which would be high on your list to look for.
17 So you can move past that unless you see
18 something. There's no obvious indication that
19 the patient was in immediate circulatory
20 collapse so you can move past that. So you can
21 get down into a trauma, multi trauma IV
22 protocol, that area, at this point.
23 Q: Okay. Well let's turn to T-1, we can start
24 there, page 42.
25 A: All right.

1 Q: Okay. Would T-1 be applicable?
2 A: Sure. This is a general trauma standard of
3 care. So certainly this falls under trauma,
4 this is care for trauma in general. So yeah.
5 This would be an applicable protocol.
6 Q: What's trauma mean?
7 A: Well it depends on whether you want the Oxford
8 dictionary definition or not. But in South
9 Carolina trauma and traumatic injury is
10 actually defined in regulation. And it is the
11 application of a extrinsic force to the body of
12 a person that produces injury, which has a
13 substantial likelihood to require either
14 medical or surgical intervention to reduce or
15 prevent the risk of disability or death. So
16 that's actually a technical definition for
17 South Carolina when we refer to trauma or
18 traumatic injury, that's what that's based on.
19 Q: Okay. And I think you're referring to the
20 trauma regulation ---
21 A: Correct.
22 Q: --- regulation 61-116.
23 A: Correct. And that is part of the EMS system.
24 Q: Okay. All right. Did this patient suffer
25 trauma?

1 A: Correct. Yes.
2 Q: Okay. Now the first one, T-1, general trauma
3 standards of care. Is there a more specialized
4 trauma protocol that would be applicable for
5 this patient?
6 A: Well, sure. There was a -- over on Bates 43,
7 we see the multiple trauma slash shock
8 protocol. And that would be certainly
9 appropriate for this.
10 Q: All right. Why is that applicable?
11 A: Because this patient had a multiple trauma or
12 potentially multiple trauma. And we've got to
13 assess for potentialities. So this potentially
14 was multiple trauma based upon systems that
15 could be involved from the mechanism of injury.
16 Q: Okay. What about shock?
17 A: The patient had the potential for shock, but
18 based upon the documentation I've been given,
19 there was no indication of current shock.
20 Q: Okay. Now did Mr. Davenport comply with this
21 protocol?
22 A: No.
23 Q: Okay. How did he fail to comply with it?
24 A: Well, so in this one it states to initiate
25 cardiac monitor lead two, initiate intravenous

1 access protocol. So in that sense he failed to
2 do those two things within this protocol.
3 Q: Okay. Anything else?
4 A: There are parts of this protocol that were not
5 indicated. For example, initiate airway
6 management protocol. He -- and we could
7 clearly see the patient did not have that as an
8 issue, so he checked it, it's not there, he can
9 move ahead. So a couple of these things do not
10 particularly apply in this case. Let me just
11 see. Up at the top under general information
12 it state that intravenous access is initiated
13 en route to the medical facility unless
14 extrication is required. So the fact that, by
15 what we know, the paramedic was driving. He
16 therefore could not follow that part of the
17 protocol.
18 Q: Okay. Anything else?
19 A: No. That's all I see right there.
20 Q: Okay. Well you mentioned that the airway
21 management protocol, and just for clarification
22 -- excuse me, you talked about oxygen therapy.
23 A: Okay.
24 Q: Turn back to the front, page 5, GP-1
25 A: Bates 5.

1 **MR. ROTHSTEIN:** Your Honor, I'm not trying to
2 interrupt Mr. Wicevic, but there own expert on
3 paramedics said oxygen was not required for
4 this patient. And now they're going to offer
5 Dr. Deschamps to apparently contradict their
6 own expert. I mean I think this is ---
7 **MR. WICEVIC:** Well he was talking about the EMS
8 generally accepted standards. I just want The
9 Court to know Dr. Deschamps' opinion on this
10 matter. He's talking about protocol
11 compliance. I just want you to understand Dr.
12 Deschamps' opinion. I think that will be
13 helpful with your rendering of a decision in
14 this matter. I'll try to make this quick. I'm
15 trying to get through this.
16 **THE COURT:** Okay. The objection is overruled.
17 Q: Dr. Deschamps, can you explain why or why not
18 this oxygen therapy was required pursuant to
19 this order?
20 A: Well it says initiate adult airway management
21 protocol. And then it gives respiratory rate
22 greater than ten, administer oxygen as
23 indicated for mild distress, nasal cannula two
24 to six liters per minute. And so he didn't do
25 that. Now you know, you can make the argument

1 that the guy had adequate O2 stats. But the
2 way this protocol is written, that's a
3 violation.
4 Q: Okay. Is it a violation of an order or a
5 protocol. Well it would be an order 'cause
6 oxygen counts as a medicine, and it says, if
7 this do that.
8 Q: Okay. And where are you referring to in this
9 GP-1?
10 A: GP where?
11 Q: GP-1. Are you referring to ---
12 A: I was looking under EMT paramedic respiratory
13 rate greater than ten per minute, administer
14 oxygen as indicated, mild distress, nasal
15 cannula two to six liters per minute, which is
16 the second paragraph there. I mean certainly
17 the guy -- the patient did not need his airway
18 opened. It was clearly open, so a lot of this
19 is really not necessary. And you can make that
20 argument because under his pulse oximetry scale
21 he was, if I remember right, above 95 percent.
22 So you can make that argument.
23 Q: Okay. Anything else with regards to GP-1?
24 A: Not that I see.
25 Q: Okay. All right. Let's turn back to T-3, page

1 43. Initiate cardiac monitor lead two. You
2 said that was an order?
3 A: Yes.
4 Q: Okay.
5 A: Yeah, that's not a debate. It says, do this.
6 Q: Okay. Did Mr. Davenport comply with that
7 directive?
8 A: No. He was not in the back.
9 Q: Okay. Initiate intravenous access protocol.
10 A: That's correct. It's under the paramedic
11 section and it says do that.
12 Q: Okay. Well let's turn back to GP-3, page 6.
13 A: Okay.
14 Q: Can you explain the applicability of this
15 particular protocol?
16 A: Well this is just a protocol on how to initiate
17 an IV. And under -- it lists that which is
18 appropriate in South Carolina, only an
19 intermediate EMT or paramedic level EMT are
20 able to do this. And under paramedic for
21 example it states the type of fluid to utilize
22 and whether or not you can utilize bolus fluids
23 or what sites to be utilized.
24 Q: Okay. And what would be appropriate for this
25 particular patient?

1 A: Well certainly the patient needed IV access.
2 I would have minimal difficulty if he capped
3 it, hep-locked it or saline locked it. But the
4 point was the patient needed the IV access.
5 Q: Okay. And Mr. Davenport did not comply with
6 that?
7 A: No.
8 Q: Okay. All right. Getting back to those trauma
9 protocols, I think you went through everything
10 applicable in T-3 ---
11 A: What Bates page are you on again?
12 Q: I'm sorry. Page 43.
13 A: Okay.
14 Q: Any complaints with compliance with T-2
15 regarding transport?
16 A: No. I don't recall any particular issues
17 there. They did the right thing. They got him
18 out and gone.
19 Q: Okay. And I don't think I asked you this for
20 the trauma shock protocol or the intravenous
21 access protocols. Are those both in accordance
22 with the state protocols?
23 A: Are these protocols? Yes. They're in
24 accordance with ---
25 Q: Okay.

1 A: --- South Carolina State protocols.
2 Q: Okay. We've got the IV. Where does the
3 paramedic, where does Mr. Davenport go from
4 here?
5 A: In what respect?
6 Q: In his patient care. Are there any other
7 applicable protocols?
8 A: Well, I mean I think that those are the major
9 ones. You know, starting at the house, the
10 walking of the patient has to do with patient
11 safety and universal care. Then the failure to
12 initiate an IV while in the back of the unit
13 was a problem. So I think those are the
14 biggest issues we've got.
15 Q: Any concerns with transport who was riding in
16 the patient compartment?
17 A: Right. Yeah. I mean, that's what I've said
18 all along is that the highest qualified person
19 should have been in the back. So that's an
20 issue but it's not necessarily a failure to do
21 some step in a protocol. It's a failure to
22 oversee the entire picture of the call. The
23 higher level person should have been in the
24 back.
25 Q: Okay, so thus far, you have problems with Mr.

1 Davenport's conduct and verbal interactions ---
2 A: Correct.
3 Q: --- the transfer from the scene of the injury
4 to the ambulance ---
5 A: Correct.
6 Q: --- IV access, and then the transport decision
7 as far as who rides?
8 A: Correct.
9 Q: Do these inactions and actions of Mr. Davenport
10 create a substantial possibility of death or
11 serious bodily harm?
12 A: They did.
13 Q: Can you explain to The Court how you made that
14 determination?
15 A: Well in the absence of an adverse outcome does
16 not indicate adequate or good medicine. And
17 the failure to foresee and provide for such
18 things as IV fluids for acute decompensation by
19 having the highest trained member in the back
20 could have lead to severe worsening of the
21 patient's condition and or death.
22 Q: Okay. I mentioned a number of failures that we
23 just discussed. Did any of them individually
24 create a substantial possibility of death or
25 serious harm?

1 A: Well sure. Yes. The walking of the patient,
2 the failure to initiate an IV. All of those
3 things could potentially lead to worsening of
4 the situation. Or failure to correct a
5 worsening situation.
6 **MR. WICEVIC:** I beg The Court's indulgence.
7 Q: Dr. Deschamps, that's all the questions I have
8 for you.
9 A: Okay.
10 Q: Please answer any questions by Mr. Rothstein.
11 **DR. DESCHAMPS - CROSS-EXAMINATION BY MR. ROTHSTEIN:**
12 Q: Dr. Deschamps, a minute ago I think you
13 testified that the regulations actually define
14 the term trauma.
15 A: Trauma or traumatic injury.
16 Q: And what regulations are you talking about?
17 A: That's the South Carolina trauma regulation.
18 Q: Okay. Do you know what number of the South
19 Carolina Trauma Regulation?
20 A: 61-116.
21 Q: 61 ---
22 A: I think.
23 Q: --- 116.
24 A: I'd have to pull it up and look at it. I never
25 can remember all the numbers. But it's the

1 South Carolina trauma regulation.
2 Q: And does that regulation apply to emergency
3 medical services?
4 A: Yes.
5 Q: Okay. I thought regulation 61-7 was the
6 regulation for emergency medical services.
7 A: It does. But we have several regulations that
8 also impact EMS. For example, the AED
9 legislation and regulations can affect EMS.
10 **MR. ROTHSTEIN:** At the risk of breaking this
11 machine, Your Honor, is it possible for me to
12 try to use the Elmo?
13 Q: Can you see that, Dr. Deschamps, 'cause I can
14 zoom in a little bit.
15 A: Okay.
16 Q: Do you recognize the regulation 61-7 is the
17 DHEC regulation for emergency medical services?
18 A: Yes.
19 Q: Okay. And if you'll look, this is for the
20 little table of contents. You see section 200
21 says, definitions?
22 A: Correct.
23 Q: Okay. All right. I'll turn in the book to
24 section 200, okay?
25 A: All right.

1 Q: And I'll represent to you I believe these
2 definitions are in alphabetical order. See
3 where starts advanced life support has a
4 definition?
5 A: I do indeed. Yes.
6 Q: Okay. Then I'm going to go down to hh in the
7 section 200, the suspension, right? It has a
8 definition of the suspension.
9 A: Okay.
10 Q: And then it skips to the department, you see
11 that?
12 A: I do.
13 Q: Okay. And then vocational school.
14 A: I do.
15 Q: Okay. There's no definition of the word trauma
16 or traumatic injury in the EMS regulations, is
17 there?
18 A: It's in the trauma regulations is what I said.
19 Q: But my question is there's not one in the EMS
20 regulations?
21 A: Not in the EMS regulations.
22 Q: Now, Mr. Wicevic went through a bunch of
23 policies in this notebook, okay. You now Dr.
24 Kickham?
25 A: Yes. I mean not personally on a friendly

1 basis. But he's been at it a while and I've
2 been at it a while.
3 Q: Okay. That Exhibit 1 in that big notebook
4 there is the standards and protocols for
5 Anderson County EMS, isn't that right?
6 A: It is.
7 Q: So that's what Dr. Kickham expects paramedics
8 and EMT's under his medical license to abide
9 by, isn't that right?
10 A: Correct.
11 Q: So those protocols aren't what DHEC expects
12 paramedics and EMT's to abide by, right?
13 A: Yes.
14 Q: In terms of the standards of care that DHEC
15 expects of a medical provider, that's not
16 reflected in Exhibit 1, is it?
17 A: Yes. It is.
18 Q: Okay. Those are Dr. Kickham's expectations,
19 not DHEC's expectations, right?
20 A: But his expectations cannot exceed our
21 expectations. So, yes they are his
22 expectations, but they are also the
23 Department's expectations.
24 Q: Okay. The Department publishes a set of
25 protocols as well, right?

1 A: Correct.
2 Q: And those are the standards that DHEC expects
3 paramedics to -- it's sort of like -- I think
4 somebody testified yesterday about floor and
5 ceiling. I think they had it exactly
6 backwards. You have the DHEC standards as the
7 floor. You can't drop below the DHEC
8 standards, right?
9 A: No. You're incorrect. The DHEC protocols are
10 the ceiling. The paramedic, basic, or
11 intermediate cannot exceed what is stated
12 within those protocols. They may do less than
13 that under medical order. In other words, for
14 example, if we allowed surgical
15 cricothyrotomies, where you cut the neck to
16 provide an airway, the State says you may go up
17 to that level. But if Dr. Kickham does not
18 feel comfortable with his medics doing that, he
19 does not have to include it. And even if his
20 paramedics are trained in that, they cannot do
21 it.
22 Q: What if the State protocol says you can do
23 something, and Dr. Kickham says you can't do
24 it?
25 A: Then you can't. End of story.

1 Q: Okay. But that's Dr. Kickham's expectations of
2 his paramedics. That's not DHEC's standard for
3 that paramedic, right?
4 A: If that medic does that procedure, even though
5 we allowed it at the State and Dr. Kickham has
6 said you can't do it, that paramedic is in
7 violation and it would be punitive.
8 Q: Punitive by Dr. Kickham, right?
9 A: By us.
10 Q: Okay. Where does it say that you can enforce
11 other -- I mean there's hundreds of EMS
12 agencies around the state of South Carolina,
13 right?
14 A: Correct.
15 Q: With hundreds of different Medical Control
16 Physicians, right?
17 A: 147 or so, I think.
18 Q: And there's not a lot of uniformity in those
19 protocols, is that right?
20 A: There's surprising uniformity but there is
21 variation.
22 Q: Okay. For example, if Dr. Kickham says that
23 patients should ambulate or should not ambulate
24 to the hospital, okay? But you go from
25 Anderson County next door to Greenville County,

1 and Greenville County says it's okay to walk
2 patients in certain circumstances. DHEC
3 doesn't have a, sort of, a dog in that fight as
4 to whether you can walk that patient or not,
5 does it?
6 A: No, but here's the thing. If you're the
7 paramedic and you're working with Kickham and
8 he says don't do it, and you're that same
9 paramedic and you go to Greenville and they say
10 you can do it, if you come back to Kickham you
11 can't do it again.
12 Q: Okay, but you at DHEC are not going to
13 discipline that or take enforcement action
14 against that paramedic who let the patient walk
15 ---
16 A: When he should not have?
17 Q: --- when Dr. Kickham says don't walk?
18 A: Yes. If he violated his services protocol,
19 then we may do so. Now a lot of times the
20 local service will say, you violated that
21 protocol. We're going to reprimand you in this
22 fashion. We may or may not know about that.
23 Q: That's a local problem local solution, right?
24 A: Correct.
25 Q: You've heard that phrase before, haven't you?

1 A: We try to abide by that. Yes.
2 Q: Okay. You've heard Dr. Alier say that in the
3 IRC?
4 A: Sure. We ---
5 Q: We looked at this and we thought it was a local
6 problem local solution, right?
7 A: Correct.
8 Q: Until we saw that video?
9 A: I don't remember if he added that in, but ...
10 **MR. ROTHSTEIN:** Can we switch over to my computer on
11 here? Is that possible to do that?
12 Q: All right. Do you have that on your screen,
13 Dr. Kickham -- I mean, sorry. Dr. Deschamps.
14 A: The DHEC, yes. I do.
15 Q: Okay. Do you recognize that as the DHEC
16 homepage on their website?
17 A: That is the DHEC official SC Government site,
18 it appears to be.
19 Q: Okay. And it's for the record it's
20 www.dhec.sc.gov. You recognize that?
21 A: I do.
22 Q: And then under health there's a tab that says
23 EMS training requirements and protocols, right?
24 A: Okay.
25 Q: And so if I wanted to find out what DHEC's sort

1 of expectations or standards for a paramedic,
2 and I'm not talking about different, among the
3 hundreds of different Medical Control
4 Physicians. I want to know what DHEC's
5 expectations and standards for paramedics and
6 EMT's is, I can go to this website, right?
7 A: It may be one of the sites you could utilize.
8 Q: Okay. You see where it says protocols and
9 forms?
10 A: I see that.
11 Q: All right. I'm going to click on protocols and
12 forms.
13 A: Okay.
14 Q: And it pulls up this screen, right?
15 A: I see that. Yes.
16 Q: Okay. And if I click on this little memo here,
17 that gives me a PDF document that sort of
18 introduces the protocols. Have you ever seen
19 that document before?
20 A: Yes.
21 Q: I'm going to hand -- this is not in our exhibit
22 notebook. I've marked it as Exhibit 23. Okay.
23 You see Exhibit 23?
24 A: I do.
25 Q: Does it look like the documents on the website?

1 Do you recognize that as ---
2 A: It does appear the document that's on the
3 website.
4 Q: Okay. So this is a memorandum dated November
5 the 1st, 2010, right?
6 A: Correct.
7 Q: Okay. Is this the set of protocols that was
8 applicable on March 19th, 2016, on the date of
9 the stabbing incident?
10 A: I would say -- well this isn't the protocols
11 but I would say this is referencing those, yes.
12 Q: Okay. It references a set of 2010 EMS pre-
13 hospital protocols for DHEC, right?
14 A: That is correct.
15 Q: Okay. Is there a more recent version of the
16 DHEC protocols than this document?
17 A: Yes.
18 Q: Okay. When was that document published?
19 A: I believe it was April of this year. April of
20 '17.
21 Q: Okay. So were there any versions between
22 November 1st, 2010 and April of this year,
23 2017?
24 A: Not full versions. There may have been updates
25 or individual changes.

1 Q: I'm going to turn your attention to the -- you
2 know who Jennifer Paddock is?
3 A: Jennifer Paddock was a previous Director for
4 the Bureau of EMS, division of EMS at that
5 time.
6 Q: Okay. Is Mr. Wronski her successor in that
7 position?
8 A: He is one of them.
9 Q: Okay. Maybe not immediate, but ---
10 A: Correct.
11 Q: --- that's the same position, right?
12 A: Right.
13 Q: Okay. Did you review these protocols and the
14 memo before, I assume, Ms. Paddock sent this
15 out?
16 A: Probably, but I do not have independent
17 recollection of having reviewed it.
18 Q: Okay. As the State DHEC Medial Director for
19 EMS, for the DHEC, you would expect to have
20 reviewed this before it went out ---
21 A: Yes.
22 Q: --- is that right? Okay. And if you look at
23 the first paragraph, the latest addition --
24 this is the second sentence in the first
25 paragraph. This latest addition contains

1 treatment modalities for all levels of
2 emergency medical response in accordance with
3 the recently published national EMS education
4 standards. You see that?
5 A: I see that. Yes.
6 Q: And then it goes on. It says, it is intended
7 to be all inclusive of information necessary to
8 provide the appropriate treatment and
9 transportation to citizens and visitors of our
10 State, right?
11 A: I see that. Yes.
12 Q: Okay. You agree that this document set's forth
13 the standards of care that DHEC expects of its
14 paramedics and EMT's?
15 A: It sets forth the protocols we expect -- these
16 were not mandated protocols. These were given
17 out to the services to adapt. So these were
18 put together by the Medical Control Committee
19 and sent out to the services for their use.
20 Q: Okay. Then it says, after the sort of the
21 little index there about the difference types
22 of protocols it says, like earlier additions it
23 is important to remember that this document
24 serves as a guideline only, right?
25 A: That is correct.

1 Q: So these are protocols, these are not orders?
2 A: These were protocols which included orders.
3 But that document was a guideline for services
4 to utilize.
5 Q: All right. Let me get back, see if I can find
6 that website. All right. I'm going to click
7 on the State approved protocols. You see where
8 I am on the website?
9 A: I do.
10 Q: All right. And sections one through four are
11 included at this link, right?
12 A: Correct.
13 Q: And you see this table of contents?
14 A: Correct.
15 Q: And the protocol number eight is the protocol
16 for behavioral matters. Do you see that?
17 A: I do.
18 Q: Let me see if I can find that one real quick.
19 It'll take me a second to scroll down. And
20 this -- just as we go through this -- this is
21 sort of the flow chart or decision tree or
22 algorithm that we've been talking about. This
23 is in a different format than Dr. Kickham's
24 protocols, but this is that type of a document,
25 correct?

