

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 3 OF 4

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1 this meeting or was that Mr. Naugler?

2 A: Oh gosh, sir. I couldn't tell you.

3 Q: You don't remember?

4 A: I don't remember.

5 Q: Okay. Did your strategies include entrapment?

6 A: No.

7 Q: Okay. Did your strategies include manipulating
8 Mr. Davenport?

9 A: I don't think manipulating is a good word. No.

10 Q: Okay. Did your strategies include pressuring
11 Mr. Davenport into accepting some sort of
12 enforcement action?

13 A: We did not propose enforcement action at those
14 conferences.

15 Q: Okay. Did your strategies include intimidating
16 Mr. Davenport in any way?

17 A: No, sir.

18 Q: Okay. Now Mr. Wicevic played the very
19 beginning of the video just sort of to
20 establish -- that video's like almost two hours
21 long, isn't it?

22 A: It is. Yes, sir.

23 Q: And when was the last time you listened to that
24 video?

25 A: The audio in it's entirety?



1 Q: I'm sorry. I said video. I meant audio.
2 Thank you.

3 A: In its entirety it's been a while.

4 Q: Okay. And you said at some point during the
5 meeting, the attitudes changed. Do you recall
6 that?

7 A: My attitude changed. Yes, sir. I don't know
8 if I used attitude, but the temperature of the
9 room changed drastically. Yes, sir.

10 Q: And who changed the temperature of the room?

11 A: Who changed it?

12 Q: Who changed it?

13 A: Myself and Mr. Davenport.

14 Q: Okay. And I think you described this as -- in
15 your testimony a few minutes ago you said it
16 was slightly more adversarial at some point in
17 the meeting. Is that right?

18 A: When Mr. Davenport saw the video, yeah he
19 bristled at it.

20 Q: I'm not talking about Mr. Davenport's response.
21 I'm talking about you and Mr. Wiznuski and Mr.
22 Naugler. Y'all became more than just slightly
23 adversarial toward Mr. Davenport, didn't you?

24 A: Poor Mr. Davenport did just fine in that
25 interview, sir.



1 Q: Okay. But your voices got raised. Do you
2 agree with that?

3 A: I believe mine did once when he laughed. Yes,
4 sir.

5 Q: Okay. And would you say your blood pressure
6 increased a little bit?

7 A: I'll say, yes.

8 Q: Okay. You certainly conveyed anger toward Mr.
9 Davenport. Do you agree?

10 A: I conveyed anger to Mr. Davenport's attitude.

11 Q: Okay.

12 A: And I don't think it was anger. I think it was
13 just disbelief more than anything.

14 Q: Okay. And at some point during this
15 escalation, you actually had to tell, I think
16 it may have been Mr. Naugler, don't get angry,
17 calm down. You had to calm him down. Do you
18 recall that?

19 A: I wanted to keep it civil as much as possible.
20 Yes, sir.

21 **MR. ROTHSTEIN:** Your Honor, I'd like to play a
22 little bit of the video. I mean the audio. I
23 keep saying video. But I'm going to need the
24 thing switched to my computer. See if I can
25 get this to work. The volume may be a little



1 off here, so please bare with me.

2 (Audio Played)

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

7 A: It does. Yes, sir.

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

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

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

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

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

21 A: Yes.

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

24 A: Uh-huh.

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



1 Anderson County took looked appropriate.

2 A: For what information they had I believe is what
3 I said.

4 Q: Okay. And you said ---

5 A: Words to that effect.

6 Q: You said we called you down here because we
7 have a few things to follow up. We have no
8 statement from you. We have a statement from
9 your partner on one of the calls. We wanted to
10 get a statement from you, do a quick review of
11 these calls. Do you recall?

12 A: Yes, sir.

13 Q: Okay. And I think you used the term root cause
14 analysis, right?

15 A: Yes, sir.

16 Q: Okay. So you lead Mr. Davenport to believe
17 that this was a QA matter, you're trying to get
18 to a root cause analysis, you already had an
19 investigation done, you want to get his side of
20 the story to make sure was complete, right?

21 A: The investigation wasn't done. It was still in
22 process. Yes, sir. And I also said to make
23 sure that whatever happened didn't happen
24 again. It was on the tape.

25 Q: Okay. But you're talking about the QA matters,



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

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

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

9 A: No, sir. We did not.

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

13 A: For what information they had.

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

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

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

21 A: To do quality assurance? Yes, sir.

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



1 with their QA right?

2 A: I didn't use those words. No, sir. But ...

3 Q: Okay. And you said you wanted to chitchat
4 about these. Do you recall that you used that
5 phrase chitchat?

6 A: I did.

7 Q: Okay. Then the next 50 something minutes of
8 the tape, and I'm going to skip over it. I
9 think I'm going to skip over most of it, was
10 talking about three incidents, right?

11 A: Yes, sir.

12 Q: Okay. You started with the elderly gentleman
13 and you said, Mr. Davenport it looks like
14 there's some sort of pattern of ALS versus BLS
15 calls in connection with these three cases,
16 right?

17 A: Yes, sir.

18 Q: Okay.

19 A: I will take your word for it that there was.
20 I recall that that's probably part of the
21 conversation we had, that it was ALS versus BLS
22 on the calls. Yes, sir.

23 Q: And what was the demeanor like discussing those
24 three calls with Mr. Davenport over the next 50
25 minutes?



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

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

18 A: Yes, sir. We did.

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

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



1 Q: Okay. And you're also trying to put Mr.
2 Davenport at ease and establish a little bit of
3 a rapport with him. Is that fair?

4 A: That's fair.

5 Q: Okay. Still hadn't told Mr. Davenport you'd
6 seen the body cam video, right?

7 A: No, sir. We did not.

8 Q: And then we get to this -- we go through the
9 two calls and then we get to the third call.
10 And again, it'll be in evidence. The Judge can
11 listen to the entire thing. You get to the
12 stabbing trauma patient, right? And the first
13 thing you do is you say, Mr. Davenport will you
14 just run through the call from start to finish?
15 Do you recall something -- I may not have the
16 words quite right.

17 A: That's mostly how we practice. We ask them to
18 run through the call.

19 Q: Do you recall when you got to the part about
20 Mr. Davenport standing the patient up with a
21 knife impaled in his chest and walking out to
22 the thing. I think you made a comment, Rich is
23 breaking out in cold sweats right not. Do you
24 recall saying something like that?

25 A: I might have. Yes, sir.



1 Q: Okay. And do you recall some discussion with
2 Mr. -- Rich refers to Mr. Wiznuski ---

3 A: Mr. Wiznuski. Yes, sir.

4 Q: And he's the trauma ---

5 A: Director. He's the Director of the division of
6 trauma.

7 Q: And he reports directly to you, right?

8 A: Yes, sir.

9 Q: And there was a discussion about whether this
10 patient required a level one -- to be seen by
11 a level one trauma center, or whether this was
12 a level one trauma?

13 A: Whether it was a level one trauma patient.
14 Yes, sir.

15 Q: Okay.

16 A: A level one trauma patient can go to a two or
17 a one. They can go to a three if that's all
18 that's available, but we prefer twos or ones.

19 Q: And then there was some question about Mr.
20 Stoller's recommendation of the PEPL class. Do
21 you remember a discussion about the PEPL class?

22 A: I don't specifically recall it, but I do
23 remember that we talked about the PEPL class.
24 If you want my specific recollection, one of
25 the things that stuck out was that Mr.



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

3 Q: That sticks out in your mind?

4 A: Kind of does.

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

7 (Audio Played)

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

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

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

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

13 (Audio Played)

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

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

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

19 A: I said I believe.

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

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

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



1 investigation? Let me say prior to the IRC
2 meeting?

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

6 Q: Okay.

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

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

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

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

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

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

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

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

24 (Audio Played)

25 Q: And you recall that discussion ---



1 A: Sure.

2 Q: --- where Mr. Davenport says, I don't care if
3 this is a stubbed toe, if my partner's not
4 comfortable riding the call in, I'm not going
5 to make her ride it, I'm going to ride in the
6 back of the truck, right?

7 A: He did say that. I don't think he demonstrated
8 it, but he said it.

9 Q: You recall telling Mr. Davenport several times
10 during this interview that we've got to take
11 care of people who can't take care of
12 themselves?

13 A: I was saying that for specific reasons. Yes,
14 sir. I wanted to see his reaction.

15 Q: Okay.

16 A: Because that patient -- I'm sorry. Go head.

17 Q: Okay. And there was a -- I went back after the
18 hearing yesterday and listened to the whole
19 thing. I mean I was up till about 2:00 o'clock
20 last night.

21 A: Yes, sir.

22 Q: I counted four separate times when you told Mr.
23 Davenport, we've got to take care of people who
24 can't take care of themselves.

25 A: And that was for specific reactions, and wanted



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

2 Q: That was part of the strategy?

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

5 (Audio Played)

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

12 A: In his experience.

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

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

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

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



1 Q: Over 20 year prior to your interview with Mr.
2 Davenport?

3 A: Yes.

4 (Audio Played)

5 Q: So at that point in the video, it sounds like
6 things are wrapping up. You went around the
7 table. Anybody else have any questions. That
8 kind of thing. Was that part of your strategy
9 with Mr. Davenport as well?

10 A: Well any more questions regarding that call, or
11 did he have anything else he wanted to add
12 about the call. Because we wanted him to tell
13 us everything he remembered to see if it
14 matched up with what was in the video.

15 Q: Okay.

16 (Audio Played)

17 Q: Okay. So, was part of your strategy going into
18 this meeting to ask Mr. Davenport a bunch of
19 questions y'all already knew the answer to
20 after you watched the video?

21 A: Not all the questions we knew the answers to.

22 Q: Some of the questions ---

23 A: But some of the questions we thought we knew
24 the answers to. Yes.

25 Q: Okay. And this meeting was on I think the



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

4 A: Yes.

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

8 A: We were. Yes.

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

12 A: Yes, sir.

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

16 A: I think just the patient care report.

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

20 A: No, sir.

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

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

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



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

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

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

16 A: Yes, sir.

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

19 A: We did.

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

22 A: We did.

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



1 him ---

2 A: Uh-huh.

3 Q: --- about things like did he do an assessment
4 in the house, right?

5 A: Uh-huh.

6 Q: And Mr. Davenport said he remembered bending
7 down and doing a pedal pulse and that kind of
8 thing. And I think there was a question about
9 breath sounds or lung sounds, right? And at
10 some point they said, well how do you check for
11 lung sounds? And somebody mentioned a
12 stethoscope, right?

13 A: Yes, sir.

14 Q: Okay. So at the time all that occurred, Mr.
15 Davenport did not know that y'all had already
16 seen the video, right?

17 A: No.

18 Q: Okay. But you already knew the answer to that
19 question because you can't see a stethoscope
20 around Mr. Davenport's neck ---

21 A: Yes, sir.

22 Q: --- right?

23 A: Uh-huh.

24 Q: Okay. So you kind of trapped him into laying
25 the foundation that he did breath sounds and



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

4 A: That's not a trap.

5 Q: It's not a trap.

6 A: No, sir.

7 Q: Okay.

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

14 Q: Okay.

15 A: That's not a trap.

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

18 A: I'm not an attorney.

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

23 A: Yes, sir.

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



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

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

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

17 A: Yes, sir. And he chuckled.

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

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

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



1 A: I did not jump on him. I calmly said, do you
2 see anyone else laughing. Please watch the
3 video.

4 Q: Okay.

5 A: If you're asking me was I a little uptight at
6 that point, yes, sir I was.

7 Q: Okay this is just about when the temperature of
8 the room's starting to change a little bit?

9 A: Oh it changed at that point. Yes, sir. It
10 did.

11 Q: All right, so I'm going to skip through the
12 rest of the body cam video.

13 (Audio Played)

14 Q: That last comment. Who is that making that
15 comment?

16 A: That was me.

17 Q: Okay. You said, would it surprise you if he,
18 meaning the stabbing patient ---

19 A: Uh-huh.

20 Q: --- said that you treat him like this
21 regularly?

22 A: Yes, sir.

23 Q: Okay. And have you ever met the patient in
24 this stabbing call?

25 A: Never.



1 Q: Okay. Have any of the investigators in here
2 met this stabbing patient?

3 A: Not officially.

4 Q: Okay.

5 A: Not that know of.

6 Q: All right. So you're kind of telling Mr.
7 Davenport that you all have spoken to the
8 patient, and he said that Mr. Davenport
9 regularly treats him like this, right?

10 A: I said, would you be surprised if the patient
11 said that?

12 Q: Okay. Was that loaded question you asked Mr.
13 Davenport a part of your strategy?

14 A: That was not an original strategy. That came
15 into effect when -- that came into my head
16 then. I didn't write that down as a strategy.
17 No, sir. But sometimes we'll ask someone if we
18 have some sort of proof to see if they will,
19 you know, say, well maybe I've talked to him
20 like that before. And he did say he's run him
21 five times previously too, and he has not run
22 him five times before.

23 Q: Now, have you taken some sort of investigator
24 or interrogation training?

25 A: I have not.



- 1 Q: Okay.
- 2 A: My inspectors do, but I don't.
- 3 Q: Okay. Is this part of your watching too much
- 4 TV, like you said with the Grand Jury thing.
- 5 A: No. It's worked before.
- 6 Q: Okay. So when you told Mr. Davenport, would it
- 7 surprise you if he, meaning the patient, said
- 8 that you treat him like this all the time,
- 9 that's ---
- 10 A: I didn't indicate that I spoke to the patient.
- 11 Q: But you certainly lead Mr. Davenport to believe
- 12 that you had spoken to the patient.
- 13 A: And he said he did not.
- 14 Q: That's a bit of a loaded question, right? It's
- 15 like saying ---
- 16 A: He said he didn't.
- 17 Q: That's like the classic, when did you stop
- 18 beating your wife question, right?
- 19 A: Classic. Yes, sir.
- 20 Q: Okay.
- 21 (Audio Played)
- 22 Q: Okay. So at that time you told Mr. Davenport
- 23 a copy of this tape or this video has not left
- 24 the building, right?
- 25 A: Yes, sir.



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

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

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

13 A: Right.

14 Q: --- from the Iva Police Department.

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

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

20 A: I will say, yes.

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

22 A: When he saw it. Yes, sir.

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

25 A: Yes, sir.



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

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

5 (Audio Played)

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

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

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

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

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

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



1 didn't.

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

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

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

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

24 Q: So going into the meeting ---

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



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

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

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

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

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

18 **(Audio Played)**

19 Q: Who was that speaking?

20 A: That was Mr. Naugler.

21 Q: Okay. What is a revoktion?

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

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



1 to involve having your paramedic certificate
2 revoked?

3 A: I did not say that.

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

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

8 Q: Okay.

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

12 THE COURT: Okay.

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

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

16 MR. ROTHSTEIN: Right.

17 THE COURT: Okay.

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

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

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

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

25 Q: Good afternoon ---



1 A: Afternoon.

2 Q: --- Mr. Wronski. Do you have that Exhibit 3
3 that we were looking before the -- the log of
4 the ...

5 A: I think I gave it back.

6 Q: You gave it back to me? And we established
7 that that was the log of the of investigation
8 with -- regarding Mr. Davenport's case.

9 A: Yes, sir.

10 Q: And do some of the injuries in here have your
11 initials on them?

12 A: Yes, sir. They do.

13 Q: Primarily it's Mr. Naugler that filled that
14 out?

15 A: Yes, sir. According to his initials, yes, sir.

16 Q: Okay. And then in your paramedic training, I
17 think we've had several people that testified
18 that there's a saying that says if it's not
19 written down, it didn't happen?

20 A: On a patient care report. Yes, sir.

21 Q: Well do -- you think these investigation notes
22 are important, the document and what was done
23 on the investigation?

24 A: Yes, sir.

25 Q: Okay. Do you think that this Exhibit 3 is a



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

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

6 Q: Okay. That's fine.

7 A: Okay.

8 Q: And do you recall that after the meeting on the
9 19th, where the stuff we went over before
10 lunch, April 19th, that you called Mr.
11 Davenport up on the 27th of April and made an
12 offer of a consent order. Do you recall that?

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

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

19 A: Yes, sir.

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



1 A: Not that I can recall, truly.

2 Q: All right. And then on the 27th, they're
3 saying -- later on the 27th, about an hour and
4 a half after you first offered Mr. Davenport
5 the two year consent order, you told him that
6 he could come by and pick up copies of the
7 investigative file?

8 A: 'Cause he asked for it. Yes, sir. He
9 requested them.

10 Q: Okay. And you told him we'll make it available
11 to you here in Columbia but we're gonna have to
12 have to redact all of patient care reports
13 because of HIPAA concerns, right?

14 A: Yes, sir.

15 Q: Okay. And then later on the 28th, the whole
16 investigator file that you had for that date
17 was copied and placed in a confidential
18 envelope and Mr. Davenport picked it up the
19 next day, right?

20 A: According to the log, yes, sir.

21 Q: And one of the -- one of the things you gave
22 Mr. Davenport when you came and picked -- or
23 the Department gave Mr. Davenport when he
24 picked up the packet was a copy of the -- the
25 log of what y'all had done in the



1 investigation of that date, right?

2 A: I don't know what was all in the packet, sir.

3

4 Q: If you look down at the entry on the 29th of
5 April ---

6 A: Okay.

7 Q: It says, Mr. Davenport picks up investigative
8 packet and signed receipt, placed in filed a
9 copy given to him, right?

10 A: Yes, sir.

11 Q: Okay. So that entry wouldn't be on the copy of
12 the log that Mr. Davenport picked up right,
13 'cause that entry happened after Mr. Davenport
14 picked up the packet. You agree with that?

15 A: I guess I would have to.

16 Q: Okay. So everything -- and this was a
17 chronological listing of it.

18 A: Correct.

19 Q: So my point is that everything after that
20 entry was not on the log that was given to
21 Mr. Davenport as here's a copy of the
22 investigation, right?

23 A: I don't know. If he was given it, it shouldn't
24 have had any entries that were predated, no.

25 Q: Okay. And did you do any investigation



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

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

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

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

15 Q: Okay.

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

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

22 A: No.

23 Q: --- terms would be?

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

25 Q: Okay.



1 A: He may come back and told me a year and I
2 would've had to think about it and we go back
3 and forth until we come to what the actual
4 consent should say before we write it. It may
5 take awhile.

6 Q: Okay. And on May 2nd, I sent you a letter of
7 representation saying I'm representing Mr.
8 Davenport and he's turning down the two year
9 proposed consent order, right?

10 A: Yes, sir.

11 Q: All right. And the next thing you did was
12 scheduled this IRC meeting, correct?

13 A: Yes, sir because at that point, I still felt
14 that some sort of suspension was in order and
15 I have to have the Investigative Review
16 Committee look at that, so ...

17 Q: Okay. And that notice of the IRC was sent out
18 -- looks like on May the 6th, 2016? You see
19 the entry on the second page?

20 A: Yes, sir.

21 Q: And the date of the IRC meeting was
22 originally listed as May 25th. Do you recall
23 that?

24 A: Yes, sir, I do.

25 Q: Okay. And I had a -- I had court protection.



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

6 A: Yes, sir.

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

9 A: Yes, sir.

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

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

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

19 A: Uh-huh.

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

24 A: Yes, sir.

25 Q: Had Mr. Wiznuski got in the actual Emergency



1 Department medicals records at that time?

2 A: I -- Mr. Rothstein, I would like to say that we
3 had them, but I do not recall at the top of my
4 head when they arrived. We have a very thick
5 package of information.

6 Q: It doesn't appear to be an investigative log,
7 does it?

8 A: No.

9 Q: Okay. I'll represent to you that the packet
10 that you gave to Mr. Davenport doesn't have any
11 ED notes from AnMed. Would you have a copy of
12 that?

13 A: We didn't have them at that time, No, sir.

14 Q: Okay. Then the IRC meeting was held on June
15 the 23rd.

16 A: Yeah.

17 Q: Looks like it lasted about a total of maybe
18 three or three and a half hours, something like
19 that?

20 A: Yes, sir.

21 Q: Okay. And this is the first IRC meeting you
22 ever been involved or were ever involved in as
23 the EMS ---

24 A: Second.

25 Q: This was the second?



1 A: Yes, sir.

2 Q: Okay. 'Cause I thought you told me at the
3 beginning of the IRC that no one here had done
4 one before.

5 A: Before I got there.

6 Q: Yeah. Before Mr. Davenport's?

7 A: No, sir.

8 Q: Okay. When was the first IRC meeting that you
9 were involved in after you became Bureau Chief?

10 A: Eighteen months. Eighteen months ago give or
11 take.

12 Q: And so, I think you testified earlier that you
13 learned a lot from the first IRC meeting ---

14 A: Yes, sir.

15 Q: --- about how to handle Mr. Davenport's IRC
16 meeting. Is that right?

17 A: Just some pearls, yes, sir.

18 Q: Okay. So you had already had sort of a
19 learning experience with the IRC before you met
20 with Mr. Davenport, right?

21 A: It was a learning experience, yes, sir.

22 Q: And what does it mean in your mind -- I think
23 you used the term recuse. You said sometimes
24 that one of your investigators or somebody has
25 a personal connection or a direct connection



1 with the subject or the compliant, they recuse
2 themself.

3 A: Uh-huh.

4 Q: What does that mean in your mind?

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

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

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

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

22 A: Yes, sir.

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



1 recuse himself from the Russia investigation,
2 right?

3 A: Yes, sir.

4 Q: Okay. And that means he's not supposed to have
5 anything to do with the invest- -- the Russia
6 investigation, okay?

7 A: Okay.

8 Q: Okay. And I think you talked earlier, I think
9 ---

10 A: I don't think I used the work, recuse with
11 regards to Dr. Alier. I just said sometimes we
12 do do that.

13 Q: Okay. I'm going to hand you this document.
14 Have you ever seen the document before, Mr.
15 Wronski?

16 A: Yes, sir.

17 Q: Okay. This is the interrogatory responses DHEC
18 submitted to me in this case. Do you
19 understand that?

20 A: Yes, sir.

21 Q: And do you understand that interrogatory
22 responses are signed or provided under oath or
23 under penalty of perjury?

24 A: Yes, sir.

25 Q: Okay. One of the things I asked for was to



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

6 A: Yes, sir.

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

12 A: Yes, sir.

13 Q: Dr. Alier oversees the operations of EMS
14 division which administers the EMS regulatory
15 program. Dr. Alier received the complaint,
16 which alleged regulatory violations against
17 Mr. Davenport and initiated the investigation.
18 I read that right?

19 A: Yes, sir.

20 Q: And that last sentence there says, Dr. Alier
21 recused himself from the investigation into
22 Mr. Davenport.

23 A: Yes, sir.

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



1 A: If the definition is that he should've not been
2 involved with the investigation at all if he
3 was not recused.

4 Q: He was not recused?

5 A: If that's the definition of recuse. We kept
6 him out of it, absolutely as much as possible.

7 Q: Okay. And tell me again why you felt it
8 necessary to keep Dr. Alier out of things as
9 much as possible.

10 A: Because his -- he knew Mr. Stoller.

11 Q: Okay.

12 A: He -- he had a relationship with Mr. Stoller.
13 They teach classes together.

14 Q: Were you aware they were former partners
15 together with the Greenville County EMS?

16 A: Not until we got into this, no, sir.

17 Q: Okay. Did Dr. Alier disclose to you that Scott
18 Stoller, the Anderson County EMS director, was
19 his former partner with Greenville County EMS?

20 A: Not until we got into this, no, sir.

21 Q: Now Mr. Wicevic asked you some questions about
22 whether you teach paramedics and EMT's. And I
23 think you said because you're over the
24 paramedic teaching programs in South Carolina,
25 the only place you can teach is outside of



1 South Carolina?

2 A: Yes, sir.

3 Q: And that's because of the conflict of
4 interest?

5 A: That and the department won't let me. Yes,
6 sir.

7 Q: Now, let's talk about the IRC meeting again.
8 I think you described it at one point as a
9 grand jury proceeding and I think you said that
10 may have been too much TV, right?

11 A: Yes, sir.

12 Q: Okay. There's a white notebook up there. No
13 I think it maybe ...

14 MR. WICEVIC: 8?

15 MR. ROTHSTEIN: Exhibit 8? Is that what you said?

16 A: The transcript is right here.

17 MR. WICEVIC: Correct.

18 Q: You see the Exhibit 8 in the DHEC notebook?

19 A: Yes, sir. I'm here.

20 Q: After the IRC meeting, did you have a chance to
21 -- have you HAD a chance to review the
22 transcript?

23 A: Yes, sir.

24 Q: Okay. To your knowledge or to the best of your
25 ability or best of your recollection, when you



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

4 A: Yes, sir.

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

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

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

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

17 Q: Are you sure about that?

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

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

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

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



1 session?

2 A: I do not know why the IRC did not do that, sir.

3 Q: Okay. Executive session is kind of a secret
4 meeting, isn't it?

5 A: I don't think there's a true executive session
6 on this committee but it's not secretive. It's
7 in the transcript.

8 Q: Okay. And for a lack of better term, I mean,
9 would you consider the executive session for
10 the like the deliberations of the -- of the
11 panel.

12 A: Yes, sir. I do.

13 Q: And I'll you to turn to page -- there's four
14 pages on a page. Executive page 30 of the
15 document, but it's page 119 of the transcript.

16 A: Yes, sir.

17 Q: Okay. This -- is that part of the executive
18 session portion of the IRC?

19 A: I would have to go back through the whole thing
20 sir, and ... Can I read it real quick and tell
21 you how ---

22 Q: I don't think you need to go back through the
23 whole thing. Let me direct you to page ...

24 A: It says on page 116 that we re-entered the room
25 at that point. So right before page 119.



1 Q: Okay. So that's during the executive
2 session. You went out to the lobby, came
3 back in. Is that right?

4 A: We were out for quite a while. Yes, sir.

5 Q: Okay. And at this particular, on page 119,
6 y'all are talking about the appropriate
7 grounds for taking some type of enforcement
8 action against Mr. Davenport's certification,
9 right?

10 A: Yes, sir.

11 Q: Okay. And there's a Dr. Clanton. He's starts
12 on page -- on line 5. And he says, I having a
13 hard time really fitting this behavior into any
14 of these 17 things here, right?

15 **MR. WICEVIC:** Your Honor, I'm gonna object to that.
16 He moved to have that offered as truth of the
17 matter is served. Dr. Clanton is not here.
18 It's hearsay.

19 **MR. ROTHSTEIN:** I'm asking Mr. Wronski if he recalls
20 that -- that happening.

21 **THE COURT:** The objection is overruled.

22 Q: Do you recall that happening?

23 A: I recall this conversation, yes, sir.

24 Q: And then he says, there are some things you can
25 make a case for but I mean, it's hard to really



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

7 A: Yes, sir.

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

12 A: Yes, sir.

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

16 A: Uh-huh.

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

20 A: Yes, sir.

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

24 A: Yes, sir.

25 Q: Okay.



1 A: To my knowledge.

2 Q: Now if you look at page 120, you continued.
3 Line 5 you say, we never, to date, in two and
4 a half years used F as an example because
5 judgments can be judgements, right?

6 A: Okay.

7 Q: And you agree with that statement that
8 judgements can judgements?

9 A: Based on as many facts as you can gather, yes,
10 sir.

11 Q: And then at the bottom of page 120, Dr. Clanton
12 says -- says, you know, and this starting line
13 21, you know in the trauma parameters or
14 protocols, I really don't see anything about
15 penetrating trauma as a criteria specifically
16 spelled out. So it's hard to say that he
17 violated protocol, right? You agree with that?

18 A: I agree that's what you read, yes, sir.

19 Q: Okay. And you were present when that
20 discussion was happening, correct?

21 A: Yes, sir.

22 Q: Okay. And what protocols were you looking at
23 in the IRC meeting to see if Mr. Davenport
24 comply with or violated the protocols?

25 A: It's hard to recall exactly which ones but



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

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

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

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

11 A: Yes, sir.

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

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

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

20 A: We had left at that point, sir.

21 Q: Oh, you had left at that point?

22 A: Yes, sir, we had.

23 Q: Okay.

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



1 Q: After the -- after the IRC meeting you -- I
2 got a recommendation and I think you
3 described earlier from the IRC about what the
4 appropriate enforcement action against Mr.
5 Davenport's certificate is, right?

6 A: Sure, that sounds correct.

7 Q: After the IRC meeting, you received their
8 recommendation from the IRC about what the
9 appropriate or what they believe would be
10 appropriate enforcement action against Mr.
11 Davenport certificate.

12 A: I receive two, yes.

13 Q: Okay. And after that point you had -- or you
14 meaning DHEC, prepared another proposed consent
15 order for Mr. Davenport. Is that right?

16 A: That would've been the first one we prepared.

17 Q: Okay.

18 A: Not another one.

19 Q: Did you review that document before it was sent
20 out?

21 A: Yes, sir.

22 Q: Okay. I thought I had a hard paper copy of it
23 but I don't. So I'm going to show it to you on
24 the screen here if I can make this work. I'm
25 just gonna scroll through. Do you recognize



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

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

4 Q: Okay. I'm scrolling down. This gonna be page
5 2 of the document.

6 A: Okay.

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

13 A: Yes, sir.

14 Q: You see that?

15 A: Yes, sir.

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

19 A: Yes, sir.

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

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

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



1 complaint, right?

2 A: We don't file complaints. No, sir.

3 Q: I thought you said you can take action if you
4 received information from somebody. It's not
5 in a formal complaint. And then you can convert
6 that into a complaint?

7 A: Right.

8 Q: Okay. Which happened here? Did you receive a
9 complaint or did you receive information and
10 turned it into a complaint?

11 A: We received information that was concerning to
12 someone. So it could go either way. We call
13 it a complaint. We don't file complaints. We
14 either get a complaint or we don't get a
15 complaint.

16 Q: Okay. That's fair it enough. And Mr.
17 Davenport rejected this consent order, right?

18 A: Yes, sir. He did.

19 Q: And this consent order, if he had signed it
20 he would've sort of giving up his certificate
21 for a least a year, right?

22 A: Not at least, one year, sir.

23 Q: Okay. And he would've -- well, he -- couple
24 with that, giving it up for a year, he would
25 have to go to a psychiatric evaluation. Is



1 that right?

2 A: I would have to read just to be sure, sir.

3 Q: Okay. So in this proposed consent order,
4 you're asking Mr. Davenport, number one, to
5 admit that he committed a misconduct, right?

6 A: That's the first part. Yes, sir.

7 Q: Subsection B also admits misconduct, right?

8 A: Yes, sir, it does. C as well.

9 Q: C admit misconduct. Okay. Here's the
10 agreement, right?

11 A: Yes, sir.

12 Q: Mr. Davenport agrees to suspension of his EMT
13 paramedic certificate for a period of one year,
14 right?

15 A: Yes, sir.

16 Q: And suspension means that his paramedic
17 certificate is temporally voided, right?

18 A: Yes, sir.

19 Q: Okay. Suspension of his EMT paramedic
20 certificate includes all levels of EMT
21 certification, right?

22 A: Yes, sir.

23 Q: Okay. So you can't even work as a basic or
24 intermediate?

25 A: Not under this suspension. No, sir.



1 Q: Item two. Mr. Davenport agrees to submit to a
2 comprehensive psychiatric evaluation within 45
3 days of execution of this consent order, right?

4 A: Yes, sir.

5 Q: And was he required to pay for that?

6 A: In the consent order I would guess, yes, sir,
7 that he'd pay.

8 Q: Did you tell them there was a \$15,000 grant per
9 paramedic per year?

10 A: I don't think there was at time. It was right
11 after this that we signed the paperwork.

12 Q: Okay. And you specifically said that the
13 evaluation needed to include an assessment for
14 anger management, right?

15 A: Yes, sir.

16 Q: Okay. And then it said, proof of the
17 evaluation should be provided to the
18 Department prior to reinstatement of Mr.

19 Davenport as a paramedic, right?

20 A: Yes, sir.

21 Q: So, for some reason in that 45 day period, he
22 didn't get the evaluation done, his suspension
23 would continue indefinitely. Is that right?

24 A: Yes, sir. But if I may, we do negotiate days
25 all the time. If somebody says they couldn't



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

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

8 A: Yes, sir.

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

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

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

16 A: Yes, sir. PEPL class.

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

19 A: Yes, sir. Within the 12 months.

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

23 A: Yes, sir.

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



1 A: Yes, sir..

2 Q: So Mr. Davenport rejected that consent order,
3 right?

4 A: Yes, he did.

5 Q: Okay. And that lead to the entry of the
6 administrative order that caused us to appeal
7 to this Court, right?

8 A: Yes, sir.

9 Q: When was the last time you actually rode an
10 emergency call as paramedic on an ambulance?

11 A: I think it was Charleston County.

12 Q: Okay.

13 A: Unless I rode in when I was in Mt. Pleasant we
14 had an ALS entry program. So a lot of the
15 times our paramedics would jump on the
16 Charleston County ambulance. I may done that
17 a few times.

18 Q: What year are we talking about?

19 A: Before 2010.

20 Q: So it's more of seven or eight years ago. Does
21 that sound about right?

22 A: As a paramedic, yes, sir.

23 Q: You used an interesting phrase, I wrote this
24 one down too, IV lifeline. What is a IV
25 lifeline?



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

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

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

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

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

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

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



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

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

5 **A:** Yes, sir.

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

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

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

12 **A:** Yes, sir.

13 **Q:** Okay.

14 **MR. WICEVIC:** Your Honor?

15 **THE COURT:** Yes.

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

22 **THE COURT:** That's in affect, okay.

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



1 Q: This is the one in book, section 1100, right?

2 A: Yes, sir.

3 Q: And I think we're talking about subsection
4 eight.

5 A: Yes, sir. I see it.

6 Q: Okay. The holder of the certificate has
7 after initiating care of patient at the scene
8 of an accident where illness discontinued such
9 care or abandon the patient without the
10 patient's consent or without providing for the
11 appropriate administration of care by equal or
12 higher medical authority. You see that?

13 A: Yes, sir.

14 Q: Okay. So that's the -- that's one of the bases
15 alleging this comment against ---

16 A: Yes, sir. Not the abandonment but the
17 discontinuing of care.

18 Q: Okay. Does the statute or regs define the
19 term abandonment or discontinuation, excuse
20 me, discontinuation of care?

21 A: I'll have to look at the definition, sir.

22 Q: Well, when you made ---

23 A: It have to be a original one denied.

24 Q: But when you made the determination that Mr.
25 Davenport discontinued care of his patient, did



1 you consult the Anderson County protocols?

2 A: No. I don't think we did for discontinuation.

3 Q: Look in the book.

4 A: Yes, sir.

5 Q: Exhibit 1, page 89. Authority of a patient
6 management policy.

7 A: Which page is this, I'm sorry.

8 Q: 89.

9 A: 89.

10 Q: And it's actually the bigger pages so you ---

11 A: Okay.

12 Q: Yeah.

13 A: Yes, sir.

14 Q: Under procedure, I'm gonna go down to the
15 fourth paragraph.

16 A: Okay.

17 Q: The most appropriately trained and
18 knowledgeable provider at scene is ultimately
19 responsible for all patient care activities
20 while he or she is present. You see that?

21 A: Yes, sir.

22 Q: Was Mr. Davenport present throughout the entire
23 encounter from the -- when he goes into the
24 trailer until patient's dropped off at the
25 emergency department?



1 A: He was.

2 Q: Okay. And it says, he or she may delegate
3 all or part of the patient management and
4 transportation to others, who are qualified to
5 meet the patients immediate needs or
6 reasonable perceive needs.

7 A: Yes, sir.

8 Q: Okay. Semicolon, however, he or she must
9 intervene and take control anytime if
10 management of a patient becomes unacceptable.
11 You see that?

12 A: Yes, sir.

13 Q: Okay. So this part of the policy appears to
14 align Mr. Davenport if that patient was stable
15 and the EMT basic handled the immediate needs
16 are reasonably perceive needs to let the EMT
17 ride in the back of the truck and Mr. Davenport
18 drive the truck, right?

19 A: Yes, sir.

20 Q: Okay. And if that patient, for some reason,
21 starts have an -- what are the first to shock
22 that you were gonna -- if a patient goes into
23 shock, what are the first signs that you're see
24 with regard to that patient?

25 A: The first signs of shock you're gonna see is



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

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

9 A: Yes, sir.

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

13 A: Uh-huh.

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

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

19 Q: Okay. And you've seen their vital signs taken
20 ---

21 A: There were.

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

24 A: Somehow. Yes, sir.

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



1 paramedic, did they have the Life Pack 15?

2 A: No.

3 Q: Well, how did you do a pulse back then?

4 A: With a Life Pack 5 or 10

5 Q: Okay.

6 A: Or by manual ---

7 Q: That's what I was gonna -- you can take a
8 manual pulse, can't you?

9 A: Yes, sir. You can.

10 Q: Okay. And EMT basis can be do manual pulses,
11 right?

12 A: They're trained to. Yes, sir.

13 Q: So if that --- Ms. Aiken started to see that
14 patient exhibit signs of, you know, increase
15 pulse rate ---

16 A: Uh-huh.

17 Q: --- she can James, the patient's pulse is
18 changing, right?

19 A: She could, yes.

20 Q: Okay. In fact, she had duty to do that. If
21 there's a change in the vital signs, the basic
22 needs to tell the paramedic?

23 A: I would hope she would, yes, sir.

24 Q: And if that were the case, then Mr. Davenport
25 to pull the truck over in a safe position and



1 switch places with Ms. Aiken. Isn't that
2 right?

3 A: Not best practice but he could. Yes, sir.

4 Q: Okay. But that's what the policy in Anderson
5 County says he could do.

6 A: I don't ever think I said he violated this
7 policy. I said my in order that he
8 discontinued care of the patient on the scene
9 and did not provide for a high level of care.

10 Q: Okay. But the patient didn't need a higher
11 level of care.

12 A: It -- that's why we're -- that's why we're
13 here. I -- I believe that that patient did.

14 Q: All right.

15 A: I absolutely believe that, sir.

16 Q: And I wanna ask you to turn to page 125 of the
17 Anderson County policy.

18 A: Yes, sir.

19 Q: And Mr. Davenport reminded me, these policies
20 are submitted to DHEC, aren't they?

21 A: They are.

22 Q: Any they are approved by DHEC, right?

23 A: We don't approve them. We just check to make
24 sure they don't exceed what the State allows.

25 Q: All right. This is the non-paramedic transport



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

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

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

8 A: I don't believe so.

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

16 A: Yes, sir.

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

20 A: No dispute.

21 Q: Okay. And then it says, if the technician
22 determines that the patient is stable, then all
23 patients care needs can be manage by the lower
24 level provider. Patient care can be
25 transferred to a technician of lower



1 certification for care while en route to the
2 hospital. You see that?

3 A: Yes, sir.

4 Q: That's what happened in this case, isn't it?

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

6 Q: Bullet four. Mr. Davenport ---

7 A: Yes, sir.

8 Q: Is the technician on the scene.

9 A: Uh-huh.

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

12 A: Yes, sir.

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

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

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

22 A: The ones you just read.

23 Q: But Mr. ---

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



1 Q: What is a subjective interview?

2 A: It's when you can obtain subjective, objective
3 to -- there's a -- they're medical terms in
4 which you obtain a subjective interview. Takes
5 a subjective interview of the patient by
6 subjective ---

7 Q: What's the difference between subjective and
8 objective?

9 A: You mean?

10 Q: What is the different -- do you understand the
11 difference between something that's subjective
12 versus something that's objective?

13 A: Yes. It's what see and feel. What you -- what
14 you can determine without getting too deep into
15 what's going on.

16 Q: Okay. Subjective is from the point of you, the
17 paramedic on the scene assessing that patient,
18 right?

19 A: Yes, sir.

20 Q: Okay. And Mr. Davenport, you saw him in the
21 video talk to the patient for, I don't know,
22 two or three, four minutes before they stood up
23 and walk out the bank to the ambulance?

24 A: I would not call that a subjective evaluation
25 of a patient, sir. No.



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

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

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

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



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

4 Q: How many times did you review the video?

5 A: Five or six.

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

7 A: Today. I listened to it today.

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

10 A: A couple days ago.

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

15 A: Yes, sir.

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

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

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



1 screen or were you looking at it on a ---

2 A: I didn't -- never watched it on a phone size
3 screen. Its been a computer screen or the tv's
4 in this room.

5 Q: Wasn't there some interaction in the video
6 about Mr. Davenport -- some interaction about
7 whether Mr. Davenport -- whether the patient
8 had to go to the hospital to have the knife
9 removed?

10 A: Yes.

11 Q: And that occurred after the idiot comment,
12 right?

13 A: Yes.

14 Q: Okay. And remember the patient was hesitate to
15 go to the Operating Room, right? He said, you
16 mean I gotta go to the OR to get this taken
17 out? You can't take it out for me?

18 A: Right.

19 Q: And Mr. Davenport said, oh, I can take it out
20 but I'd lose my job, right?

21 A: Yes, sir.

22 Q: Okay. If Mr. Davenport took that knife out of
23 that patient and sutured him up like he
24 could've done if the patient were in
25 Afghanistan, that would be a clear violation of



1 his paramedic scope of practice ---

2 A: Yes, sir.

3 Q: --- as a civilian, right?

4 A: Uh-huh.

5 Q: He didn't do that?

6 A: He did not.

7 Q: Okay. He carefully pick the knife in place and
8 stabilized the knife. You agree that this was
9 an appropriate thing to do?

10 A: It was an appropriate treatment for that. Yes,
11 sir.

12 Q: Okay. And he spent some time conversing with
13 the patient. I know you don't agree with the
14 demeanor or the tone of his conversation or the
15 words that were used. But he talked to the
16 patient for several minutes.

17 A: He cursed at the patient. Yes, sir. But
18 again, I would agree he talked to the patient
19 but not in a manner that you should ever speak
20 to a patient, ever.

21 Q: And where is that writ- -- is that the protocol
22 that says, professionalism and courtesy?

23 A: In every textbook that you read when you learn
24 how to talk to patients. Yes, sir.

25 Q: Isn't that more of a aspiration thing in terms



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1 of paramedic service?

2 A: Not to me.

3 Q: Okay. Have you ever heard paramedics in your
4 experience in a firehouse or ER's use what you
5 would consider unprofessional or discourteous
6 language?

7 A: In a firehouse? Yes, sir. Not to a patient or
8 at a patient. As I stated previously, when we
9 hear somebody curse in front of a patient, not
10 even at the patient, we look down upon that.

11 Q: Okay. Well, did you see at the end of the
12 video, when Ms. Aiken was in the -- in the side
13 of the truck, the door -- well, side door of
14 the ambulance was open. And she uttered the
15 word shit.

16 A: Yes, sir. She did.

17 Q: And that door was open in front of the patient,
18 right?

19 A: Uh-huh.

20 Q: Have you taken any disciplinary action against,
21 I'm sorry, enforcement action against Ms.
22 Aiken's paramedic -- EMT basic certificate?

23 A: No, we have not.

24 Q: Okay. But under your definition, she was
25 unprofessional when she used the word, shit, in



1 the presence of the patience, right?

2 A: I said we frown upon that when you say it in
3 the presence of a patient.

4 Q: But I thought you said that that was a standing
5 order because it said, demonstrate,
6 professionalism and courtesy.

7 A: Okay. Yes.

8 Q: That's not a standing order. That's a
9 protocol, isn't it?

10 A: I'll have to look at the page to verify that,
11 sir. I'm not sure which one it would fall
12 under at this point. But she was not in front
13 of the patient. She was outside the patient.

14 A: But the door was open, right?

15 Q: I believe it was at that point. When she was
16 standing outside, there were two Police
17 Officers inside, I believe, at that point or
18 one at least and her outside.

19 Q: Okay. Do you remember in the video where Mr.
20 Davenport had just put the patient to the back
21 of the compartment. And the door was open.
22 There's some discussion about who was gonna
23 ride in the call.

24 A: Yes, sir. There was.

25 Q: Okay. And I think somebody came in and Ms.



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

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

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

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

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

11 A: Police might. But we don't.

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

14 **MR. DAVENPORT:** 1086.

15 Q: 1086 ---

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

17 Q: Okay. And did you hear him say, oh wee, he
18 1086 crazy?

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

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

23 A: In front of the patient? Yeah.

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



1 A: I don't know if the patient heard it. I know
2 the patient heard what Mr. Davenport said to
3 him.

4 Q: Okay. Well if I remember correctly, at the
5 interview we listened to, somebody made the
6 comment that the Police Officer gave better
7 care or was more compassionate with a patient
8 then Mr. Davenport.

9 A: Towards the patient. Yes, sir.

10 Q: Okay.

11 A: I believe that comment was made.

12 Q: You believe that's just the meaning to say, oh
13 wee. Somebody -- that guy's crazy. 1086
14 crazy?

15 A: I don't have any jurisdiction over that Police
16 Officer.

17 Q: Well, why would you compare Mr. Davenport's
18 language in assessing this patient to the cop's
19 language?

20 A: Because he was the primary patient care giver
21 at that point. Not the Police Officer. But
22 the Police Officer was much more compassionate
23 to that patient than Mr. Davenport was.

24 Q: Well, the Police Officer coddled him. Would
25 you agree with that?



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

7 Q: Okay. You remember ---

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

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

17 A: Yes, sir.

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

22 A: Yes, I do.

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

25 A: Yes, sir.



1 Q: And the cop said, I am a nice guy.

2 A: Uh-huh.

3 Q: And he said, don't make me be bad guy.

4 A: Right.

5 Q: Okay. That's like talking to a -- to a six
6 year old child, isn't it?

7 **MR. WICEVIC:** Your Honor, I'm going to object. This
8 is going off the subject, what the Police
9 Officer did.

10 **MR. ROTHSTEIN:** Well Your Honor, he just said that
11 the Police Officer showed more compassionate
12 and care to the patient that Mr. Davenport did.
13 And -- I mean, I think talking somebody to like
14 they are a six year child is not compassionate
15 and caring.

16 A: The Police Officer at that point could've
17 immediately handcuff that patient, but he did
18 not. So he just let him know he did not want
19 to be the bad guy. I'm speculating, but he
20 could've immediately handcuff that patient he
21 wanted to and he did not. So yes, he was more
22 compassionate. By talking him out of it first.
23 That's my belief not a fact.

24 **MR. ROTHSTEIN:** Beg The Court's indulgence for one
25 minute. I may be about finish.



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

3 A: Yes, sir.

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

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

11 THE COURT: What's the purpose of that question, Mr.
12 ---

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

24 THE COURT: If there was an investigation.

25 Q: You recall handling an investigation about



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

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

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

15 A: Yes, sir. We did.

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

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



1 Q: And did you convene an Investigative Review
2 Committee?

3 A: We did not.

4 Q: Okay. Did you offer Mr. Stoller a consent
5 order?

6 A: We did not.

7 Q: How long did your investigation of Mr. Stoller
8 take?

9 A: A month or so.

10 Q: No further questions.

11 A: May I? We did asked Mr. Davenport to come and
12 give a statement. He did not.

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

15 **THE COURT:** Okay. Thank you.

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

17 Q: Okay, Mr. Wronski. Just a few follow up
18 questions for you.

19 A: Yes, sir.

20 Q: Can you explain to The Court, your strategy
21 going into an interview.

22 A: Every interview is different. We have
23 different strategies that we go in with.

24 Q: What's your ultimate goal?

25 A: The ultimate goal is to ---



1 **MR. ROTHSTEIN:** Your Honor, this is asked and answer.

2 He asked that on direct. I was just
3 emphasizing what the ultimate goal was.

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

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

9 **Q:** What's his role at the Department.

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

12 **Q:** Okay. Why was Mr. Naugler present?

13 **A:** He was the lead investigator.

14 **Q:** Why was Ms. White present?

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

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

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



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

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

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

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

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

16 Q: When they have not consult counsel?

17 A: Absolutely.

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

20 A: Yes, sir.

21 Q: Can you explain that?

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



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

6 Q: Are you still working on that process?

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

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

13 A: No patient care issues, no.

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

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



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

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

11 A: Minimum, very minimum.

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

14 A: Yes, sir.

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

17 A: Discontinuation ---

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

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

23 Q: Well let's turn to the policies.

24 A: Sure.

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



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

2 MR. WICEVIC: 89.

3 THE COURT: 89.

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

6 A: Yes, sir.

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

9 A: Yes, sir.

10 Q: Second sentence, paragraph four.

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

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

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

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

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

25 A: Yes, sir.



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

3 A: Yes.

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

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

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

20 **THE COURT:** What was your question, please.

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

25 **THE COURT:** Okay. You can ask the question.



1 Q: Mr. Wronski.

2 A: One more time please. I'm sorry, sir.

3 Q: Under policy 26, it says the following patients
4 cannot be transferred to the lower level
5 certification.

6 A: Yes, sir.

7 Q: Are any of those listed patients applicable to
8 the is matter?

9 A: There's -- there's definite and one probable.
10 The one definite is, one, two, three, four,
11 five, six, seven -- seven down. That's
12 applicable here because the crew member did
13 express discomfort when assuming care of the
14 patient. She asked if it should have been an
15 ALS patient and he said, you're fine.

16 Q: Have you read through all of them?

17 A: Oh, yeah. The line above it. The patient has
18 received ALS intervention. The patient should
19 have received ALS intervention, but they did
20 not.

21 Q: Any others?

22 A: One more time. The one above it, slightly. I
23 mean there -- there applicability too even the
24 last one. Paramedic test to rule out pathology,
25 so when checking the skin color temperature,



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

6 Q: Okay.

7 A: Yes, sir.

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

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

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

17 **THE COURT:** If it is not permanent, they can reapply
18 ---

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

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

22 **MR. WRONSKI:** They can petition for ---

23 **THE COURT:** --- to receive the license.