1 A: It is.
2 Q: All right. So if I go down to behavioral, you
3 see where I am?
4 A: I do.
5 Q: Okay. I'm going to scroll down here to the
6 bottom. You know what the term pearls means?
7 A: Yeah. Those are little information things that
8 help you along.
9 Q: Okay. And do you see -- well if you don't
10 count the red bullet, the fourth bullet down
11 there?
12 A: I do.
13 Q: You see where it says, do not irritate the
14 patient with a prolonged exam?
15 A: I see that.
16 Q: Okay. Did the interaction with Mr. Davenport
17 and the stabbing patient involve a behavioral
18 situation that would trigger this protocol?
19 **MR. WICEVIC:** Your Honor, I'm going to object. The
20 Department's not alleging that Mr. Davenport
21 failed to comply with State protocols. The
22 State protocols are there for guidance in Med.
23 Control Physicians' development of their own
24 respective protocols and orders. This isn't
25 something that he has to comply with. We're

1 not saying he didn't comply with this. Further
2 more, it's from 2010. If Mr. Rothstein wants
3 to ask if the Med. Control orders of Dr.
4 Kickham were not in accordance with the
5 ceilings that these set, I think that's fine.
6 But compliance with these State recommended
7 protocols is not an issue of dispute.
8 **THE COURT:** Mr. Rothstein?
9 **MR. ROTHSTEIN:** Your Honor, Dr. Deschamps says this
10 is the version that was in existence on March
11 19th, 2016, the date of the stabbing incident.
12 The new volume for the new version didn't come
13 out until April, 2017. So I think he
14 established these are the applicable protocols
15 for the State.
16 **THE COURT:** The objection is overruled.
17 Q: Okay. You see where it says, do not irritate
18 the patient, right?
19 A: Correct.
20 Q: Okay. Is that an order or a protocol?
21 A: it is a pearl. The protocol is above that and
22 there are orders there. For example, the 50
23 percent Dextrose adult 25 percent Dextrose
24 pediatric if the blood glucose is less than 60.
25 That is an order. This is the protocol, this

1 is helpful information.
2 Q: But it's written in mandatory language. It
3 says, do not irritate the patient, right?
4 A: It is, but it's also within the pearl section.
5 Q: Okay. So just because something uses mandatory
6 language doesn't make it a standing order,
7 right?
8 A: For example, if it is up in the first part
9 where you got the purple block, remove patient
10 from stressful environment, that is a direct
11 order as part of the protocol for the first
12 responder level.
13 Q: Okay. Give me a second. I'm going to scroll
14 down.
15 A: And then it said, use verbal calming techniques
16 under that as well.
17 Q: Give me one minute. I'm trying to find one of
18 the protocols. While we're getting that loaded
19 up, let me ask you this question. Now toward
20 the end of your testimony, you said that a
21 paramedic is always -- or you said that you
22 believe Dr. Kickham's protocols require the
23 highest appropriately trained pre-hospital
24 provider to ride in the back of the ambulance.
25 Is that right?

1 A: I think what I said was that that is generally
2 accepted in patients who have severe or
3 significant injuries or where there's likely
4 decompensation. If the protocol requires a
5 procedure en route that a lower level is unable
6 to perform, then by default you need the higher
7 level in the back.
8 Q: Okay. But if that patient's stable, there's no
9 need for the higher level.
10 A: Stability doesn't enter into it. Potential is
11 what enters into it.
12 Q: Okay. And where does it say that in Dr.
13 Kickham's protocols?
14 A: The protocol doesn't say that. That's
15 generally accepted pre-hospital EMS medical
16 knowledge. It's the generally accepted
17 principle for treatment of patients.
18 Q: You don't have a standing order that says, all
19 ambulance calls have to be ridden in by a
20 paramedic, do you?
21 A: No.
22 Q: Okay. You could do that if you wanted to,
23 right?
24 A: Sure. You could write that.
25 Q: You could say our standard is anytime an

1 ambulance goes out we want to have a paramedic
2 in the back of the truck?
3 A: Sure.
4 Q: Okay. But DHEC has never taken that position?
5 A: No.
6 Q: DHEC does allow a basic paramedic to ride the
7 back of the truck in certain circumstances,
8 even if it's a -- I'm sorry, a basic EMT, even
9 if it's a paramedic EMT partnership that goes
10 out to ride that call, right?
11 A: In certain circumstances that could occur.
12 Q: Now I'm going to turn your attention to the
13 multiple trauma protocol for DHEC. You believe
14 this stabbing incident was a multiple trauma
15 case?
16 A: Correct.
17 Q: So this protocol would apply, right?
18 A: Correct.
19 Q: All right. So this sets the minimum standard
20 that DHEC would expect a paramedic to
21 administer care in a multiple trauma situation,
22 right?
23 A: No. We are not setting standards from DHEC.
24 We are making recommendations to local services
25 of how we think it is best to be handled. It

1 is up to the local service to adopt this
2 protocol or adapt this protocol.
3 Q: Okay. I'm not asking whether, like Anderson
4 County for example, has adopted that protocol
5 ---
6 A: Right.
7 Q: --- okay. I'm looking only at DHEC's protocol,
8 okay? And according to that memo that was at
9 the beginning of this, you said, we developed
10 these protocols that are in accordance with
11 what we expect pre-hospital providers to
12 provide the residents and visitors of our State
13 -- or citizens and visitors of our State,
14 right?
15 A: It is the information necessary to provide
16 appropriate treatment. It is not mandated.
17 Q: Okay. Well let me look at this flow chart.
18 And this isn't the pearl section. I'm talking
19 about the actual protocol section, okay?
20 A: Sure.
21 Q: And if you'll look down as you go through the
22 flow chart, universal patient care protocol.
23 You work your way down to vital signs,
24 including GCS, Glasgow Coma Score, right? You
25 see where I am?

1 A: Yes. Right.
2 Q: And then there's a decision tree that says, if
3 the vitals are normal you go off to the right
4 ---
5 A: Correct.
6 Q: And if the vitals are abnormal you go off to
7 the left, right?
8 A: Okay.
9 Q: Were the stabbing patient's normal or abnormal?
10 A: They were normal.
11 Q: Okay. So Mr. Davenport goes off to the right
12 under normal. Is there IV access indicated for
13 a normal vital sign ---
14 A: No.
15 Q: --- under this protocol?
16 A: No.
17 Q: Okay. So at least in DHEC's protocols, Mr.
18 Davenport acted appropriately?
19 A: It is not required is what we're saying. But
20 these again are not mandatory protocols.
21 Q: Do you agree with the statement -- let me make
22 sure I get it right. I'm going to quote this.
23 Quote, there is no single way to provide good
24 medicine, close quote. Do you agree with that
25 statement?

1 A: I agree with that.
2 Q: Okay. Does it sound familiar to you?
3 A: I may have had part of the authorship on that.
4 Q: Okay. I'll hand you Exhibit 24, Respondent's
5 Exhibit 24.
6 A: Okay.
7 Q: Okay. If you'll turn -- this is the, I think,
8 the protocols that you testified a minute ago
9 went into effect in April of this year, right?
10 A: Correct.
11 Q: Okay. This is a pretty big undertaking by DHEC
12 to update the protocols that were seven years
13 old, would you agree with that?
14 A: It was substantial.
15 Q: And if you'll flip through the first little
16 section about the table of contents, you get
17 down to a document called Author's Statement,
18 right?
19 A: Okay.
20 Q: And if you turn to the second statement, do you
21 recognize your signature above the signature
22 block, Edgar G. Deschamps, right?
23 A: Correct.
24 Q: And the last sentence above your signature
25 says, there is no single way to provide good

1 medicine, right?
2 A: Where you reading that now?
3 Q: Right above your signature. Last sentence.
4 A: Oh, okay. Yeah. Right. There's no single way
5 to provide good medicine.
6 Q: Do you agree with that?
7 A: Yes.
8 Q: Okay. All right. If you'll turn a couple more
9 pages down, I think you'll find the
10 introduction.
11 A: Okay.
12 Q: There's a little sort of table about levels and
13 certainty of evidence or something. Are you on
14 the introductory page?
15 A: This page, introduction?
16 Q: Yes. If you'll look at page one of four in
17 that document, this is -- did you review the
18 introductions before it was released?
19 A: Several times, but there can be errors still.
20 Q: Okay. The first part of the introduction is
21 the definition, right? It says, a medical
22 protocol or algorithm or guideline is a
23 document with the aim of guiding decisions and
24 criteria regarding diagnosis, management, and
25 treatment in specific areas of healthcare.

1 A: Right.
2 Q: Is that an accurate definition of what a
3 protocol is?
4 A: Yeah.
5 Q: Sometimes they're referred to as algorithms or
6 guidelines?
7 A: Correct.
8 Q: Okay. You know what the term guideline comes
9 from?
10 A: I don't know the specific.
11 Q: I had a case one time, I looked it up. There's
12 the little line on the side of the highway is
13 a guideline, okay? Sometimes you have to
14 outside the guidelines, right?
15 A: Well if a deer jumps in front of you, you
16 might.
17 Q: There you go. That's different, than say, a
18 New Jersey median right, that has a big
19 concrete thing. You can't go outside of that
20 guideline?
21 A: Right.
22 Q: So a guideline is a little more flexible than
23 say an order. You agree?
24 A: Correct.
25 Q: Okay. And the goal of educating paramedics is

1 for them to develop their own experience and
2 knowledge base that they're not bound by the
3 guidelines or rigidly follow the guidelines.
4 You agree with that statement?
5 A: Right. And we actually say that in here
6 somewhere.
7 Q: Okay. I'm glad you recognize that. So look at
8 the second paragraph from up from the bottom.
9 Paragraph says, medical algorithms based on
10 best practice can assist everyone involved in
11 delivery of standardized treatment by a wide
12 range of clinical care providers, right?
13 A: Correct.
14 Q: Many are presented as protocols and it is a key
15 task in training to ensure providers step
16 outside the protocol when necessary, right?
17 A: Correct.
18 Q: Okay. So this document says that when you're
19 training paramedics, don't make them blindly
20 follow the protocols. If they need to step
21 outside the protocols, they should have the
22 judgement and assessment skills to do that,
23 right?
24 A: In a sense, yes.
25 Q: Can you step outside an order?

1 A: No. Not generally. There could be exceptions.
2 Q: Okay. If you'll look to the next page, page
3 two of four of the introduction about half way
4 down the page, whereas a protocol guideline or
5 algorithm guides decisions and criteria for
6 diagnosis, management, and treatment of
7 specific cases, a standing order is a specific
8 written policy that prescribes a definitive
9 action to be taken for a particular condition
10 or situation, right?
11 A: That's what it says, yes.
12 Q: Okay. Standing orders include medication
13 dosages, routes of administration, therapeutic
14 procedures, et cetera to be implemented.
15 A: Correct.
16 Q: Okay. Then it says, standing orders are often
17 included within protocols.
18 A: Correct.
19 Q: Okay. I know that it was a little hokey, but
20 did you see the Venn diagram I drew?
21 A: See it right over there. Yes, sir.
22 Q: Is that an accurate sort of representation of
23 the relationship between protocols and orders?
24 A: I would say it's generally an acceptable idea.
25 The standing orders might be bigger or smaller

1 depending upon the protocols.
2 Q: Well it's not intended to be to scale but ---
3 A: Right.
4 Q: --- there's some overlap. Some orders are
5 standing orders which are within the written
6 protocols.
7 A: That's correct.
8 Q: But some orders are completely outside the
9 protocols where you have to call -- like if you
10 call a doctor and get online medical control.
11 A: Correct.
12 Q: And you're not allowed as a paramedic to step
13 outside of that red box, right? If a doctor
14 orders something, you can't say, well I'm just
15 going to disregard that. I'm going to do
16 something else, right?
17 A: With rare exceptions, you're correct.
18 Q: So there's a lot of green area within the
19 protocols for judgements and, you know, making
20 the right decision based on the circumstances
21 presented at the time. Do you agree with that?
22 A: In that drawing, yes.
23 Q: Okay. If you look further down page 2, there's
24 another highlighted sentence that says, each
25 medical emergency must be dealt with

1 individually and appropriate determined
2 accordingly, right?
3 A: Correct.
4 Q: Professional judgement is mandatory in
5 determining treatment modalities within the
6 parameters of these protocols. You agree with
7 that?
8 A: That is correct.
9 Q: Okay. And have you turn over to the next page
10 it states, professional judgement hierarchy.
11 It's the second sentence. See where I'm
12 reading from?
13 A: Gotcha.
14 Q: There's a colon ---
15 A: Right.
16 Q: --- says, first of all the pre-hospital
17 provider may determine that no specific
18 treatment is needed. So as the paramedic or
19 EMT's going through the protocol, may not need
20 to do a certain step, right?
21 A: Correct.
22 Q: Then it says, or the pre-hospital provider may
23 follow the appropriate treatment protocols and
24 then consult medical control, right?
25 A: Correct.

1 Q: And then it says, or the pre-hospital provider
2 may consult medical control before initiating
3 any specific treatment.
4 A: That's correct.
5 Q: Are you aware of any situation where Mr.
6 Davenport has ever disregarded a consultation
7 with online medical control?
8 A: No. I have no knowledge of any such thing.
9 Q: Are you aware of him violating any standing
10 orders of Dr. Kickham?
11 A: Well, as we talked about earlier, within the
12 protocols it said things such as, in this
13 situation initiate IV. That was not done. I
14 approach that as a standing order. Because as
15 you pointed out back here, the standing order
16 includes therapeutic procedures such as
17 initiating IV.
18 Q: You've got that notebook in front of you, Dr.
19 Deschamps?
20 A: Which now?
21 Q: Dr. Kickham's protocols.
22 A: Okay. Where do you want me?
23 Q: Page 6.
24 A: Okay.
25 Q: Specifically the intravenous access protocol,

1 right?
2 A: Okay.
3 Q: The first bullet under patient assessment says,
4 assess patient for indications, right?
5 A: Correct.
6 Q: It doesn't say start an IV, right?
7 A: Correct.
8 Q: That's a decision tree as to whether you start
9 the IV or not.
10 A: Sure.
11 Q: Okay. If you start the IV, then you're down
12 into looking at those standing orders for what
13 type of fluid that you provide to the body and
14 that type of thing, right?
15 A: Correct.
16 Q: And this protocol has a standing order that, if
17 you have a trauma patient, you start normal
18 saline sodium chloride, right? .09 percent
19 sodium chloride for a trauma patient?
20 A: Give me just a second. Let me locate it.
21 Okay.
22 Q: And so this protocol says if you have a trauma
23 patient and you start an IV, you have to give
24 him saline, right?
25 A: You have to hang saline, yes.

1 Q: But the decision is whether to start the IV in
2 the first place is the decision that's up to
3 the paramedic, under the protocol?
4 A: No. It's reflected in the trauma protocol,
5 which says start IV. So it takes you down
6 below that first section.
7 Q: Okay. Are you talking about trauma 03?
8 A: What page was that, 43 maybe? Hang on a
9 minute.
10 Q: Yes. 43.
11 A: Okay. Right. So you're coming down there
12 under multiple trauma shock, and it says,
13 initiate intravenous access protocol. So it's
14 ---
15 Q: Wait a minute. That says ---
16 **MR. WICEVIC:** Your Honor, can he finish his answer?
17 **THE COURT:** Yes. Let him finish.
18 **MR. ROTHSTEIN:** Okay.
19 A: So it says, initiate IV access protocol utilize
20 y blood sets. Attempt to establish two lines.
21 Infuse at a rate to maintain systolic blood
22 pressure greater than 90.
23 Q: And you think that that protocol and standing
24 order applies to this patient?
25 A: Yes.

1 Q: Okay. It doesn't say start IV, it says
2 initiate the protocol, right?
3 A: Right.
4 Q: So it refers you back to the protocol which
5 says assess the patient, whether they need an
6 IV or not.
7 A: Well you're kind of getting into this cyclic
8 thing. The trauma protocol says to initiate an
9 IV.
10 Q: No, no, no. Look. It says initiate the
11 intravenous access protocol.
12 A: But then under that it clearly lists -- you
13 could not go back to that IV access protocol
14 and say, this patient doesn't need it, but I'm
15 going to use a y blood set and infuse saline to
16 maintain a blood pressure greater than 90.
17 Q: But didn't your expert testify a -- you were
18 here when he testified, right?
19 A: Right.
20 Q: And he testified that he would have started an
21 IV -- no start an IV, he would have initiated
22 what do they call that? A hepwell?
23 A: Yeah, or saline lock, or heplock.
24 Q: He didn't say he was going to start two IV's,
25 did he?

1 A: I didn't hear that.
2 Q: Okay. He also didn't say that he was going to
3 utilize y blood sets, did he?
4 A: I did not hear him say that specifically.
5 Q: He didn't say that he would infuse at a rate to
6 maintain the systolic blood pressure of more
7 than 90, did he?
8 A: I didn't hear that.
9 Q: Okay. So if he had treated the patient
10 according to what he would have recommended
11 that would have violated an order, right?
12 A: Not necessarily. If you start the lines and
13 they systolic blood pressure's 120, you don't
14 need to infuse anything. The guidance there is
15 what type line to start. You want to start a
16 large bore IV, you want two if you can get
17 them, and you want it set with a blood set
18 which allows you to deliver large quantities of
19 fluid or blood if you need it. It's a bigger
20 bore.
21 Q: Wait. Is a hepwell a blood set?
22 A: No. The blood set is the connecting thing from
23 where you plug into the cannula.
24 Q: Now I think you testified a little while ago
25 about Dr. Kickham's -- Anderson County protocol

1 that said, should not ambulate the patient to
2 the ambulance or something along those lines,
3 right?
4 A: Correct.
5 Q: Okay. That phrase says, should not ambulate,
6 right?
7 A: Correct.
8 Q: It doesn't say, do not ambulate.
9 A: Well, isn't should a derivative of shall, which
10 is a declarative?
11 Q: To me it's a little weaker than shall, right?
12 A: It may be. I'm not an English major, so I
13 don't know. But I thought should was part of
14 shall. So if you should do this we expect it
15 to be done. If you could do this, you may or
16 may not.
17 Q: When you read, should not ambulate the patient,
18 is that under any circumstances?
19 A: I would say that there may be some circumstance
20 where you had to. For example, in Mr.
21 Davenport's career, I'm sure that if you're
22 under fire you're going to get those guys
23 moving however you can. So I don't have an
24 objections to that, to in his other career.
25 But in civilian EMS I would have an objection

1 to it.
2 Q: Now I think that that same protocol, it may be
3 the patient safe- -- it's one of the general
4 ones. It says that an appropriate carrying
5 device should be used, right?
6 A: Correct.
7 Q: Do you think a kitchen chair is an appropriate
8 carrying device?
9 A: In certain circumstances it might be. It
10 wouldn't be my first choice. I've carried
11 people on kitchen chairs before.
12 Q: Did you see the video of this patient encounter
13 before the IRC meeting?
14 A: Yes.
15 Q: Okay. Did you see the video of the patient
16 encounter before Mr. Davenport ever saw the
17 video?
18 A: I have no idea.
19 Q: Okay. Do you know if you saw the video before
20 Mr. Davenport was called down to Columbia and
21 met with Mr. Wronski, Mr. Naugler, and Mr.
22 Wiznuski?
23 A: I have no idea. I don't recall specifically
24 when I saw it, but it was prior to the IRC.
25 Q: Prior to the IRC did you ever tell Mr. Wronski

1 that you thought the video showed violations of
2 statutes and regs of DHEC?
3 A: I may have. I probably did.
4 Q: So you were the chair of the IRC, right?
5 A: Correct.
6 Q: Okay. When you went into that meeting you
7 already had a preconceived idea about whether
8 Mr. Davenport based on the video had violated
9 DHEC standards?
10 A: Yes.
11 Q: So you weren't an unbiased participant in the
12 IRC?
13 A: I had an idea based on what I had seen so far.
14 I had not spoken to Mr. Davenport for
15 explanations.
16 Q: Okay. So you made the decision before you even
17 heard from Mr. Davenport's side of the story,
18 right?
19 A: No. Decisions were made after the IRC met.
20 Q: No. I mean I think you said after you viewed
21 the video the first time before the IRC, you
22 made a decision in your mind that what you saw
23 in the video violated DHEC standards?
24 A: Based upon what I saw in that video, yes.
25 Q: And I think Mr. Wicevic asked you what you

1 looked at at the IRC, and you said information
2 from the investigator. Who was the
3 investigator in this matter?
4 A: Richard Naugler.
5 Q: Any other investigators other than Mr. Naugler?
6 A: I don't recall any. I think he made the
7 presentation.
8 Q: And then you said you reviewed witness
9 statements. Plural with an s on the end of it,
10 right?
11 A: I may have said it that way, yes.
12 Q: Okay. Which witness statements, plural, did
13 you look at?
14 A: Well I think we had -- by witness statements I
15 mean to say statements. So we had, I think we
16 had a declaration that Ms. Aiken, and we talked
17 with Scott Stoller during the meeting.
18 Q: Okay. Wasn't your discussion with Mr. Stoller
19 after the IRC meeting?
20 A: No. It was during. Well it was during the
21 deliberative phase, after y'all had left.
22 Q: Okay. So Mr. Davenport and I had already left
23 the building by the time you called Mr.
24 Stoller, right.
25 A: I don't know when you left the building. You

had certainly left the room, I think.
Q: Okay. So when you said that Mr. Davenport and I had an opportunity to make our case and ask questions and all that stuff, that was before you even got Mr. Stoller on the phone, right?
A: Right. And I think I asked you that and Mr. Davenport if there was anything else y'all wanted to say and had we given you ample opportunity to say what you wanted.
Q: And do you recall Mr. Davenport and I wanted to hand up a grievance packet that he had submitted to ---
A: I do.
Q: --- Anderson County?
A: Yeah.
Q: Okay. And you wouldn't allow that into evidence, would you?
A: It was irrelevant to this particular call from our standpoint.
Q: I think you said you saw the PCR, patient care report, right?
A: Correct.
Q: And you said you saw medical records. Which medical records other than the PCR did you see?
A: I would have to go back and look at the minutes

1 from the IRC to document it, but I think at
2 that point we saw the ER record, maybe the OR
3 record at that point, but I'm not -- I would
4 have to look at the IRC transcript.
5 Q: Okay. And you also saw the video, right?
6 A: Correct.
7 Q: How many times did you view the video, or how
8 many times did you say you viewed the video in
9 total?
10 A: Less than 10 I would think.
11 Q: Okay. How many of those occurred prior to the
12 IRC meeting? How many times did you see it ---
13 A: Once.
14 Q: --- before the IRC? One time?
15 A: Correct.
16 Q: Okay. How many times did you watch it during
17 the IRC meeting?
18 A: I think we watched it in its entirety once, and
19 then I think there were a couple of questions
20 that members had and they had to go to certain
21 portions of the video.
22 Q: The first part of that meeting for about the
23 first hour and a half of the IRC meeting, Mr.
24 Davenport and I weren't in the room, were we?
25 A: No, sir.