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

25 **THE COURT:** Credentials.



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

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

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

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

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



1 completed that.

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

5 **MR. WRONSKI:** Yes, ma'am.

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

9 **MR. WRONSKI:** That meeting, we have not made any
10 changes, but from the first one to the second
11 ---

12 **THE COURT:** Okay.

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

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

23 **MR. WRONSKI:** Yes, ma'am.

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



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

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

12 **THE COURT:** Okay.

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

17 **THE COURT:** Okay.

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

25 **THE COURT:** Okay. Okay. Thank you.



1 MR. WRONSKI: Thank you.

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

4 MR. WICEVIC: Yes, Your Honor.

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

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

8 THE COURT: Okay Mr. Rothstein.

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

11 THE COURT: Uh-huh.

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



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

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

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

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

21 **THE COURT:** Uh-huh, yeah.

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

24 **THE COURT:** Yes.

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



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

5 **THE COURT:** Yeah. I -- yeah.

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

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

14 **MR. WICEVIC:** Right.

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

16 **MR. WICEVIC:** Right.

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

20 **MR. ROTHSTEIN:** Right.

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

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



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

2 **MR. WICEVIC:** Yeah, I will.

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

5 **THE WICEVIC:** Yes, Your Honor.

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



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



1 diverted motion if they hadn't gotten the ball
2 past the 50, your case over and we win. Here,
3 there's no need for us -- and I appreciate Your
4 Honor's patience sitting here all day. I
5 really thought case would take three -- three
6 days to present the entire case. We're here on
7 day four, and we just finished DHEC case in
8 Chief. I think I can get my entire defense
9 case on in less than a day and a half. But I
10 don't think it's necessary for us to do
11 anything because at the end of this first
12 period, they haven't gotten the ball near the
13 50 yard line. And, Your Honor, in typical, I
14 do a lot of jury trials. Well, not a lot of --
15 no jury trials are tried very much anymore.
16 But then a trial standard for a directed
17 verdict is, you have the Judge kind of like the
18 referee in the middle of a field. And if it's
19 a close call about whether the -- the plaintiff
20 was carrying the burden of proof, you can call
21 out the jury. What's the -- the chain referees
22 that have that ten yard chain to see if they go
23 a first down. And if that ball is ever so
24 slighted to even touching that chain, you gotta
25 deny your motion -- the motion for directed



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



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



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



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



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



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



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



1 ambulance door or the am- -- the ED door
2 closes, Mr. Davenport and Ms. Aiken go clean up
3 the rig and -- we don't know what happened in
4 that ER between the time they dropped him off
5 and he reported that his pain was a nine.
6 There's a lot of dressing and tape on that
7 knife. If the -- it the ER doctor starts
8 looking up the knife to see how bad the wound
9 is and rips off that tape and pull hair with
10 it, I mean, that's gonna hurt. Maybe that will
11 explain what -- why there was a nine. There
12 was -- but there's -- there's no doubt that
13 this patient was stabled. And that's a
14 judgment that Mr. Davenport can make on the
15 scene. The fact that some of these other guys
16 that haven't ridden an ambulance in 20 or 30
17 years, may have treated this patient
18 differently or put him on oxygen, O2 IV
19 monitor, has nothing to do with whether Mr.
20 Davenport provided appropriate care of this
21 patient. So, they can't win on the issue of
22 appropriate treatment. This patient -- all
23 three of the patients that we talked about had
24 good outcomes. Okay. Nobody had a worsen
25 condition from the treatment they received from



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



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



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



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



1 asking for -- show me what I did wrong on March
2 the 30th, he never got a response. So they
3 never gave him an opportunity to document what
4 he did in this case. The first meeting they
5 had in -- in Anderson County was on Friday, the
6 25th of March, 2016 when Mr. Davenport. You
7 recall the -- for some testimony that Mr.
8 Stoller, Dr. Kickham, met with James Davenport,
9 in morning, actually it was after. They met
10 with Kim Aiken first. And they hadn't told Mr.
11 Davenport why he was suspended -- I mean
12 specifically why he was suspended except -- the
13 letter just says, we gotten some concerns.
14 You're hereby suspended until further notice
15 pending an investigation. Two days later,
16 bring Mr. Davenport to get his side of the
17 story. That's the first time Mr. Davenport was
18 given an opportunity to even to know what three
19 case they're talking about. They have the
20 elderly gentlemen from the nursing home that
21 had a low systolic reading -- systolic reading
22 of his blood pressure. They had the pediatric
23 seizure patient and then the had the stabbing
24 patient. Well, the significance of the two --
25 well they -- I think Mr. Wronski said -- were



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



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



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



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



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

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



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



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



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



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



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



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



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



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



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

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

13 **MR. ROTHSTEIN:** Okay.

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

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



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

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

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

15. **THE COURT:** Okay.

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

17. **THE COURT:** Okay. Mr. Rothstein?

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

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

23. **LEO DEASON,** having been duly sworn, testifies as
24. follows:

25. **MR. DEASON - DIRECT EXAMINATION BY MR. ROTHSTEIN:**



1 Q: Good morning, Mr. Deason.

2 A: Good afternoon.

3 Q: Can you state your name for the record, please.

4 A: Leo Jack Deason.

5 Q: Okay. Where are you from, Mr. Deason?

6 A: Birmingham, Alabama.

7 Q: What do you do for a living?

8 A: I have two different living, no three. One I
9 make firefighter paramedic. I'm with -- coming
10 up on 25 years. I'm also a EMS program chair
11 for a EMS program in Birmingham. Recently
12 credited, non-profit private university. And
13 I'm also in the military.

14 Q: I want to had you -- we marked as Exhibit 22.

15 A: Yeah.

16 Q: You recognize that document?

17 A: Yes, sir. I do.

18 Q: And is that a copy of your current curriculum
19 vitae?

20 A: Yes, sir.

21 MR. ROTHSTEIN: Your Honor, move Exhibit 22 in
22 evidence.

23 MR. WICEVIC: No objection, Your Honor.

24 THE COURT: Okay. It's entered.

25 (Respondent's Exhibit Number 22 was admitted into



1 evidence.)

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

4 A: Yes, I am.

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

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

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

13 A: Yes, sir.

14 Q: --- through that time.

15 A: Yes, sir.

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

18 A: No, sir.

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

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

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



1 paramedicine?

2 A: Yeah, we have -- we have a lot of trauma in
3 Birmingham, in the Homewood area. We have a
4 lot, you know, kind of penetrating traumas,
5 stabbing, that type of stuff. We have a lot of
6 crime in our area. A lot -- lot of overdoses,
7 also. A lot of heroin usage right now.

8 Q: Okay. Kind of describe the school you worked
9 with or for in Birmingham?

10 A: Yes, sir. I worked for Herzing University.
11 There are 11 campuses across country. We
12 originally accredited with North Central
13 Association out of Wisconsin in that are. It'
14 liked Michigan, Wisconsin and all that. The
15 reason is that's where the home office is. I
16 started the paramedic program seven years ago.
17 We started out with five students. And I have
18 the largest in Alabama.

19 Q: What is your school's philosophy about treating
20 or training paramedics and EMT?

21 A: Our philosophy, we train to the national
22 standard.

23 Q: Okay. You been here for a couple of days and
24 do you still teach 02 IV monitor?

25 A: No, sir.



1 Q: And how has that been obsolete for awhile?

2 A: At least seven years. At least since 2010
3 since I got into the education program.

4 **MR. ROTHSTEIN:** Okay. Your Honor, I tendered to
5 offer Mr. Deason as a expert in emergency
6 medical education the standards of care of --
7 a certified national register and certified
8 paramedic.

9 **MR. WICEVIC:** May I voir dire?

10 **THE COURT:** Yes.

11 **MR. DEASON - VOIR DIRE BY MR. WICEVIC:**

12 Q: Good afternoon, Mr. Deason My name is Vito
13 Wicevic.

14 A: How are you?

15 Q: Doing well. It's kind of late in the
16 afternoon. I'm a little tired. I might tongue
17 tied.

18 A: I gotcha.

19 Q: If I say something you don't understand just
20 let me know.

21 A: I will.

22 Q: So you have a significant experience in the
23 military. First of all, thank you for your
24 service.

25 A: You're welcome.



1 Q: Let's focus on your care EMS experience?

2 A: Okay.

3 Q: So, you have your CV in front of you?

4 A: Yes, sir. I do.

5 Q: Okay. Perfect. Well, it looks like you
6 received your bachelors of the science degree.

7 A: Under education? Yes, sir.

8 Q: You got it? I'm going to -- so, it looks like
9 you received your bachelor of science and your
10 criminal justice and psychology. No
11 relationship of ---

12 A: None.

13 Q: --- EMS? Associates degree in applied of
14 science. Fire Science?

15 A: Fire science. Yes, sir.

16 Q: That doesn't relate to pre-hospital care, does
17 it?

18 A: First responders falls under fire science.

19 **MR ROTHSTEIN:** Your Honor ---

20 A: So yes, it would.

21 **MR. ROTHSTEIN:** --- I mean, this is gonna take -- he
22 put his case on four days. I've got a day and
23 a half to my case my done. If he wants to go
24 back to this gentleman's undergraduate, we're
25 just wasting time. I mean, if he wants to voir



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

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

9 **THE COURT:** Okay. You can go on.

10 **MR. WICEVIC:** Okay.

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

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

18 **A:** Yes, sir.

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

21 **A:** Yes, sir.

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

24 **A:** Yes, sir.

25 **Q:** '96 you obtain your paramedic and PRMT?



1 A: That's right. I was in intermediate also.

2 Q: Okay.

3 A: Yeah.

4 Q: You're currently in the Army, correct?

5 A: Yes, sir.

6 Q: When did you join the Army?

7 A: '87.

8 Q: How often during this time period, I guess,
9 from '94 to present were off on obligations?

10 **MR. ROTHSTEIN:** Your Honor, this has nothing to do
11 with his qualifications. Whether he's in the
12 Army or was deployed somewhere had nothing to
13 do with whatever he's ...

14 **THE COURT:** Mr. Wicevic, how does that relates to his
15 qualification?

16 **MR. WICEVIC:** Well, if he's -- he's off on military
17 duty, he's not practicing civil paramedicine.
18 He's not doing civil pre-hospital care. I
19 think it's -- I mean, if he's not practicing,
20 that goes his experience which is relevant to
21 making your determination as to his
22 qualification as a witness.

23 **THE COURT:** Okay. You can answer his question.

24 A: The total, 48 months, since 1994.

25 Q: 1994? That's nothing.



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



1 tactical medics on squad teams.

2 Q: Okay.

3 A: It's for civilian paramedics. Yes, sir.

4 Q: So your 24 years of fire rescue, correct?

5 A: Yes, sir. Coming up on 25 years.

6 Q: Now substantial part of that does not have to
7 deal with patient care. Is that correct?

8 A: No. I ride an ALS fire truck, sir.

9 Q: Okay. But -- okay. Firearm truck, correct?

10 A: Yes, sir.

11 Q: Your duties at Homewood. They maybe focused
12 firefighting?

13 A: No. It's mainly -- 80 percent of our calls are
14 EMS.

15 Q: Okay.

16 A: That's a statistic. A known statistic.

17 Q: Well, it does look like you had supervisor
18 position?

19 A: Yes, sir.

20 Q: How often you get out in the field?

21 A: I'm in the field every -- every third day.

22 Q: Every third ---

23 A: I ride only in fire truck. Yeah. And the way
24 Alabama works, me being a senior medic with
25 those license. I am with a medic on every



1 call.

2 Q: Okay.

3 A: So I run five to ten calls a day, every third
4 day.

5 Q: Every third day?

6 A: Yes, sir.

7 Q: Okay. Are Homewood Fire and Rescue Service and
8 also the McCalla Fire District, are they
9 licensed services?

10 A: Yes, sir. Yes, sir.

11 Q: Now it's my understanding they're not
12 transporting services.

13 A: Right. We don't transport.

14 Q: So you don't transport patients?

15 A: But we're ride in with them. We -- we continue
16 care of them.

17 Q: So would you be aboard another license
18 ambulance service?

19 A: Yes.

20 Q: And would you be a subject to the -- those
21 Medical Control Physicians ---

22 A: No.

23 Q: --- protocols?

24 A: If we maintain the patient contact, then it, --
25 it stays as our care under our physicians.



1 Q: Okay.

2 A: Yes. That's Alabama state law. The way -- way
3 it works, the City of Homewood owns a
4 jurisdiction for EMS. The transport company is
5 a private transport that we only use to
6 transport patients.

7 Q: Yeah.

8 A: But if we have an ALS call, then we have to
9 continue care.

10 Q: Okay.

11 A: A medic -- one of our medics or myself would
12 ride in.

13 Q: I understand. Okay. I see that you're also
14 part of Alabama EMS Association?

15 A: Yes, sir.

16 Q: Is that just pay a fee and you're a part of it?

17 A: Pretty much. But we have a voice in protocol
18 for the state of Alabama. I'm actually the
19 vice chair of the EMS education division. So
20 we help -- we help develop protocol in the
21 state of Alabama. We have a voice.

22 Q: Now have you ever been sued for malpractice?

23 A: No, sir.

24 Q: You said you never subject to disciplinary
25 action but an -- an employer?



1 A: No, sir.

2 Q: Okay. Now you're not certified as a South
3 Carolina EMT. Is that correct?

4 A: No, sir.

5 Q: Okay. You're not familiar with the standard
6 practice here in South Carolina. Is that
7 correct?

8 A: No. All I know is they follow the national
9 registry.

10 Q: That's correct. You are familiar with practice
11 in Alabama, correct?

12 A: No. I'm national standard. I'm a national
13 registry EMT representative.

14 Q: Okay. So the national standard and then
15 Alabama?

16 A: Yes, sir.

17 Q: Now, EMS practice varies significantly by
18 state, correct?

19 A: It varies based on legislation.

20 Q: Right.

21 A: Yes, sir.

22 Q: I mean, Alabama standards are completely
23 different than South Carolina's. Is that
24 correct?

25 A: I can't really tell you that. I don't ...



1 Q: 'Cause you're not familiar with South Carolina,
2 correct?

3 A: This correct.

4 Q: Alabama has a set of protocols that are
5 developed by their Alabama Department of
6 Health, their office of EMS, correct?

7 A: It's advisory boards.

8 Q: Okay.

9 A: Yeah.

10 Q: And are all EMT's in the state -- and when I
11 say EAT's I'm talking ---

12 A: I know what you're saying.

13 Q: --- they're all subject to that protocol,
14 right?

15 A: Yes, sir.

16 Q: Okay. We are you aware ---

17 A: Except -- except flight medics. Flight medics
18 are not.

19 Q: Okay. Do you understand here in South
20 Carolina, EMT's protocols, they are required to
21 comply with, vary by agency?

22 A: Yes, sir. There are some states that do that.
23 Texas does the same, so does California.

24 Q: Okay.

25 A: It's not an uncommon practice.



1 Q: Right.

2 A: And it can -- it can go by jurisdiction also.

3 Q: Okay.

4 A: Alabama just falls under one umbrella.

5 Q: And your teaching responsibilities at Herzing.

6 It appears that you're the department chair.

7 Is that correct?

8 A: That is correct.

9 **MR. ROTHSTEIN:** Your Honor, the purpose of voir dire
10 is to challenge the expert's credentials, not
11 to establish the expert's credentials. All Mr.
12 Wicevic is doing is reading his CV. This is
13 gonna take another hour if he wants to go
14 through everything in the CV. I'm trying to
15 move this along and get this finish this week,
16 Your Honor.

17 **MR. WICEVIC:** I am too, Your Honor. I'm just trying
18 to understand his qualifications. If he wants
19 to be qualified as an expert in education, I
20 think I have a reason to explore his actual
21 instruction within the university that he
22 works. My understanding is department chairs
23 don't do a whole lot of instruction, so I think
24 I'm well within my bounds to inquire ---

25 **THE COURT:** Yeah. But you need to move it along.



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1 MR. WICEVIC: Okay. Yes, Your Honor.

2 Q: The periods that you served as department
3 chair.

4 A: Yes, sir.

5 Q: What are your teaching responsibilities?

6 A: I teach at least 15 hours a week.

7 Q: 15 hours a week?

8 A: Yes, sir.

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

11 A: Seven.

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

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

15 Q: Okay.

16 A: Several years ago.

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

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

21 Q: And that's ---

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

24 Q: Let me ask the question.

25 A: Oh, okay.



1 Q: So medical training within the services, that's
2 in-service training, correct?

3 A: It's certification courses.

4 Q: Is it in-serviced training for your agency?

5 A: No. They don't require that. ACLS and BLS are
6 not required of the agency.

7 Q: Okay. So they're kind of continuing education.

8 A: Continuing education.

9 Q: Okay.

10 A: For national registry. If you deem you want
11 teach those right.

12 Q: When was the actual associates degree in the
13 EMS program establish that Herzing?

14 A: When I started.

15 Q: Okay. And you said you had five students ---

16 A: We started with five EMT students. Yes, sir.

17 Q: Okay.

18 A: And I got 125 paramedics.

19 Q: So it's EMT's and paramedics.

20 A: And paramedics. Yes, sir.

21 Q: What about the other

22 A: We did advanced EMT for awhile. Kind of like
23 Mr. Douglas said, we really didn't find a need
24 for it in our area. It's an optional
25 instructional base ---



1 Q: Yeah.

2 A: You know it helps in rural areas maybe,
3 volunteer services. They can do a little
4 extra. But it -- we don't -- we go for EMT and
5 paramedics. And it's five total semesters.
6 One for EMT and then four for paramedic.

7 Q: Okay.

8 A: With 600 hours of rotations.

9 Q: Now have you provided patient care to patient
10 with impaled abdominal injury?

11 A: Yes, sir.

12 Q: Okay. About how many times?

13 A: I can't tell you really how many times. We
14 have a -- I've had people shoot themselves in
15 the stomach with nail guns. I'm had rebar.
16 I've had pencils. I've had knives. So, a few
17 over the 25 years.

18 Q: Okay. When was the last time?

19 A: The last time has probably been about eight
20 years ago.

21 Q: Eight years. Okay. Now you've never been
22 qualified as an expert in the pre-hospital care
23 education field, have you?

24 A: No, sir. Not in a courtroom, no.

25 Q: What's that mean? Have you been retained to



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

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

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

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

17 **MR. WICEVIC:** Thank you.

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

20 **MR. WICEVIC:** Thank you, Your Honor.

21 **MR. DEASON - DIRECT EXAMINATION BY MR. ROTHSTEIN**

22 **(CONT.):**

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

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

25 Q: Can oxygen be dangerous?



1 A: Yes, it can.

2 Q: Have you ever heard of oxygen being used as a
3 pain relief therapy in pre-hospital patients?

4 A: I have not

5 Q: You heard Mr. Wronski -- were you here -- you
6 were here for Mr. Wronski's testimony.

7 Q: Yes, sir.

8 A: When he said -- I asked him that question, he
9 said, just ask a patient with a heart attack if
10 oxygen is a pain reliever. Something along
11 this lines. You recall that testimony?

12 A: I did. I heard.

13 Q: Okay. Do that catch your attention in anyway?

14 A: It did.

15 MR. WICEVIC: Your Honor, I'm going to object to
16 pitting witness about something that's not even
17 related, heart attacks. Is that correct?

18 THE COURT: The objection is overruled.

19 Q: And why did that catch your attention, Mr.
20 Deason when Mr. Wronski said something about
21 using oxygen with heart attack patients?

22 A: American Heart Association has -- and let me
23 qualify. The primary heart Association is what
24 the national registry standard goes by.
25 They're influence. So, we -- we've ben giving



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

18 Q: Okay.

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

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



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

3 A: Just a few hours really.

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

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

8 Q: Okay.

9 A: --- medical also.

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

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



1 what I already knew.

2 Q: Okay.

3 A: And he concurs.

4 Q: All right. Let's focus on this particular
5 case. Have you seen the video -- the body
6 camera video in this case?

7 A: Yes, sir. I have.

8 Q: Okay. How many times did you watched the
9 video?

10 A: Only two times.

11 Q: Okay. When you watched the video, were they --
12 was it the same. I mean, did you do anything
13 different from one viewing?

14 A: First time I watched it, I watched without
15 sound.

16 Q: Without sound?

17 A: Yes, sir. Without sound.

18 Q: Why did you watched the video without sound
19 first?

20 A: I wanted to watch it objectively without the
21 emotion of being involved in it.

22 Q: Okay. And when you saw it the first time
23 without sound, did you see anything that caused
24 you any concerns?

25 A: No, sir.



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

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

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

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

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

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

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



1 A: I didn't hear him.

2 Q: Have you ever heard that in a anatomy or
3 physiology course?

4 A: No. They're attached by ligaments.

5 Q: Are you familiar with a different organs that
6 are in the left upper quadrant of the abdomen?

7 A: Yes, I am.

8 Q: Okay. Are there more then the three that Mr.
9 Douglas mentioned?

10 A: You got the pancreas, you got the spleen. You
11 got your colon -- small intestine. Part of the
12 liver goes up toward the left. It's mainly
13 underneath the rib cage. The liver is pretty
14 well protected by the ribs.

15 Q: Are you familiar with this? I'm going to hand
16 you international trauma life support for ---

17 A: Yes, sir.

18 Q: --- emergency care. Are you familiar at all
19 with that publication?

20 A: Yes, sir. Actually, Dr. Campbell who wrote
21 this was our State Medical Director.

22 Q: For Alabama?

23 A: Yes, sir.

24 Q: Is that book used, to your knowledge in
25 national registered paramedic EMS for paramedic



1 training courses?

2 A: It is an optional tool, it's optional. It's
3 not required in -- we teach it in Herzing, yes.

4 Q: Okay. Do you -- have you use that book before
5 in your ---

6 A: Yes, sir.

7 Q: Okay. Is it a generally accepted learned
8 treatise in the area of pre-hospital training
9 and care?

10 A: Yes, sir. It's one of them.

11 Q: Do you recognize that diagram?

12 A: Oh, yes.

13 Q: What is the retro peritoneal abdomen?

14 A: That's -- that's the area right here that we're
15 talking about. Right to the stomach. Inside
16 of it.

17 Q: Inside the stomach?

18 A: Stomach. Back toward the spine area.

19 Q: What causes most death in a abdomen trauma in
20 your experience?

21 A: Depends on what it hits. If it hits the liver,
22 it's got a be hemorrhage.

23 Q: And let's say it doesn't hit a vital organ.

24 A: It's gonna be an infection.

25 Q: Okay. What type of infection are typically



1 caused by abdominal traumas?

2 A: The bowels dumping into it.

3 Q: Okay. Is there anything a paramedic can do
4 from the time he arrives on the scene until the
5 patient is transported to the Emergency
6 Department in an abdominal trauma to cure an
7 infection?

8 A: No. No, sir.

9 Q: How are infect -- or potential infections
10 treated with abdomen trauma patients?

11 A: Antibiotics is all I know.

12 Q: Okay. And do you know -- are those antibiotics
13 typically started in the field or they
14 typically started at the hospital?

15 A: No. They would be at the hospital.

16 Q: Okay.

17 A: Under physician's care.

18 Q: All right. Tell me about the second time you
19 viewed the video of this care of this
20 particular patient.

21 A: Yes. The second time I viewed it with the
22 sound bite sound audio.

23 Q: Okay. Did anything about Mr. Davenport's
24 interactions with the patient caused you any
25 concerns about Mr. Davenport's care for that



1 patient?

2 A: Not for the care of the patient, no.

3 Q: You reviewed the patient care report or the run
4 report that was prepared in this case?

5 A: I did. I did.

6 Q: Okay. Could you tell by looking at the
7 patient's vital signs of whether or not the
8 patient in your expert opinion was stable at
9 the time that Mr. Davenport arrived on the
10 scene?

11 A: Yes, sir. He was stable.

12 Q: Okay. In your professional opinion was Mr.
13 Davenport, I mean, was the patient stable at
14 the time they place the patient to the back of
15 ambulance?

16 A: Yes, sir.

17 Q: Okay. And based on your review of the records,
18 do you have an opinion to a reasonable degree
19 of medical certainty about whether the patient
20 was stable throughout the trip to the hospital?

21 A: Apparently, it seemed so.

22 Q: Okay. Do you treat -- I mean, I'm sorry. Do
23 you teach your students in Alabama how to move
24 patients?

25 A: It taught at EMT level.



1 Q: Okay. All right. Is moving patients in any
2 textbooks for ITLS?

3 A: I don't think so.

4 Q: Okay. And what are the typical ways that you
5 can -- they have available to move a patient
6 from the site of a trauma to a place where you
7 can transport them like the ambulance?

8 A: Oh, there's many ways. You got -- it depends
9 if they're stable, unstable or if they
10 ambulatory or not ambulatory. All that plays
11 into the factors.

12 Q: Okay. If a patient is ambulatory -- what does
13 ambulatory means?

14 A: They can walk.

15 Q: Okay.

16 A: They can walk with no risk to them or harm.

17 Q: Okay. You've seen the video again of the knife
18 being impaled and left in place. Have you ever
19 responded to a call like that where there's a
20 knife still stuck in the abdomen?

21 A: I have.

22 Q: Okay. And what's the most important thing to
23 do with regard to -- the position of that knife
24 position of that knife?

25 A: You gotta stabilize that knife.



1 Q: Okay.

2 A: The main thing is, don't allow the knife itself
3 it to move.

4 Q: Okay. You believe the use of any type of
5 improvised carrying device would be appropriate
6 with a patient with a knife impaled in his
7 stomach?

8 A: I wouldn't take a chance on it.

9 Q: Okay. You think a kitchen chair -- just grab a
10 kitchen from the house would be appropriate to
11 move this patient?

12 A: That is not appropriate.

13 Q: Okay. Does this patient need to be moved in a
14 seated -- like a fowler's position or ---

15 A: Oh, semi fowler's position?

16 Q: Semi fowler's position?

17 A: You move the patient which is best for the
18 scene in a situation, sir.

19 Q: And you're ---

20 A: You know, I move patients different ways all
21 the time. It depends on the patient and the
22 injury.

23 Q: So, in your professional opinion and to a
24 reasonable degree of medical certainty, did the
25 manner in which Mr. Davenport remove this



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

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

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

7 A: Absolutely.

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

10 A: Negative.

11 Q: Okay. Why not?

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

24 Q: Okay.

25 A: Walking the patient out is not a bad choice



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

4 Q: Okay.

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

12 Q: Okay.

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

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

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

24 A: Yes. I have one in my school.

25 Q: Okay. What is that device?



1 A: That's a -- that's a stair chair.

2 Q: Okay. And you can explain to The Court how you
3 go about using the stair chair properly?

4 A: You get a patient sitting there, who's not
5 ambulatory. You go to sit in it and strap the
6 top strap. You strap that across the legs and
7 you strap lower ankles on that stair chair.
8 That right there is what we call low bed stair
9 chair.

10 Q: Okay. Is that a fairly common stair chair?

11 A: It is. It's correct.

12 Q: I noticed that one didn't have the -- sort of
13 the railing or something. I think somebody
14 testified earlier that there are some stair
15 chairs that have a rail.

16 A: They got tracks. If you buy one that's called
17 the stryker. The stryker come two ways. It
18 comes with tracks or without tracks. It's --
19 without the tracks, it's \$1,500, and to put the
20 tracks on, it's \$1,500 additional. So it goes
21 to \$3,000 just for the tracks. I've seen a lot
22 of agencies use things 'cause they can't afford
23 the \$3,000 stair chair.

24 Q: Okay. Do you see this upper strap on this
25 particular stair chair? Where would that strap



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

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

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

6 A: It's close to it. Yeah.

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

11 A: Sure.

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

15 A: Correct.

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

20 A: Absolutely.

21 Q: Okay.

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



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

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

24 A: Not really.

25 Q: Okay.



1 A: Just what I've heard in here.

2 Q: Okay. Have you ever seen a standing order
3 where a Medical Control Physician has ordered
4 his people under his medical control not to
5 ambulate a patient?

6 A: No, sir. I've never seen that.

7 Q: Okay. When using the normal stretcher on the
8 back of the ambulance be an acceptable way to
9 move the patient -- the stabbing patient that
10 you saw in video? The stretcher from the
11 ambulance up the stairs.

12 A: No. You, no? You don't move the stretcher up
13 and down the stairs? That's -- it's in the
14 textbooks. That's everywhere. That's under
15 safety and most liability for ambulance
16 companies and all that. There -- they won't
17 allow them to move them up and down stairs
18 anyway. Too dangerous. And it exceeds
19 weight. What we're dealing with, we're dealing
20 with weight.

21 Q: Do you know how heavy an empty stretcher -- a
22 typical empty stretcher in an ambulance is?

23 A: About 100 pounds, probably.

24 Q: Okay.

25 A: It depends on the brand.



1 Q: Okay.

2 A: Yeah. Some are lighter than others, but yeah.

3 Q: Is it a -- like a range is what you say of
4 weights for ambulance stretchers that you've
5 encounter?

6 A: Yeah. Yes, sir. And some of them have battery
7 operated where they lift them up and down
8 because -- of course, biggest injury to all
9 medics and EMS personnel are back injuries.

10 Q: Okay.

11 A: So now you have these battery operated, and
12 they're hitting. Oh they're weighing 175
13 pounds probably just the stretcher. And the
14 standard is anything over 250 pounds, it takes
15 more than two people to move it.

16 Q: Okay.

17 A: If you're gonna do any lifting.

18 Q: What happens if the more people you add to
19 moving situation, what happens to the risk
20 factor involved in moving that patient?

21 A: Trippage.

22 Q: Okay.

23 A: Yeah. You got fall hazards. Too many moving
24 pieces.

25 Q: What about a back board. Would you given your



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

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

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

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

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

15 A: Yes, sir.

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

20 A: Yes, sir.

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

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



1 drops.

2 Q: Okay.

3 A: We're probably not gonna get them back.

4 Q: What happens first when a patient first
5 starting heading shock in your experience?

6 A: The first thing gonna happen, their heart rate
7 is gonna go up and their breathing is gonna up.

8 Q: Okay.

9 A: I could use medical terms but I mean, Yeah.
10 Heart rate goes up, breathing goes up. You
11 have anxiety. And when they start going in to
12 decompensated shock, the first thing that's
13 gonna go is altered mental.

14 Q: Altered mental?

15 A: Their -- yeah because they're not getting
16 enough blood going to the brain. So when they
17 become -- when they become -- say like this guy
18 with the knife in him. If he had got to the
19 point where he didn't know he had a knife in
20 him and what was going on, I would start
21 thinking he's moving altered mental. But this
22 guy, he had mental function the whole time.

23 Q: Okay. Do you teach EMT basics, how to interact
24 with patients to detect whether there's an
25 alteration of their status?



1 A: Yes, sir.

2 Q: Okay. Do you teach EMT basics how to monitor
3 blood pressure. I'm sorry, pulse and
4 respiration rate?

5 A: Yes, sir.

6 Q: Okay. Do you teach EMT basics to alert a
7 higher certified pre-hospital provider like a
8 paramedic if there's a change in any of these
9 vital signs?

10 A: Yes. There's -- there's always that step.
11 Anytime we need additional resources, we call
12 for them. And that would be an EMT basic when
13 -- if they realize they can't handle what they
14 have in they call for additional resources
15 which means a higher level of care. Or it
16 could mean hazmat. It could mean fire service.
17 It could be extrication. Anything they can't
18 handle, the first thing they need to do is, I
19 need additional help.

20 Q: Okay. If a paramedic has difficulty starting
21 an IV on a patient who needs fluids or needs
22 treatment for -- to head off the effects of
23 shock and they can't get an IV start on, are
24 there mechanisms to provide some fluid to that
25 patient?



1 A: Yes, sir.

2 Q: What is the -- the standard for rapidly
3 infusing fluid in the patient where you can't
4 start an IV?

5 A: We can do a interosseous.

6 Q: Okay. What is interosseous?

7 A: Interosseous, there's methods you can use or
8 different devices. They're really not methods.
9 Basically we put the catheter into one of your
10 bone, and we're able to infuse fluid or
11 medication through your bone. We can do the
12 tib-fib. We can do femurs in small children.
13 You can do the humerus up here. And basic --
14 there's three different devices right now that
15 I know we use and that we teach. Well, we
16 can't use them all right now, but we teach
17 them. The EZ-IO drill. It look like a Dewalt
18 drill and I can punch this into your shoulder
19 and I can drill and put a catheter into your
20 humerus. It's a very quick method. It takes
21 about -- I can do it like 10 to 15 seconds,
22 initiate an IV. If I can't get an IV catheter
23 started in a vein. The other one is Fast. Fast
24 goes in your manubrium right here. The
25 military really use the Fast one. The Fast one



1 is probably the best device out there. Most
2 people don't buy them because they cost around
3 \$275 each. There are expensive. But they
4 interfere with nothing and they are the closest
5 to all your vital organs, it's got the shortest
6 route to get into your systems. The other is
7 called a bone injection gun. Bone injection
8 guns, I've used them where it acts as a spring
9 loaded -- it's almost like a ram set. You know
10 what a ram set is. But long story short, you
11 put it against your shin bone and we can shoot
12 it in and it'll put a catheter inside your bone
13 marrow. And then we can infuse you.

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

16 A: Yes, sir. They are required.

17 Q: Okay. Is that an ALS skill?

18 A: Yes, sir.

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

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



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

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

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



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

3 A: I have not.

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

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

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

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

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

16 A: What I remember him saying. Yeah.

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

22 A: I do. There was no harm.

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



1 A: Yes, sir.

2 Q: Okay. Do you know Mr. Davenport personally?

3 A: Me and Mr. Davenport have business
4 transactions.

5 Q: Okay. And by business transactions, can you
6 explain to The Court what you mean?

7 A: Yeah. I heard of Mr. Davenport through a
8 mutual friend. Another Colonel in the Army.
9 I needed an 18-Delta to come teach a tactical
10 medical course, the one that I teach and I know
11 18-Deltas are the most highly trained tactical
12 medics there are.

13 Q: How many course would say that Mr. Davenport
14 has taught at your school?

15 A: I think we've done four.

16 Q: Are you familiar with Mr. -- or have you
17 observe Mr. Davenport's knowledge base and
18 experience in treating critical trauma
19 patients?

20 A: Just through instruction.

21 Q: Did Mr. -- I assume if Mr. Davenport was not
22 doing a good job you wouldn't have hired him
23 four times. Were you pretty pleased with the
24 level of ---

25 A: Very, very pleased. He's very demanding right



1 now, to come teach a courses.

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

4 A: Yes, sir.

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

9 A: It's changed since then...

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

12 A: No, sir.

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

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



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

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

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

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

12 A: No, sir.

13 Q: --- testimony?

14 A: No, sir.

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

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

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

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

24 Q: This is in Alabama?

25 A: Yes, sir.



1 Q: Okay.

2 A: June 26th.

3 Q: So it's -- I think you said this is more of a
4 business relationship with Mr. Davenport. Is
5 that correct?

6 A: Yes, sir.

7 Q: Am I correct that if DHEC were to revoke his
8 certificate that would affect his NREMT
9 credentials? Is that your understanding?

10 A: I'm not sure how South Carolina reports.

11 Q: If they did report it, would the ---

12 A: Yes. I think would.

13 Q: Now that would impact his ability to teach your
14 courses. Isn't that correct?

15 A: No, sir. You don't have to be a -- you don't
16 have to qualified. 18-Delta is qualified to
17 teach this course.

18 Q: Okay. So NREMT is not a requirement to teach
19 the tactical medical course?

20 A: No, sir.

21 Q: Did you ever serve or deploy with Mr.
22 Davenport?

23 **MR. ROTHSTEIN:** Your Honor, I asked him that exact
24 question.

25 **THE COURT:** You did.



1 MR. WICEVIC: Okay.

2 A: No, sir.

3 Q: I'm sorry. I was talking with my client. The
4 only thing you reviewed in this matter were the
5 patient reports, body camera footage. Anything
6 else?

7 A: I read some of the deposition.

8 Q: Which deposition?

9 A: I think it was the IRC or maybe not. Maybe it
10 was the one where he was in there. I can't
11 remember. This one, I read short piece of it.

12 Q: Now, is it correct to say that a Special Forces
13 Medic and a civilian paramedic are totally
14 different?

15 A: Scope of practice, yes.

16 Q: Scope of practice. Are there any other
17 differences?

18 A: I can't qualify that.

19 Q: There's not ---

20 A: Well, I can't qualify it because I know the
21 Special Forces training is a higher level than
22 civilians, so I really don't know.

23 Q: Okay.

24 A: Just specifics. I think. I couldn't lay it
25 out on a piece of paper and say yeah, this one,



1 this one, this one, so ...

2 Q: All right. This patient -- the patient in
3 question, he had a significant trauma injury.
4 Is that correct?

5 A: Well, it didn't look like it.

6 Q: You wouldn't consider that a traumatic injury?

7 A: Yes, that's traumatic injury, so is a broke
8 toe.

9 Q: Okay. But you wouldn't -- you told me, it's
10 not a trauma injury?

11 A: No, this is trauma. You said a significant.

12 Q: Okay. So it's not significant, yet it would
13 require surgery. Is that correct?

14 A: Correct.

15 Q: Okay. And this patient did have surgery?

16 A: Correct.

17 Q: And there was a knife penetrated the
18 peritoneum?

19 A: Right. If I'm remembering.

20 Q: So something requiring surgery is not
21 significant?

22 A: My wife broke her ankle the other day and had
23 to get pins put in with surgery.

24 Q: So you're ...

25 A: Surgery doesn't -- surgery does not qualify to



1 be significant.

2 Q: Okay.

3 A: There are a lot of significance traumatic
4 injuries that require no surgery.

5 Q: So I know you said that this patient was
6 hemodynamically stable throughout the call.

7 A: From the numbers. Yes, sir.

8 Q: Okay. Now isn't it correct that. He could've
9 decompensated to the point that he was in
10 shock?

11 A: Could he? He could had a heart attack also.

12 Q: Right. Well I mean, this type of injury,
13 wouldn't that present a significant
14 possibility?

15 A: Well it didn't. Could it? You know we had a
16 guy -- I'll give you a for instance but yeah.
17 The last penetrating trauma call I went on, it
18 was a gunshot wound. The guy got shot I the
19 stomach and he got shot in the back of the
20 knee. The back of the knee shot killed him. It
21 hit his popliteal artery. The abdominal wound
22 was not his death fall, it was the back of his
23 leg.

24 Q: Right.

25 A: So, when we -- when we look at things that are



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

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

6 A: Depends on which one.

7 Q: Which one would be significant?

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

10 Q: The liver?

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

12 ---

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

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

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

25 A: Correct.



1 Q: So that's an uncertainty that we're presented
2 with.

3 A: It is.

4 Q: Would you err on the side of caution?

5 A: What do you mean?

6 Q: When you have uncertainties such as the length
7 of the knife.

8 A: We don't treat for shock unless shock presents
9 itself.

10 Q: What about the potential for shock?

11 A: I can put an IO in ten seconds.

12 Q: But you're an expert in paramedicine. Can an
13 EMT?

14 A: An EMT? No. Advanced EMT's can.

15 Q: Do you straight to an IO before you or do you
16 -- is IO acceptable to an IV?

17 A: It is acceptable practice. Yes, sir.

18 Q: It is?

19 A: Yeah, yeah. Anybody who is a life threat and
20 decompensated fast, you can go straight IO.

21 Q: Right. But I mean the preferable treatment
22 would the IV prior to the IO, correct?

23 A: That's gonna be opinion.

24 Q: Is that something you teach your students to go
25 straight to the IO?



1 A: For the life threat. Yes, sir. We do.

2 Q: We'll take life threat out of the equation.

3 A: Then you just do an IV. But here's what we
4 teach our students. If we're gonna an IV and
5 we can't accomplish that, you gotta be willing
6 to start the IO or they did not need it at all.

7 Q: Yeah. I don't think that's the ---

8 A: Yeah. So that's the theory behind IV's now.
9 Talking to trauma docs, Dr. Will Ferguson, Shay
10 Durin, Dr. Chandler. He's a professor at UAB,
11 the thought is, I treat what is there. I don't
12 add to what I have because I can cause harm.
13 Starting that on somebody that doesn't need it
14 is potential harm just as much as other things,
15 you know, the ways of the world. But to start
16 an IV, I can start an IV, I mean, if you're
17 good medic, you start an IV. Ten or 15 seconds
18 will get it going. And if not, you have a IO
19 backup. And so, you treat significant injuries
20 when they prevail. When they show themselves.
21 Q: Okay. So, I mean, there's occasions where
22 yeah, I'm not gonna treat for an IV or
23 establish IV access to the point where he
24 decompensates, to the point where I can't do an
25 IV so I move to the IO. So, is that a practice



1 that you teach?

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

25 Q: So the IV is preferable.



1 A: Yes, sir.

2 Q: So you shouldn't wait until you need to use the
3 IO when the -- when you can establish an IV?

4 A: Say that one more time.

5 Q: You shouldn't wait to establish an IO when you
6 can establish an IV?

7 A: Well the standard on that is this. You go for
8 an IV because the hospital -- you go for an IV,
9 but -- and I'm gonna speak from Alabama or any
10 care. If I decide IO is a better route, then
11 it's a better route. You take somebody with
12 amputations. You may not have IV access. You
13 may have to go IO route. So the situation
14 dictates. The bottom line is, you have to get
15 IV access to somebody that is in the need of
16 it. There's only two reasons to even start
17 IV's or IO's. One is for drug medication and
18 continuous infusion of fluids. If I'm not
19 gonna do it continuous infusion fluids, there's
20 really not a need for it.

21 Q: Okay. So what were those two? Need for fluids
22 or medications?

23 A: Or medications, correct.

24 Q: What happens when you suspect somebody would
25 decompensated and you need to establish IV



1 access? Isn't that one of the reason why ---

2 A: Well, they'd have to have signs of shock for me
3 to indicate that.

4 Q: So ---

5 A: They'd have indicators.

6 Q: So you wait for the signs of shock to ---

7 A: Absolutely.

8 Q: --- begin? Even when it's an injury where you
9 suspect shock might be coming?

10 A: No if I -- if I suspect shock to be coming, I
11 go ahead and initiate, yes.

12 Q: Okay.

13 A: Yes. That is correct.

14 Q: Now, would you consider this a trauma that
15 would require a trauma alert?

16 A: In South Carolina, I really can't tell you.
17 Alabama, that would not be.

18 Q: And why is that?

19 A: It doesn't meet any of the criteria.

20 Q: Okay.

21 A: Yeah. Trouble alerts come with criteria. And
22 those are deemed by your state.

23 Q: Okay.

24 A: And I don't -- I don't know your trauma system.
25 I don't know your trauma system in South



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

5 Q: Okay.

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

8 Q: All right.

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

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

16 A: No. Not all of them, no.

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

20 A: No. Not anymore.

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

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



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

8 Q: Right.

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

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

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

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

16 A: Yeah.

17 Q: --- 259, please.

18 A: Okay.

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

21 A: Yes, sir.

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

24 A: Okay.

25 Q: Intervention should follow priorities



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

12 A: That is correct.

13 Q: So ---

14 A: I read that.

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

18 A: That's what it says.

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



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

10 A: Right.

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

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

19 Q: You told me ---

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

22 Q: Okay.

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



1 Q: Okay. So you disagree with this? This
2 guidance in this text?

3 A: Not all of it.

4 Q: Okay.

5 A: Yeah. Just that one part ---

6 Q: What I read to you?

7 A: Yeah. And this is -- what's the publishing
8 date on it? The eighth edition, 2016. 2012,
9 2016. There's been a couple modifications.
10 Seventh edition was out for a long time.

11 Q: Okay.

12 A: And then they came out with this a couple of
13 years ago. And, you know.

14 Q: So you're telling me the standards have changed
15 since 2016?

16 A: This isn't, yeah. This isn't the absolute
17 standard.

18 Q: Okay. All right. So there's significant
19 differences between the pre-hospital trauma
20 life support and this international ---

21 A: I'm not really familiar with pre-hospital.
22 Like I said, not that manual. Not that
23 textbook.

24 Q: Well aren't you certified to teach both of
25 these, ITLS?



1 A: No. No, ITLS not PHDLS.

2 Q: Well, ITLS is what I just read to you.

3 A: Yes. I'm certified in it, correct. Not the
4 PHDLS.

5 Q: Is that an acceptable standard?

6 A: It is.

7 Q: Okay. So you're not certified in acceptable
8 standards?

9 **MR. ROTHSTEIN:** Your Honor, Mr. Wicevic is throwing
10 around this term, acceptable standard. I mean
11 that -- as far as I know that's not a relevant
12 term to anything. I mean, if this were a
13 malpractice case, it would be the standard of
14 care expected of pre-hospital provider. If --
15 I think what Mr. Wicevic would have to share is
16 whether DHEC viewed Mr. Davenport's actions as
17 below DHEC's acceptable standard. Whether it's
18 contrary to what's in a book is completely
19 irrelevant.

20 **MR. WICEVIC:** Well then I -- I mean, he's just
21 testifying to his subjective professional
22 judgement. I don't know the relevancy of that
23 to this determination regarding our allegation
24 for acceptable medical treatment. Our
25 position, that goes to national standards of



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

5 **THE COURT:** The objection is overruled.

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

9 A: No, sir.

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

13 A: Correct.

14 Q: Okay.

15 A: Not in the field.

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

18 A: Yes.

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

23 A: Correct.

24 Q: Okay. Intraosseous?

25 A: Correct.



1 Q: Now, for traumatic injuries, time of the
2 essence. Is that correct?

3 A: Yes.

4 Q: And you've heard of the golden hour rule?

5 A: That's out. The golden period is what they all
6 it now.

7 Q: Okay. So there's no set hours?

8 A: No. It's no set hours.

9 Q: And that refers to the time, I guess injury
10 occurs?

11 A: It does.

12 Q: Okay.

13 A: Until they get to the OR.

14 Q: Okay.

15 A: Right.

16 Q: But that's in general, I mean, time is of the
17 essence?

18 A: Absolutely.

19 Q: So I mean, if you had pulled over -- if you
20 find a safe spot to pull over. Have the
21 paramedic come out of the ambulance, switch
22 places with the EMT, do another assessment
23 because you don't have your personal
24 observation of the patient and then make the
25 appropriate treatment call. I mean that's



1 wasting a quite a bit of time, isn't it.

2 A: He's got a stable -- I mean, he was stable. He
3 was showing signs of stability.

4 Q: He ---

5 A: Total stability. He was showing no signs of
6 decompensation at all.

7 Q: But if he were to decompensated?

8 A: Well, if you got into a wreck at a red light,
9 it would be bad.

10 Q: That's a good point.

11 A: I mean the number one issue in ambulances these
12 days is wrecks.

13 Q: What's that?

14 A: The normal is wrecks. One of the worst patient
15 cares that's taking place now are ambulances
16 that are being involved in accidents going to
17 the hospital or going to the scenes. And that
18 will delay care a lot more?

19 Q: So you -- you feel ---

20 A: So ---

21 Q: You feel like that's more of significant threat
22 than providing preventative care for this?

23 Q: We don't do preventative care. Our job is pre-
24 hospital emergency care.

25 A: Okay. So, a principle of pre-hospital care is



1 not to prevent the preventable?

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

7 Q: But you can prepare for it.

8 A: But it doesn't prevent it.

9 Q: Well, can you prepare for it?

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

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

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

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

19 A: For what?

20 Q: Surgery.

21 A: I would say so.

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



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

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

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

20 A: Significant trauma.

21 Q: Okay.

22 A: Life threatening trauma.

23 Q: Life threatening?

24 A: Life threatening trauma.

25 Q: All right.



1 A: If we trauma alert them, a paramedic rides even
2 though there's a paramedic in the back of the
3 ambulance.

4 Q: I'm sorry?

5 A: See we don't transport. So there's already a
6 paramedic in the back of the ambulance just our
7 city policy, we continue care so we have
8 continuation of care.

9 Q: Right.

10 A: For anybody who's decompensating.

11 Q: And this gets back to the non-transport,
12 transport distinction.

13 A: Uh-huh.

14 Q: The only time you would -- I mean, when you
15 ride there you ride there in a fire truck. Is
16 that correct?

17 A: We drive up to the house fire truck, yes.

18 Q: QRV's, do y'all have those?

19 A: No.

20 Q: So it's only fire trucks?

21 A: Yeah. We have on our fire trucks -- in
22 Homewood, we have at least four people on a
23 fire truck at time and at least three
24 paramedics. The only thing we don't carry is
25 the transport of ambulance.



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

4 A: Right.

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

6 A: Correct.

7 Q: Tried to do some kind of stabilization
8 procedure?

9 A: Correct.

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

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

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

15 A: Correct.

16 Q: How often do you ride the call in?

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

20 Q: Three times a shift.

21 A: Yeah.

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

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

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



1 A: Right, right.

2 Q: It's a discussion with, I guess, the EMT?
3 Again, I'm saying EMT generally.

4 A: Yes.

5 Q: EMT aboard the transporting agency as far as
6 who is riding it in?

7 A: Yeah. It depends on severity.

8 Q: Okay.

9 A: For which one of us rides it.

10 Q: Right.

11 A: And mainly it's so we can continue care. And
12 also we have another paramedic in the back
13 assist us. But we maintain control of the
14 call. If it's significant.

15 Q: Okay.

16 A: So it -- I'm the one who makes the decision for
17 the last -- since 2003 on significant calls
18 'cause I'm the lead medical on my truck. Oh
19 my. I'm the highest ranked and based on our
20 state laws, I have to make decisions on
21 significance.