1 Q: Okay. At that point Mr. Naugler and Mr.
2 Wronski and Dr. Alier were in the room, right?
3 A: I don't know specifically who all was there.
4 They may have been. Again I need to look at
5 the transcripts. I know people, they came in
6 and out. Mr. Naugler was there at least for
7 part of it. Mr. Wronski was there for part of
8 it. I'm not sure whether Dr. Alier was there
9 or not. He may have been in and out. I don't
10 remember.
11 Q: So neither Mr. Davenport nor I had an
12 opportunity to listen to what Mr. Naugler said,
13 right?
14 A: That is correct.
15 Q: And we didn't have an opportunity to ask Mr.
16 Naugler any questions about his investigation?
17 A: That is correct.
18 Q: And we also didn't have an opportunity to sit
19 through the video as you were watching it,
20 right?
21 A: No.
22 Q: Okay. And as questions came up about the video
23 while you were watching it, Mr. Davenport
24 didn't have a chance to respond to any of the
25 comments back and forth about what the video

1 showed, right?
2 A: Not during that initial viewing, no.
3 Q: Now when you called Mr. Davenport and me into
4 the room after you dismissed Mr. Naugler, did
5 you see the video again?
6 A: Again, we'd have to go look. I don't think we
7 showed the entire thing while y'all were there.
8 Q: Okay. I don't recall seeing it, but I was just
9 wondering if you had a different ---
10 A: I don't recall it either.
11 Q: How many medical malpractice suits have you
12 been involved in during your medical career?
13 A: In what format?
14 Q: As a defendant.
15 A: A couple.
16 Q: Have you been sued in Lee County?
17 A: Yes.
18 Q: Okay. You recall in 1992 you were sued by a
19 woman who was your patient, came in with
20 bronchitis.
21 A: I know her well, yes.
22 Q: Okay. And you ---
23 **MR. WICEVIC:** Your Honor, I'm going to object to the
24 relevance of this inquiry.
25 **MR. ROTHSTEIN:** Your Honor, if I remember correctly,

1 when my expert witness was on the stand, Mr.
2 Wicevic asked about medical malpractice cases.
3 I think it's very relevant. I mean it goes to
4 impeach an expert witness. It goes to his
5 medical knowledge and his medical expertise.
6 I think it's valid cross-examination material.
7 I mean what's good for the goose is good for
8 the gander. He asked my witness the same
9 questions, Your Honor.
10 **MR. WICEVIC:** But I think my questioning was during
11 the voir dire. He's already been qualified as
12 an expert. I'm not sure what the point of it
13 is now. If he's questioning his
14 qualifications, he should have done it during
15 that period.
16 **MR. ROTHSTEIN:** I'm going to have to proffer this
17 information anyway. I mean I think it
18 relevant. I think the rules clearly allow
19 impeachment of an expert witness by asking them
20 if they've ever been sued for violating the
21 standard of care, and whether they've actually
22 had a jury finding that they violated the
23 standard of care, and were ordered to pay money
24 as a result of that finding.
25 **THE COURT:** I'm going to take this matter under

1 advisement and call a ten minute break at this
2 point. I do need to use the phone anyway.
3 **MR. ROTHSTEIN:** Okay. Thank you, Your Honor.
4 **(Off the record from 5:10 p.m. until 5:23 p.m.)**
5 **THE COURT:** Okay. Mr. Wicevic, I think what we've
6 got here is you're objecting to Mr. Rothstein's
7 ---
8 **MR. WICEVIC:** That's correct, Your Honor. I think
9 the inquiry into his qualifications has ended.
10 This appears to be some attempt to impeach Dr.
11 Deschamps. And the rules on impeachment 608-B
12 will not allow this. Specific instances of
13 conduct of a witness for the purpose of
14 attacking the witness's credibility other than
15 conviction crimes listed in rule 609 may not be
16 proved by extrinsic evidence. It may however
17 in the discretion of The Court if probative of
18 truthfulness or untruthfulness be inquired into
19 on cross-examination of the witness concerning
20 the witness's character. Truthfulness or
21 untruthfulness. Your Honor, this is not an
22 inquiry to Dr. Deschamps Truthfulness. It's an
23 inquiry into his past medical practice, and I
24 think Mr. Rothstein even said that in his
25 response to my objections about his

1 qualifications.
2 **THE COURT:** Yeah. Mr. Rothstein, I'm somewhat
3 confused. Exactly what are you attempting to
4 do with this line of questioning?
5 **MR. ROTHSTEIN:** Well there's two things, Your Honor.
6 I don't have to conduct a voir dire of an
7 expert. If I agree that the expert's
8 qualifications allow him to be qualified as an
9 expert, I can forego my opportunity to voir
10 dire the witness, and I can impeach him on
11 cross-examination with whatever is within the
12 bounds of what I'm allowed to do under the
13 rules of evidence. There's two points that I'm
14 going to make here, Your Honor. One, it does
15 go to his, sort of level of expertise. He's
16 been qualified as an expert witness. It does
17 tend to impact his credibility. That's the
18 exact reason Mr. Wicevic asked my witness the
19 same question. The only difference here is my
20 witness had no cases reported against him.
21 This witness does. And so that's the first
22 point, Your honor. The second point is Dr.
23 Deschamps is testified that he has not
24 disciplinary actions against his medical
25 license. And I was going to ask him if he

1 thinks it's fair -- or if the Board of Medical
2 Examiners moved to take his license after that
3 first malpractice verdict against him where he
4 caused permanent injury to a Lee County
5 resident. If he thought it'd be fair for the
6 Board of Medical Examiners to yank his ability
7 to practice medicine based on that bad outcome.
8 And I think that is relevant.
9 **THE COURT:** A civil suit and a disciplinary action,
10 that's different. I'm sustaining Mr. Wicevic's
11 objection.
12 **MR. ROTHSTEIN:** Okay. Just for the record, Your
13 Honor, I'd like to proffer this.
14 **THE COURT:** Okay. You can. Go ahead.
15 **MR. ROTHSTEIN:** Do you want me to do it just
16 verbally to you or you want me to ask questions
17 of the witness? It's probably quicker if I
18 just summarize.
19 **THE COURT:** It would be quicker, yes.
20 **MR. ROTHSTEIN:** Okay. The testimony I would elicit
21 was that there was a case brought against Dr.
22 Deschamps in 1992 in Lee County, South
23 Carolina. A woman went in to his practice
24 complaining of bronchitis. She was
25 administered an intramuscular injection into

1 her rear end. She was given a shot in the
2 buttocks with some type of a steroid. The
3 needle was improperly placed in the wrong
4 position. It struck the patient's sciatic
5 nerve in the back of her leg and caused her
6 permanent nerve damage, which rendered it ver
7 painful for her to walk, and she became
8 disabled and was unable to work. The case
9 ended up with a jury verdict in 1994 against
10 Dr. Deschamps in favor of the plaintiff for
11 $900,000.00.
12 **THE COURT:** Thank you. I'm assuming you've got
13 additional questions for ---
14 **MR. ROTHSTEIN:** Just a few. I know it's been a long
15 day.
16 Q: Now you testified earlier that you've been
17 involved in one other ALJ matter involving a
18 paramedic?
19 A: Yes.
20 Q: And that was the Stuart Platt case from
21 Lexington County?
22 A: Correct.
23 Q: Okay. Do you recall what year that was?
24 A: I don't recall specifically. Six or seven
25 years ago maybe.

1 Q: Okay. Could it have been more than 15 years
2 ago, or about 15 years ago?
3 A: If it has time flies. Maybe it has, but I
4 don't remember it.
5 Q: I'm going to hand you this. I don't know that
6 we need to mark this as an exhibit. I don't
7 intend to actually move to introduce it, but I
8 want to ask some questions. Dr. Deschamps, in
9 discovery in this case, you may not be aware of
10 it, but we asked in request for production
11 number three, for DHEC to produce any and all
12 document related to the suspension,
13 revokation, demotion, or other disciplinary
14 action taken against any license or certificate
15 of a paramedic in South Carolina from January
16 1st, 2011 to the present. And that is the
17 response we got from Mr. Wicevic on behalf of
18 DHEC.
19 A: I've never seen this.
20 Q: I did an analysis of the list of the cases
21 here, and there were two cases where a
22 paramedic had their suspension revoked for 48
23 months, for four years since January 1st of
24 2011. You have any reason to dispute that?
25 A: I have no reason to dispute it.

1 Q: Okay. One of those individuals is sitting to
2 my left, Mr. Davenport. Okay. The other
3 individual -- and I can use abbreviations. His
4 initials are J-A-D. He's on page 4 of this
5 document. It's the first full item on the
6 list. You see that?
7 A: The second paragraph down?
8 Q: Second paragraph down.
9 A: Okay. I see that.
10 Q: Okay. And this particular paramedic committed
11 misconduct, did not carry a stretcher to the
12 cardiac patient, did not start CPR until the
13 patient was on the stretcher, and only gave the
14 patient one dose of epinephrin in 30 minutes.
15 You see that?
16 A: I see that.
17 Q: Okay. Was that appropriate medical care for a
18 cardiac patient?
19 A: No.
20 Q: Pretty clear violation of the standard of care?
21 A: Yes.
22 Q: Do you know what happened with this particular
23 patient?
24 A: I have -- no, I do not.
25 Q: Do you know if the patient died?

1 A: I do not know. I'm not familiar with this
2 particular one.
3 Q: Okay. And this case was actually resolved by
4 what's called a consent order. Are you
5 familiar with that?
6 A: I am.
7 Q: Okay. And that's where the paramedic agrees to
8 accept the punishment and doesn't contest the
9 punishment, right?
10 A: Correct.
11 Q: And this isn't the first time that paramedic J-
12 A-D was before the Board. Do you recall seeing
13 him another time?
14 A: You talking about the one on this page 4?
15 Q: Yeah.
16 A: Is that who you're referring to as J-A-D?
17 Q: Right.
18 A: Okay. No. I do not. I mean, it's possible.
19 I see a bunch of these come through. I'm not
20 familiar with this document and I often do not
21 remember any of the names.
22 Q: Okay. I'm going to ask you to flip back to
23 page 2 of this document. Look down from the
24 second name from the bottom. You see the same
25 paramedic J-A-D?

1 A: I do.
2 **MR. WICEVIC:** Your Honor, I'm going to object. Dr.
3 Deschamps says he didn't now about this
4 particular EMT.
5 **THE COURT:** I'm going to allow the question. I'm
6 overruling your objection.
7 **MR. WICEVIC:** Thank you.
8 **THE COURT:** Go on, Mr. Rothstein.
9 Q: The first time this paramedic J-A-D came before
10 the Board, there was another challenge to his
11 provision of care to patients, right?
12 A: Give me just one second please.
13 Q: You see this is another consent order dated
14 February 15th?
15 A: Right. Okay. I see it.
16 Q: Okay. And in this consent order, DHEC and the
17 paramedic agree that the paramedic would
18 surrender his paramedic license for nine months
19 and sort of be bumped down to an EMT basic
20 during that period, right?
21 A: Right.
22 Q: And in this case the paramedic failed to
23 perform a systematic patient assessment,
24 neurological examination, or obtain complete
25 patient history including the patient's

1 medications, right?
2 A: Correct.
3 Q: This resulted in being unable to correctly
4 assess and properly care for an 87 year old
5 fall victim with a head injury, correct?
6 A: Correct.
7 Q: And that patient actually had to be airlifted
8 to a different hospital because of the actions
9 or inactions of this particular paramedic,
10 right?
11 A: Okay. Correct.
12 Q: You agree that's a pretty bad outcome for a
13 patient encounter?
14 A: Well, I mean, yes. It is. It's not what you
15 want at all.
16 Q: Okay. And when the patient was airlifted, that
17 caused further deterioration. The paramedic
18 also failed to immobilize this patient's spine.
19 Right? According to the fall protocol?
20 A: Correct.
21 Q: Pretty serious allegations against a paramedic.
22 Would you agree with that?
23 A: Yes.
24 Q: Okay. And DHEC agreed in this consent on
25 February, 2013 to suspend -- not completely

1 revoke his license, but suspend it for nine
2 months and allow him to work as an EMT basic.
3 A: Right.
4 Q: Right? So I think we talked about this J-A-D
5 fellow. The next highest -- over the 48
6 months, Mr. Davenport and J-A-D have been
7 before you twice. The next highest one I can
8 find initials G-A-L. I'm sorry, J-M. And
9 that'll be on page 4.
10 A: And it's what letters again?
11 Q: J-M.
12 A: Okay.
13 Q: Second name from the bottom. You see that?
14 A: I do.
15 Q: And this paramedic also entered into a consent
16 order, right?
17 A: Yes.
18 Q: He agreed with the punishment and did not
19 challenge this through the IRC or through the
20 administrative law process, right?
21 A: Correct. As far as I can tell from what's
22 recorded here.
23 Q: Okay. And this is another cardiac patient
24 where the paramedic in question disregarded the
25 Sumter County EMS protocols for emergency

1 treatment, failed to perform basic cardiac life
2 support on the patient causing the patient to
3 suffer further injury as well as creating a
4 substantial possibility of death. You see
5 that?
6 **MR. WICEVIC:** Your Honor, I just wanted to object
7 again. Dr. Deschamps makes recommendations to
8 the Department. We wouldn't allow Dr.
9 Deschamps' recommendations with IRC into the
10 record. I don't know why we're going into this
11 long inquiry into the Department's past
12 enforcement actions. I think if he want's to
13 ask questions about that, Mr. Wronski who will
14 be testifying later, he makes the decisions on
15 behalf of the Department. He'd be the person
16 to answer those questions.
17 **THE COURT:** Okay. Mr. Rothstein, why are you ---
18 **MR. ROTHSTEIN:** Dr. Deschamps has been there since
19 1985 I think he testified earlier. Mr. Wronski
20 has only been there about two or three years.
21 So a lot of these cases predated Mr. Wronski's
22 involvement.
23 **THE COURT:** Yeah, but you're not asking him a
24 question. You're reading from this document.
25 What's the question that you've got for the

1 witness?
2 Q: That was what that paramedic was accused of
3 doing in terms of violating protocols, right?
4 A: What you read. I agree you read what's here,
5 yes. Again, I want to say I don't know these
6 people by name. I may have had some
7 involvement in recommendations but I do not
8 recall that. So I can't give you anymore
9 details about it.
10 Q: Okay. What happens if you fail to provide CPR
11 and AED on a cardiac arrest patient?
12 A: They'll certainly die.
13 Q: And you've got all the documents that I got
14 from DHEC. And again I'm just going to
15 summarize what my analysis was and see if you
16 have a reason to dispute that. According to my
17 case, there were a total of 50 cases that were
18 on that list.
19 A: This list?
20 Q: That list.
21 A: I haven't counted them, so I can't ...
22 Q: And out of those cases there were 19 what they
23 call ESO's. do you know what an ESO is?
24 A: I do not.
25 Q: Okay. Have you ever heard of an emergency

1 suspension order?
2 A: Oh, okay. Right. Yes.
3 Q: Emergency suspension order is when a paramedic
4 has been arrested for a felony or serious crime
5 of moral turpitude? Is that right?
6 A: Yes, that's part of it. I'm sorry. It's a
7 little bit late.
8 Q: And so DHEC has the authority to act
9 immediately to suspend that paramedic pending
10 the outcome of the criminal charges, correct?
11 A: Correct.
12 Q: Okay. So if you take out the 19 emergency
13 orders, there were actually 30 consent orders
14 from DHEC at in time. Do you have any reason
15 to dispute that?
16 A: I have no reason to dispute anything about
17 what's here or how it's accounted at all,
18 'cause I'm not familiar with this. I'll take
19 your word for it.
20 **MR. WICEVIC:** Your Honor, I think that's the key to
21 our objection. He testified he doesn't know
22 anything about this.
23 **MR. ROTHSTEIN:** Well, Your Honor, he signed off on
24 every one of these cases. The fact that he
25 can't remember while he's sitting here today is

1 not ---
2 A: No. I have not signed off on ... I don't sign
3 off. I may be consulted for a recommendation,
4 but there's no paper that I sign.
5 **THE COURT:** Okay. The objection is sustained.
6 Q: Would you be surprised to know that Mr.
7 Davenport's the only paramedic who's been
8 recommended for enforcement action against his
9 paramedic certificate since January 1st of
10 2011, who's files a contested case hearing
11 request?
12 A: I would not be surprised. I don't recall any.
13 Q: Your expert in the case, Mr. Douglas, do you
14 recall him testifying that he's a member of a
15 committee that looks into the, sort of,
16 wellness of mental health issues of paramedics
17 and EMT's?
18 A: I don't remember that specifically.
19 Q: Do you agree that begin a paramedic and an EMT
20 can be a stressful job?
21 A: Absolutely.
22 Q: You aware that paramedics and EMT's face a
23 higher incidence of suicide and depression and
24 alcohol and metal health issues at a rate
25 higher than many other occupations and

1 professions?
2 A: Generally healthcare associated professions
3 show that, yes.
4 Q: Okay. When you worked as a paramedic back in
5 the day, did you work long hours?
6 A: Yes.
7 Q: Typically did you work 24, 48 type shifts?
8 A: No. When I was at Bishopville, it was
9 24,7,365. We were volunteer service and
10 basically I worked anytime they needed someone.
11 Q: Would you agree that working long hours like 24
12 hours on can also take a toll on a paramedic or
13 EMT's well-being?
14 A: Yes, sir.
15 Q: Now, to your knowledge, what has DHEC done to
16 address these types of wellness and mental
17 health issues for paramedics and EMT's in South
18 Carolina?
19 A: Well, DHEC really does not have authority that
20 I know of to get into the work place and set
21 hours or standards for hours. That's out of my
22 area. We do have symposiums and meetings where
23 health and wellness is discussed, and we bring
24 in folks to try and help educate the people who
25 do make those decisions, which are the service

1 providers. But we don't regulate how many
2 hours somebody can work, or at least I don't
3 think we have that authority. I've never been
4 involved with anything like that.
5 Q: And I'm not talking about regulating hours.
6 I'm talking about, sort of, wellness and
7 concern for the paramedics and EMT's that are
8 licensed in South Carolina. Are you aware of
9 any efforts that you or your office, or people
10 under your supervision have taken to promote
11 the health and wellness and care for the
12 paramedics and EMT's?
13 A: There may be some. I'm not personally familiar
14 with them at this time.
15 Q: Are you familiar with something called the Code
16 Green Campaign?
17 A: I am not.
18 Q: Okay. You've never heard of the Code Green
19 Campaign?
20 A: I have not.
21 Q: Now I think there was some testimony earlier
22 from one of the witnesses that talked about
23 what a differential diagnosis was.
24 A: Yes, sir. I remember something about that.
25 Q: And a differential diagnosis is sort of

1 potential explanations for a certain condition,
2 right?
3 A: Potential explanations or problems that may be
4 associated with a certain condition, yes.
5 Q: Okay. I think you testified when you first saw
6 the video, you had some concern about Mr.
7 Davenport's interactions and his, sort of,
8 demeanor toward the patient, correct?
9 A: I did.
10 Q: Okay. Did you during the IRC discussions talk
11 about whether that was a response to stress
12 that Mr. Davenport may have been under?
13 A: We discussed multiple possibilities for it and
14 wanted to make sure that he had good care.
15 Q: Okay. Did you discuss the possibility that he
16 might be burned out?
17 A: I think that was one of the statements that was
18 brought up.
19 Q: Okay. Were you aware that Anderson County lost
20 a paramedic to suicide in February of 2016?
21 A: I don't often know how folks die. I'll know
22 that they expire. We'll be notified, but I
23 don't specifically recall a suicide.
24 Q: Do you know if Mr. -- when you viewed the
25 video, did it appear that Mr. Davenport was

1 having trouble getting around a little bit?
2 A: I don't recall. If you want to play it I can
3 look at it, but I don't recall. I recall at
4 some point hearing that he was having some
5 pain. And I have no doubt that he may have.
6 Q: Okay. In the IRC meeting, do you recall
7 discussions among the members of the committee
8 about whether they thought Mr. Davenport might
9 have been suffering from post traumatic stress
10 disorder?
11 A: I remember that was brought up and discussed at
12 some point.
13 Q: Okay. You recall a discussion about possibly
14 him having a traumatic brain injury from the
15 blast he received in Afghanistan?
16 A: That may have been discussed. I don't
17 specifically recall that, but it could have
18 been.
19 Q: Okay. Did you discuss the possibility that Mr.
20 Davenport might have been having difficulty in
21 returning to civilian life after being in
22 active duty combat?
23 A: Yes.
24 Q: Okay. And what specifically did you and the
25 committee members do to follow up on those

1 concerns and those discussions about Mr.
2 Davenport's health or well being?
3 A: Well that was part of one of our
4 recommendations to the Department was that he
5 at least has some evaluation to see if any of
6 that may be true. That was part of one of the
7 recommendations. We did not say that any of it
8 was true, only that we were concerned it might
9 be and we'd like some professional to tell us
10 whether -- we didn't even need to know. Just
11 have some professional look at him. If they
12 said, nothing is there, end of story.
13 Q: Okay. You never offered that to Mr. Davenport
14 prior to the recommendations that his paramedic
15 credentials be suspended or revoked, did you?
16 A: That was one of the recommendations from the
17 IRC.
18 Q: Recommendation was we're going to suspend him
19 and make him go to an evaluation, right?
20 A: One of the recommendations was we will take
21 some time -- we felt that there had to be some
22 punitive action based upon the results.
23 Sometime, some smaller time, and at least a
24 single evaluation with the recommendation that
25 if something was discovered and further therapy

1 was recommended that he attend that. But if
2 nothing was discovered and no therapy was
3 recommended, end of story. Or a longer period
4 of revokation or suspension, and those two
5 terms kind of get mixed up as to what they
6 mean, if he did not wish to do that. We gave
7 options.
8 Q: All right. But before you made the
9 recommendation of suspension, you didn't say,
10 hey we need to have Mr. Davenport see if he can
11 go to an EAP or some sort of counseling to see
12 if he's got some mental health issue that
13 explains the way he acted toward this patient
14 on that night, did you?
15 A: Before we went through the IRC?
16 Q: No, no. Before you offered Mr. Davenport a
17 consent order where he would agree to a
18 suspension of his license for at least a year,
19 right?
20 A: I think that the Department may have offered a
21 consent order at or about the time of the IRC,
22 which lead to the IRC. I don't remember
23 specifically. But in the IRC we had a couple
24 of recommendations. One was a smaller time
25 without certification, coupled with some sort

1 of professional evaluation, or a longer period
2 without certification if he declined that.
3 Q: Okay. Well I know this is late, but my
4 question is before you made the suspension
5 recommendation, you never said, hey let's have
6 him evaluated first and consider that as part
7 of the IRC, right?
8 A: No. That came out of the IRC is what I'm
9 trying to say.
10 **MR. ROTHSTEIN:** I don't have any further questions,
11 Your Honor.
12 **THE COURT:** Okay.
13 **MR. WICEVIC:** Your Honor, I'll make it quick.
14 **DR. DESCHAMPS - RE-DIRECT EXAMINATION BY MR. WICEVIC:**
15 Q: Just a few follow up questions.
16 **MR. WICEVIC:** Could we get the monitor?
17 Q: Now, Dr. Deschamps, I believe in your direct
18 testimony to my questioning said there's a lot
19 of moving parts to paramedic practice.
20 A: Correct.
21 Q: Might there be other protocols regarding IV
22 access besides this multiple trauma shock ---
23 A: Oh sure. You may see IV access under cardiac
24 arrest or under respiratory distress or under
25 back pain. I mean, IV access may be under

1 multiple issues. And that's part of the
2 formulation that the medic has to sort through.
3 Q: Okay. Well let's look at -- and again, these
4 are the State recommended protocols, correct?
5 A: Correct.
6 Q: Okay. Let's look at IV access. I have it up
7 on the screen.
8 A: Okay.
9 Q: Would that be applicable to this particular
10 patient?
11 A: Sure.
12 Q: And why?
13 A: Well, I mean, first off you do universal
14 patient care protocols. Then it says, assess
15 need for IV. Emergent or potentially emergent
16 medical or trauma condition. So either there's
17 clearly an emergency or a potential emergency
18 that could develop. And in those cases you
19 initiate the IV.
20 Q: Was there an emergent or potentially emergent?
21 A: Sure. I mean, that's what we've said all along
22 is that we felt, given the mechanism of injury
23 and the findings, that the potential for
24 injury, prolonged injury, death, disability was
25 there.

1 Q: Okay.
2 A: And that's all you need is to check that box
3 for potential.
4 **MR. WICEVIC:** And, Your Honor, please stop me if you
5 don't need this, but there was some reference
6 about DHEC not being concerned with order
7 violations. And I was going to have Dr.
8 Deschamps review the regulation to respond to
9 that. But I know The Court's familiar with our
10 laws.
11 Q: Dr. Deschamps, what are the various bases that
12 the Department can take enforcement?
13 A: Basically any violation whatsoever of the
14 regulations.
15 Q: Okay. What else?
16 **MR. ROTHSTEIN:** And, Your Honor, again this is --
17 he's testifying about legal matters at this
18 point. I think it's improper for this witness
19 to instruct you on what the law is.
20 **THE COURT:** I agree with that.
21 **MR. WICEVIC:** Okay. Fair enough. I trust The Court
22 can figure out the legal matters in this. You
23 mentioned that there are certain circumstances
24 which would allow a paramedic or EMT to deviate
25 from an order. Could you explain the meaning?

1 A: Okay. So, you're going down your protocol and
2 it comes to a place where it say, start an IV.
3 Okay? In the next section you come to says,
4 administer epinephrin. Okay? Well if you
5 can't get the IV started, you may not move to
6 the second point. So you by default have to
7 deviate from that. If you're under potentially
8 life threatening situation such as an active
9 shooter or something, and it says, do not
10 ambulate the patient. Well if you're getting
11 shot at the quickest thing may be to ambulate
12 the patient. The goal is to protect the medic
13 first. If the medic in injured then nobody
14 helps the patients. So anytime where you may
15 need to deviate to protect the provider, that's
16 an acceptable sort of thing.
17 Q: Well did you observe those types of
18 circumstances with this ---
19 A: I did not.
20 Q: Okay. Dr. Deschamps, the only reason why I
21 bring this up is because it was brought up
22 during your cross-examination. What's the
23 first step according to the State protocol for
24 caring for a behavioral patient?
25 A: First step is scene safety and universal

1 patient care.
2 Q: Then what's next?
3 A: Then after that remove the patient from the
4 stressful environment. Use verbal calming
5 techniques because communication is very
6 important, reassurance, calm, establish a
7 rapport, and then check the Glasgow Coma Scale.
8 From there go to an appropriate protocol.
9 Q: Okay. Did you see compliance with that second
10 bullet point?
11 A: No.
12 Q: Okay. No further questions. Thank you, Dr.
13 Deschamps.
14 **MR. ROTHSTEIN:** Your Honor, there's two things. I
15 promise I'll be less than two minutes.
16 **THE COURT:** Okay.
17 **DR. DESCHAMPS - RECROSS-EXAMINATION BY MR. ROTHSTEIN:**
18 Q: I think it was just on the screen. What does
19 the pink F mean?
20 A: First responder, which is now referred to as
21 rapid. We coded ours by color for level. So
22 anybody at or above that level can fulfill that
23 obligation. So if you see a P for paramedic,
24 only a paramedic can do it. If you see an I
25 for advanced, then an advanced or a paramedic

1 can do it. So that's the floor.
2 Q: So as an F, that's something that you don't
3 even need a EMT basic to do, right?
4 A: Correct.
5 Q: Okay. The first person on the scene may be a
6 firefighter or ---
7 A: Correct.
8 Q: --- a Police Officer who's trained in first
9 response. Okay. And on that IV access one
10 that Mr. -- it doesn't say administer an IV,
11 right? In that second bullet down after
12 universal care protocol. It says, assess need
13 for an IV, right?
14 A: Right. But then it comes down under A and
15 says, peripheral IV. That's a statement.
16 Start the IV.
17 Q: Okay. But if you assess the need for the IV
18 and there was no need for the IV 'cause the
19 patient was stable, you don't go further down
20 the protocol, right?
21 A: Stability has nothing to do with it. Potential
22 emergent medical or trauma condition. So
23 stability is great and we aspire for that. But
24 that has nothing to do with the protocol. If
25 the potential exists you treat to the

1 potential.
2 Q: Okay. I think you said you checked that box,
3 right?
4 A: Yeah. Once you get there and say this, then
5 you don't have to go any further. You know,
6 it's like if you are assessing a patient for
7 cardiac disease in an older man, he's got chest
8 pain, it doesn't matter how much negative you
9 find, that chest pain's enough positive that
10 you got to exclude heart as an issue.
11 Q: I understand, but when you say check the box
12 medicine, that's inconsistent with having the
13 paramedic have the critical skills to think for
14 themselves.
15 A: No, no, no. I figured you might ask that. But
16 you're checking the box in the sense of once
17 you come to this point and get an affirmative
18 negative answer, whichever way it is, then you
19 are obligated to do something. So if you check
20 the box that there's a potentially emergent
21 medical condition, if you say in your mind, in
22 this situation there's a potentially emergent
23 situation, then everything else is moot. You
24 go down and start an IV.
25 **MR. ROTHSTEIN:** I don't have any further questions,

1 Your Honor. Thank you.
2 **THE COURT:** Okay. Thank you, Dr. Deschamps.
3 **DR. DESCHAMPS:** You're welcome. Thank you.
4 **THE COURT:** And I think it's five minutes before
5 6:00, so we're going to stop for today. And
6 we'll start again -- I'm sorry. Go on.
7 **MR. WICEVIC:** I was just going to say we just have
8 one more witness.
9 **THE COURT:** You've just got one more witness?
10 **MR. WICEVIC:** Yes, Your Honor.
11 **THE COURT:** Okay. Good. We'll start with that
12 witness at 9:00 a.m. in the morning. Okay?
13 Good.
14 **(Whereupon, the hearing adjourned at 5:57 p.m. and**
15 **was reconvened on Thursday, July, 27, 2017 at 9:07**
16 **a.m.)**
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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT
Docket No. 17-ALJ-07-0003-CC

South Carolina Department of Health and Environmental Control,

Petitioner,

v.

James Davenport,

Respondent.

ADMINISTRATIVE HEARING

****

Thursday, July 27, 2017
9:07 a.m. - 5:43 p.m.

The hearing before the Honorable Shirley Canty Robinson, was taken at the Edgar A. Brown Building, 1205 Pendleton Street, Suite 224, Columbia, South Carolina, on the 27th day of July, 2017 before Travis McLeod, Court Reporter and Notary Public in and for the State of South Carolina.

APPEARANCES

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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.)

Petitioner's Exhibit Number 6 36
(AnMed Emergency Department Record)
Petitioner's Exhibit Number 7 37
(AnMed Operating Room Procedure Notes)
Petitioner's Exhibit Number 9 29
(James Davenport DHEC Interview)
Petitioner's Exhibit Number 28 66
(Affidavit for Iva Police Department)
Petitioner's Exhibit Number 29 66
(Affidavit for AnMed Health)
Respondent's Exhibit Number 3 87
(DHEC Division of EMS and Trauma Investigation Log re: Davenport)
Respondent's Exhibit Number 15 317
(Davenport Military Discharge Documents and Listings of Awards/Medals)
Respondent's Exhibit Number 16 318
(Davenport Proficiency Reports from Military)
Respondent's Exhibit Number 22 220
(Curriculum Vitae of Leo Deason)

(The original exhibits were retained by Judge Robinson.)

STIPULATIONS

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

1 **THE COURT:** The hearing is called to order, and do
2 we have anything that we need to take care of
3 before Mr. Wicevic calls his last witness?
4 **MR. WICEVIC:** I do not believe so.
5 **THE COURT:** Okay
6 **MR. ROTHSTEIN:** I'm good, Your Honor.
7 **THE COURT:** Okay. We're ready to hear your witness.
8 **MR. WICEVIC:** Yes, Your Honor. The Department calls
9 Robert Wronski.
10 **THE COURT:** Okay. Mr. Wronski, you've been sitting
11 here so you know the drill.
12 **MR. WRONSKI:** Yes, ma'am.
13 **ROBERT WRONSKI**, having been duly sworn, testifies as
14 follows:
15 **MR. WRONSKI - DIRECT EXAMINATION BY MR. WICEVIC:**
16 Q: All right. Good morning, Mr. Wronski.
17 A: Good morning.
18 Q: Please state your full name for the record.
19 A: Robert Anthony Wronski.
20 Q: Mr. Wronski, can you state -- can you explain
21 your education?
22 A: I graduated from high school in Western New
23 York, Niagara County in 1984, directly into the
24 U.S. Navy. 20 years in the Navy. Various
25 submarines, submarine squadron commands. My

1 last four years I had some kidney stones and I
2 was chained to a desk, so I still completed 20
3 years in the Navy. Beyond that I have an
4 Associates degree from Trident Technical
5 College, 1991, a Bachelor's degree in public
6 health administration from Columbia Southern
7 University, and a masters in business
8 administration with a concentration in public
9 administration from Columbia Southern
10 University.
11 Q: What was your associate's degree in?
12 A: Just in general science. I was trying to get
13 into nursing school.
14 Q: Okay. Your job experience. You talked about
15 your military. What did you do after you got
16 out of the military?
17 A: Out of the military directly into full-time
18 position with a Fire Department that I had been
19 volunteering with as a paramedic firefighter.
20 And I stayed at the Beach Park Fire Department
21 in Illinois outside Chicago until 2006 when I
22 moved back to Charleston. I've been stationed
23 in Charleston and I always wanted to come back.
24 So I came back down to Charleston. I worked
25 for Charleston County EMS for a bit and missed

1 the fire side of things, and I was hired by the
2 Mt. Pleasant Fire Department to be their
3 Medical Training Officer and to start an
4 advanced life support paramedic engine program
5 with them. Stayed there for about four years,
6 resigned from that position, went to private
7 EMS for about seven or eight months, and then
8 back to the Fire Department as the training
9 officer for the St. Andrews Fire Department,
10 and then eventually was promoted to Assistant
11 Chief of that Department before taking this
12 position.
13 Q: Okay. Can you explain your patient care roles,
14 I guess beginning with your Fire Department
15 experience outside of Chicago?
16 A: I was the Medical Training Officer for the
17 Beach Park Fire Department for a period of
18 time, but I was also a shift commander, I was
19 a Captain. Lieutenant first, sorry, promoted
20 to Captain before I left, and I rode the
21 ambulance early when I worked there for most
22 shifts that I was on. I was one of the senior
23 providers there. And then I, as a shift
24 commander, I switched more to an engine and
25 command role.

1 Q: Okay.
2 A: But I still provided advanced life support
3 patient care.
4 Q: And then you moved down to Charleston. Can you
5 tell about your patient care?
6 A: When I was in Charleston County I was strictly
7 on an ambulance as a crew Chief, and was there
8 for 18 months give or take before I took the
9 position with Mt. Pleasant where I also then
10 provided advanced life support care via quick
11 response vehicle.
12 Q: Okay. And perhaps I should have gotten to this
13 before we got to your job and experience.
14 Explain your various certifications as a EMT.
15 A: So I got my EMT basic, actually the Navy put me
16 through EMT school between duty stations. They
17 were putting EMT's on submarines to assist the
18 one corpsman that's on a submarine. And so in
19 between my duty stations between South Carolina
20 and Virginia I attended Tidewater Community
21 College in Virginia Beach and obtained my EMT
22 certification.
23 Q: When was that?
24 A: 1991.
25 Q: Okay.