22 Q: Okay. Are you familiar with the CDC trauma
23 triage guidelines?

24 A: Yes, sir.

25 Q: Are they accepted within Alabama?



1 A: It's an acceptable practice, yes.

2 Q: Are you aware that that guideline lists
3 abdominal penetrating injuries as a trauma
4 injury requiring trauma transport?

5 **MR. ROTHSTEIN:** Your Honor, if he's gonna characterize

6 ---

7 A: We have.

8 **MR. ROTHSTEIN:** --- the guideline, I think he's
9 gotta hand it to the witness. And I don't he

10 ---

11 **MR. WICEVIC:** I'm just asking him ---

12 A: Yeah.

13 **MR. WICEVIC:** --- if he's aware ---

14 **THE COURT:** I'll allow the question.

15 A: I'm kind of lost on what you mean by trauma
16 transport.

17 Q: If that is a trauma injury that would require
18 transport to a trauma center?

19 A: Oh, that. Well I mean, if you break your
20 ankle, that's a trauma and you need to go ---

21 Q: Yeah. But I'm talking ---

22 A: --- to the hospital. I mean ---

23 Q: I'm talking about trauma alert.

24 A: Oh okay. You didn't say that. Okay. Trauma
25 alerts, they go to level one.



1 Q: Right. But a penetrating abdominal injury,
2 would that be something that would require a
3 trauma alert according to the CDC guidelines?

4 A: Yes. If it's significant, yes.

5 Q: Okay.

6 A: But now let's take a -- let me just describe
7 penetrating traumas. If I take a thumb tack
8 and I stick it in your abdominal, that's
9 penetrating trauma.

10 Q: Right.

11 A: That's not significant.

12 Q: Yeah. I mean that's a little obvious. So ---

13 A: Definition of penetrating trauma is anytime you
14 break the skin with hard object. Okay? If I
15 stick a thumb tick in your stomach, that is not
16 significant abdominal trauma, but it is
17 penetrating trauma. That would not be a trauma
18 alert. That would probably fire. If I showed
19 up at UAB level one, your doctor would just eat
20 me alive for trauma alerting him.

21 Q: So I mean, how long does the knife does the
22 knife have to be to be a significant
23 penetrating trauma?

24 A: It depends on the patient.

25 Q: It depends on the patient?



1 A: It does.

2 Q: I mean, and again, you don't know the length of
3 the knife?

4 A: No.

5 Q: So ---

6 A: Yeah. We look for signs. Signs of that shock.

7 Q: Okay.

8 A: Yeah.

9 Q: So you can move into a different subject.
10 Behavior and verbal interactions. Would you
11 characterize Mr. Davenports language to actions
12 as being rude not professional?

13 A: I would say he was rude. Yes.

14 Q: Okay. Would this raise a concern with you if
15 you saw one of your co-workers ---

16 A: It would be an employee supervisor issue.

17 Q: Okay. And what would you do?

18 A: Basic remediation.

19 Q: Okay. I mean you never spoken to a patient like
20 this before, have you?

21 A: Not that I'm aware of.

22 Q: Now, you'd agree that the way you interact with
23 the patient consists in gaining that patient's
24 confidence?

25 A: True.



1 Q: And to establish that confidence is something
2 important.

3 A: True.

4 Q: And that's something you teach at school,
5 correct?

6 A: That is correct.

7 Q: You want the patient to communicate with you?

8 A: True.

9 Q: Did you see that appropriate communication in
10 this particular incident?

11 A: Well that's why I watched it the first time
12 with no audio to see -- I'm looked at it
13 objectively from a patient care. Did he do the
14 right steps in his patient care. And he did.
15 The patient care was okay. The interaction, he
16 probably needs remediation.

17 Q: Okay.

18 A: I think it's more of an employee issue than a
19 licensing issue. This is not a license -- the
20 way somebody talks to a patient is not
21 licensing issue. I mean ---

22 Q: Well you're not a part of the licensing
23 authority, are you?

24 A: No, sir. But I do give advice about it.

25 Q: Okay. And you're not familiar with DHEC's



1 procedures?

2 A: No, I'm not.

3 Q: All right. The ambulation of the patient. Now
4 you have experience transferring these patients
5 from the scene of the accident or illness to
6 the ambulance?

7 A: Yes, sir.

8 Q: Okay. Now, at this patient -- at the scene of
9 the injury. Patient already suffered a serious
10 bodily injury or would you disagree with that
11 characterization?

12 A: Based on objective -- I can't say it was
13 significant 'cause we -- like I said, we don't
14 we length of the knife. It could've been a one
15 inch knife but he had no signs instability at
16 all.

17 Q: Okay.

18 A: He was not unstable and he was showing no
19 signs. Matter of fact, the guy, I mean if I
20 had a knife in my stomach I'd probably be a
21 little more upset than he was. I mean, he was
22 looking pretty relaxed to me with that knife
23 stuck in his stomach. And I've seen that
24 before. It, you know, with somebody else stuck
25 a knife in their stomach, so.



1 Q: But the bottom line is you don't know, and
2 there's no way to know ---

3 A: Yeah, we don't know about.

4 Q: All right. So, I know you talked about moving
5 a patient, hands on, whether they're among
6 other things you said ambulatory.

7 A: Correct.

8 Q: How do you know a patient is ambulatory?

9 A: They have the ability to walk under their own
10 will.

11 Q: I mean, how do you make that call?

12 A: You ask them.

13 Q: You ask them? Did you see Mr. Davenport ask
14 this patient before?

15 A: No. He got up and started walking.

16 Q: Okay. So you say, get up walk ---

17 A: Uh-huh.

18 Q: --- and then you make a call? I mean ---

19 A: Yeah.

20 Q: --- isn't that kind of after the fact?

21 A: Yeah, but if I couldn't walk, I'd tell you I
22 couldn't walk.

23 Q: Okay. Now, stabilizing the knife. That's the
24 first thing he did.

25 A: Right.



1 Q: Now ambulating the patient after stabilization
2 ---

3 A: Uh-huh.

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

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

18 Q: Yeah.

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

20 Q: Okay.

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

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



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1 patients feel some harm.

2 A: Say that again?

3 Q: Didn't you said you want the patient to feel
4 some harm?

5 A: No, no, no.

6 **MR. ROTHSTEIN:** Your Honor, he said pain.

7 A: No, no, no. no, no, no.

8 **THE COURT:** Yeah, I ---

9 A: You don't remove the pain. You don't remove
10 pain. I don't pain, but I don't remove the
11 pain. So he can move under his own will and he
12 knows what's hurting or not. Pain is a good
13 indicator of how people move. I mean, if you
14 sprain your ankle, you're gonna walk
15 differently on that ankle than you normally
16 would. You're gonna walk so you don't create
17 more injury. But if I move you, I can create
18 more injury because I don't feel your pain. So
19 we let patients move ambulatory if they're
20 ambulatory.

21 Q: Okay. So I mean, if you have a way to avoid
22 pain, you don't utilize that manner?

23 A: What do you mean?

24 **MR. ROTHSTEIN:** Your Honor, it's after 5:00 o'clock.
25 I've got one more witness who's out of state.



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

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

11 **MR. WICEVIC:** Not that long, Your Honor.

12 **THE COURT:** Okay.

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

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



1 readily apparent. Wasn't that correct?

2 A: Oh, yeah. He had a knife in his stomach.

3 Q: So wouldn't you want to take every step to
4 avoid pain for this patient?

5 A: He didn't look like he was in very pain.

6 Q: Well he was in some pain, correct. I mean
7 reviewed the patient care reports.

8 A: I looked at risk. What if I give him morphine
9 and put him in anaphylactic shock and killed
10 them? Then you're sending different levels of
11 -- he kind of -- you brought harm on to that
12 patient. Removing the patient -- pain
13 management, it is only if the pain is hindering
14 the patient care. His patient care was not
15 being hindered by his pain.

16 Q: All right.

17 A: It was not creating harm to him.

18 Q: We talked about the stair chair sometimes. It
19 sounds you don't use the stair chair all that
20 often. Is that correct?

21 A: No, I do. We do use it.

22 Q: Under what circumstances?

23 A: If we're up several flights of stairs, that's
24 what it's designed for. To move the non-
25 ambulatory who's conscious.



1 Q: Isn't designed for transporting down stairs?

2 A: Yes. That's what it's designed for.

3 Q: Well you said ambulatory patient.

4 A: Non-ambulatory, I'm sorry, non-ambulatory. The
5 non-ambulatory. You move the non-ambulatory
6 with it.

7 Q: So if a patient is on the second floor but he
8 or she is ambulatory, you wouldn't use the ---

9 A: No. I'd walk them down the stairs.

10 Q: Now doesn't that increase movement for the
11 patient?

12 A: I don't think there's any research on that, no.
13 Never seen ---

14 Q: Well it's just common sense. I mean when
15 you're walking, you're using a lot of muscles,
16 correct?

17 A: You ever been on a stair chair?

18 Q: No. But I seen pictures of ---

19 A: They're not smooth. Now, if you pay \$3,000,
20 you can have those tracks on there. And no
21 they're still -- and still, you're moving that
22 patient. And what happens is, if you slip or
23 move, you're gonna create more harm by your
24 actions.

25 Q: You can slip and fall a walking patient, right?



1 A: Well I can, yeah. But the patient won't ...

2 Q: Well the patient can slip and fall too.

3 A: Sure.

4 Q: You said you need three people. At least three
5 people to utilize the stair chair? Do you know
6 how many people were on scene for this?

7 A: Looked like four or five.

8 Q: Now the straps, you said that was an obstacle
9 for the stair chair. The straps can be -- I
10 mean if it -- you can manipulate them to use --
11 -

12 A: Yeah. You can do different things.

13 Q: Okay.

14 A: Yeah. You can do different things. It depends
15 on the chair. Anytime that you alter -- you
16 gotta be careful. Anytime you alter you alter
17 something -- anytime a mobilization equipment
18 or movement equipment and you alter and
19 something does happen, now you fall under a
20 different liability.

21 Q: What do you mean liability?

22 A: If you hurt the patient because you altered
23 that equipment. We're not really allowed to
24 altered equipment.

25 Q: You're talking about negligence?



1 A: No. It can be. It depends on how you alter
2 it. Yeah.

3 Q: Let me read through my outline. I think that
4 might be might everything. Let me ask you this.
5 Significant trauma, you agree -- I know you
6 don't consider this significant trauma injury.
7 That being said, if there was significant
8 trauma injury, who would have to ride in the
9 back of the truck, the ambulance truck.

10 A: Significant, would be the paramedic.

11 Q: Okay.

12 A: Now that's in Alabama.

13 Q: Okay. What about the national standards?

14 A: National standard, highest level.

15 Q: Highest level?

16 A: Yeah. Now let me caveat this. I've actually
17 been called to doctors offices in the hospitals
18 in Birmingham, where doctors turn over care to
19 us all the time because we're emergency care
20 providers and we're viewed as a lesser level
21 but -- let's say if I go to an internist's
22 office and I have a patient with chest pain or
23 something. That physician is gonna turn over
24 care to us and we're lower level but we're more
25 trained at that type of care ---



1 Q: Yeah.

2 A: --- or equal.

3 Q: So you're talking about at a hospital?

4 A: I have been. Yes, sir.

5 Q: Okay.

6 A: I mean the hospital rooms and transporting
7 patients out of hospital rooms.

8 Q: All right. That's all I have for you. Thank
9 you, Mr. Deason.

10 **THE COURT:** Okay. Do you have anything on redirect?

11 **MR. ROTHSTEIN:** Just a few questions.

12 **MR. DEASON - RE-DIRECT EXAMINATION BY MR. ROTHSTEIN:**

13 Q: Have you ever heard of a requirement that EMT's
14 need to carry all of the equipment into the
15 house or into the scene of a -- where they have
16 to treat the patient?

17 A: No. You can't carry all of it.

18 Q: Is that a feasible or reasonable requirement?

19 A: No.

20 **MR. ROTHSTEIN:** Okay. No further questions, Your
21 Honor.

22 **THE COURT:** Thank you. Thank you, Mr. Deason. Mr.
23 Rothstein, before you move to your next, let's
24 take just a five minute ---

25 **MR. ROTHSTEIN:** Okay.



1 THE COURT: Because it's been awhile.

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

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

5 MR. ROTHSTEIN: I call Sergeant Derrick Crus.

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

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

10 FIRST SERGEANT CRUS - DIRECT EXAMINATION BY MR.
11 ROTHSTEIN:

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

15 A: It's John Derrick Crus.

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

17 A: Birmingham, Alabama.

18 Q: Do you go by Deek?

19 A: Yes.

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

21 A: I am a residential builder.

22 Q: Okay. Do you have any military positions?

23 A: Yes.

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

25 A: 27 years.



1 Q: Okay. Are you currently in the military?

2 A: Correct. In the national guard.

3 Q: Okay. And what functions do you serve in the
4 national guard?

5 A: I am a First Sergeant for a Special Force
6 Medical Company. I think ---

7 Q: Can you lean up a little bit.

8 A: Sure, sorry.

9 Q: And tell The Court what a Special Forces
10 Medical Company is.

11 A: Within our group we have what we call a
12 battalion. It's a group support battalion.
13 Within that battalion we have companies. And
14 one of these companies is a medical company.
15 We have PA's, veterinarians, RN's, medics,
16 dentists. And I manage those individuals.

17 Q: Okay. And can you describe to The Court what
18 your position as First Lieutenant is?

19 A: First Sergeant.

20 Q: I'm sorry. First Sergeant.

21 A: You demoted me again.

22 Q: As a First Sergeant. Can you explain to The
23 Court what your duty is as the First Sergeant?
24 Are you a team leader, a Special Forces team
25 leader?



1 A: No. That was previously to this position.

2 Q: Okay. I'm sorry.

3 A: I manager where people go to do contingency
4 operations within the scope of large strategic
5 defense of the country.

6 Q: And that was my -- do you know James Davenport?

7 A: Absolutely.

8 Q: And how do you know James Davenport?

9 A: I served with James Davenport from roughly 2006
10 to 2012.

11 Q: Were you and Mr. Davenport on the same Special
12 Forces Team?

13 A: That is correct. At that time, I was an ODA
14 Team Sergeant for the Senior Enlisted Advisor
15 for the ODA for the operational detachment.

16 Q: And how big was the -- it probably changed from
17 time to time, but give The Court an idea of how
18 big a Special Forces Team is that you were the
19 ---

20 A: Doctrinally it's six to twelve.

21 Q: Did you work closely with Mr. Davenport during
22 those six or so years that you were on the same
23 team?

24 A: No choice.

25 Q: Okay. And what was Mr. Davenport's role on the



1 team?

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

3 Q: Okay. How did you first meet Mr. Davenport?

4 I mean, did you select him for the team or was
5 he sort of put on your team?

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

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

16 A: Correct.

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

19 A: He was tops of his class.

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

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



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

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

13 A: Absolutely.

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

19 A: Never had a filter since day one.

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

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

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



1 A: That's hard to say -- directly with? Maybe up
2 to 20.

3 Q: And can you explain to the Judge what sort of
4 the team structure is? I know you said you had
5 six to twelve members of a team. How is a team
6 comprised?

7 A: Well, we've got a team leader who is an
8 officer. He's responsible for dealing with
9 people higher up in the ODA. And then you have
10 the Team Sergeant which is the role I was in
11 when James was on my ODA. And I deal with
12 everything team related to include -- well,
13 everything team related. Below me, you have an
14 Operation's Assistant and intelligence guy. I
15 have weapons. Two weapons guy on the ODA which
16 they have various responsibilities. They're
17 not just weapons guys, but they are familiar
18 with all the weapons systems in the world. I
19 have engineering guys who can build stuff and
20 destroy stuff. And of course, communication
21 guys who can let us communicate anywhere in the
22 world.

23 Q: Okay.

24 A: That pretty much sums that up.

25 Q: And what about the 18-Delta. Can you explain



1 to The Court what an 18-Delta is.

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

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

9 A: OCONUS?

10 Q: OCONUS.

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

18 Q: Okay.

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

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

25 A: It's just the Americans.



1 Q: Okay. Just the Americans.

2 A: The six to twelve.

3 Q: Okay. So if you are actually deployed into
4 another country, are there other, I guess
5 foreign people or when you're there they're
6 local people that you actually work with on the
7 Special Forces team?

8 A: Correct

9 Q: Okay. And what is Mr. Davenport's role as the
10 medic with regard to providing the local team
11 member on your team ---

12 A: We're responsible for saving lives. He's
13 responsible for saving lives in a critical
14 scenario. Sometimes we're limited. It depends
15 on the SOFA agreement between the United State
16 and whatever country we're operating in. But
17 if it comes to life, limb, or eye sight, he's
18 able to make those call.

19 Q: Okay. Have you been in active deployments and
20 sort of, I guess, Special Operations
21 assignments with Mr. Davenport outside of the
22 United States during that six or seven year
23 period when he was on ---

24 A: Yes, sir.

25 Q: Some of those involved pretty hostile parts of



1 the world?

2 A: Yes, sir.

3 Q: I know we can't pinpoint everything. I'm sure
4 it's somewhat classified. Can you give the
5 court an idea of generally where you been
6 assigned or deployed or signed on special
7 assignments.

8 A: The last one was Iraq. And Operation New Dawn.
9 And prior to that was a South American -- was
10 operating Enduring Freedom -- it's central
11 something central Americans. Oh we have CCA.

12 Q: Has Mr. Davenport ever rendered medical care or
13 attention to you?

14 A: Yes.

15 Q: Okay. Has Mr. Davenport -- have you ever
16 observed Mr. Davenport render medical care to
17 either team members or enemy combatants or
18 local affiliates for lack of better word during
19 some sort of an assignment or mission?

20 A: Yes.

21 Q: Or training exercise?

22 A: Uh-huh.

23 Q: Can you explain to The Court your observations
24 of Mr. Davenport's medical skills and
25 competencies?



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

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

14 A: That was Iraq.

15 Q: All right. And what happen?

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

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

24 A: I did. I was on the roof.

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



1 combatant sustained?

2 A: He broke his ankle and he had some upper torso
3 blunt force trauma. I don't know the extent
4 of what that was but I know he broke his ankle.

5 Q: Did Mr. Davenport ever refuse to provide care
6 to that enemy combatant?

7 A: Absolutely not.

8 Q: What ended happening to that enemy combatant
9 after Mr. Davenport rendered care?

10 A: He treated them, actually casted the guy. He
11 set the bone, casted him. We maintained
12 control of the guy and stayed in his care and
13 we went about our task at hand.

14 Q: Was Mr. Davenport on your team at the time of
15 his first significant injury in battle?

16 A: No.

17 Q: Okay. You know about that situation he
18 described? I think it was on the interview
19 where he had piece of metal stuck on the back
20 of his leg. How do you know about that?

21 A: I was called ---

22 Q: Okay.

23 A: --- directly.

24 Q: Now, a medic on a Special Forces team, is that
25 just the guy that kind of trials behind



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

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

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

20 A: Top.

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

24 A: Yes, I do.

25 Q: And can you tell The Court what those documents



1 are?

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

4 Q: And did you recommend³ Mr. Davenport for any
5 awards for his con- -- conduct and performance
6 during his assignment to your ODA?

7 A: I've authored some of these.

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

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

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



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

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

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

15 **MR. WICEVIC:** Thanks you.

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

18 **A:** Yes, I do.

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

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

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



1 during his time on your team?

2 A: There is, I don't think all these are mine, but

3 ...

4 Q: At least during the time that you evaluated
5 him, did he ever did anything less than an
6 outstanding report from you?

7 A: Not that recall. I glanced through these but
8 I don't recall ever having less than excellent
9 evaluation report on James.

10 **MR. ROTHSTEIN:** Your Honor, I'll move Exhibit 16 into
11 evidence.

12 **MR. WICEVIC:** Just a similar objection.

13 **THE COURT:** Okay. Thank you. It's admitted.

14 **(Respondent's Exhibit Number 16 was admitted into**
15 **evidence.)**

16 Q: Mr. Crus, if you were involved in a significant
17 trauma walking out of a building today, would
18 you have any hesitancy in Mr. Davenport
19 rendering pre-hospital emergency care to you?

20 A: Absolutely not.

21 Q: Okay. Would you have any hesitancy to Mr.
22 Davenport rendering pre-hospital emergency care
23 to any of your family members?

24 A: Absolutely not.

25 **MR. ROTHSTEIN:** No further questions, Your Honor.



1 THE COURT: Okay.

2 MR. WICEVIC: Just like five minutes.

3 FIRST SERGEANT CRUS - CROSS-EXAMINATION BY MR.

4 WICEVIC:

5 Q: Sergeant Crus ---

6 A: Yes, sir.

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

11 A: We're pretty close.

12 Q: Okay. How often do you communicate?

13 A: Maybe once every three weeks.

14 Q: So y'all are pretty good buddies?

15 A: Yes, sir.

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

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

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

21 THE COURT: Okay. Anything on redirect.

22 MR. ROTHSTEIN: No, Your Honor.

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

25 MR. CRUS: Yes, ma'am.



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

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

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

7 **MR. ROTHSTEIN:** Okay.

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

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



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

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

ADMINISTRATIVE HEARING

Friday, July 28, 2017
9:12 a.m. - 4:40 p.m.

The hearing before the Honorable Shirley Canty Robinson, was taken at the Edgar A. Brown Building, 1205 Pendleton Street, Suite 224, Columbia, South Carolina, on the 28th day of July, 2017 before Travis McLeod, Court Reporter and Notary Public in and for the State of South Carolina.



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Also Present:

Tia Hazel, Law Clerk

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EXHIBITS

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

Respondent's Exhibit Number 4	234
(Suspension Letter of 3/22/2016)	
Respondent's Exhibit Number 5	243
(Reinstatement Letter of 3/25/2016)	
Respondent's Exhibit Number 8a	95
(Email from Stoller to Alier 3/25/2016 11:32 a.m.)	
Respondent's Exhibit Number 10	95
(Email from Stoller to Alier 3/25/2016 5:19 p.m.)	
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(Text Messages Between Davenport and Aiken)	
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Respondent's Exhibit Number 25	23
(Investigation Packet)	
Respondent's Exhibit Number 27	96
(Email from Stoller to Alier)	
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Respondent's Exhibit Number 29	134
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(The original exhibits were retained by Judge Robinson.)

STIPULATIONS

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



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

THE COURT: I'm going to call the hearing to order.

Mr. Rothstein, we're ready to hear from your next witness.

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

THE COURT: Uh-huh.

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

THE COURT: Okay.

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



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



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



1 6th or so, but the letter would spell it out
2 probably. Question, prior to receiving the
3 actual complaint from DHEC had you heard that
4 Mr. Davenport had complained about
5 mismanagement or misuse of department funds or
6 property? Answer, not in any detail. I heard
7 that he was complaining about me, or that he
8 had concerns. Something came up about a
9 grievance, but I've never seen or heard about
10 it. Then on page 167, this questioning by
11 DHEC's attorney Ms. Susan Nelson, who was
12 present -- or questioning for DHEC. Line 14.
13 Question, this summery says that you have
14 knowledge about your mismanagement and misuse
15 of department funds and assets. Is that the
16 rumor you were speaking about when you heard
17 that Mr. Davenport was? Answer, there were
18 some rumors, yes. There were some rumors about
19 spending money on a fence, for instance, for
20 the dog, a bomb dog that belongs to the county.
21 There were some things along those lines.
22 Question, Okay, did that come up before or
23 after you sent your email to Arnold Alier at
24 DHEC? Answer, this was going on long before.
25 That's it Your Honor.



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

6 **THE COURT:** We'll do that.

7 **MR. WICEVIC:** Thank you.

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

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

14 **THE COURT:** Okay.

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

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

20 **RICHARD NAUGHLER,** having been duly sworn, testifies
21 as follows:

22 **MR. NAUGHLER - DIRECT EXAMINATION BY MR. ROTHSTEIN:**

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

25 **A:** I'm not sure.



1 Q: Okay, can you state your full name for the
2 record.

3 A: Richard Carter Naugler.

4 Q: And I understand that you were the primary
5 investigator for DHEC in this matter. Is that
6 right?

7 A: Yes, sir.

8 Q: How long have you been an investigator for
9 DHEC?

10 A: My position is Inspector 3 and November will be
11 four years.

12 Q: Okay. What does Inspector 3 mean?

13 A: Inspector 3 means like preform investigations,
14 do compliance checks, inspect the ambulances,
15 inspect the agencies, and pretty much anything
16 else covered underneath my purview as far as
17 DHEC's concerned.

18 Q: Can I get you to lean forward, and talk into
19 that microphone if you don't mind.

20 A: Yes, sir..

21 Q: How long have you been at DHEC in total? In
22 the inspector type position?

23 A: Three years, some months.

24 Q: Okay. Were you hired on an Inspector 3?

25 A: Yes, sir.



1 Q: Okay. Are there different levels of inspector,
2 like Inspector 1, Inspector 2, Inspector 3?

3 A: It's a large area. We haven't quite figured
4 out what Inspector 1 or Inspector 2 are, but in
5 our area, the Inspector 3's are the ambulance
6 inspectors.