1 A: After that I was sort of bit by the bug, so I
2 took my CPR instructor certification relatively
3 quickly. Joined a volunteer rescue squad in
4 Abingdon, Virginia, which is in Glaucester
5 County, and while I was on sea duty, and as I
6 could I volunteered with Abingdon Rescue Squad
7 and moved up through my cardiac technician with
8 is just a -- there were several levels in
9 Virginia. It's above an EMT, above an advanced
10 EMT. And volunteered for Abingdon until I left
11 Virginia to go to Chicago where I obtained my
12 paramedic certificate in 2001, which is step
13 above. I bridged up to paramedic when I got to
14 Chicago Great Lakes.
15 Q: Okay. We talked about all the certifications,
16 EMT, paramedic. When did you get your
17 paramedic?
18 A: My paramedic license was 2001.
19 Q: Okay. Are you currently certified as ---
20 A: Yes.
21 Q: --- a paramedic in this State of South
22 Carolina?
23 A: Yes, sir.
24 Q: Okay. What's your position now?
25 A: I'm the Bureau Chief for the Bureau of EMS and

1 Trauma at South Carolina DHEC.
2 Q: Okay. Can you explain your responsibilities as
3 a Bureau Chief?
4 A: As Bureau Chief I oversee the operations and
5 the personnel at the five direct reports within
6 the agency, but we have 18, soon to be 19 on
7 the Bureau. We handle basically everything
8 that's related to EMS and trauma as well as
9 athletic trainers in South Carolina. So
10 certifications of personnel, agency licenses,
11 ambulance permitting, education program
12 approval, athletic trainer certification and
13 recertificaion, and that's on the EMS side, and
14 the ambulance inspections and all that go with
15 that, as well as any investigations that may
16 come up or complaints. And on the trauma side,
17 it's all time sensitive emergencies, so it's
18 trauma, pediatrics, stroke, stymies which are
19 heart attacks, and sepsis is part of our time
20 sensitive division. And we have a data
21 division as well. It's our third division
22 within EMS.
23 Q: Okay. Dr. Alier and Richard Naugler are here.
24 What are their roles within the Bureau?
25 A: Dr. Alier is my division head with the division

1 of EMS. We've got the division of EMS, the
2 division of trauma and time sensitive
3 emergencies, and the division of date, the date
4 division. He's the head of the EMS division.
5 Q: Okay. What about Mr. Naugler?
6 A: Mr. Naugler is an EMS inspector. Inspector
7 three I believe is his level.
8 Q: Okay. Do you have any, I guess, paramedic or
9 EMT teaching responsibilities?
10 A: I don't have any responsibilities now. We
11 regulate every education institution. I would
12 have to go to North Carolina, Georgia to teach.
13 But I previously had through paramedic
14 instructor certification. And then all the
15 ancillary course instructorship that go with
16 those, and I still maintain those.
17 Q: Have you received any kind of awards in the
18 field of EMS?
19 **MR. ROTHSTEIN:** Your Honor, I object. I don't think
20 any awards he's received is relevant with
21 anything in the case.
22 **MR. WICEVIC:** I'll withdraw.
23 **MR. ROTHSTEIN:** He's trying to bolster a witness.
24 **MR. WICEVIC:** I'll move on.
25 Q: Mr. Wronski, we talked about the division of

1 EMS. Can you explain the general investigation
2 process?
3 A: The investigation process is ---
4 Q: Of EMT's. Let's be specific.
5 A: Of EMT's? Specifically with EMT's? An
6 investigation may result upon the receipt of a
7 complaint. We like to have a written complaint
8 with a name attached to it, but we don't always
9 get those. Our statute regulation is pretty
10 clear that we can act on any kind of
11 information that we get if we feel it's
12 necessary. Once we have that information in
13 hand, we'll assign an investigator to it.
14 Q: Well let's back -- before you get into that.
15 How do you determine whether or not to
16 investigate some kind of information you
17 receive?
18 A: It depends what we get. It truly does. Some
19 of the information, it comes in either as a
20 complaint of this paramedic treated me poorly
21 or this agency was, you know -- sometimes
22 they're even about bills. We don't handle
23 things about bills, but up to we'll receive an
24 entire package from an agency that says this
25 happened to us, we investigated it, tell us

1 what you think. Or, you know, if you think it
2 needs more -- if there's more that needs to be
3 done at the DHEC level. Here's our package
4 that we've completed.
5 Q: Okay. I mean are you looking for information
6 that might fall afoul of our regulations or
7 statutes?
8 A: That's what we do, that's what we look for is
9 specifically are misconducts within the
10 regulation and the statute.
11 Q: Right. I mean, you mentioned the billing of --
12 -
13 A: Uh-huh.
14 Q: I mean, is that something that's within the
15 scope of our ---
16 A: It is not, and we get those quite frequently.
17 But we just simply tell them that it's between
18 them and the agency.
19 Q: Okay. So the determination to inves- -- or
20 talk about whether to investigate. What's the
21 investigation process?
22 A: Our investigation process is to then assign an
23 investigator to the complaint to first check
24 for veracity and if there's any teeth to it
25 based on what we have and then what we can

1 quickly obtain. So if it's a patient care
2 complaint, we can quickly pull patient care
3 reports in the office. If there's any
4 statements that have been given to us, we can
5 you know, check the statements versus the
6 patient care report. And then we sort of have
7 a little huddle after that and we say, okay
8 this is something we absolutely need to
9 investigate and move forward and take a deep
10 look at, or send a letter back and say we're
11 not going to investigate it. Rarely do we not
12 investigate stuff that comes in.
13 Q: Okay. Well what does -- there's something
14 mentioned during the cross of Dr. Deschamps,
15 local problems local solutions.
16 A: Right.
17 Q: Can you explain what that means?
18 A: Local problems local solutions is where we may
19 investigate it, but we then determine that what
20 was done at the local level is akin to what we
21 would have done or in many cases it's more than
22 what the agency based on when we look at what
23 violation may have occurred to the active
24 regulation. And we say, okay this was a
25 training issue, that this person didn't have

1 any ill intent or ill will, just had a training
2 issue or they performed a skill incorrectly and
3 the Department is going to have them do A, B,
4 C, and D to correct that issue, and we feel
5 it's best handled at the local level with a
6 local solution. We wouldn't do that much more
7 or anymore based on the violations that we
8 could see.
9 Q: Are there any other factors that you look into
10 in making that determination to investigate, or
11 is that generally it?
12 A: I mean it's generally a group decision. No one
13 person ever really makes a decision on these.
14 But we look at so many different things. We
15 look at, again, whether it was a training
16 issue, whether it was intent, you know?
17 Q: What do you mean intent?
18 A: If it was just somebody -- it's a term I don't
19 like to use too often, but if somebody's just
20 being lazy or somebody just forgot, or if there
21 was just, I'm not going to do this. You know,
22 we will occasionally see those that come in,
23 and that's when we definitely determine we
24 usually will bring in an investigation and
25 start the formal interview process and

1 collecting more data.
2 Q: Okay. So you determine to initiate the
3 investigation, do the investigation, find that
4 there were violations. What's the enforcement
5 process?
6 A: If we still feel that there may be violations
7 -- can I back up one second?
8 Q: Sure.
9 A: There's one part of the investigation process
10 or the enforcement process that are for
11 emergency suspension orders. Those don't get
12 a ton of investigation. If we get a report
13 from SLED, all of our EMT's and paramedics are
14 fingerprinted, and we get SLED reports for
15 felony arrest that will come in occasionally.
16 And if it's a felony arrest, if it's an arrest
17 for something pertaining to moral turpitude, we
18 will do emergency suspension orders. And it's
19 based on the arrest report, the police report,
20 the charges, and we'll do an emergency
21 suspension if we feel there's a danger to
22 public safety. So there's that side of it too.
23 But then on to the regular investigations.
24 What was your last question. I apologize.
25 Q: I was just asking if you could explain the

1 general enforcement process.
2 A: So once we determine that we may have enough to
3 proceed forward, then we'll bring in who we
4 think are key people we need to talk to. And
5 a lot of times it's just the people that were
6 involved on the call. It could be just the
7 paramedic and the EMT, could be the supervisor
8 if the supervisor witnessed something we might
9 bring the supervisor in. And we bring them in
10 to speak to them, to get their side of the
11 story. Those are all taped. No one's sworn,
12 but we do tape them and we inform everyone
13 ahead of time that we're going to be taping
14 them. And we will provide them to the people
15 if they ask for them.
16 Q: Okay. And if you still believe that there's a
17 violation after that, then what do you do?
18 A: If we believe there's a violation after that,
19 then we again, reconvene the EMS Director if
20 there's no direct relationship with him, and
21 the investigator. We may bring in the
22 compliance manager, to discuss so he can
23 refresh us. I don't remember every case we
24 ever had, but he's really good at remembering
25 those kind of things. So he can say, yep we

1 had something similar to this and this is what
2 we did. And then we'll propose that to the
3 person. A lot of it is based on that interview
4 and a lot is based on what they tell us, you
5 know, where the enforcement goes from there.
6 A vast majority of people that come in that
7 have been alleged to have done something wrong
8 know they've done something wrong. And they
9 say, I did it, I'm sorry, I forgot, I blew this
10 off, I didn't think about it, you know. And
11 they really are remorseful and we take that
12 into consideration as well as can this be
13 corrected with remediation? We don't like to
14 use punishment. We like to rememdiate as much
15 as possible. What role does the State Medical
16 Control Physician play in the investigation and
17 enforcement process?
18 A: Investigation and enforcement process, we don't
19 role him in to everyone that we do. But if see
20 a potential that there's going to be a serious
21 one, whether we think that there may be some
22 serious action or if I just say, hey I want an
23 outside set of eyes to look at this to see if
24 I'm on the right track, I'll say, hey Doc can
25 you take a look at this file or can you look at

1 this investigation, and it can be early on or
2 it can be later just depending on as we gather
3 more information because many times during an
4 investigation, we'll think one thing and
5 something will pop up and we'll see something
6 else.
7 Q: What's the Investigative Review Committee?
8 A: The Investigative Review Committee is set in
9 our statute. When we feel the need that we may
10 need to suspend or revoke a license and we
11 can't obtain that sort of consent order with
12 the party, we have to convene the Investigative
13 Review Committee to review our investigation
14 and make a determination for us. Not for us
15 but to make a recommendation for us based on
16 what we provided to them and the questions they
17 ask. The parties don't have to be there, but
18 we always invite them if they want to come.
19 And they may -- you know, we've had three or
20 four different people come into an IRC for one
21 case, not for -- we've only had two IRC's
22 actually in the last three and a half years.
23 But it consists of the State Med. Control
24 Physician, one representative from the Regional
25 EMS Council from the non-affected regions we

1 say. So whatever region it was, this incident
2 was in the Upstate region, so it was Pee Dee,
3 Midlands, and Low Country, one paramedic at
4 large which can be anyone. We like to pick
5 somebody with a lot of experience. And if it's
6 a medical, we'll pick somebody with really good
7 medical experience. If it's a trauma, we try
8 to get someone with trauma experience. And
9 then one other physician who is a Medical
10 Control Physician and a practicing emergency
11 room physician. The statute is very specific
12 that they have to be both. There's not a lot
13 of those but we don't have a lot of IRC's.
14 Q: Okay. Moving onto this particular incident,
15 the James Davenport matter. How did we become
16 aware of this matter?
17 A: The Department became aware that there was a
18 review that was taking place by Anderson County
19 and or Iva. I'm not sure if I was initially
20 rolled into the review. We received it from
21 the Director of Anderson County. And it was --
22 when it initially came into the office I was
23 not aware of it. My division directors often
24 times get these reviews or complaints and I do
25 rely on them to make good decisions, and I

1 trust them implicitly to make good decisions as
2 to, you know, whether we need to ramp one up or
3 not. And this came in as a review I believe.
4 I can't testify exactly the thought process of
5 what came in, but it came in as a review on
6 several calls with some recommended action. So
7 one of these local solutions for local
8 problems. That's how it came in.
9 Q: Okay. Who received it?
10 A: I believe Dr. Alier did.
11 Q: Okay. And what was the Department's response.
12 At that point was there an investigation?
13 A: There was not an investigation that had opened
14 at that time.
15 Q: Okay. Is there a reason for that?
16 A: Based on their review and our review of the
17 EPCR's. It looked like there was a paramedic
18 who was needed some remediation on protocols
19 and needed some remediation on, you know, what
20 maybe best practices were. And they were going
21 to handle it at their level.
22 Q: Okay. Now the Department did open an
23 investigation into this?
24 A: Yes we did.
25 Q: When was that?

1 A: The official investigation, I would have to
2 look at the notes to tell you the date. I
3 apologize. But the official -- it was the date
4 of the day after we received the video tape.
5 Q: Okay.
6 A: Or video recording.
7 Q: Okay. So who was assigned to this particular
8 investigation?
9 A: Richard Naugler was assigned as the lead
10 investigator on this one.
11 Q: Okay. And so what ---
12 A: I have an Upstate inspector but she had some
13 ties to that area, so that, because it's such
14 a small community, that will occasionally
15 happen. And we won't assign an investigator to
16 something that they may or may not have some
17 ties to.
18 Q: You said a small community. Could you explain
19 that? What do you mean by a small community?
20 A: South Carolina EMS? As we've seen in the
21 courtroom in the last few days, everybody knows
22 everyone. And I know a lot of people across
23 the State by face but not intimately familiar
24 with. Everyone in this community has worked
25 with somebody who's worked with somebody that

1 knows somebody. It's not a -- people will jump
2 agencies in South Carolina. Some people will
3 stay in one place for 30 years, and some people
4 will work 30 places in 30 years.
5 Q: So when is a recusal amongst DHEC
6 investigations?
7 A: If there's a direct relationship between the
8 Department or the agency that we're looking at
9 or with a particular person who has a direct
10 relationship with someone who's being accused
11 of doing some misconduct.
12 Q: Okay. So what did the Department's
13 investigation into this matter consist of?
14 A: The investigation cons- ...
15 Q: What did the Department do as part of it's
16 investigating?
17 A: Okay. Part of the investigation -- obviously
18 the investigation was open based on the video
19 tape.
20 Q: Right.
21 A: After we received the video tape. Dr. Alier
22 received it one night. I saw it the next
23 morning, and that's the day we opened the
24 investigation. That began the investigation.
25 Within the video tape it appeared that we had

1 some pretty serious violations of the active
2 regulation. Dr. Deschamps couldn't remember
3 yesterday when he saw the video, and I for the
4 life of me couldn't remember at what point he
5 saw it. But it was near the time that we then
6 brought in Mr. Davenport for an interview. So
7 the next step on that was to collect PCR's, I
8 believe we got the Emergency Room report, I'm
9 not positive when we got the OR report. We had
10 the video tape, we had statements from Ms.
11 Aiken I believe, a statement from Ms. Aiken,
12 and a chart review that was included with the
13 initial package. And that's when we brought
14 Mr. Davenport in.
15 Q: Let me hand you the DHEC proposed Exhibits. Or
16 you have a copy up there?
17 A: There's one up here, yeah.
18 Q: Perfect. See if we can identify the documents.
19 ---
20 A: There's a copy of our reg. and act I here too.
21 Q: All right. Is the patient care report that you
22 reviewed as part of this investigation in this
23 exhibit packet? There's a table of contents.
24 A: I would have to verify the date. There's a
25 bunch of PCR's in here.

1 Q: What was the date of the incident that prompted
2 the Department's ---
3 A: The 19th.
4 Q: Okay. So which exhibit would that be?
5 A: That would be Exhibit 11b.
6 Q: Okay. What other documents or files do you see
7 in this exhibit packet that you reviewed as
8 part of your investigation?
9 A: Ms. Aiken's statement, the AnMed Operating
10 Room.
11 Q: So wait.
12 A: Sorry.
13 Q: Ms. Aiken's statement, Exhibit 4?
14 A: Exhibit 4, yes. I'm sorry.
15 Q: Okay.
16 A: So I'll start at the top. Exhibit 1, Anderson
17 County protocols, the body cam footage,
18 eventually the AnMed OD department, the radio
19 call, the audio file that's there, Ms. Aiken's
20 statement. And I want to apologize. I was
21 limiting to what we started our investigation
22 with. But we have reviewed all these as part
23 of the entire investigation. So I'll keep
24 going down.
25 Q: And I'm really talking about before the

1 issuance of this.
2 A: Before the issuance of anything we reviewed all
3 of these exhibits that are in here actually.
4 Just let me -- before I commit to that let me
5 .... Until very recently I had not seen Exhibit
6 14. But the rest of those, we have seen and
7 received as part of the investigation. Yes,
8 sir.
9 Q: All right. So you get all the documentation,
10 then you brought Mr. Davenport in for an
11 interview?
12 A: Yes.
13 Q: I want to be clear, we didn't have all of these
14 exhibits that are here prior to bringing Mr.
15 Davenport in.
16 Q: Okay.
17 A: But we wanted to get his side of the story. We
18 do. So we -- like I said, that's a key, when
19 we bring somebody in, is there recognition that
20 something was potentially done wrong, we want
21 to hear their side of it. There's always
22 another side to a story. And so we wanted to
23 make sure that we brought him in to have his
24 side of it.
25 Q: Okay.

1 A: We had Ms. Aiken's statement, so we didn't want
2 to bring her in. And to be quite honest, the
3 reason we didn't bring her in for an official
4 interview with us is watching the video tape
5 and holding her statement, they run pretty
6 concurrently. The run pretty accurately
7 together as to what happened on scene. So her
8 statement stood for us.
9 Q: Okay. Did you record the interview with Mr.
10 Davenport?
11 A: We did.
12 Q: Who was present during that interview?
13 A: Myself, Richard Naugler, Bently White who was
14 our Communications and Policy Director at DHEC.
15 Mr. Rich Wiznuski, who is our Trauma Director.
16 He's my Trauma Director and this was a trauma
17 call so I wanted him in there on the initial
18 interview, myself, and I cannot tell you if Mr.
19 Nix was in there. I don't believe he was.
20 Q: Okay.
21 A: We go around the room on the recording and
22 identify everybody who's in the room.
23 Q: How do you ---
24 A: And Mr. Davenport. I'm sorry.
25 Q: I'm sorry. How do you record the interview?

1 A: We have two digital audio recorders. We record
2 on one of the digital audio recorders.
3 Q: Okay.
4 A: We mark the time, we mark the date, we say
5 who's in the room, and then at the end we mark
6 the time and the date and say if anybody has
7 left or come or gone.
8 Q: Okay. And where is that recording stored?
9 A: It's stored on a secure drive at DHEC on a t-
10 drive in our investigations file. Each
11 investigation has a number assigned to it, and
12 it's stored within that file.
13 Q: Okay. Who has access to that file?
14 A: Mr. Nix, myself, Mr. Alier, and the
15 investigator that's assigned to it. Sorry.
16 They have to be able to put stuff in to that
17 investigation file.
18 Q: I don't want to play the whole audio recording,
19 but let me play the file. See if you can
20 identify it. Hopefully we won't have any
21 technical difficulties. And this is Exhibit 9
22 of the DHEC proposed exhibits.
23 **(Audio Played)**
24 Q: Can you identify that voice?
25 A: That's Mr. Naugler.

1 Q: Okay.
2 **(Audio Played)**
3 A: That's myself and I'm marking the time.
4 **(Audio Played)**
5 Q: Is that the beginning of the audio file?
6 A: That's the beginning. I verify via photo ID
7 and the credentialing information system
8 profile to make sure we have the right person.
9 We don't know everybody, so ...
10 **MR. WICEVIC:** All right, Your Honor. The Department
11 would like to admit DHEC's Exhibit 9 the audio
12 file DHEC interview with Mr. Davenport into
13 evidence.
14 **MR. ROTHSTEIN:** Your Honor, I think if this is going
15 to be admitted into evidence, the whole video
16 needs to be played rather than little snip-its.
17 I think it's misleading to cherry pick certain
18 statement that are made in the audio without
19 having entire context. So he's going to try
20 and introduce parts of it, I think the whole
21 thing needs to be played.
22 **MR. WICEVIC:** Well I was just going to insert it
23 into evidence. I wasn't even going to play
24 clip-its of the audio recording. I was just
25 admitting it into the record for The Court's

1 consideration.
2 **THE COURT:** Just the entire audio?
3 **MR. WICEVIC:** Yes, Your Honor. And it's two hours
4 long, and there's a lot of discussion. I don't
5 think it's ...
6 **THE COURT:** It's admitted.
7 **(Petitioner's Exhibit Number 9 was admitted into**
8 **evidence.)**
9 **MR. WICEVIC:** Thank you, Your Honor.
10 **THE COURT:** And, Mr. Rothstein I'm sure that 2 hours
11 long, you have no objections to them not
12 playing the entire thing.
13 **MR. ROTHSTEIN:** I have not. As long as it's in
14 evidence we're fine.
15 Q: Okay. Mr. Wronski, can you explain -- let me
16 ask, do you have strategies going in to an
17 interview?
18 A: We have strategies that we employ going in. We
19 don't claim to know everything that's going on,
20 but we do like to have the what we think are
21 the answers to several of the questions that
22 we're going to ask, so that when we ask those
23 questions we then will filter in some other
24 questions that we maybe don't have all the
25 answers to. And then we can sort of in our

1 heads check the what we think might be the
2 truthfulness of those statements. If they're
3 answering truthfully to five, and then number
4 six we don't know. Then we'll probably assume
5 that number six is truthful as well.
6 Q: Okay.
7 A: So that's a strategy we go in. I mean there's
8 just several different strategies. Sometimes
9 there's no strategy to it. It's that we have
10 this complaint and we want to hear their side
11 of the story. We just want to know what
12 happened and what's going on.
13 Q: Okay. I mean what's the ultimate objective of
14 your interview?
15 A: Ultimate objective of the interview is to try
16 to get answers to our questions, find out how
17 the person feels about whatever allegations
18 have been brought forth by whomever. If
19 they're readily admitting during this interview
20 that, you know, what they did is true and it's
21 on there, then we'll try to talk them through
22 it and see what their mind set was and see why
23 they did what they did, and have them explain
24 it to us, so we can -- you know, we don't like
25 to bring people in two and three times to do

1 these kinds of things. Try to get them all
2 hammered out as much as possible. And so our,
3 I guess, to shortly answer your question, is to
4 get as much of the truth as we can, and to get
5 as much of a picture from that person who was
6 involved, that person was directly there.
7 Q: Okay. Well what did you learn as a result of
8 this interview?
9 A: We had three patient care reports that had come
10 in this initial complaint, I'm sorry, the
11 initial review, and that we used for the
12 investigation. And so we walked through the
13 first two of those. We wanted to get a feel
14 for patient care, patient treatment, thinking,
15 how he felt about the protocols, how he made
16 determinations with different patients, how he
17 went through things in his mind, whether he was
18 good with the protocols, didn't like the
19 protocols, didn't know the protocols in some
20 cases. Not saying he did or didn't. We just
21 like to -- we walked him through those first
22 two calls before we got to the one that we were
23 really concerned about.
24 Q: Okay.
25 A: There were concerns with the other calls,

1 obviously. The Department sent them down. But
2 upon our review of those, there were really
3 good explanations for some of the things he
4 did.
5 Q: Okay. Well with the March 19th call.
6 A: Uh-huh.
7 Q: What was your finding with regard to that?
8 A: We walked him through that call first before we
9 showed the video tape. Asked him some
10 questions about it. He gave us answers to
11 those questions. And then I informed him that
12 when we do these investigations we collect as
13 much evidence as we can, and in this case we
14 had a video tape, and I wanted to then show him
15 the video tape. And that's when we started the
16 video.
17 Q: And then what transpired?
18 A: Attitudes changed a little bit. I will admit
19 mine changed a little bit. When we started the
20 video, right when we started it, Mr. Davenport
21 chuckled and said, yeah this is where I call
22 him an idiot. And I said, Mr. Davenport you're
23 the only one in here laughing right now. And
24 it went from there. So it became slightly more
25 adversarial at that point, after the video was

1 over and started to ask more poignant questions
2 regarding what he had told us prior to that.
3 Q: What were the other components of the
4 investigation?
5 A: The entire investigation?
6 Q: Yes, sir.
7 A: Most of these exhibits that are in here.
8 Q: Okay.
9 A: And I want to just correct that just so that I
10 don't go offline. Some of these, Dr.
11 Deschamps's CV, Dr. Kickham's CV, this email
12 that's down here, the Med. Control agreement.
13 Those weren't considered in our investigation.
14 Those are exhibits that are here for The Court.
15 So the majority of the things that are from
16 Exhibit 8 up, 9 up actually and then the other
17 calls that are there.
18 Q: Okay.
19 A: So some of those things weren't involved in our
20 investigation but the majority of the top ones
21 were. Yes, sir. The chart review, the DVD,
22 the standards of care.
23 Q: Okay. Well you said you had medical records,
24 is that correct?
25 A: Yes, sir.

1 Q: Okay. Let's turn to Exhibit 6. Can you
2 identify this?
3 A: This is the AnMed emergency department
4 physician record.
5 Q: Okay.
6 A: It's been redacted, but I recognize the
7 address.
8 Q: How'd you obtain this?
9 A: I believe we asked for it first from the -- Mr.
10 Wiznuski I think got it for us. And then we
11 also then obtained it through subpoena I think.
12 Q: Okay.
13 **MR. ROTHSTEIN:** I'm sorry. Did I miss when? Did
14 you ask him when he requested it?
15 **MR. WICEVIC:** I asked him how. The Department would
16 like to admit Exhibit 6 into evidence.
17 **MR. ROTHSTEIN:** Your Honor, I object to this
18 document on several grounds. For one they
19 don't have a foundation for this document.
20 Number two, the document's hearsay. Number
21 three the document contains hearsay within
22 hearsay. Number four this is not part of their
23 investigation contrary to what Mr. Wronski just
24 testified about. This document was obtained by
25 a subpoena I believe in June of sometime. If

1 I'm not mistaking, in June of this year,
2 probably less than two months ago.
3 **MR. WICEVIC:** And, Your Honor, I have an affidavit
4 of the records custodian. If there's
5 particular -- may I approach the bench?
6 **THE COURT:** Yes.
7 **MR. WICEVIC:** So we have an affidavit with the
8 records custodian. I believe this is a
9 business record. It contains -- if you look at
10 rule 803, memorandum, report, record, or data
11 compilation, or any form of acts, events,
12 conditions, or diagnoses made at or near the
13 time by or from information transmitted by
14 person with knowledge kept in the normal course
15 of business. I submit to you this was made by
16 various persons within the emergency
17 department. They regularly make these records.
18 They're made by individuals with knowledge of
19 these observations these conditions, diagnoses.
20 If there's particular statement's within here
21 that are hearsay, for example I believe there's
22 something to the fact that the patient stated
23 that -- there's a statement within the records
24 saying the patient stated he's feeling pain or
25 something along that line. I think that would

1 be hearsay within hearsay. However I think
2 that would be satisfied by the statements made
3 for purposes of medical diagnoses or treatment.
4 So I think -- I mean, if there's a particular
5 statement within here that Mr. Rothstein
6 objects to we can talk about it, but I think,
7 from my review, it looks like this is a
8 business record. I think it's accepted. I did
9 some case law research and it appears, you now,
10 across the country, medical records are
11 accepted as business records.
12 **THE COURT:** I accept it and I am admitting it.
13 **(Petitioner's Exhibit Number 6 was admitted into**
14 **evidence.)**
15 **MR. WICEVIC:** Okay. Thank you, Your Honor.
16 Q: Mr. Wronski?
17 A: Yes, sir.
18 Q: Exhibit 7, can you identify that?
19 A: This is a procedure notes from a surgeon that
20 performed the surgery on our patient with the
21 abdominal stab wound.
22 Q: Okay.
23 **MR. WICEVIC:** Your Honor, the Department would like
24 to admit Exhibit 7 as well for the same
25 reasons.

1 **MR. ROTHSTEIN:** Same objections, Your Honor.
2 **THE COURT:** Okay. It's admitted.
3 **(Petitioner's Exhibit Number 7 was admitted into**
4 **evidence.)**
5 **MR. WICEVIC:** Thank you, Your Honor.
6 Q: Mr. Wronski, can you explain why medical
7 records are relevant to your investigation?
8 A: The medical records are relevant to our
9 investigation and there's a degree of
10 relevancy.
11 Q: Okay.
12 A: So the direct patient care report has a high
13 degree of relevancy to what decisions we may
14 make or to what directions we go. And other
15 records may have less relevancy, but we like to
16 refer to them just to see what happened after.
17 See what kind of patient outcomes we had, and
18 maybe occasionally there will be some notes
19 within the notes of the medical records that
20 say what happened. Because a paramedic will
21 turn over a patient in the Emergency Room and
22 they'll say, I said this. Then the nurse will
23 say, well no they said this. And those notes
24 will sometimes end up in that part of the
25 record of the Emergency Room. So we like to

1 collect the other ancillary records as well.
2 Q: Okay. Any other components in your
3 investigations that we didn't discuss? If you
4 think of something ---
5 A: If I think of something I'll come back to it.
6 I can't think of right off the top of my head.
7 I was in the patient care records, so I'll have
8 to clear my ...
9 Q: Sure. Did you seek any kind of advice for
10 disciplinary recommendations from Dr. Deschamps
11 for this matter?
12 A: Not directly from Dr. Deschamps, but from the
13 Investigative Review Committee.
14 Q: Okay. So when do you convene the Investigative
15 Review Committee?
16 A: As I said before, whenever we're considering
17 taking someone's license, which we do not take
18 lightly, we will try to reach that via consent
19 order. And if we can't obtain an consent order
20 with the party, then by law we have to convene
21 the IRC if we're going to do an administrative
22 order ---
23 Q: Okay.
24 A: --- to see if they agree.
25 Q: Do you recall about when you convened the IRC

1 for this matter?
2 A: There were two dates and I apologize. We
3 attempted to convene it once and we delayed it
4 at the request of some of the parties. And I
5 believe it was a month after that. If I could
6 refer to my notes I could tell you the exact
7 date, but it was about a month after that that
8 we convened it.
9 Q: Okay.
10 A: I apologize.
11 Q: Can you explain the basic procedure for these
12 IRC meetings?
13 A: The procedures, I got none handed to me when I
14 took the job at DHEC. So our first one we
15 worked our way through. We had a really good
16 investigation. We gave it to the IRC, and we
17 learned from that one for our next one. So for
18 this one we notified the regions to send us a
19 representative on a particular day for an IRC
20 via email. I also approached Dr. Clanton who
21 I now because he attends Medical Control
22 Physician Meetings and I don't have any direct
23 relationship with him. And plus he was in, I
24 believe he was in the Pee Dee region. And then
25 my paramedic at large, I obtained a Training

1 Officer from Colleton County Fire and Rescue,
2 but at the last minute he had to have surgery,
3 so his Fire Chief, who was also a paramedic for
4 25 or 30 years in Colleton County attended as
5 the paramedic at large.
6 Q: Okay. So you convened the meeting.
7 A: So we convened the meeting. I explained to
8 them -- and Mr. Rothstein has said during the
9 course that I referred to it as a Grand Jury.
10 I watch too much television probably. But I
11 saw it as us providing evidence to a body to
12 make a determination as to whether there were
13 violations or not and then to make a
14 recommendation to us. That's not what a Grand
15 Jury does turns out. But those are the words
16 I used. And so I don't run the meeting. I
17 sort of keep it on track. I don't chair it.
18 Dr. Deschamps is the chair of the meeting. But
19 I told them why they were there. We gave them
20 what we had so far as far as evidence. We told
21 them that Mr. Davenport and his attorney were
22 here. They wanted to question them because
23 they don't have to. It's up to them what they
24 do, and it's up to them what evidence they
25 accept in or don't accept or look at. And I

1 mentioned that several times. And then I was
2 there for parts of it, but I wasn't there for
3 every part. Especially during deliberations
4 there was no one from DHEC in the room that I
5 can recall. I wasn't there. I don't know Dr.
6 Alier and Richard Naugler weren't in there. We
7 had come out. I also let them know that Mr.
8 Stoller was available by phone if they needed
9 him. He wasn't able to attend. But if they
10 wanted to speak to him, excuse me, they could
11 speak to him.
12 Q: Okay.
13 A: And so I just sort of keep it on track. And if
14 they need somebody to run and get something,
15 that's us. We run and get them, whatever they
16 need. And then at the end of the day, we did
17 a transcriptionist, is that the right term?
18 Court reporter, I'm sorry, we had a court
19 reporter, then they transcribed it. But we had
20 a court reporter there as well. We learned
21 from the first one after having to transcribe
22 that one ourselves, that we wanted a court
23 reporter for the next one. So we had to obtain
24 a court reporter as well. We didn't swear
25 anyone it, but we did have a court reporter in

1 the room.
2 Q: Who presented on behalf of DHEC?
3 A: Richard Naugler presented the investigations
4 since he was the lead on it.
5 Q: Okay. Was Mr. Davenport allowed to present?
6 A: After we presented to the Investigative Review
7 Committee, I don't know if they took some time
8 to talk first and then brought Mr. Davenport
9 up, or if they brought Mr. Davenport right up.
10 I cannot remember the exact how much time
11 elapsed in there. But yes, Mr. Davenport and
12 Mr. Rothstein came up to the IRC.
13 Q: Okay. Well what were the recommendations at
14 the IRC?
15 A: The recommendations that came out of the IRC
16 were a -- there were two. A one year
17 suspension of Mr. Davenport's paramedic
18 certificate along with they recommended an
19 evaluation for different things, anger
20 management, basically, I hate to use the word,
21 but a psychiatric evaluation. It's just to see
22 if there was something in there that was
23 preventing him from providing good patient
24 care.
25 Q: Okay.

1 A: He also had to maintain his other courses
2 throughout this suspension. His advanced
3 cardiac life support CPR, and they recommend we
4 do that a lot in our orders, so that when
5 somebody does come off suspension that they're
6 ready to, you know, come off the suspension,
7 get their license back, and we can reissue it
8 if they fulfilled all the consent orders and
9 administrative orders.
10 Q: Okay.
11 A: All the conditions within it.
12 Q: Were there other recommendations?
13 A: The second recommendation was if Mr. Davenport
14 did not agree to that consent order, for a four
15 year revokation, or a revokation which in this
16 case would have been four years. We could at
17 the time revoke up to -- a revokation for an
18 EMS license is strange in the statute to me.
19 When I think revoke I think revoke. But revoke
20 at the time meant up to the period of
21 certification. So in Mr. Davenport's case he
22 had recently recertified I think. It would
23 have been about four year revokation of his
24 license. I asked the IRC while I was in there
25 if there was any negotiation, that they would,

1 and they said there was a little with the
2 suspension. I think that's maybe when Dr.
3 Clanton piped up and said if there was
4 treatment that was recommended beyond a year,
5 as long as he was still going to that treatment
6 you could give him his license back, but not
7 keep it if he was in some sort of a treatment
8 program for whatever. But there was no real
9 negotiation. It was recommended by the IRC to
10 us, to the Department.
11 Q: Did you adopt those recommendations?
12 A: We did. We did. I've several advisory
13 councils that advise the Department. And the
14 IRC is one of these that we consider. And when
15 they give us recommendations we consider them
16 very strongly. And so we did adopt both of
17 those recommendations. Well we adopted the
18 first one first. And it was rejected. And
19 then we adopted the second.
20 Q: And here we are.
21 A: Yes, sir.
22 Q: There was some discussion about, on somebody's
23 cross, about DHEC not offering mental health
24 treatment, or not being understanding of that.
25 Do we? Does DHEC do anything as far as mental

1 health treatment?
2 A: A couple years ago at the annual EMS bike ride
3 that we have across the State, I was asked to
4 speak. And that bike ride is I memory of
5 people that have passed that are involved in
6 EMS. Some people die in line of duty. Very
7 few die in the line of duty, but some do. Some
8 just pass from cancer, and unfortunately many
9 commit suicide. I acknowledged that in that
10 speech and I made a commitment to everyone that
11 was there that we were going to do what we
12 could. We're a regulatory body. There's not
13 a lot we can do where we get involved, but I
14 said we would do what we could do. And one of
15 my inspectors Ms. Kristen McConnell who's in
16 the Upstate is a huge proponent of the project
17 that Mr. Rothstein brought up yesterday. She
18 is a member of that organization. She has a
19 masters in psychology.
20 Q: I'm sorry. What organization?
21 A: Is it Project Green?
22 **MR. ROTHSTEIN:** Green Code.
23 A: Green Code, Code Green. I'm sorry. Code Green
24 project that focuses on first responders, not
25 mental health, but first responders, the way

1 they deal with things. And so I asked her what
2 we could do to start getting involved. She
3 came back to me and told me, so she is now a
4 participating member of the FAST team, which is
5 when there's a critical incident across the
6 State, the FAST team will deploy immediately to
7 these agencies where recently, not recently,
8 but a while ago we had an accident in Florence
9 where an EMT, a paramedic had her leg amputated
10 in an accident. Whenever in Beaufort County
11 she had to leave her recent conference because
12 she had to go lead a team to Beaufort County
13 when an ambulance struck a person who was
14 laying in the middle of the road in the middle
15 of the night. So we go down, we sent a team
16 out immediately. We combine with the
17 firefighters assistance team to do that. The
18 biggest project that we've taken on so far for
19 responder mental health, which I think is
20 amazing, is that we partnered with the South
21 Carolina Firefighter's Association, SLED also
22 got part of the grant, but our partner in this
23 was the South Carolina Firefighters Association
24 where if a person, whether they've gone to a
25 critical incident stress debriefing or not,

1 usually this is where they come out of the
2 critical incident stress debriefing, and
3 they'll recommend that you go talk to someone
4 else. If they do have to seek the help of a
5 mental health professional, they can use their
6 insurance if they have it. Whatever out of
7 pocket expenses they have, this program picks
8 up. We have a grant that pays for insurance
9 for $15,000.00 per person per incident to pick
10 up their cost. And if they don't have
11 insurance it'll pick up their cost up to
12 $15,000.00 per person per incident. So if you
13 have two bad incidents in a year, this program
14 this insurance will pick up $30,000.00 of that.
15 So we are very concerned about the mental
16 health of our professionals because too many
17 people commit suicide.
18 Q: Okay. Moving on to this particular
19 enforcement. What was the Department's
20 decision in this matter?
21 A: Our final decision?
22 Q: Yes.
23 A: Our final decision was to issue an
24 administrative order to revoke Mr. Davenport's
25 license.

1 Q: Okay. And the grounds for that beginning with
2 the disregarding an appropriate order by a
3 physician concerning emergency medical
4 treatment?
5 A: Yes, sir.
6 Q: Can you explain to The Court the difference
7 between protocols and orders?
8 A: We've been over this quite a few times. But
9 the difference between a protocol and an order
10 is a protocol is -- it goes by man names in
11 cases. It could be a protocol, it could be a
12 guideline, it could be many different things.
13 But a protocol is what will lead you down the
14 path of treatment for a patient. And then
15 within the protocols there are standing orders
16 that must be followed for the treatment of a
17 patient. And in some cases the full protocol
18 is the standing order.
19 Q: Okay. All right. Well what is the
20 Department's determination with regards to Mr.
21 Davenport's compliance with the orders of
22 Anderson County?
23 A: We did determine that he did violate and
24 disregard specific orders that were given to
25 him by Dr. Kickham in this case.

1 Q: Okay. Well you have Anderson County, Exhibit
2 1. Can you explain to The Court the violations
3 by Mr. Davenport?
4 **MR. ROTHSTEIN:** Your Honor, this is getting kind of
5 cumulative. He's had at least four witnesses
6 do the exact same thing, and I'm sure he's
7 going to do the same thing with -- and that's
8 why we're here on the fourth day of the case.
9 **MR. WICEVIC:** Your Honor, does The Court need any
10 additional explanation about the Department's
11 position on compliance with these various
12 orders?
13 **THE COURT:** You can get into testimony, but just let
14 him very briefly explain how they -- because he
15 is in their compliance department, how the
16 Department viewed it.
17 **MR. WICEVIC:** Right. And that's ...
18 Q: Can you follow that directive?
19 A: If I may, I have been here through the trial,
20 and there have been discussions about whether
21 the intravenous access protocol was followed.
22 We believe the protocol was not followed
23 because it was not used, and there are orders
24 within that protocol.
25 Q: Okay. And what's ---

1 A: I'm sorry, that's protocol number, it's page 6.
2 Obviously the general protocols that we've
3 discussed as well.
4 Q: Well can you be more specific? Mr. Wronski,
5 can you be a little bit more specific?
6 A: Can you refer me to those Bates pages real
7 quick for those particular protocols, so I can
8 ---
9 Q: Tell you what, there's a table of contents.
10 A: Sure.
11 Q: Page 3.
12 A: Right. So GP-18 has been mentioned. That is
13 one that definitely has violations within it.
14 GP-16 also with the patient safety protocol.
15 We've discussed the walking of the patient and
16 not using proper carrying devices I believe are
17 located within that one.
18 Q: What was the failure for GP-18?
19 A: GP-18 is the universal patient care. Can I
20 refer to that real quick?
21 Q: Yeah. And that's page 15, Bates page 15.
22 A: So, under the EMT paramedic management, the
23 orders in this case for this protocol, bring
24 all equipment to the patient's side. He
25 brought what he thought he was going to need

1 short of a carrying device. And that happens
2 all too frequently where somebody will get
3 caught not having a proper carrying device, but
4 that's not the major concern in this one. The
5 major concern in this one is the, demonstrate
6 professionalism and courtesy. And Mr.
7 Davenport I believe has stated to us that he
8 did check the temperature measurement of the
9 patient by feeling his skin. So that wouldn't
10 be a violation. But the main one in this one
11 is the adult assessment procedure. A complete
12 adult assessment was not completed, and the
13 Department felt also he did not demonstrate any
14 professionalism or courtesy towards this
15 patient or on the scene itself with other
16 responders.
17 Q: Okay. Any other referring back to the table of
18 contents?
19 A: My apologies. We could get into the trauma at
20 that point.
21 Q: Okay.
22 A: The T-1.
23 Q: Sure. And that is on Bates page 42. Begins on
24 page 42.
25 A: Okay.