7 Q: Okay. And I'm just -- is the designation 3
8 after inspector, is that like a job, state job
9 classification?

10 A: I believe so.

11 Q: Or is that the part of the region that you're
12 an inspector for?

13 A: No, sir.

14 Q: Okay. So that sort of indicates a level of job
15 classification. Is that fair to say?

16 A: We have not figured out what the 3 stands for.

17 Q: Did you ever receive any training on conducting
18 investigations when you were hired on -- or on
19 the job training at DHEC?

20 A: Yes, sir.

21 Q: Okay. And what were you trained on on how to
22 conduct an investigation?

23 A: Part of mine comes from my previous history.
24 I was a law enforcement Officer and another is
25 part of CLEAR where I'm a basic certification



1 investigator, national certified investigator.

2 Q: Okay. What is your understanding generally of
3 the purpose of a DHEC investigation of a
4 complaint against a paramedic or EMT?

5 A: Against a paramedic or EMT?

6 Q: Right. What is the purpose of an
7 investigation?

8 A: To get to the truth. To see if there is any
9 violations of regulation type.

10 Q: Okay. When you say get to the truth, what's
11 involved in your experience as an instigator
12 getting to the truth?

13 A: Taking an investigation, getting statements,
14 taking a complaint, get any investigation
15 material that we can acquire.

16 Q: And is important to get all the facts before
17 you make a conclusion?

18 A: Yes, sir.

19 Q: In part of your training, have you ever been
20 trained to go into an investigation with a
21 primary goal, or primary objective in mind
22 other than getting to the truth?

23 A: No, sir.

24 Q: Do you think it would be an improper use of an
25 investigation to set somebody up?



1. A: Ask it again please.

2 Q: Do you think it would be an improper use of an
3 investigation to set somebody up?

4 A: Are you talking about entrapment?

5 Q: Yes.

6 A: Are we talking about law enforcement, you
7 talking about EMS?

8 Q: Either one.

9 A: Okay, well --

10 Q: Is it legal to do that in law enforcement?

11 A: I'm not a law enforcement expert, I can't
12 answer that, I'm sorry.

13 Q: Did you conduct this investigation for DHEC the
14 same the way that you would have conducted a
15 law enforcement investigation when you were in
16 law enforcement?

17 A: I had a strategy. I do believe we have a
18 strategy, Yes, sir.

19 Q: Now you had a strategy for the interrogation of
20 Mr. Davenport, right?

21 A: I pretty much think you would go into any case
22 with a strategy, so yea, we probably had a
23 strategy of what we were going to do.

24 Q: Okay. But did you have a strategy -- I'm not
25 talking about the interview, I'm talking about



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

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

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

9 A: Yes, sir.

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

12 A: Midlands.

13 Q: Okay. Is it just called the Midlands?

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

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

18 A: Right now there are four different regions.

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

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

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



1 A: Yes.

2 Q: And does it include Anderson County?

3 A: No, sir.

4 Q: And what region is Anderson County in?

5 A: That would be in the Upstate.

6 Q: Okay. And who was the Upstate inspector for
7 DHEC on April 13, 2016?

8 A: I believe Kristen McConnell.

9 Q: Okay. Do you know if she's an inspector 3 as
10 well?

11 A: Yes, sir.

12 Q: Okay. Why didn't the inspector or the
13 investigator for the Upstate region handle an
14 investigation involving an Upstate matter?

15 A: Because I do believe she had some history in
16 the area, and possibly worked in the area. We
17 weren't sure of any prior knowledge. I have no
18 knowledge of anything in Anderson County.

19 Q: But wouldn't the Upstate inspector, did you
20 know where she lives?

21 A: No, sir.

22 Q: Okay. Wouldn't the Upstate inspector who's in
23 charge of inspecting the Upstate, have some
24 ties to EMS and agencies and departments in the
25 Upstate?



1 A: Yes, sir.

2 Q: Are you a certified paramedic?

3 A: Yes, sir.

4 Q: How long have you been a certified paramedic?

5 A: I became a paramedic in 1998.

6 Q: And when you went through paramedic training
7 school, do you recall that mantra O2, IV,
8 monitor?

9 A: Actually it's IV, O2, monitor.

10 Q: Okay. I'm sorry.

11 A: That's okay.

12 Q: When was the last time you actually worked on
13 an ambulance responding to an emergency call?

14 A: Actually, in January I backed up a Lexington
15 County truck in my neighborhood, loading a
16 patient up to a stair chair, to get him outside
17 of the house.

18 Q: Okay. January of this year?

19 A: Yes, sir. And then after that about two weeks
20 later, I was in the back of a truck at Bi-Lo
21 helping them hold down a treated seizure
22 patient that we rode into the hospital.

23 Q: Okay. You may have misunderstood my question.
24 My question wasn't when did you actually
25 respond to a scene, it was when was the last



1 time you actually worked on an ambulance?

2 A: It would have been probably, I began in
3 November 2013, so probably October 31st
4 probably.

5 Q: Of 2013?

6 A: Yes, sir.

7 Q: So it's been almost four years sense you worked
8 on a truck? It would be four years in October
9 sense you worked on a truck?

10 A: Worked on a truck? I've been on a truck. But
11 are we talking about working on a truck or --

12 Q: I'm talking working, not like working on your
13 garage on a truck. I'm talking about working
14 as a paramedic in an ambulance, responding to
15 emergency calls.

16 A: I did that is January of this year. As far as
17 officially working as a paramedic full-time,
18 that would have been in October 2013.

19 Q: Okay, what agency was that?

20 A: It was either Midlands Med Tech, or Trustus.

21 Q: Okay. Were those private ambulance services?

22 A: Private, Yes, sir.

23 Q: Have you ever had any time of disciplinarian
24 action against you as a paramedic or EMT?

25 A: No, sir.



1 Q: Now let's talk about this investigation about
2 Mr. Davenport. Let's see if we can find
3 Exhibit 3 here. Do you recognize Exhibit 3?

4 A: Yes, sir.

5 Q: Okay. And what is Exhibit 3? I think that's
6 already in the record, but can you tell The
7 Court what you recognize that as?

8 A: These are the progress notes made during the
9 investigation.

10 Q: Okay. And this is a three page document that
11 Mr. Wicevic asked me to supplement the last two
12 pages. Do you understand that?

13 A: Uh-huh.

14 Q: Now when this document was first provided to
15 Mr. Davenport, it wasn't three pages long was
16 it?

17 A: I believe it was filled out up until the point
18 that he came and picked it up.

19 Q: Okay. And on the first page of Exhibit 3,
20 there's an entry about when it was copied and
21 made available for him to pick up, and then
22 there's a later entry about when he actually
23 picked it up, right?

24 A: I'm looking at it. Mr. Davenport picked up
25 investigation packet, signed and receive. Yes,



1 sir.

2 Q: Okay. So, the time it was copied and placed
3 into a confidential envelope, the log ended at
4 April 28, 2016 at 9:40, right? Everything
5 that's below that was added after Mr. Davenport
6 was given the copy of the investigative packet,
7 right?

8 A: Actually, I do believe he picked up on 4/29/16.

9 Q: Yeah, but you had to copy it first and put it
10 into a sealed packet, right?

11 A: Yes, sir.

12 Q: Okay. So everything on the copy that was given
13 to Mr. Davenport would have been before the
14 entry where he picked it up. You agree with
15 that?

16 A: I believe so. Yes, sir.

17 Q: Okay. I'm going to show you a group of
18 documents and I'm going to ask if you recognize
19 that as the packet that was provided to Mr.
20 Davenport when he picked it up on April 29th,
21 2016.

22 A: I'll take your word on it. Yes, sir. It looks
23 like it.

24 Q: Okay. Sitting here today looking at it, do you
25 see anything that's missing from that packet



1 that was provided to Mr. Davenport? I know
2 you're just seeing that for the first time, but
3 ---

4 A: I have no idea.

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

8 A: From the investigation. Yes, sir.

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

14 A: For medical records, yes.

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

18 A: Yes, sir.

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

22 A: Most of the notes. Yes, sir.

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



1 A: Yes, sir.

2 Q: There's a chart at the bottom that sort of
3 identifies whose initials are whose, right?

4 A: Yes, sir.

5 Q: Okay. And do you recognize the initials AA as
6 Arnold Alier?

7 A: Yes, sir.

8 Q: All right. And that entry says that after 5:00
9 o'clock in the afternoon on the 13th of April,
10 Mr. Alier -- I'll just read it. It says,
11 secure email and file sent to Dr. Alier from
12 Scott Stoller at Anderson EMS with
13 investigation material they had gathered and
14 performed on an Iva Rescue Squad paramedic.
15 Investigation initiated by Bureau and file
16 started. Who actually typed that entry into
17 that log?

18 A: I would have no idea. I don't know.

19 Q: Do you know who generally types the entries in
20 the logs? Is it like a secretary or a ---

21 A: No, sir. It'd be one of us.

22 Q: Okay. One of the investigators would put that
23 in there?

24 A: It could be Arnold, it could be Rob, it could
25 be me.



1 Q: Okay. Who has access to making entries into a
2 log?

3 A: Investigator, the Director of EMS, and the
4 Bureau Chief.

5 Q: Okay. Did you write that first entry?

6 A: I cannot recall if ---

7 Q: Can't recall?

8 A: --- typed that. No, sir.

9 Q: Okay. The first entry I see with your initials
10 on it looks like it's the next one down, April
11 14th, 2016 9:00 o'clock. Investigation folder
12 started. You see that?

13 A: Yes, sir.

14 Q: Okay. CIS printed and secured in desk drawer.

15 A: Yes, sir.

16 Q: At the time you open the folder, did you put
17 anything into the folder that you received from
18 Mr. Alier?

19 A: It would have been the CIS profile, it would
20 have been progress notes like this, and
21 whatever else that was there, but that would
22 have been probably about it to start the
23 folder.

24 Q: Okay. What is CIS mean?

25 A: It is our credentialing system that we have,



1 sir.

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

4 A: If I may?

5 Q: Yeah.

6 A: This back here in this ---

7 Q: In the packet?

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

15 Q: Excuse me just one second.

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

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

23 **MR. WICEVIC:** May I?

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

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



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

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

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

14 **THE COURT:** Okay.

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

17 **THE COURT:** Okay. Thank you, but I'm admitting it.
18 **(Respondent's Exhibit Number 25 was admitted into**
19 **evidence.)**

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

25 **A:** It would have been the CIS, then progress



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

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

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

10 Q: Okay. And I don't see any other entries in
11 there from the 14th through the 18th, which I
12 guess would be the following Monday. Did you
13 do any investigation between 9:00 o'clock on
14 the 14th when you put the file in the desk
15 drawer and the next entry on Monday, April the
16 18th of 2016?

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

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

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



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1 Q: Okay. Do you recall having some difficulty
2 reaching Mr. Davenport on the phone number that
3 was in the CIS?

4 A: Yes, sir. The telephone number wasn't correct.

5 Q: Okay. Did it take a day or two to track him
6 down before you could finally ---

7 A: Yes, sir.

8 Q: --- get a hold of him?

9 A: I do believe I had to contact Iva Rescue Squad,
10 give them my contact information 'cause I
11 didn't want them to release anything via phone
12 because you never know who you talking to over
13 the phone. So I have them my contact
14 information so they could pass it onto Mr.
15 Davenport.

16 Q: Okay. So if you look back at the log, April
17 14th, 2016 the entry says, phone and email
18 contact made Iva PD. That's the Iva Police
19 Department?

20 A: Yes, sir.

21 Q: In reference to records for incident and formal
22 request via email for incident reports and
23 records pertaining to stabbing call.

24 A: Yes, sir.

25 Q: And it has your initials to the right.



1 A: Yes, sir.

2 Q: Okay. Is the email that you sent to the Iva
3 Police Department in that packet?

4 A: I'd have to look. I'm not sure.

5 Q: Is that something you'd normally put in the
6 packet?

7 A: Yes, sir. Probably.

8 Q: Okay. Do you recall who you spoke with at the
9 Iva Police Department to request the video?

10 A: There are some notes here. I talked to Jason
11 Hawkins.

12 Q: Okay.

13 A: Chief. These look like my hand written notes
14 right here I scratched. And he gave me John
15 Bench, Iva PD was apparently their
16 administrative person for Mr. Hawkins. And
17 that's who I sent the email to.

18 Q: Okay. When you spoke to the Chief, did you --
19 what did you ask him?

20 A: I asked him if he was familiar with the
21 stabbing call that Iva Police Department had
22 handled.

23 Q: Okay. And what was his response?

24 A: I'm not sure.

25 Q: Did he immediately put you in touch with Mr.



1 Bench?

2 A: No I do believe he said he was familiar with
3 it. I don't know his exact words, sir.

4 Q: Okay. Did you ask him for an official copy of
5 the body camera footage?

6 A: Yes, sir.

7 Q: Okay. How did you know about the body camera
8 footage?

9 A: Because of the video that was sent to Arnold
10 Alier.

11 Q: I beg your pardon?

12 A: Because of the video that was sent to Arnold
13 Alier.

14 Q: Okay. All right. So you called Iva Police
15 Department, asked for the incident report and
16 the video on the 18th. Do you recall what time
17 of day you called them? Is that indicated in
18 your notes?

19 A: I don't believe I put the time on there. No,
20 sir.

21 Q: Okay. And at some point you were able to get
22 in touch with Mr. Davenport once you found out
23 a correct number for him, right?

24 A: Yeah. I do believe, by my notes here it
25 appears that I called at 9:34, got a voice



1 mail.

2 Q: Voice mail ---

3 A: And then called and I think he called me back.

4 Q: Okay. And when you finally hooked up with Mr.
5 Davenport, what did you tell him?

6 A: I talked to Mr. Davenport and told him, I
7 identified who I was and that we were doing an
8 investigation in reference to some concerns
9 with his being a paramedic at Iva. I do
10 believe wanted to see if he would come down and
11 talk to us.

12 Q: Okay. Did you tell him that a complaint had
13 been filed against him?

14 A: I don't remember the exact conversation.

15 Q: Okay. Did you tell him that y'all were
16 reviewing a QA matter?

17 A: I don't remember the exact conversation, sir.

18 Q: Did you tell him how many calls were at issue?

19 A: I don't remember the exact conversation. It
20 was a conversation to get Mr. Davenport to come
21 in and talk to us if he wanted to come in and
22 talk to us.

23 Q: Okay. Did you tell Mr. Davenport you had
24 reviewed a body camera video footage of the
25 incident?



1 A: I don't recall.

2 Q: What was Mr. Davenport's response?

3 A: He said -- I'm not sure. I don't remember the
4 -- he agreed to come in and meet with us.

5 Q: Okay. Was he fairly cooperative?

6 A: Yes, sir.

7 Q: Okay. Did you have any previous interactions
8 with Mr. Davenport prior to that call?

9 A: No, sir.

10 Q: Okay. To your knowledge, have you ever met Mr.
11 Davenport prior to that?

12 A: I don't believe we ever have. No, sir.

13 Q: Okay. Your notes indicate what time of day it
14 was that you were finally able to get Mr.
15 Davenport to call you back?

16 A: I'd have to look through again. I don't
17 believe so.

18 Q: Was it after you spoke to the Iva Police Chief?

19 A: I don't recall.

20 Q: So then the next entry looks like April 19th,
21 2016 at 10:00 o'clock. Shows an interview with
22 James Davenport at Columbia Mills. Is that
23 where the DHEC offices are?

24 A: Yes, sir. We call it Cola Mills. Yes, sir.

25 Q: Cola Mills, sorry.



1 A: Yes, sir.

2 Q: With R. Wronski, R. Naugler, R. Wiznuski, and
3 Bently White were present?

4 A: Yes, sir.

5 Q: The interview was recorded and saved to t-drive
6 along with jump drive attached to investigation
7 folder. Right?

8 A: Yes, sir.

9 Q: And your initials there as well?

10 A: Yes, sir.

11 Q: At the time you interviewed with Mr. Davenport
12 and these other individuals that are identified
13 in that meeting, did you have the official
14 version of the body camera footage?

15 A: I don't believe so.

16 Q: Okay. In fact, when you talked to Mr. Bench at
17 the Iva Police Department, the administrative
18 guy ---

19 A: Uh-huh.

20 Q: --- he told you he'd have to overnight mail you
21 or email you -- I'm sorry, snail mail you or
22 overnight mail you an actual hard copy CD ---

23 A: Yes, sir.

24 Q: --- of the video?

25 A: Yes, sir.



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

4 A: Yes, sir.

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

8 A: As far as the investigation?

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

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

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

19 A: It appears to be a shared folder.

20 Q: Okay. And if I can just -- it looks like an
21 email from Scott Stoller through a Google drive
22 account to Naugler comma Richard on April 14th,
23 2016 at 9:54 a.m. You see that?

24 A: Yes, sir.

25 Q: The subject is AC 2013 invitation to



1 collaborate, right?

2 A: Yes, sir.

3 Q: Okay. Do you know whether that email was sent
4 to your DHEC email account?

5 A: Not by this. I have no idea. This just says
6 Richard Naugler.

7 Q: Okay. Do you recall receiving an invitation
8 from Mr. Stoller to join some sort of Google
9 shared folder?

10 A: This was probably when we talked about the
11 protocols I imagine.

12 Q: Okay. So you think that was the protocols that
13 were sent to you?

14 A: Yes, sir. I do believe so.

15 Q: Didn't Mr. Wronski say you already had the copy
16 of the protocols?

17 A: We have a copy of the protocols there and saved
18 to our t-drive, but we also like to see if
19 there's any updated protocols that may not have
20 been to our t-drive.

21 Q: Okay. So did you print out the protocols Mr.
22 Stoller sent to you?

23 A: I do not recall.

24 Q: Okay. There's a -- if you look back at the
25 packet, it looked to me like there was a number



1 of Anderson County EMS protocols in there,
2 right?

3 A: Yes, sir.

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

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

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

10 A: Yes, sir.

11 Q: Any others?

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

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

15 A: Multiple trauma shock protocol.

16 Q: Okay. What was T-10?

17 A: T-10 is extremity trauma protocol.

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

20 A: Yes, sir.

21 Q: Okay. What does extremity trauma?

22 A: Trauma to the extremities.

23 Q: Okay. What's an extremity?

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

25 Q: Okay. So an arm or a leg?



1 A: Yes, sir.

2 Q: Is your head considered an extremity

3 A: By true definition, I'm not sure.

4 Q: Okay. What about the abdomen? Is the abdomen
5 an extremity?

6 A: No, sir.

7 Q: All right. What's after T-10?

8 A: After T-10?

9 Q: Yeah. Off your list.

10 A: M-6, medical hypotension protocol.

11 Q: Medical ---

12 A: Hypotension.

13 Q: Okay. In your medical training, what does
14 hypotension mean?

15 A: Low blood pressure.

16 Q: Okay. Is there a difference between, like a,
17 chronic low blood pressure and like a single
18 incident of having a low reading on a blood
19 pressure cuff?

20 A: Please clarify.

21 Q: Yeah. Does hypotension refer to like a chronic
22 condition or say you have normal blood pressure
23 and then you have a reading that was
24 substantially lower than it was before. Is
25 there a difference in that term, hypotension?



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



1 Q: In the conduct of your investigation did you
2 actually pull the full book of Anderson County
3 protocols for the EMS department?

4 A: We don't keep them in a book. We keep them on
5 a t-drive.

6 Q: Okay. Did you pull up the entire t-drive?

7 A: I'm sure we looked at the t-drive. Yes, sir.

8 Q: Now I think there were actually more than just
9 the stabbing complaint in the initial pack that
10 you got, is that right, in the investigative
11 packet?

12 A: In the initial packet. Are the other two calls
13 in here?

14 Q: Well that's what I'm asking. Is there
15 information about more than just the stabbing
16 patient in that investigative packet?

17 A: Yes, sir. It appears that the internal review
18 that Anderson County did is in here. Yes, sir.
19 And a statement from Ms. Aiken. And their
20 review.

21 Q: All right. And did one of those involve a
22 pediatric patient?

23 A: Yes, sir.

24 Q: Okay. You understand that the gentleman you
25 saw, you wouldn't consider the gentleman in the



1 stabbing video to be a pediatric patient, would
2 you?

3 A: No, sir.

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

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

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

11 A: No, sir..

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

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

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

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

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



1 did.

2 A: My investigation came from the video.

3 Q: That's all you considered was the video, is
4 that right?

5 A: That's all I needed.

6 Q: Okay. You didn't speak with the actual Medical
7 Control Director for Anderson County, Dr.
8 Kickham, at any point during your
9 investigation, did you?

10 A: No, sir.

11 Q: Okay. You also did not obtain or print out a
12 complete copy of the Anderson County EMS
13 employee handbook, which contains policies,
14 procedures, protocols, and standing orders for
15 all EMS departments acting under Dr. Kickham's
16 medical control, did you?

17 A: No, sir.

18 Q: Okay. You also didn't speak with Anderson
19 County EMS Director Scott Stoller about the
20 Davenport matter as part of your investigation,
21 did you?

22 A: No, sir. He wasn't there that night.

23 Q: Okay. You didn't speak with anyone at the Iva
24 Rescue Squad about Mr. Davenport?

25 A: No, sir. We had Ms. Aiken's statement. She



1 was the only one that was there that night
2 other than her husband who was in the law
3 enforcement, I do believe.

4 Q: Okay.

5 A: He drew his weapon.

6 Q: Did you talk to Ms. Aiken?

7 A: No, sir. We had her statement.

8 Q: Okay. Did you ask Ms. Aiken whether the
9 statement was coerce?

10 A: I believe Mr. Davenport brought that up.

11 Q: That wasn't my question. My question is did
12 you ask Ms. Aiken if her statement was coerced?

13 A: No, sir.

14 Q: Okay. Did you speak with the Officer that took
15 the body cam video from Iva Police Department?

16 A: I have spoken with him since. Yes, sir.

17 Q: As part of your investigation ---

18 A: Uh-huh.

19 Q: --- did you speak with the person that took the
20 video that's shown in the body worn camera?

21 A: No, sir.

22 Q: Did you speak with Craig Lawless?

23 A: No, sir.

24 Q: Do you know who Craig Lawless is?

25 A: No, sir. He wasn't there that night.



1 Q: Are you familiar -- when you were a paramedic,
2 did you ---

3 A: I'm still a paramedic, sir.

4 Q: I'm sorry. When you were working for an agency
5 as a paramedic, or a private ambulance service
6 ---

7 A: Yes, sir.

8 Q: --- were you familiar with the QA process?

9 A: Yes, sir.

10 Q: Okay. And what is the QA process?

11 A: Quality assurance.

12 Q: Okay. Did your ambulance service have a QA
13 Officer, quality assurance Officer or somebody
14 in that function who reviewed calls for
15 compliance with protocols?

16 A: Yes, sir.

17 Q: Did you talk to the QA Officer for the Iva
18 Rescue Squad about Mr. Davenport's three calls
19 that were apart of your investigation?

20 A: No, sir. I investigated the video that I saw.

21 Q: Okay. Did you talk to the Anderson County
22 Training Officer, the Anderson County EMS
23 Training Officer about this matter?

24 A: No, sir. She wasn't there on that call.

25 Q: Did you speak to the Chief of the Iva Rescue



1 Squad, Sandy Sutherland about Mr. Davenport's
2 call?

3 A: Also was not there at the call.

4 Q: Did you obtain Mr. Davenport's personnel file
5 from Anderson County to see whether he had any
6 type of history or pattern of misconduct or
7 inappropriate or deficient care as a paramedic?

8 A: I did not. No, sir.

9 Q: Did you speak with Mr. Davenport's partners in
10 the other two calls, the pediatric seizure
11 patient? Well let's start with that one first.
12 I won't ask a compound question. Did you speak
13 with Mr. Davenport's partner on the pediatric
14 seizure call?

15 A: Was not part of my investigation.

16 Q: Okay. Did you even find who that patient or
17 who that EMT basic was that was on that call
18 with Mr. Davenport?

19 A: No, sir. But I don't believe she was at the
20 stabbing call.

21 Q: Okay. Did you speak with anyone named Jennifer
22 Brickle? That name sound at all familiar to
23 you?

24 A: No, sir. I don't believe she was at this call
25 either.



1 Q: Okay. You speak with Tommy Miller, the
2 Assistant Chief of the Iva Rescue Squad?

3 A: No, sir.

4 Q: Did you speak with anybody who helped Mr.
5 Davenport or was on a crew with Mr. Davenport
6 with the elderly gentleman that was taken from
7 the nursing home to the hospital in the second
8 of the three calls that were part of your
9 investigation?

10 A: My investigation was about the video, sir.

11 Q: Okay.

12 A: My misconduct is in the video.

13 Q: Okay. Did you speak with anyone else on the
14 scene that night about what you saw or thought
15 you saw on the video?

16 A: No, sir. I had a witness. I had video.

17 Q: Did you speak with Officer Burns who took the
18 photographs with the still camera? Did you
19 speak with him?

20 A: No, sir.

21 Q: Did you obtain any medical records from the
22 hospital Emergency Department of AnMed as part
23 of your investigation?

24 A: I believe Rich Wiznuski obtained those, sir.

25 Q: Okay. Did you as the lead investigator obtain



1 those records?

2 A: Rich Wiznuski, who is the Trauma Director has
3 access to those records and obtained them for
4 us.

5 Q: I'm not trying to be difficult. But my
6 question's a little simpler than that. Okay.
7 Did you as the lead investigator in this matter
8 contact the AnMed Emergency Department to get
9 medical records?

10 A: We often work together in our office and he
11 obtained them for me. So, no. I did not
12 directly contact them. No, sir.

13 Q: Okay. Did you direct anyone to get records
14 from AnMed Emergency Department about this
15 matter?

16 A: I believe our Bureau Chief, Mr. Wronski,
17 answered that earlier that he directed Rich
18 Wiznuski to do it.

19 Q: Okay. If you look in that investigative packet
20 that we marked. I think it's 25.

21 A: There's not a number one it.

22 Q: On the bottom left, Exhibit 25?

23 A: Yes, sir.

24 Q: Are there any medical records from AnMed
25 hospital Emergency Department in that packet,



1 sir?

2 A: This packet that you gave me?

3 Q: Yes.

4 A: I don't see any. No, sir.

5 Q: Do you see any entries under log prior to the
6 date Mr. -- Exhibit 3, the log of your
7 investigation, prior to Mr. Davenport picking
8 up the copy of the packet. Do you see anything
9 in there about obtaining records from AnMed
10 Hospital?

11 A: No, sir. I do believe they were received after
12 that.

13 Q: Okay.

14 A: So they wouldn't have been available.

15 Q: So they would have been received after the
16 initial interview you had with Mr. Davenport,
17 right? Or that you participated in at the Cola
18 Mills, is that correct?

19 A: Repeat the question.

20 Q: You just mentioned that the AnMed records were
21 received after that. You're talking about
22 after Mr. Davenport picked up the packet from
23 you. And my question was, so at the time you
24 met with Mr. Davenport at Cola Mills, for the
25 initial interview, you didn't have records from



1 the AnMed Hospital, right?

2 A: I'd have to listen to the audio recording just
3 to verify. I'm not sure.

4 Q: Did you obtain any operation room record from
5 AnMed Hospital?

6 A: Did I?

7 Q: Yes, as part of your investigation?

8 A: I did not. I do believe Rich Wiznuski did,
9 sir.

10 Q: Have you ever seen the operating room records
11 from AnMed Hospital?

12 A: As part of -- I do believe they're in here.

13 Q: Do you recall when you saw those for the first
14 time?

15 A: I don't recall. No, sir.

16 Q: Was it within the last say month?

17 A: May have been. I'm not sure.

18 Q: Okay. Now you mentioned everything you needed
19 to see was on the body camera video. Did you
20 see the patient's wife in the trailer?

21 A: Yes, sir.

22 Q: Did you ever talk to the patient's wife about
23 the stabbing call?

24 A: No, sir.

25 Q: Did you ever speak to the patient himself about



1 the stabbing call?

2 A: No, sir. I do believe he said he had psycho-
3 social history. So I do believe we wouldn't
4 have gotten anything reliable. And what I
5 needed was in the video.

6 Q: Do you know of anyone from DHEC, either you,
7 Mr. Wronski, or Mr. Wiznuski ever spoke to the
8 patient?

9 A: As far as myself. I can speak for myself. No,
10 sir. I did not.

11 Q: Did you ever direct anybody to go speak with
12 the patient to see how he interpreted the
13 statements that you saw in the video?

14 A: No, sir.

15 Q: To your knowledge, did the patient ever file a
16 complaint with DHEC against Mr. Davenport for
17 the conduct that was displayed in the video?

18 A: To my knowledge, no, sir.

19 Q: Okay. To your knowledge, did anyone in the
20 patient's family ever file a complaint with
21 DHEC about the conduct that was displayed by
22 Mr. Davenport in the video?

23 A: No, sir.

24 Q: Now, Mr. Wronski talked about sort of a little
25 strategy meeting that occurred prior to the



1 interview or interrogation of Mr. Davenport.
2 Do you recall that testimony from Mr. Wronski?

3 A: Prior to the interview we probably sat down and
4 talked a little bit. Yes, sir.

5 Q: Okay. Who was involved in that sort of
6 strategy discussion?

7 A: I believe probably just me and Mr. Wronski.
8 Maybe Mr. Wiznuski. I'm not sure.

9 Q: Okay. How many times have you viewed the video
10 before you sat down with Mr. Davenport and had
11 that meeting on April the 19th of 2011?

12 A: Probably like two or three times, sir.
13 Actually maybe more than that 'cause I took
14 actually some -- yeah, probably more than that.

15 Q: Okay. Tell me about the context in which you
16 viewed that video. Were you sitting by
17 yourself looking at your computer screen in a
18 cubical?

19 A: Yes, sir.

20 Q: Okay. Did you ever look at the video with any
21 other people prior to meeting with Mr.
22 Davenport?

23 A: I believe I might have been there when Dr. Ed
24 saw it.

25 Q: Who's Dr. Ed? Dr. Ed Deschamps?



1 A: Yes, sir.

2 Q: Okay. Were you here when he testified earlier
3 in the case?

4 A: Yes, sir.

5 Q: Okay. You recall him saying he didn't know
6 whether he saw the video before Mr. Davenport
7 saw the video?

8 A: Yes, sir.

9 Q: Okay. Can you clear that up?

10 A: Not for him. No, sir. I can't clear it up for
11 him.

12 Q: Okay. Well you just said you believe that you
13 were in the meeting with Dr. Ed ---

14 A: But I'm not sure if that was before or after
15 the interview. I just remember I'm pretty sure
16 I was there when Dr. Ed viewed the video, sir.

17 Q: Okay. Were you ever present when Mr. Wronski
18 viewed the video?

19 A: Yes, sir. We viewed it together.

20 Q: Okay. Were you ever present when Dr. Alier
21 viewed the video?

22 A: I think so. Yes, sir.

23 Q: Did that occur prior to the interview with Mr.
24 Davenport on April the 19th?

25 A: Yes, sir.



1 Q: You recall discussing -- I think Mr. Wicevic
2 called it the ultimate objective of meeting
3 with Mr. Davenport? You recall that?

4 A: Yes, sir.

5 Q: Okay. What was the ultimate objective in this
6 case?

7 A: To get to the truth. To find out if there was
8 any misconduct or regulation violations.

9 Q: And I think y'all discussed some type of a
10 strategy or like a game plan before you brought
11 Mr. Davenport down. Is that right?

12 A: Sir, I've been a firefighter, police Officer,
13 paramedic. We don't go into anything -- we
14 have game plans and strategies just like you
15 do.

16 Q: Your conclusions were already reached in this
17 case before any investigation was done, isn't
18 that right?

19 A: My conclusions?

20 Q: Your conclusions.

21 A: My observations.

22 Q: Your investigation was completed before it
23 started, isn't that right?

24 A: No, sir.

25 Q: Okay. You just said you saw the video and



1 that's all you needed.

2 A: If we'd have just done that we'd have never
3 called Mr. Davenport in. We would have just
4 sent him a letter. We always bring people in
5 and have them try to explain their actions
6 because, number one, it's patient advocacy.
7 There's no patient advocacy that night on that
8 scene. So I became that patient advocate.
9 Still brought Mr. Davenport in for him to
10 explain why would you mock a patient like this.
11 Why would you treat a patient like this.

12 Q: How do you know Mr. Davenport was mocking that
13 patient?

14 A: I've worked the streets. I read people. He
15 was mocking that patient.

16 Q: And did you see Mr. Davenport facial expression
17 in the reflection of the mirror when he said,
18 did anybody ever tell you that you're an idiot?

19 A: As a matter of fact I looked at it again last
20 night. He did not smile. There was actually
21 a part where he actually mocks him at the back
22 of the truck.

23 Q: When you say he mocks him at the back of the
24 truck, what do you mean he mocked him?

25 A: When they were standing at the back of the



1 truck after -- I believe you testified they
2 walked him gingerly to the truck.

3 Q: I haven't testified. I'm a lawyer.

4 A: I apologize. That they walked him to the
5 truck. Mr. Davenport actually walked in front
6 of him to the rear of the truck, opened the
7 door, they're unloading the stretcher. The
8 patient, I don't want to say his name, was
9 talking to the police Officer about his wife,
10 the concentrator, depression. The police
11 Officer's talking to him and Mr. Davenport
12 turns around and you can hear, yeah, yeah, yeah
13 as if mocking the patient. --

14 Q: Okay. Do you know what Mr. Davenport was
15 referring to when he said, yeah, yeah, yeah?

16 A: I know what it appeared to be.

17 Q: Okay. You're just going by what you saw on the
18 video right?

19 A: That he verified it was him calling him an
20 idiot during the interview, Yes, sir.

21 Q: Have you ever worn a body worn camera as a
22 police Officer?

23 A: I worn a body mic, not a body camera. No, sir.

24 Q: Okay. Does that camera generally go on the
25 front of the Officer's body?



1 A: I believe if you look at the video, it is
2 centered on his bullet proof vest. Yes, sir.

3 Q: Okay, and you can see that in the reflection of
4 the mirror, right?

5 A: Yes, sir.

6 Q: So, do you know what the scope of view of that
7 camera picks up?

8 A: It varies upon camera. That one, I'm not sure.
9 Cameras pick up a variety of area.

10 Q: Have you seen more than one view of this scene,
11 in terms of body camera footage?

12 A: No, sir.

13 Q: Okay. So, the camera doesn't show us going
14 behind the Officer, does it?

15 A: No, sir.

16 Q: Okay. It doesn't show us going on far to the
17 right outside of the view of that camera, does
18 it? It doesn't show us going on to the left of
19 the scene.

20 A: No, sir.

21 Q: Okay. It doesn't show us going on below the
22 frame of the camera, right?

23 A: No, sir.

24 Q: So, a lot of time in that video, you see just
25 the patient's head in the -- you don't even see



1 the knife in some of that video when the
2 Officer's standing there, and Mr. Davenport's
3 providing care to him, right?

4 A: Until the Officer moves down and the knife
5 comes in to view, Yes, sir.

6 Q: Okay, but you can't see what Mr. Davenport is
7 doing below the frame of that camera, can you?

8 A: No, sir, but in this particular part, Mr.
9 Davenport's face is right there because the
10 camera is pointing straight at him.

11 Q: Your testimony is that you can see everything
12 that Mr. Davenport was doing on that scene?

13 A: No, sir. I'm talking about the one part, right
14 there.

15 Q: Now, you were here when we listened to sorta
16 snippets from that interview, remember?

17 A: Yes, sir.

18 Q: Was that you that sort of raised your voice at
19 Mr. Davenport.

20 A: Yes, sir.

21 Q: Okay. And at some point Mr. Wronski had to say
22 to you, whoa no no, calm down, let's not get
23 mad. Do you recall that?

24 A: Yes, sir. Can I explain?

25 Q: Well -- you also said to Mr. Davenport when



1 asked for a response, oh that's what you're
2 going to go with now. Do you remember saying
3 that? Was that your voice that said that?

4 A: I'd have to listen to the tapes.

5 Q: Okay. I think the discussion was about why Mr.
6 Davenport laid the patient flat on the
7 stretcher.

8 A: Uh-huh.

9 Q: And Mr. Davenport's response was, he didn't
10 want the patient looking down at the knife on
11 the ride to the hospital, right?

12 A: I'd have to listen to it sir, I'm not sure.

13 Q: Okay, and your response to that was, oh that's
14 what you're going to go with now.

15 A: I'd have to listen to the tape. You're telling
16 me, I'm not sure.

17 Q: Okay. Who was it in the interview that
18 actually said you harmed -- you deliberately
19 hurt that patient James. Was that your voice
20 or Mr. Wronski's voice?

21 A: You would have to play the tapes sir, I'm not
22 sure.

23 Q: Have you ever had a knife in your belly?

24 A: I've had a dog bite into my belly, Yes, sir.

25 Q: Have you ever had an impaled object in your



1 belly?

2 A: No, sir.

3 Q: Have you ever treated a patient that had an
4 impaled object in their belly.

5 A: Yes, sir, I do believe so.

6 Q: How many times have you done that in your
7 career?

8 A: Mr. Rothstein, I've run thousands of calls. To
9 tell you exactly, I have no idea. But yea, I
10 know I've bandaged, and I do remember
11 mobilizing something in somebody's stomach one
12 time and transporting them the best that I
13 could, Yes, sir.

14 Q: Was it early in your paramedic career, or
15 toward the end when you were hanging it up and
16 moving to DHEC?

17 A: I'm sorry, hanging it up and moving to DHEC --

18 Q: I'm sorry, in your clinical career.

19 A: I'm still a clinical paramedic sir.

20 Q: Can you recall when in your career you saw a
21 penetrating abdominal wound, stomach where the
22 object was still impaled in the victim?

23 A: It could have been five years ago, it could
24 have been seven. I'm not exactly sure.

25 Q: Doesn't stick out in your mind? You don't



1 remember?

2 A: There are a lot of calls that stick out in my
3 mind, but for other reasons.

4 Q: Okay. Particularly like a critical trauma
5 would stick out in your mind?

6 A: No, I've had a lot of violent trauma. I've
7 worked a lot of trauma.

8 Q: Okay. Did you work as an EMT basic at some
9 point in your career?

10 A: Six years, Yes, sir.

11 Q: Okay. Was the stabbing calls you can recall or
12 the impaled objects in abdomen calls that you
13 can recall, were you the paramedic or the EMT
14 on that?

15 A: I was paramedic.

16 Q: Okay. During your career as a paramedic or
17 EMT, have you ever heard a first responder,
18 paramedic, EMT on the scene use language that
19 you thought was offensive.

20 A: Oh yea, always. And I've always corrected them
21 too.

22 Q: Okay. Have you ever filed a complaint against
23 their paramedic or EMT certificate after that.

24 A: I have not filed against their certificate. I
25 went to my supervisor, and we let them handle



1 it from there.

2 Q: That's the proper way to handle this, right?
3 Is to take Davenport aside as supervisor, take
4 Mr. Davenport aside and say James, you can't
5 talk to patients like this. That's not a
6 certification issue is it?

7 A: It can be, yes.

8 Q: But that's not how you handled it when you
9 heard inappropriate language in the field.

10 A: I wasn't in the office where I'm at now.

11 Q: I've got one other thing. There's a white
12 notebook with the DHEC exhibits in it. Let me
13 ask you, you mentioned those two private
14 ambulance services that you worked for at the
15 end of your career. Were those emergent
16 called, or were those transport?

17 A: Actually, both. I've actually -- the Midlands
18 MedTech we took patients, responded to 9-1-1
19 calls in the Sumter area.

20 Q: Was that a BLS truck, or an ALS truck?

21 A: It was an ALS truck.

22 Q: If you'll turn to tab 8.

23 A: 8?

24 Q: 8.

25 A: Yes, sir.



1 Q: Do you recall participating in an Investigative
2 Review Committee meeting over Mr. Davenport's
3 situation?

4 A: Yes, sir, and if I may, Your Honor, just to
5 make sure. My nickname Naugy, and I do believe
6 you might see this in the transcript. I think
7 Dr. Deschamps calls me Naugy instead of Richard
8 Naugler, just to make sure.

9 **THE COURT:** Yes, sir, go ahead Mr. Rothstein.

10 Q: I'm going to ask you to turn to page 4. And
11 again this is one of those things that's got
12 reduced page, and I said four pages on each
13 page. Big page 4, little page 13, okay?

14 A: Yes, sir.

15 Q: There's a discussion. You see your name down
16 there starting on line 19?

17 A: Yes, sir.

18 Q: Okay. And I'm just going to have you read
19 along silently as I read it. It says, Mr.
20 Naugler the other two calls that we had a whole
21 QA packet that was originally sent to us. This
22 is the whole QA packet. Dr. Deschamps says,
23 and there was multiple. And you responded,
24 there were multiple, right? Do you recall that
25 discussion in the IRC meeting?



1 A: Yes, sir.

2 Q: Okay. So you were trying, you and Dr.
3 Deschamps are trying that there are more than
4 just one call against Mr. Davenport's
5 situation, right?

6 A: No, I think we were answering Dr. Clanton, and
7 so there are these other charts. We were
8 trying to clarify what the other charts were.

9 Q: Okay. And you were trying to imply that Mr.
10 Davenport has a pattern of misconduct. This is
11 not just a single event, this is more than one
12 event, right?

13 A: No, sir, I wasn't trying to imply anything. I
14 was just explaining that there were more than
15 one chart.

16 Q: But more than one chart was discussed at the
17 IRC, isn't that right?

18 A: I'd have to look at the notes, I'm not sure.

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

21 MR. WICEVIC: I just have a couple -- thank you,
22 Your Honor.

23 **MR. NAUGLER - CROSS-EXAMINATION BY MR. WICEVIC:**

24 Q: Mr. Naugler, here at the beginning there's a
25 mention of your training of inspecting. You



1 mentioned that thing CLEAR.

2 A: Yes, sir.

3 Q: What is CLEAR?

4 A: It's a counseling licenser that certifies
5 investigators and compliance Officers.

6 Q: Okay. So you're certified by them?

7 A: Yes, sir.

8 Q: What did you have to do for that?

9 A: It's a pretty aggressive course that you take.
10 I did it in Raleigh. It was about a three day
11 course, and you have to test and be certified
12 by them.

13 Q: Okay.

14 **MR. ROTHSTEIN:** Mr. Naugler, I'm having a little
15 trouble hearing you.

16 **MR. NAUGLER:** I'm sorry.

17 **MR. ROTHSTEIN:** Thanks.

18 **MR. NAUGLER:** Uh-huh.

19 Q: This is Exhibit 3 the DHEC investigation log.
20 Can you just give the court a general
21 explanation of how you complete that?

22 A: As things come in, we try to log them as best
23 possible, and just keep up with notes. Try to
24 keep a pattern going as far as our
25 investigation.



1 Q: Does it act like a timeline?

2 A: It can be a timeline. Yes, sir.

3 Q: I think that's all I have for you.

4 A: Okay.

5 THE COURT: Anything Else?

6 MR. ROTHSTEIN: Not with this witness, Your Honor.

7 THE COURT: Okay, thank you Mr. Naugler.

8 MR. ROTHSTEIN: Next call Arnold Alier to the stand
9 Your Honor.

10 THE COURT: Mr. Rothstein, before you get to your
11 next one, so we don't have to interrupt, let's
12 take our ten minutes here before we get into
13 it.

14 (Off the record from 10:16 a.m. until 10:30 a.m.)

15 THE COURT: We're going to call the hearing back to
16 order. And you can get the witness up to the
17 witness box to be sworn in.

18 DR. ARNOLD ALIER, having been duly sworn, testifies
19 as follows:

20 DR. ALIER - DIRECT EXAMINATION BY MR. ROTHSTEIN:

21 Q: Good morning, Dr. Alier. I'm David Rothstein.
22 I don't know that you and I have ever actually
23 met before. I guess we introduced each other
24 at IRC meeting.

25 A: Yes, sir. I think we did.



1 Q: Okay. Could you state your full name for the
2 record please?

3 A: Arnold Alier. No middle name.

4 Q: Okay. And I noted we've been referring to you
5 as Dr. Alier. You're not a medical doctor, is
6 that correct?

7 A: No, sir. I've got my doctorate in education.

8 Q: Okay. And where did you get your doctorate of
9 education?

10 A: Bob Jones University in Greenville.

11 Q: Okay. Is that in the paramedic education or
12 EMT education?

13 A: It was in adult education. There was a process
14 by which I got my masters first in education
15 and then my doctorate. I had a bachelor's
16 degree when I started in EMS in an unrelated
17 field. And once I switched over from the
18 career that I was in, 'cause I was a Public
19 Safety Officer for the university, I took the
20 EMT class, and sort of like a lot of people,
21 the bug bit me. In 1985 I switched over to
22 Greenville County, went back to school, got my
23 associate's degree in EMS. Worked the street
24 in Greenville for 21 years. When I was
25 promoted to the Training and Education



1 Coordinator even though I had two degrees I
2 felt I needed to validate that as adult
3 education. So I went back to school, got my
4 masters in education, and then proceeded on and
5 got my doctorate in education.

6 Q: Okay. So that was to assist with your, I
7 guess, instilling education in as a part of
8 your Training Officer role. Is that a fair --
9 at Greenville County EMS?

10 A: That's correct. As well as at the time I sort
11 of had a dual career like a lot of folks in EMS
12 do. So I taught EMT classes at the Bob Jones
13 University Program, the Greenville Tech
14 Program, as well as in Tricounty Tech.

15 Q: Okay. And you said you had got your
16 associate's degree in EMS from Greenville Tech
17 in 1985?

18 A: I started in '85, finished in '87.

19 Q: Okay.

20 A: We were the first graduating paramedic class in
21 that program in the State.

22 Q: And then you went from there to Greenville
23 County EMS, right?

24 A: In '85 I had started working for Greenville
25 County while I was going to school. I was



1 first what they call a comspect dispatcher
2 prior to the 9-1-1 system where you dial the 9-
3 1-1. So I did that for about a year before
4 going to the field as an intermediate. And
5 then a year later I graduated as a paramedic
6 and stayed in the field as a paramedic.

7 Q: I understand that while you were a field medic
8 for Greenville County you were partners at one
9 point with a gentleman named Scott Stoller?

10 A: That's correct. Sometime probably around '94
11 I think. '94, '95.

12 Q: How long were you and Mr. Stoller partners?

13 A: I don't remember exactly but it's probably
14 about a year 'cause usually what they do you
15 change partners about every six months or you
16 change -- I should say you change at that time
17 stations about every six months. And we worked
18 two stations, one in Simpsonville first and
19 then we went to the one in Gantt, which is the
20 lower west side of Greenville area.

21 Q: After your partnership, did you remain friends
22 with Mr. Stoller?

23 A: We were acquaintances. I mean we never ate
24 lunch or visited each other or anything like
25 that. I knew him. We had a lot of people in



1 Greenville County, and you sort of develop a,
2 I would say a longtime friendship with all your
3 partners. I still keep up with folks that I
4 had worked with in the past. Some are in
5 Spartanburg, some are in Anderson. The EMS
6 community is a very tight knit community.
7 That's good for a lot of reasons. There's a
8 lot of support when somebody's hurting or
9 somebody dies, we all see each other at
10 funerals. So everybody knows each other pretty
11 much.

12 Q: Okay. Would you consider yourself to be -- Mr.
13 Stoller to be a friend of yours if I said ---

14 A: That's a good characterization. Yes, sir.

15 Q: Okay. Would you consider him a close friend of
16 yours?

17 A: Close friends are the ones that would come to
18 my house, we would have dinner, we go to
19 church. That's a very small group. Is he
20 friends with me on FaceBook, yes. But I've got
21 well over 400.

22 Q: Do you keep in touch with Mr. Stoller on a
23 regular basis?

24 A: We do professionally. We are both members of
25 a Law Enforcement Officer's Team. We started



1 that program back in January of 2016 as a
2 result of the Fifth Circuit Collicitor's Office
3 initiative. He brought three agencies, DAODAS,
4 Solicitor's Office, and EMS. And at the time
5 when we started looking at the training program
6 we specifically were looking at not just
7 paramedics doing the teaching. The law
8 enforcement community is very distinct although
9 we share a lot of things with the first
10 responders. So we wanted to get paramedics
11 that were also Officers. And so Sergeant Jeff
12 Ward with the Sheriff's Office was one of the
13 ones that we invited to look at materials as
14 well as Scott Stoller 'cause he's both a
15 Officer as well as a paramedic, and he's got a
16 bomb dog. I know that was a real concern with
17 the program of K-9 Officers.

18 Q: Okay. Would you say you speak with Mr. Stoller
19 regularly more than once a month?

20 A: Yes, sir. We have training usually about once
21 a week or once every couple weeks. Not
22 everybody on the team makes it to every single
23 session. We try to do that for the large
24 agencies. So we have all hands on deck. But
25 not necessarily every day. Usually our



1 trainings are on Fridays, and so I will send
2 out a memo or Assistant Solicitor Shankar will
3 send out a memo or an email to all of us. So
4 that's sort of the communication we have.
5 We're going to be doing a class in Charleston
6 or we're going to be doing a class in Sumter.
7 That's the normal chitchat that we usually
8 have. Or when we have a save, an Officer save
9 someone, there's a group text that goes around
10 kind of celebrating the success of that.

11 Q: How many people would be in that group text?

12 A: Five.

13 Q: Okay. You have Mr. Stoller's cell phone number
14 in your phone contacts?

15 A: Yes, sir. I do.

16 Q: Okay. Do you regularly communicate with Mr.
17 Stoller by email?

18 A: Not that frequently. He has sent me a couple
19 of packages in the past on my DHEC mail.
20 That's usually the extent of our communication.