1 Q: Okay. What were the bases for violating this
2 protocol or these protocols?
3 A: As has also been discussed, the Department also
4 felt this was a critical trauma, and the scene
5 time wasn't horrible, so they did okay with the
6 scene time. And they did notify the hospital,
7 and then you get down to all IV lines will be
8 established en route, and there were no IV's
9 that were established on this patient.
10 Q: You finished with T-1?
11 A: We've talked about oxygen, but I think oxygen's
12 more applicable when we get to the actual
13 protocol for treatment of the patient.
14 Q: Okay. Well let's go onto T-2 and T-3.
15 A: So T-2 is the trauma transport protocol. This
16 trauma transport protocol defines what your
17 traumatic injuries are that you need to
18 consider with trauma transport guidelines.
19 This patient throughout the transport appeared
20 to remain hemodynamically stable, but we did
21 have a penetrating abdominal injury. So this
22 was a traumatic injury that should be
23 considered for the trauma transport protocol.
24 The patient taken to a level two trauma center.
25 T-3, we get over to T-3, and I think this is

1 the one we had the biggest problem with is that
2 ---
3 Q: Well first, why was that applicable?
4 A: Multiple system trauma or shock, again as we've
5 discussed or has been discussed, the patient
6 had the potential and that is the key in
7 emergency medicine is to do everything you can
8 for the patient without overtreating them, to
9 not allow bad things to happen to them while
10 you're taking care of them. So anything you
11 can do for the patient, what the patient needs
12 or may need is important. Recognizing what
13 might happen is key. We don't take that
14 ability away from them. We say plan for the
15 worst that could happen.
16 Q: So how was T-3 violated?
17 A: So T-3, this was or could have potentially
18 been a multiple system trauma. It affected the
19 largest system in the body to start with. It
20 absolutely affected the integumentary system.
21 But then there were several systems beneath
22 where the wound occurred that could have been
23 affected as well. So it would have fallen to
24 the multiple trauma or multiple system trauma,
25 multiple trauma shock protocol. And the

1 patient obviously at any time had the potential
2 to go into hypovolemic shock.
3 Q: Okay. Well what did that order? What does T-3
4 order?
5 A: T-3 orders the paramedic to initiate airway
6 management, spinal immobilization, or use a
7 rapid extrication technique, which is mostly
8 for somebody who's trapped somewhere, in a
9 vehicle or a building, a piece of machinery.
10 Control the bleeding which was done. Tension
11 pneumothorax for plural decompression protocol.
12 I believe that during Mr. Davenport's
13 depositions and statements, he related that he
14 saw equal rise and fall of the chest. He did
15 not listen to lung sounds, which is the best
16 way to rule out a tension or a pneumothorax is
17 to listen to lung sounds. Any signs that you
18 might see indicating a tension pneumothorax are
19 very late signs that you're going to see, so
20 it's important to listen to lungs early and get
21 a baseline lung sound baseline vital signs.
22 They did load and go the patient, all be it I
23 believe improperly. And then a cardiac monitor
24 was not initiated. There were not fractures to
25 splint. And then, of course, as we get to the

1 bottom, the main contention is that this
2 patient needed at least one intravenous
3 lifeline started.
4 Q: Okay. So of the various orders you read.
5 Which ones did he violate?
6 A: I believe the oxygen that the patient could
7 have gotten would be in the airway management
8 -- it starts at the worst and goes down. If
9 the patient doesn't have an airway you need to
10 establish an airway. And then if they do have
11 an airway but require oxygen or may need
12 oxygen, you can place it. We did not, I
13 believe, include the spinal immobilization as a
14 violation, but we did include the cardiac
15 monitor because that is a tool that you
16 absolutely should have if there's not blood all
17 over the patient preventing you from attaching
18 the cardiac monitor, that's just another tool
19 you have in the toolbox. Maybe you're typing
20 on your keyboard and that's what you're
21 listening to. You can hear that beep and you
22 can immediately look up and see if there's
23 anything going on with the patient's rhythm as
24 well as finally the IV lifelines.
25 Q: Okay. You mentioned the airway management

1 protocol. Turn back to page 6.
2 A: Yes, sir.
3 Q: Excuse me, page 5. Would this protocol, GP-1
4 be applicable and if so, could you explain why?
5 A: So the adult airway protocol tells us at the
6 top the respiratory rate -- I'm sorry. It
7 starts with the pulse oximetry and mild
8 distress and moderate distress definitions.
9 Works down to whether there's an airway
10 obstruction, you would eliminate whatever the
11 obstruction was first, and then use forceps and
12 get an airway if you need one. Or if you can't
13 recover the airway by removing the object and
14 then it goes into oxygen administration.
15 Sorry.
16 Q: Okay. And would oxygen administration be
17 applicable this particular call?
18 A: In this particular call, per the protocol, per
19 the standing order it is. It is. Despite the
20 arguments of the pulse oximetry, which I
21 understand, and the conversation back and forth
22 whether oxygen can relieve pain, there are pain
23 relieving qualities to oxygen. Ask any person
24 who has ever had a heart attack. And so in
25 this case this was a severe trauma based on the

1 penetrating abdominal wound, and the patient
2 should have been placed under a non-rebreather
3 mask.
4 Q: Okay. Mr. Wronski, turn back to the table
5 contents. Any other protocols, orders that
6 would be applicable? If not we can move on.
7 A: Yeah, I'm trying not to take too much time.
8 I'm going to go ahead and say no at this time.
9 Q: Okay. Next misconduct that was alleged after
10 initiating care of a patient at the scene of an
11 accident or illness, EMT discontinued such care
12 or abandoned the patient without the patient's
13 consent. Not providing for administration of
14 care by the equal or higher medical authority.
15 Mr. Wronski, can you explain the distinction
16 between a discontinuation of care, and
17 abandonment?
18 A: Sure, there are distinctions there. An
19 abandonment would be coming to a vehicle
20 accident, or someone's home, maybe evaluating
21 them and then either talking them out of being
22 transported to the hospital, which happens
23 occasionally, or just doing a cursory
24 evaluation and then leaving and abandoning the
25 patient without taking them to the hospital and

1 leaving them in a higher level of care. So
2 that would be abandonment.
3 Q: What about discontinuation?
4 A: Discontinuation of care is what we find to be
5 applicable in this case. Applicable in this
6 case, to where Mr. Davenport did initiate care
7 of the patient. He took the patient to the
8 ambulance, and then turned the patient over to
9 an EMT basic, which is a lower level of care,
10 not a higher level of care. And being in the
11 front of the ambulance, we did consider it to
12 be discontinuation of care, because he has no
13 visualization of that patient, he can not
14 access the patient. And able to treat that
15 patient, he would have to find someplace to
16 stop, pull over, get out of the truck safely,
17 get back in the back of the ambulance, and then
18 begin care, and get another initial picture of
19 this patient from the beginning, starting with
20 an assessment to figure out what's going on.
21 And that's a discontinuation of care, because
22 you're starting all over from scratch.
23 Q: Did Mr. Davenport obtain the patient's consent
24 for the discontinuation?
25 A: No.

1 Q: Okay. Next misconduct. By actions, or
2 inactions created the substantial possibility
3 that death or serious physical harm could
4 result. Did the department determine Mr.
5 Davenport's actions and inactions create a
6 substantial possibility of death or serious
7 physical harm?
8 A: Yes, sir. Both actions and inactions in this
9 case we did, Yes, sir.
10 Q: Can you explain what the actions and inactions
11 were?
12 A: The actions, obviously we felt that the
13 standing up of the patient and walking to the
14 ambulance was not only a violation of the
15 standing order, but a violation -- not a
16 violation, but absolutely cause a potential to
17 have that patient injure themselves further.
18 And because of where the wound was, and because
19 the knife was still in there, had the potential
20 to cause death or serious bodily harm, Yes,
21 sir.
22 Q: Any other actions or inactions part of this
23 call?
24 A: The secondary one to that is when the patient
25 was placed on the stretcher, not only being in

1 the position of comfort of sitting up, which
2 another responder on the scene suggested at
3 first, but then the decision was made by Mr.
4 Davenport to then sit the patient down again in
5 the sitting position, and then lay him flat and
6 move him via his belt again. So that is a
7 another potential where the patient was
8 compressed and then extended again, that could
9 have caused the movement of the organs within
10 there to hit the knife.
11 Q: Just for clarification, what about the oxygen?
12 Is that something that served as a basis for a
13 substantial possibility of serious physical
14 harm or death?
15 A: No.
16 Q: IV's?
17 A: Yes.
18 Q: Please explain that.
19 A: The IV's, I mean we call them intravenous
20 lifelines for a reason. We don't have blood
21 transfusion on the field in South Carolina,
22 unless you're with an aeromedical helicopter
23 operation, but some volume can be replaced in
24 patients with an IV, and in order to replace
25 that volume if there is a rupture of the

1 spleen, or the laceration of the liver, even
2 the aorta in this case has been mentioned,
3 where you can start to get some volume back in
4 that patient to keep volume in the system. And
5 so yes, an IV as a lifeline, without
6 establishing that had the patient
7 decompensated, it could have caused death or
8 serious bodily harm. And if not death, you
9 know without oxygen to the brain could have
10 caused, you know, damage to the kidney, the
11 brain, whatever didn't get oxygen for enough
12 time.
13 Q: Okay. Anything else regarding that misconduct?
14 Substantial possibility of physical harm or
15 death?
16 A: No. Other than not being in the back of the
17 transport, but that's more of the discontinuing
18 care.
19 Q: Okay. Now there's also an allegation about the
20 failure to provide to patients acceptable
21 emergency medical treatment. Can explain the
22 basis for that?
23 A: Yes, sir. The acceptable medical treatment, and
24 I have gone over and over again what acceptable
25 medical treatment is, and had this patient just

1 not been placed on oxygen, we probably wouldn't
2 be here, but the acceptable medical treatment
3 for this patient is to start with a known
4 psycho-social history, a known epileptic
5 patient, and a known schizophrenic is to not
6 approach them like Mr. Davenport approached him
7 in the beginning of the encounter with the
8 patient. It's to calm, it's to reassure, and
9 it's to gain that patients trust, because there
10 are some procedures that you may have to do on
11 them, such as start an IV, that could be
12 slightly painful to them, and you need to gain
13 their trust and let them know. This patient
14 has had IV's in the past, so we have to gain
15 that patients trust to be able to start that
16 IV. You cannot begin an encounter the way he
17 did, nor sustain it cursing at the patient.
18 You know, we get slightly upset when people
19 curse in front of a patient, but cursing at a
20 patient is completely unacceptable medical
21 treatment. And of course the walking to
22 ambulance was unacceptable to us. The not
23 placing the patient in a position of comfort
24 was unacceptable, especially when it was
25 suggested. The turning over of the patient to

1 an EMT who was hesitant to take the call was
2 unacceptable. Telling his partner twice he
3 wasn't going to do anything else for the
4 patient. That's been discussed, but he twice
5 said, I'm not going to do anything else for
6 him, was unacceptable to us. So, the IV was
7 unacceptable, because you have to be prepared
8 for the worst, especially in these situations.
9 This knife was impaled as we've heard people
10 say throughout the trial, it's a rare occasion
11 where you still have a knife stuck in somebody,
12 or an impaled object stuck in somebody that
13 you're taking them to the hospital. Usually
14 it's a stab and run, so it's not that common.
15 So, in an uncommon situation, you need to take
16 more steps to ensure that something's not going
17 to go wrong with the patient.
18 Q: Is that all you can think of at this point? I
19 know it was a lot.
20 A: That's it. If I can come up with another one I
21 will.
22 Q: Okay. Now the regulation has a number of
23 enforcement factors that you must consider, in
24 proceeding with enforcement.
25 A: Yes, sir.

1 Q: Let me hand you a reg.
2 **MR. ROTHSTEIN:** Your Honor, I believe that
3 enforcement factors that DHEC may have
4 evaluated are irrelevant to this case. The
5 issue is for Your Honor to decide whether
6 there's sufficient grounds for enforcement. If
7 not whether DHEC considered factors.
8 **MR. WICEVIC:** And Your Honor I've just explained.
9 Let Mr. Rothstein explain the department's
10 decision to revoke this. If you feel it's
11 unnecessary for him to not discuss that, that's
12 fine by me.
13 **THE COURT:** I don't think that's necessary.
14 **MR. WICEVIC:** Yes Your Honor.
15 Q: Mr. Wronski, how does the Department attempt to
16 be objective and even handed in their
17 enforcement?
18 A: We do -- every single one is treated
19 differently. Whether we have a case of it
20 happened exactly the same way. We treat every
21 single one of them differently and objectively.
22 And we take as many factors into consideration
23 as we possibly can when we make a
24 determination. The intent especially, the
25 remorse if you will, is the patient remorseful.

1 Maybe there was a bad outcome, or maybe they
2 did the wrong thing and really could have hurt
3 a patient. In many cases the paint is not
4 hurt, but there was a potential that the
5 patient could have seriously been hurt. So, we
6 take into consideration the realization of that
7 fact, and then whether the mechanisms are in
8 place for retraining, to send them to
9 particular courses that might reinforce their
10 either lack of knowledge or their skills. In
11 some cases that we get, patients are injured,
12 and it's because the paramedic or the EMT was
13 just not able to complete the skill. So, if
14 the person can be remediated in some way to
15 reinforce that skill, whether it's time in an
16 Emergency Room, time with their medic control
17 physician, time with another paramedic.
18 Whatever those things are, we consider those as
19 whether they can be remediated or not.
20 Q: I think that's all the questions I have for you
21 Mr. Wronski. Give me one second.
22 **MR. WICEVIC:** Your Honor, before I get Mr. Wronski -
23 - finish my direct, I did want to see if I
24 could admit these affidavits that I submitted
25 up to you as exhibits. Would that be

1 necessary? I just want them to be part of the
2 records.
3 **THE COURT:** What type of affidavit?
4 **MR. WICEVIC:** These affidavits. The affidavit for
5 Iva Police Department. I handed it up to you
6 previously when we were discussing the body cam
7 footage.
8 **THE COURT:** Okay.
9 **MR. WICEVIC:** So, I would like to admit that. I
10 suppose, I think we are on Exhibit 28.
11 **THE COURT:** Okay. We can admit that.
12 **(Petitioner's Exhibit Number 28 was admitted into**
13 **evidence.)**
14 **MR. WICEVIC:** And then the AnMed Health, which would
15 be Exhibit 29.
16 **THE COURT:** That was the medical record?
17 **MR. WICEVIC:** Yes, Your Honor.
18 **THE COURT:** Okay.
19 **(Petitioner's Exhibit Number 29 was admitted into**
20 **evidence.)**
21 Q: Mr. Wronski, that's all the questions I have
22 for you. Please answer any questions from Mr.
23 Rothstein.
24 **THE COURT:** Okay. We'll admit the affidavits and
25 before Mr. Rothstein gets into his questioning,

1 what I'm going to do is just adjourn the
2 hearing for ten minutes. We're going to take
3 a ten minute break, so we don't have to
4 interrupt his testimony to do that.
5 **MR. WICEVIC:** Thank you, Your Honor.
6 **THE COURT:** Thank you all.
7 **(Off the record from 10:27 a.m. until 10:52 a.m.)**
8 **THE COURT:** The hearing is called back to order.
9 Mr. Rothstein, you may begin with your cross.
10 **MR. ROTHSTEIN:** May it please The Court.
11 **MR. WRONSKI - CROSS-EXAMINATION BY MR. ROTHSTEIN:**
12 Q: Mr. Wronski, you've talked a lot about
13 admirable things that you've done with regard
14 to EMS provider wellness. I think we talked
15 about some sort to EMS bike ride and you've got
16 somebody working with grants to provide
17 $15,000.00 a year per patient. Was that ever
18 offered to Mr. Davenport in this matter? The
19 $15,000 grant per year option?
20 A: I don't think that was in effect when this case
21 started. It's sense been established.
22 Q: So that's a fairly recent development isn't it?
23 This Code ---
24 A: The Code Green is not ---
25 Q: The South Carolina's participation is fairly

1 recent.
2 A: It is fairly recent in the last couple of
3 years, Yes, sir.
4 Q: Now this woman ---
5 A: And if I could clarify, we don't offer that
6 program. A person has to actually request
7 those funds, because we don't want to know
8 who's asking for the funds or who's asking for
9 the reimbursement. So, we don't offer those
10 coverages to people, we've just tried to inform
11 as many people as often as we can, so they can
12 go through the process to obtain them.
13 Q: You have one of the Upstate investigators
14 Kristen -- I didn't catch her last name.
15 A: McConnell
16 Q: McConnell. How long has she been the Upstate
17 investigator for DHEC?
18 A: Just about two years.
19 Q: Okay. And the Upstate includes Anderson
20 County?
21 A: Yes, sir.
22 Q: Okay. And you said you think she's a licensed
23 psychologist?
24 A: Not a license, she's got a masters degree.
25 Q: A Masters. And explain to me what that Fast F-

1 A-S-T team is.
2 A: So the Fast team is, I explained earlier, if
3 there is a critical incident that occurs
4 somewhere around the state, either involving
5 fire, EMS, or police officers, this team will
6 deploy. They're trained in critical incident
7 stress debriefing and there's two to three
8 people on the team, sometimes more depending on
9 how big th incident is. And they will
10 immediately deploy upon a call from either the
11 dispatch center, or the Chief of the department
12 or the agency -- someone in the agency, or even
13 someone in the call personally can request the
14 Fast Team to respond, and they're there within
15 a few hours to help de- -- not distress, but to
16 help with the critical incident.
17 Q: Okay. And you actually know the high rate of
18 suicide among EMT's and paramedics, right?
19 A: Yes, sir.
20 Q: Were you aware that Anderson County lost a
21 paramedic ---
22 A: I was.
23 Q: In February of 2016, about a month before this
24 incident happened?
25 A: Horry County as well, yes, sir.

1 Q: Were you aware that Mr. Davenport was pretty
2 close friends with that particular paramedic?
3 A: I was not. I'm sorry.
4 Q: Now, you also at the start of your testimony,
5 I think Mr. Wicevic was asking about your
6 employment history.
7 A: Yes, sir.
8 Q: And you said that you resigned from Mt.
9 Pleasant Fire Department, is that right?
10 A: Yes, sir. Under not great circumstances.
11 Q: Okay. You were a Captain in the fire
12 department?
13 A: Yes, sir.
14 Q: Okay. You didn't resign from that department,
15 did you?
16 A: The final determination was a resignation, yes,
17 sir. It was.
18 Q: You were actually charged with DUI.
19 **MR. WICEVIC:** Your Honor, I'm going to object to
20 this. There's no relevance to his
21 truthfulness. I don't know what an arrest for
22 DUI, an arrest at that, it's not a conviction
23 number one. Number two, it's not probative of
24 truthfulness. So I don't think it's allowed to
25 come in under the rules of evidence.

1 **MR. ROTHSTEIN:** Your Honor, it is impeachment
2 material. I think I can cross-examine him. He
3 testified that he resigned, and in truth he was
4 terminated from the department under pretty
5 questionable circumstances. The other thing is
6 at the time of the DUI, he was operating a Mt.
7 Pleasant Fire Department QRV. It was the
8 middle of the night on 526, Charleston County.
9 He smashed the car into a disabled motorist on
10 the side of the road. Both people were taken
11 to the hospital. He was charged with DUI,
12 terminated very shortly after that, and ended
13 up pleading guilty to reckless driving of some
14 sort. I wanted to explore that, Your Honor.
15 **THE COURT:** I'm going to allow him to question the
16 witness in that matter. But remember now, Mr.
17 Wicevic, we're not a jury.
18 **MR. WICEVIC:** Right.
19 **THE COURT:** It's just me, and I will determine what
20 consideration, if any, will be given.
21 **MR. WICEVIC:** Thank you, Your Honor.
22 **MR. ROTHSTEIN:** Can we get the Elmo onscreen please?
23 Q: Just to make sure your testimony's clear, your
24 testimony today is that you resigned from Mt.
25 Pleasant Fire Department?

1 A: Your statement that you read from the paper was
2 that I was terminated, and I was. And we
3 negotiated a resignation after that. Yes, sir.
4 Q: And you understood at some point that you were
5 fired from the department?
6 A: Yes, sir. I was.
7 Q: Okay. And in fact in the deposition in the
8 case of Bumgarner versus Robert Wronski, you
9 testified -- the question was, have you ever
10 been fired from a job? Answer, yes ma'am.
11 Right? Ms. Bloodgood was asking you questions,
12 Nancy Bloodgood?
13 A: Yes, sir.
14 Q: Okay. Next questions said, from where. And
15 you said, Mt. Pleasant Fire Department. Right?
16 A: (Nods head.)
17 Q: And then she says, okay tell me about that. In
18 March 2010 I was charged with DUI and
19 subsequently was released from the Mt. Pleasant
20 Fire Department due to that, right? You recall
21 testifying to that effect in the Bumgarner
22 case?
23 A: Yes, sir.
24 Q: Okay. And tell us a little bit about this
25 incident. I understand that you were operating

1 a Mt. Pleasant Fire Department vehicle, is that
2 right?
3 A: Yes, sir. I was.
4 Q: Okay. Was that a, what they call, a quick
5 response vehicle?
6 A: It was a take home vehicle. Yes, sir.
7 Q: Did it have lights and sirens on it?
8 A: It did.
9 Q: Did it have emergency equipment on it?
10 A: It did.
11 Q: Okay. And I understand that the accident
12 occurred on Highway 526 in the North Charleston
13 area.
14 A: Yes, sir.
15 Q: Okay. It was about 12:30 in the morning?
16 A: Yes, sir.
17 Q: Okay. And you ran the Mt. Pleasant Fire
18 Department vehicle into a Jeep on the side of
19 the road, right?
20 A: To be accurate, it was in the road. Yes, sir.
21 It was in the middle of the road.
22 Q: Okay.
23 A: It was not on the side of the road, it was in
24 the travel lane. Yes, sir. But I did run into
25 it.

1 Q: And there was an occupant of the Jeep, correct?
2 Waiting for someone to come take ---
3 A: Yes.
4 Q: --- the disabled vehicle off the road?
5 A: Yes, sir.
6 Q: And you were taken to the hospital, and the
7 gentleman was taken to the hospital?
8 A: Yes, sir.
9 Q: Did you suffer any injuries from that crash?
10 A: Minor injuries. Cuts and scraped.
11 Q: And the gentleman that you hit suffered any
12 injuries?
13 A: He was taken to MUCS. I don't know. He was
14 taken to a different hospital.
15 Q: Did he ever file any kind of legal claim over
16 this crash?
17 A: Not with me. I'm not sure if he did with Mt.
18 Pleasant or not, sir.
19 Q: And after you went to the hospital with your
20 minor injuries, you were taken into custody in
21 the police department, the North Charleston
22 Police Department?
23 A: State Police.
24 Q: State Police. Did you submit to a
25 breathalyzer?

1 A: Yes, sir.
2 Q: Okay. And what was the result of the
3 breathalyzer?
4 A: Point zero seven.
5 Q: Had you been drinking that day?
6 A: Yes, sir.
7 Q: Okay. And I understand that you eventually
8 pleaded guilty to a lesser charge than DUI, is
9 that right?
10 A: I did.
11 Q: And what was the charge that you pleaded guilty
12 to?
13 A: Reckless.
14 Q: Reckless driving?
15 A: Reckless driving. I'm sorry. Yes, sir.
16 Q: Were you originally charged with felony DUI?
17 A: No, sir.
18 Q: Okay. You weren't charged with DUI involving
19 a serious bodily injury?
20 A: No, sir.
21 Q: Okay. After your arrest, did you self report
22 to -- I guess you weren't the DHEC Bureau Chief
23 at the time. Did you self report your
24 misconduct to DHEC?
25 A: I did not. It's not required under the

1 statutes.
2 Q: It's not required under the statute?
3 A: No, sir.
4 Q: And you believe that you committed misconduct
5 as a paramedic in connection with that crash?
6 **MR. WICEVIC:** Your Honor, I'm going to renew my
7 objection. This is going way off the course of
8 the proceeding. Mr. Wronski's conducts not at
9 issue in this matter. I don't see how this
10 gets to credibility. He's not testifying as an
11 expert or anything.
12 **THE COURT:** Mr. Rothstein?
13 **MR. ROTHSTEIN:** Your Honor, Mr. Wronski repeatedly
14 has said, as EMT's and paramedics we owe the
15 public the duty of trust, and we have to sort
16 of hold ourselves to a standard. He said this
17 repeatedly in the interview we'll play in a
18 little bit. He said that in the IRC Committee
19 meeting. And he's sort of sanctimoniously
20 trying to punish Mr. Davenport for
21 unprofessional and discourteous conduct
22 sufficient to take his license, when Mr.
23 Davenport had three cases, no bad outcomes, and
24 he may have said one or two out of the way
25 comments to a patient. And I think it's

1 relevant, I think it's germane to the case.
2 Again, Mr. Wronski is trying to sit in
3 judgement of Mr. Davenport but doesn't want the
4 same thing done to him.
5 **MR. WICEVIC:** And, Your Honor, I mean, that's his
6 job. He's the Bureau Chief of EMS. He has to
7 make these calls. His action's not in
8 question. It'd be a different matter if DHEC
9 investigated that when it occurred and he was
10 -- even that I don't think would have been
11 relevant. This is making this case a three
12 ring circus. I think we need to focus on the
13 allegations in this matter.
14 **THE COURT:** I'm going to allow him to continue his
15 questioning the witness.
16 **MR. WICEVIC:** Thank you.
17 Q: Are you familiar with the definition in the
18 South Carolina EMS statute for misconduct for
19 a certified paramedic or an EMT?
20 A: I am, but I would rather read it than quote it.
21 Q: Can you see section 44-61-80 of the South
22 Carolina Code? I'm sorry. It's kind of all
23 over.
24 A: Yes, sir.
25 Q: You see that?

1 A: 44-61-80. That's part of the Code. Yes, sir.
2 Q: Are you familiar with that section of the Code?
3 A: That's the licensor section I believe.
4 Q: Okay. And I think this is important because
5 you keep using the term licensor.
6 A: I'm sorry. Would you like me to clarify? It's
7 another one of those interchangeable terms.
8 EMT's and paramedics are not licensed. Only
9 LLR licenses. We issue credentials.
10 Q: Okay.
11 A: Sorry.
12 Q: You do issue some licenses, but paramedics and
13 EMT's receive certificates, right?
14 A: Credential certificates. Yes, sir.
15 Q: The only licenses you issue would be to
16 somebody like Dr. Kickham, the Medical Control
17 Physician, is that right?
18 A: No, sir. We only issue licenses to agencies.
19 Q: Okay.
20 A: So the agency is licensed.
21 Q: Okay. I'm sorry. So Dr. Kickham's Anderson
22 County EMS gets the license, right?
23 A: Yes.
24 Q: Okay. So when you issue licenses it's to
25 agencies, not to paramedics and EMT's?

1 A: Correct. Yes, sir.
2 Q: The other kind of licenses you issue are to
3 paramedic training or educational facilities,
4 is that right?
5 A: We don't license them. No, sir. We just give
6 them, once they meet the requirements we give
7 them a certificate.
8 Q: Okay. And they have to have that type of
9 certificate to operate a training facility or
10 training program in South Carlina?
11 A: Yes, sir. They do.
12 Q: And that's the same kind of facility that Mr.
13 Dean Douglas, your expert witness, testified
14 about that he currently works for?
15 A: He's a JHS. Yes, sir. We would license him to
16 teach EMT programs.
17 Q: He testified yesterday about a ---
18 A: Certify, I'm sorry.
19 Q: He testified yesterday about a meeting between
20 you, Phil Head his boss, and himself some time
21 last week around Thursday.
22 A: Thursday. Yes, sir.
23 Q: And in that meeting you told Mr. Head, we
24 really need an expert witness for the case
25 coming up next week. The Judge has allowed Mr.

1 Davenport to have a paramedic expert. We need
2 to have a paramedic expert, right?
3 A: I don't know if I told Mr. Head or Mr. Douglas.
4 But yes, sir. Mr. Douglas was present.
5 Q: I got a little side tracked. Let's get back to
6 this ---
7 A: Sure.
8 Q: --- statute. So under subsection F of this
9 statute, the Department may take enforcement
10 action, okay, against the holder of a
11 certificate at any time it is determined that
12 the holder no longer meets the prescribed
13 qualifications set forth by the Department or
14 has failed to provide to patient's emergency
15 medical treatment of a quality deems acceptable
16 by the Department or is guilty of misconduct.
17 You see that?
18 A: Yes, sir.
19 Q: Okay. So this is the statutory authority for
20 you to take enforcement action against Mr.
21 Davenport, right?
22 A: Against any paramedic or EMT. Yes, sir.
23 Q: And it's not disciplinary action, it's
24 enforcement action?
25 A: It's enforcement. Yes, sir. We don't like to

1 use that word.
2 Q: And then there's 17 different subcategories of
3 misconduct. You see that ---
4 A: Yes, sir.
5 Q: --- listed in the statute?
6 A: Yes, sir. There is.
7 Q: I'm going to ask you to look down to item
8 number ten ---
9 A: Yes, sir.
10 Q: --- on this list. I got it highlighted. Item
11 ten says that if a paramedic or EMT can be, I
12 guess have an enforcement action taken for
13 misconduct if they commit and act or omission
14 without mitigating circumstances that
15 contributed to or furthered the injury or
16 illness of a patient under his care, right?
17 A: Yes, sir.
18 Q: Okay. Did that section come into play with Mr.
19 Davenport? Did he contribute or further an
20 injury to the stabbing patient?
21 A: No.
22 Q: All right. Let's look at number 11. This is
23 really what I was wanting to get at here. 11
24 provides grounds for misconduct against a
25 paramedic or EMT who is careless, reckless, or

1 irresponsible in the operation of an emergency
2 vehicle.
3 A: Yes, sir.
4 Q: Okay. So when you smashed your Mt. Pleasant
5 Fire Department vehicle into the disabled
6 motorist on Highway 526, you were operating an
7 emergency vehicle, weren't you?
8 A: I was.
9 Q: Okay. And you pleaded guilty to reckless
10 driving of that vehicle, right?
11 A: I did.
12 Q: Okay. So under the statute, even though you
13 didn't have a DUI or didn't get convicted of
14 DUI, you were guilty of misconduct of the
15 statute, isn't that right?
16 A: If the Department determined to investigate it.
17 Yes, sir.
18 Q: Okay. Now when you applied to be the EMS
19 Bureau Chief, what year was that?
20 A: Three and a half years ago. '13, '14.
21 Q: On the application for employment, did they ask
22 you for your sort of prior employment history?
23 A: I believe they did.
24 Q: Okay. Did they ask you if you've ever been
25 terminated from a job before?

1 A: I don't remember.
2 Q: Okay. Do you recall disclosing on that DHEC
3 application that you had been terminated for
4 suspected DUI from Mt. Pleasant Fire
5 Department?
6 A: I don't remember if I did.
7 Q: You think that would relevant in assessing
8 whether you'd be qualified to be the Bureau
9 Chief of EMS?
10 A: If I may? Sir, everyone in the State knew
11 about that accident. There wasn't a single
12 EMT, paramedic or firefighter in this State
13 that did not know I had been arrested for DUI,
14 and there isn't today.
15 Q: And I appreciate you saying that 'cause there
16 was a big article in the Post and Courier paper
17 about that, right?
18 A: There's articles on national websites, sir.
19 Q: I've handed you -- I've not marked this. I
20 don't think I need to put it into evidence
21 since it's a public newspaper article. Do you
22 recognize this article from the Post and
23 Courier on March 21st, 2010?
24 A: At the risk of sounding like I'm not telling
25 the truth, I was told by my attorney, and I've

1 taken that advice, never watched a news article
2 on the television, and I've tried never to
3 familiarize myself with these articles. Every
4 once in a while a Google search will come up
5 and I will glance at one, but I'm not familiar
6 with this article. No, sir. I'm familiar with
7 the heading on the article, but I am not
8 familiar with the article, no, sir.
9 **THE COURT:** Mr. Rothstein, now I've got to wonder.
10 Where are you headed?
11 **MR. ROTHSTEIN:** I've got one more question about
12 this, Your Honor.
13 **THE COURT:** Okay.
14 Q: The public who may have read that, even though
15 you may not have read it, the public read that
16 argument, that certainly holds the paramedic
17 and EMT profession in an unfavorable light,
18 doesn't it?
19 A: It certainly does.
20 Q: And Mr. Davenport's interaction with this
21 patient, the stabbing patient that we've seen
22 the video body camera footage, that's not been
23 disclosed to the public, has it?
24 A: Sir, it has not by my office.
25 Q: Okay. In fact, under the Iva Police Department

1 regulations, body camera video footage is not
2 FOIAable, right?
3 A: I do not now, sir.
4 Q: How did you get it if you didn't submit a FOIA
5 request?
6 A: We submitted a request to the Police Chief, and
7 the Police Chief provided it to us.
8 Q: Okay. So your testimony is the first time you
9 became aware of the body camera footage, and he
10 provided it to DHEC. Is that your testimony?
11 A: No, sir.
12 Q: Okay. You got it from Dr. Alier, didn't you?
13 **MR. WRONSKI:** May I re-answer?
14 **THE COURT:** Yes.
15 A: The initial recording we got was from Mr. Scott
16 Stoller to Dr. Alier. Once I viewed that,
17 within a day I told the investigator to get an
18 official copy from the Iva Police Department to
19 insure that it wasn't tampered with. That's
20 pretty standard for us when we have video. We
21 don't always have video, but when we do we try
22 to get an official copy rather than one we just
23 get sent to us, sir. So, yes. I apologize.
24 The first copy we got was from Mr. Stoller.
25 What I consider to be our official copy before

1 we subpoenaed it was from the Police Chief.
2 Q: You recall whether you subpoenaed it from the
3 Police Chief -- did you say subpoenaed it from
4 the Police Chief or requested it from the
5 Police Chief?
6 A: We requested it as the Bureau of EMS. And then
7 I believe we've subpoenaed it for purposed of
8 this case since.
9 Q: I'm going to hand you Respondent's Exhibit 3.
10 A: Yes, sir.
11 Q: Do you recognize Respondent's Exhibit 3?
12 A: These are progress notes that we keep with the
13 investigations.
14 Q: Okay. That's the log of the investigation that
15 was conducted in Mr. Davenport's case. Isn't
16 that right?
17 A: Yes, sir. Log notes, however you want to
18 describe them.
19 Q: All right. And what's the purpose of this
20 document in terms of log notes in the
21 investigation?
22 A: Just to try to keep track of who's done what
23 and if there's something we meant -- did we do
24 that, we can go back and check and see if we
25 got something we were trying to remember just

1 to -- it's a tasker if nothing else. And then
2 it just records when have interactions.
3 Q: Okay. And I'm going to look, the first entry
4 on this document ---
5 **MR. ROTHSTEIN:** And, Your Honor, I would go ahead
6 and move this into evidence at this time.
7 **MR. WICEVIC:** No objection.
8 **THE COURT:** It's admitted.
9 **(Respondent's Exhibit Number 3 was admitted into**
10 **evidence.)**
11 Q: The first entry on this document is
12 Respondent's Exhibit 3, is dated April the
13 13th, 2016 at 5:04 p.m. You see that?
14 A: Yes, sir.
15 Q: Okay. Is that the, what would be referred to
16 as a complaint?
17 A: Could be. Yes, sir. We could refer to it as
18 that.
19 Q: Okay. And it says, secure email and file sent
20 to Dr. Alier from Scott Stoller at Anderson
21 County EMS, right?
22 A: Yes, sir.
23 Q: And it says that email file included
24 investigation material they had gathered and
25 performed on an Iva Rescue Squad paramedic.

1 Investigation initiated by Bureau and file
2 started, right?
3 A: Yes, sir. It does.
4 Q: And it looks like the next day there's some
5 sort of investigation folder started and that
6 looks like it's got Mr. Naugler's initials
7 beside it, right?
8 A: Mr. Naugler's initials. Next to that Mr.
9 Alier's initials next to that first one.
10 Q: Okay. So the sequence is Dr. Alier -- and Dr.
11 Alier's not a medical doctor, is he?
12 A: No, sir. He's PHD.
13 Q: Okay.
14 A: We call him Doc. I apologize.
15 Q: That's okay. So Dr. Alier gets this email
16 after business hours on the 13th. 9:00 o'clock
17 the next morning the file is started, correct?
18 A: Yes, sir.
19 Q: And who assigned Richard Naugler to be the
20 inspector in this case?
21 A: It was myself or Dr. Alier. I couldn't testify
22 to which one it was.
23 Q: Now what region does Mr. Naugler typically
24 cover?
25 A: This region, the Midlands.

1 Q: Midlands? Does that include Anderson County?
2 A: No, sir.
3 Q: Who was the investigator or inspector for the
4 Upstate?
5 A: It would have been Kristen at that time.
6 Q: Any reason you didn't assign Kristen to the
7 case?
8 A: She had some ties with -- that was where she
9 was employed previous to working as an
10 inspector. So she had ties to the area, and I
11 didn't want to have any conflict with that.
12 Q: Okay. On that first entry, what's the
13 importance of having a secure email of this
14 file?
15 A: I don't -- I didn't type that, so I don't know.
16 Q: You know if the police body camera video
17 contains HIPAA protected information?
18 A: I'm not a HIPAA law expert, but there's a
19 photograph of the patient's face on there. I
20 don't know if it's ever identified in the video
21 other than by first name. So his address is
22 visible, his name is his first name. So if I
23 were more familiar with HIPAA I would guess
24 probably it does contain that information.
25 Q: Okay. Do you deal with HIPAA at all at DHEC?

1 A: No, sir. We do not. We forward those
2 complaints on.
3 Q: Do you think you have to comply with HIPAA at
4 DHEC?
5 A: Oh, we do. Yes, sir.
6 Q: Okay. Now the next entry down there, looks
7 like after the investigation was started, and
8 I think the 14th was a -- let me look at my
9 calendar real quick. I think that was a Friday
10 if I'm not mistaking. Let me just double
11 check. April 14th, that was actually a
12 Thursday. And the 18th was a Monday. Do you
13 agree with that? I mean, do you have any
14 reason to dispute that?
15 A: I will take your word for it, Mr. Rothstein.
16 Q: So on Monday the 16th, Mr. Naugler sends -- he
17 calls and sends an email contact with the Iva
18 Police Department ---
19 A: That'd be Monday the 18th, sir.
20 Q: Sorry. Monday the 18th. Thank you for
21 correcting me. Sends an email and calls the
22 Iva Police Department, and asks for the
23 incident reports and records pertaining to the
24 call, right?
25 A: Yes, sir. That's what the log says, yes.

1 Q: Okay. And the Iva Police Force agree to give
2 you the video, right? Or agree to provide Mr.
3 Naugler perhaps the video?
4 A: Yes, sir.
5 Q: Okay. And the next morning at 10:00 o'clock is
6 when you met with Mr. Davenport, right?
7 A: Yes, sir.
8 Q: Okay. Had you viewed the video before you met
9 with Mr. Davenport?
10 A: Yes, sir.
11 Q: How many times had you viewed it?
12 A: Before we met with him, just a couple.
13 Q: Okay. Did you view it the same day, or was it
14 a previous day?
15 A: To when we brought Mr. Davenport in?
16 Q: Yes.
17 A: Previous.
18 Q: Okay. Not you actually tried for a little
19 while to get in touch with Mr. Davenport to
20 discuss the video with him, didn't you? Do you
21 recall? I think there was maybe a phone number
22 was off in Mr. Davenport's ---
23 A: Yes, sir.
24 Q: Okay. So it took a little while to get to Mr.
25 Davenport to agree to come in, right?

1 A: Yes, it did.
2 Q: All right. But you had seen that video
3 numerous times prior to Mr. Davenport's
4 interview, right?
5 A: A couple times. Yes, sir.
6 Q: Okay. And you had seen the video prior to Mr.
7 Naugler's contact to Iva Police Department for
8 an official copy of the video, right?
9 A: I had seen the copy that was sent to us. Yes,
10 sir.
11 Q: Okay. And the copy you showed Mr. Davenport on
12 I think it was -- it sounded like it was on
13 your computer at the time of the interview, was
14 the same folder that Mr. Stoller had sent to
15 Dr. Alier to start this matter, is that right?
16 You didn't have the official copy from Iva yet?
17 You agree with me on that?
18 A: I can't, sir because I can't remember which
19 folder we used. I can't remember if we had had
20 it at that time. Because we asked for it on
21 the 18th. So I don't know why we wouldn't have
22 had it on the 19th. But I could not tell you
23 which version we used, no, sir.
24 Q: Okay. Didn't they mail you a copy of a CD with
25 the ---

1 A: Yes, they did, sir.
2 Q: Okay.
3 A: So we probably wouldn't have had it.
4 Q: Okay. So you probably wouldn't have had it at
5 10:00 o'clock in the morning the next day after
6 you ---
7 A: We probably would not. No, sir. Thank you.
8 Q: Now, the interview you had with Mr. Davenport
9 you said that you met with some people prior to
10 the meeting. Let me see if I can find my notes
11 about the word you used. While I'm looking for
12 that, who to your knowledge has seen the video
13 prior to y'all meeting with Mr. Davenport on
14 April the 19th?
15 A: Just going through my head to make sure. The
16 video was not shown in the office. It was Mr.
17 Naugler, myself, Mr. Alier, and I do not recall
18 if I showed the video to my direct supervisor
19 before or after Mr. Davenport's interview.
20 Q: Okay. And I found my notes. You testified on
21 direct that going into the interview, you came
22 up with some sort of strategy. So that was the
23 word I wanted to focus on was strategy. Do you
24 remember that?
25 A: Yes, sir.

1 Q: Okay. Who was in this strategy meeting?
2 A: Would have been just myself and Mr. Naugler
3 probably.
4 Q: Okay. Was Mr. Alier involved in that?
5 A: No. I don't think he was there.
6 Q: Okay. Was Mr. Wiznuski involved in the
7 strategy meeting?
8 A: I don't know if he was involved in the strategy
9 meeting, but I told him why I wanted him to
10 come in, that it involved a trauma call and it
11 was relatively serious and I wanted him in the
12 room.
13 Q: Okay. Was DHEC's legal counsel involved in
14 that meeting?
15 A: No.
16 Q: Okay. Was that -- I think you mentioned there
17 was some compliance person that you ---
18 A: Bently White.
19 Q: Bently White? Was she involved in the strategy
20 meeting?
21 A: No.
22 Q: Was Bently White a lawyer?
23 A: She is.
24 Q: Okay.
25 A: She's not counsel though.

1 Q: Is she hired by DHEC in an attorney capacity?
2 A: No, sir.
3 Q: Okay. And you said you had, quote ultimate
4 objective going into that meeting. You
5 remember testifying to that phrase, ultimate
6 objective?
7 A: Yes, sir.
8 Q: Okay. And wasn't your ultimate objective to
9 intimidate Mr. Davenport into taking a consent
10 order?
11 A: No, sir. We didn't offer a consent order for
12 several days after that.
13 Q: Okay. Did your strategy going into that
14 interview include misleading Mr. Davenport
15 about the investigation that was conducted into
16 this matter? Were those part of your
17 strategies?
18 A: I don't know that we mislead him. We didn't
19 tell him specifically why he was there or what
20 we were looking for. No, sir.
21 Q: You didn't tell him that you had some QA follow
22 up to this report you had about these three
23 cases from Anderson County?
24 A: I don't think that's misleading.
25 Q: Did you actually invite Mr. Davenport down to