21 Q: When was the last time you spoke with Mr.
22 Stoller?

23 A: Probably a couple days ago. I think he asked
24 me when I was going to be testifying, and I
25 said I didn't know.



1 Q: Do you call Mr. Stoller Scotty? Is that ---

2 A: No, sir.

3 Q: Never called him Scotty?

4 A: No.

5 Q: Okay. What does he call you? Dr. Alier?

6 A: No. He calls me Arnold. Unless we're in a
7 public meeting. Whenever we're doing the LEON
8 class, that's the acronym for the classes, he
9 may refer to me in public when he's talking to
10 the Officers as Dr. Alier, but for the most
11 part within the group it's just Arnold.

12 Q: Okay. So Mr. Stoller became EMS Director for
13 Anderson County. Has he frequently run things
14 by you relating to the operations of his
15 office?

16 A: I would say maybe once every six months he'll
17 run something by me, but that's pretty common.
18 Other agencies do that. In fact yesterday
19 while we were here at trial I got the same
20 courtesy from an agency in the Upstate last
21 week, one from Lexington.

22 Q: What kinds of things does he run by you since
23 you've been DHEC EMS Director?

24 A: Well he kind of wanted to get in and find out
25 when we were going to be publishing the new



1 protocols so they can look at them, adopt them.
2 The last time that the State had protocols done
3 was around 2009, so they were long overdue. We
4 have received packages from him where they did
5 an internal QA. He wanted me to review it to
6 make sure they didn't miss anything. Very
7 similar to what I get from other EMS agencies.
8 Berkeley County did the same thing, Greenville
9 County, Pickens County. But they look to us
10 for leadership and just to put eyes on things
11 to make sure that something was not missed.

12 Q: How many QA packet reviews would you say you've
13 discussed with Mr. Stoller since he became
14 Anderson County EMS Director?

15 A: I don't know. More than two, less than ten.

16 Q: Okay. Has he ever run anything more serious by
17 you other than say a QA review?

18 A: I don't recall. I think we had a conversation
19 after the shooting at the elementary school.
20 That was not necessarily a QA situation. He
21 just needed someone to talk to and so he called
22 me.

23 Q: Is providing sort of oversight of -- actually
24 how many EMS agencies or rescue squads around
25 the State does DHEC monitor?



1 A: I'll have to check because they change daily.
2 But either 247 and 268. It varies. We've had
3 some losses.

4 Q: Okay. Do you regularly at DHEC serve as an
5 oversight body for QA reviews on some or any of
6 the 240 something?

7 A: It's not an official capacity, but people do
8 run stuff by us all the time.

9 Q: Okay. Does DHEC get involved in personnel
10 matters, like human resources type matters?

11 A: No, sir. That's outside of our purview.

12 Q: Okay. Do you agree that those are local
13 problems and need local solutions?

14 A: I believe those were my words. Yes, sir.

15 Q: Did Mr. Stoller in his discussions with you
16 ever tell you he was having any problems with
17 particular paramedics in his office at Anderson
18 County EMS?

19 A: Not prior to this investigation.

20 Q: Okay. He never called you up and told you he
21 was having difficulty with a guy named James
22 Davenport that just came back from military
23 service?

24 A: No, sir.

25 Q: Let me hand you a document. It's not in



1 evidence, but I'll represent to you that that's
2 DHEC's interrogatory responses in this case.
3 Do you see that?

4 A: Okay.

5 Q: And in the first interrogatory he was asked to
6 identify the witnesses. Do you see your name
7 on the witness list from DHEC?

8 A: Yes, sir.

9 Q: Okay. And then the second interrogatory states
10 to summarize what the witnesses identified in
11 interrogatory number one might know about the
12 case or what they might testify to. You see
13 that?

14 A: Yes, sir.

15 Q: Okay. Do you see your name down there in the
16 summary of what you were expected to testify
17 about?

18 A: Hold on a second. Okay. There we go.

19 Q: If you'll follow along, I think it states, Dr.
20 Alier received a complaint which alleged
21 regulatory violations against Mr. Davenport and
22 initiated the investigation. Did I read that
23 sentence correctly?

24 A: Yes, sir.

25 Q: Okay. And then it says, Dr. Alier recused



1 himself from the investigation into Mr.
2 Davenport.

3 A: Yes, sir. I see that.

4 Q: Okay. Did I read that one correctly?

5 A: Yes, you did.

6 Q: Okay. We'll look at the receipt of the
7 complaint in a minute. But is it true that you
8 recused yourself from the investigation of Mr.
9 Davenport?

10 A: In the true sense of the word, no. I received
11 a complaint, so I'm the boss. I have to do
12 something with it. So I assigned an
13 investigator and then I had very limited
14 access. I could go to the file because I have
15 the password to get into it, permissions. I
16 did not review the video after we reviewed it
17 with Dr. Deschamps. And I think the next time
18 I saw it again was at the IRC. I was invited
19 to the IRC because I was germane to the
20 investigation receiving the initial QA package
21 that later turned into the investigation when
22 we got the video tape. But I was not in the
23 decision process for any of the interviews as
24 well as any of the consent orders or any of the
25 subsequent administrative orders.



1 Q: Okay. Let me back you up to one thing you
2 said, and make sure I understood it correctly.
3 Did you say that the first time you reviewed
4 the video was with Dr. Deschamps?

5 A: No, sir.

6 Q: Okay. When was the first time you reviewed the
7 video?

8 A: It was the day that I received it. I often
9 work late in my office. Mostly because, well
10 a couple of reasons. The phone usually stops
11 ringing at 5:00 o'clock. So I get my best work
12 done between 5:00 and 7:00. So he had called
13 me, said he was going to send me something.
14 But it was a large file and DHEC has kind of a
15 filter that if something's over I think ten
16 megabytes that it won't come through. And so
17 I gave my email address for my personal email
18 address, which has a larger capacity. And so
19 he sent me the video, and that's the first time
20 I saw it once I downloaded it and looked at it.

21 Q: Okay. Had Mr. Stoller communicated with you in
22 any way about Mr. Davenport prior to that
23 video?

24 A: Nothing other than that package that I'd
25 received, that QA package ---



1 Q: Okay.

2 A: --- that was sent to me. I believe the QA was
3 done by Mr. Eudy.

4 Q: You know Mr. Eudy?

5 A: I do. He had worked in Greenville about the
6 same time as I did.

7 Q: Were y'all ever partners?

8 A: We were never partners. We had that summer
9 between 150 and 200 employees. I remember him
10 going through the paramedic program. I may
11 have been his preceptor once or twice that he
12 rode with me. But he was never my partner.

13 Q: Okay. Would you consider Mr. Eudy one of your
14 friends?

15 A: I don't have his phone number. I don't know
16 where he lives. I would consider him a friend,
17 but again, somebody who we had a past.

18 Q: Okay. When was the last time you spoke to Mr.
19 Eudy? I mean other than -- did you see him in
20 the courtroom here?

21 A: I saw him in the courtroom.

22 Q: Prior to that.

23 A: I'm trying to think.

24 Q: Prior to that, when was the last time you spoke
25 to him?



1 A: I may have seen him at the symposium and prior
2 to that I believe at the funeral of a
3 paramedic.

4 Q: Is Mr. Eudy one of your FaceBook friends as
5 well?

6 A: No, he's not.

7 Q: Did you ever tell anybody that you were going
8 to recuse yourself from this investigation?

9 A: I don't recall if I did or not. That's usually
10 our internal policy. If we have a history with
11 an agency or an individual for purposes of
12 appearing transparent and being accountable ---

13 Q: Was this one of those instances where you felt
14 like maybe I should not be involved in this?

15 A: Yes, sir.

16 Q: Okay. And when did you make that determination
17 that this may be a little too close to home.
18 I better stay away from this investigation.

19 A: As soon as I saw the video.

20 Q: Okay. Did you ever review those interrogatory
21 answers before they were submitted or sent to
22 me? Or is this the first time you've ever seen
23 those ---

24 A: That's the first time I've see this.

25 Q: Now did anybody tell you that you should not be



1 part of the investigation, or did you say, look
2 I think I better step back from this one
3 because of my relationship with Mr. Stoller?

4 A: That was my decision with my boss.

5 Q: Okay. If you recused yourself from this
6 matter, why'd you participate in the IRC
7 meeting?

8 A: Again, they asked me to come in and they were
9 asking me about the initial QA that I had
10 reviewed. And they asked me how I received the
11 video.

12 Q: Okay. So wait. Your testimony is that you
13 were a witness in the IRC?

14 A: I was a participant in the IRC. They asked me
15 how I got the video.

16 Q: You were actually part of the IRC, right? I
17 mean the statute defines who's in the IRC ---

18 A: I had no decision making process in that, sir.

19 Q: Okay. Well why did you participate in the
20 executive committee session after Mr. Davenport
21 and I were excused from the meeting?

22 A: They called me in because I had Mr. Stoller's
23 phone number.

24 Q: Okay.

25 A: I believe they asked me to call him because



1 they had some questions for him. I came in,
2 did that, and then stepped out.

3 Q: Now, you were here when Mr. Naugler was
4 testifying a few minutes ago. Have you ever
5 seen the investigative packet that was provided
6 to Mr. Davenport?

7 A: No, sir. I've not reviewed it.

8 Q: Okay. I'm going to ask you to look at Exhibit
9 25.

10 A: Okay.

11 Q: Would you expect the actual complaint to have
12 been part of the investigative packet that was
13 provided to Mr. Davenport?

14 A: I would say that the video tape was really the
15 complaint itself. It kind of spoke by itself.
16 We didn't have a formal written complaint,
17 please look at this in relationship to that.

18 Q: Let me show you Exhibit 3. Do you recognize
19 Exhibit 3?

20 A: Yes, sir.

21 Q: And do you recognize that as the investigative
22 log in the matter?

23 A: Yes, sir.

24 Q: Okay. And you see the first entry on Exhibit
25 3 dated April 13th, 2016 at 5:04?



1 A: Yes, sir. I made that entry.

2 Q: Okay. And those are your initials over there
3 to the right, is that right?

4 A: That is correct.

5 Q: Okay. So you would have set up this entire
6 template of this document. Is that correct?

7 A: All I did was put in the first entry, initial
8 it, and then hand it off to the investigator.

9 Q: Okay. Well you would have had to fill out the
10 subject of the thing before you started typing,
11 wouldn't you? The first line says, 16-4-126-
12 Davenport. Did you put that in there on the
13 log?

14 A: I don't recall if we did that or -- I'm not
15 sure. We did usually have our Compliance
16 Officer assign numbers.

17 Q: Show is the compliance Officer?

18 A: Ryan Nix.

19 Q: Ryan Nix. How long has he been the Compliance
20 Officer? Would it be since you've been at
21 DHEC?

22 A: Yes, sir. I'm just trying to remember if it's
23 been two or three years. Something to that
24 effect.

25 Q: Okay. On the top right after subject it says



1 region and then it says region one. What is
2 region one?

3 A: Region one is the Upstate.

4 Q: Okay. Start date April 13th, 2016. Then it
5 says Inspector Richard Naugler. Who assigned
6 this to Richard Naugler?

7 A: Both Rob Wronski and I did.

8 Q: Okay. When did that happen?

9 A: That was the morning after we got the video.

10 Q: Now if you'll look down on the entry that we
11 were just -- the first entry, April 13th, 2016,
12 5:04. Is that the afternoon or the morning?

13 A: That's in the evening, sir.

14 Q: Okay.

15 A: As I explained, I'm often in the office late.
16 I'm not an early bird. I am a late bird, so --

17 -
18 Q: Okay. I just saw a lot of these things in
19 military time. I was just wondering if you
20 were a military time person or a standard time
21 person.

22 A: Usually I'm military. My watch is military
23 time. I think what I wind up doing was looking
24 at my either the email I had received or the
25 phone call just before I go the email. That's



1 where the time came from and that's what I
2 typed out.

3 Q: Okay. Is there a reason you didn't put the
4 email you originally received from Mr. Stoller
5 in the packet that you gave to Mr. Davenport?

6 A: There was no text. It was just the file
7 itself.

8 Q: Okay. And the entry you wrote says, secure
9 email and file sent to Dr. Alier from Scott
10 Stoller at Anderson EMS with investigation
11 material they had gathered and performed on an
12 Iva Rescue Squad paramedic. See that?

13 A: Yes, sir.

14 Q: Did I read that correctly?

15 A: Yes, sir.

16 Q: Okay. Then it says, investigation initiated by
17 Bureau and file started.

18 A: Yes, sir.

19 Q: When did you actually type that entry? Was
20 that before you left for the day on the 13th?

21 A: No. We typed that the next morning.

22 Q: Okay. The next day. Now I see the word secure
23 in front of email.

24 A: I think the email had a password if I remember
25 right.



1 Q: Okay. Was this email sent to your DHEC email
2 or was it sent to your personal email?

3 A: No, sir. As I stated before, It was sent to my
4 personal email, my gmail account because it
5 accepts larger downloads or attachments. I
6 think the DHEC system will automatically kick
7 out if you have anything. And I want to say
8 that the ceiling is ten megabytes.

9 Q: Let me ask you this. Prior to the 5:04 when
10 you got this on your personal email, how did
11 Mr. Stoller know to send it to your personal
12 email rather than your DHEC email?

13 A: As I stated previously, he called me and said,
14 I'm going to send you something related to the
15 QA package, or something to that effect.

16 Q: Okay.

17 A: I don't remember the exact words.

18 Q: All right. And did he call you back later and
19 said, hey I tried to send this to your DHEC
20 email and it got kicked back. It wouldn't
21 work?

22 A: No, sir. He said it was a large file. I said,
23 you're going to have to send it to my gmail
24 account because my account will kick it out if
25 it's larger than ten megs. And I asked him how



1 large it was, and I don't remember what the
2 size of the file, but he said it was larger
3 than ten megs.

4 Q: Okay. I've got a gmail account. They're
5 great. Is that the free service you use for
6 gmail or do you have something more advanced?

7 A: It's the free service.

8 Q: Okay. Do you know whether -- are you familiar
9 with a law called HIPAA?

10 A: Yes, sir.

11 Q: Okay. And what is your understanding of the
12 law HIPAA when it comes to protecting private
13 information about medical patients?

14 MR. WICEVIC: Your Honor, I don't know how this is
15 relevant. DHEC's Regulation Bureau is a health
16 oversight agency, number one. So HIPAA doesn't
17 apply to our Bureau of EMS. It might apply to
18 Mr. Stoller and Anderson County EMS. More
19 importantly, it's not relevant to this case.

20 THE COURT: I think it is. Your objection's
21 overruled.

22 Q: When you put secure email down there, were you
23 intending to indicate that that was somehow
24 HIPAA compliant?

25 A: Yes, sir.



1 Q: HIPAA's a pretty serious statute, isn't it?

2 A: I understand, yes, sir.

3 Q: Okay. And you're a paramedic and an EMT, and
4 you understand that the privacy for patients is
5 very important under this federal law, right?

6 A: Yes, sir.

7 Q: Okay. And you have a duty as a medical
8 provider to protect under HIPAA that patient's
9 personal health information or personally
10 identifiable information, right?

11 A: Yes, sir.

12 Q: Okay. Would you agree with me that the video
13 contains personally identifiable information
14 about that patient?

15 A: Yes, sir. But ---

16 Q: It has his face on it?

17 A: Let me please finish my statement.

18 Q: Okay. Sorry. Didn't mean to cut you off.

19 A: We often get information, videos, sound,
20 pictures that may violate on the initial view
21 from the public side because they provide
22 protected health information. But again, we as
23 the regulatory body have to view those to come
24 to an determination. I believe if you look at
25 the HIPAA statute of the federal law, it talks



1 about there are instances and exceptions when
2 conducting investigations for the purposes of
3 billing, for the purposes of quality assurance
4 by Training Officer, and so forth. And I think
5 my function as the Director of EMS for the
6 State would be covered under that.

7 Q: Okay. Was Mr. Stoller -- is he a certified
8 paramedic covered by DHEC?

9 A: Yes, he is.

10 Q: Okay. At the time he sent you this gmail
11 invitation, was he a certified paramedic
12 through DHEC?

13 A: Yes, sir.

14 Q: Okay. As the EMS Director of Anderson County,
15 was he somewhat involved in the provision of
16 care to this patient for the review of this
17 patient's care?

18 A: I think he reviewed the QA and he reviewed the
19 video. Yes, sir.

20 Q: You agree that he has a duty under -- you
21 understand HIPAA to protect personal health
22 information of that patient?

23 A: Yes, sir. But again, he sent that -- he didn't
24 broadcast that video to anybody. He sent it
25 directly to me in a secure email.



1 Q: Okay. Did you have any concerns that about
2 whether gmail is compliant with HIPAA?

3 A: No, sir. That didn't enter my mind. We just
4 wanted to make sure that I got that video in a
5 secure fashion.

6 Q: Okay.

7 **MR. ROTHSTEIN:** Can we switch onto my computer
8 screen?

9 Q: Did you even bother to Google whether gmail is
10 HIPAA compliant?

11 A: No, sir.

12 Q: Okay. I pulled up Google on my computer. Is
13 gmail HIPAA compliant? You see the second
14 entry down here, says, gmail is not HIPAA
15 compliant?

16 A: Can you move the mouse? It's kind of ...

17 Q: Oh, sorry.

18 A: Yes, sir. It says that but it doesn't mean
19 that it can't be. And I understand by looking
20 at the first entry up there that you can
21 encrypt and you can put password on a file.

22 Q: Okay. And you see this HIPAA compliance g-
23 suite support through Google?

24 A: Yes, sir.

25 Q: Okay. Did you ever -- have you ever had the g-



1 suite from Google, or did you just use the
2 standard gmail that's free? We talked about
3 that earlier, right? You told me you have the
4 free service.

5 A: I have the free service.

6 Q: So you never gotten the PAA through gmail that
7 would encrypt the data to make that personal
8 health information comply with HIPAA, right?

9 A: I don't recall I've ever done that.

10 Q: And Mr. Stoller actually sent you this on
11 what's called a shared Google drive. Isn't
12 that right?

13 A: I believe that's correct.

14 MR. ROTHSTEIN: Can we mark this as the next
15 exhibit?

16 (Respondent's Exhibit Number 27 was marked for
17 identification purposes.)

18 Q: Dr. Alier, I'm going to hand you Exhibit 27.
19 Do you recognize that as the email that Mr.
20 Stoller sent you to your gmail account?

21 A: Yes, sir.

22 Q: Okay. Arnoldalier@gmail.com, right?

23 A: Yes, sir.

24 Q: Okay. And it's an invitation that says, Scott
25 Stoller has shared the following video, see



1 that?

2 A: Yes, sir.

3 Q: And it was sent from Scott Stoller via Google
4 drive, right?

5 A: Yes, sir. That's what it says.

6 Q: What did you do with the video after you got
7 it?

8 A: I downloaded it to a jump drive, put a password
9 on it, secured it in my desk, and then the next
10 day offered it to the Bureau Chief, and then we
11 called Richard Naugler in to view it as well.

12 Q: How many times did you view it before you
13 opened an investigation on the matter?

14 A: Twice.

15 Q: Did you discuss it with Mr. Stoller after you
16 viewed it?

17 A: No, sir.

18 Q: You didn't call him up and say, Scott I got
19 your email, and talk to him about it?

20 A: Not to my recollection, sir.

21 Q: You believe Mr. Stoller committed misconduct as
22 defined by the statute when he sent you that
23 unsecured document to your unencrypted gmail
24 account?

25 A: I don't think so. No, sir.



1 MR. ROTHSTEIN: Can we get the Elmo up?

2 Q: Dr. Alier, are you familiar with regulation 61-
3 7?

4 A: Yes I am, sir.

5 Q: Okay. And that's the emergency medical
6 services regulations for the State of South
7 Carolina, correct?

8 A: Yes, sir.

9 Q: Okay. And section 1100 subsection B defines
10 misconduct.

11 A: Yes, sir.

12 Q: You see where it says misconduct?

13 A: Uh-huh.

14 Q: I'm going to ask you to look down to item
15 number nine. It's misconduct for the holder of
16 a certificate to reveal confidences entrusted
17 to him in the course of medical attendance
18 unless such revelations are required by law or
19 is necessary in order to protect the welfare of
20 the individual or the community. Did I read
21 that correctly?

22 A: Yes, sir.

23 Q: And do you believe that Mr. Stoller, by sending
24 an unencrypted email to you or sharing that
25 video with other people in the public revealed



1 confidential information about ---

2 A: No, sir. He did not share that with anybody
3 that I'm aware of other than myself at that
4 point.

5 Q: Okay. If you became aware that Mr. Stoller had
6 shared that with multiple people in Anderson
7 County, not even connected with the EMS
8 department, would that be misconduct under the
9 statute?

10 A: I'm not aware of him sharing that with ---

11 Q: Okay. I understand you're now aware of it.
12 But if you did become aware if it, wouldn't
13 that be misconduct under the section I just
14 read of the regulations?

15 A: Yes, sir. I could see how that would be a
16 problem.

17 Q: Okay. Now when I noticed the first entry on
18 the log that said, secure email sent to Arnold
19 Alier about the complaint, I requested a copy
20 of that email from DHEC. Are you aware of that?

21 A: Yes, sir.

22 Q: Okay. And I got a response about the email
23 that started the investigation, Exhibit 28.
24 You recognize Exhibit 28?

25 (Respondent's Exhibit Number 28 was marked for



1 identification purposes.)

2 A: I don't have that in front of me. Thank you.

3 Q: You got it now?

4 A: Yes, sir.

5 Q: Okay. You see what all those black lines are?

6 A: It's redacted information.

7 Q: Okay. Do you know what is redacted out of that
8 email?

9 A: I would have to look at the original email,
10 sir. I'm assuming that from is from Scott.

11 Q: Do you recognize that email as the email that
12 Mr. Stoller sent you on March 25th, Friday at
13 5:19 p.m. about summary of QA action? Do you
14 recall receiving an email from Mr. Stoller
15 about that?

16 A: I believe this was the QA package perhaps. And
17 this was sent to I believe my DHEC account.

18 Q: Do you know who put those black lines on that
19 email?

20 A: I do not, sir.

21 Q: Okay. And do you know why those black lines
22 are put on that email?

23 A: To redact information.

24 Q: Because the statute said that the information
25 was private or protected, right? Because it



1 related to a paramedic who's certified by DHEC?

2 A: Yes, sir.

3 Q: Okay. And that paramedic is Scott Stoller,
4 isn't that right?

5 A: I would assume that that's the email we're
6 talking about, the QA package. Yes, sir.

7 Q: I'm going to hand you Respondent's Exhibit 10.

8 **MR. ROTHSTEIN:** And this is in the exhibit notebook,
9 Your Honor, Respondent's Exhibit 10.

10 Q: That's Mr. Stoller's side of that same email
11 that we just had with the redactions. Isn't
12 that right?

13 A: Yes, sir.

14 Q: So the stuff that was blacked out was the fact
15 that it came from Scott Stoller, and had his
16 name and Anderson County or aceme.us email
17 address, right?

18 A: Yes, sir.

19 Q: Okay. Is his email address a confidential
20 matter?

21 A: I was not the one that redacted that
22 information, sir.

23 Q: Okay. I also didn't see on the redacted
24 version, an attachment. Do you see at the
25 bottom of Exhibit 10 there's an attachment



1 called jdavenport.pdf?

2 A: Yes, sir.

3 Q: Okay. What was jdavenport.pdf?

4 A: That was the QA package that I received on that
5 date?

6 Q: Okay. Why did Mr. Stoller send you a QA packet
7 from Anderson County after 5:00 o'clock on a
8 Friday about Mr. Davenport?

9 A: I'm not sure why that has relevance. I receive
10 packages around the clock.

11 Q: Okay. What did you do with the packet after
12 you got it from Mr. Stoller?

13 A: I believe I read it, reviewed it the next day.

14 Q: Okay. Did Mr. Stoller call you and give you a
15 heads up that, hey, I'm getting ready to send
16 you something on your DHEC email?

17 A: Not to my recollection, sir.

18 Q: Okay. I'm going to show you Exhibit 25. Do
19 you recognize the jdavenport.pdf QA packet in
20 that exhibit?

21 A: Is it the one that starts with Anderson County
22 cover letter? Or am I supposed to be looking
23 at something else?

24 Q: You recognize portions ---

25 A: That one?



1 Q: You think it was just a one page document?

2 A: No, sir. I believe ---

3 Q: You believe it was the whole QA packet, right?
4 It had patient run reports in it, it had a
5 statement of Ms. Aiken. Does that sound
6 familiar?

7 A: That does sound familiar, but I don't see ---

8 Q: I mean, if all you got was a letter from Mr.
9 Stoller saying, we're either initiating an
10 investigation or we're closing an
11 investigation, you can't review what Anderson
12 County did with regard to that investigation.
13 Isn't that right?

14 A: I look at the -- I believe at the end of that
15 particular package there was some directives of
16 what they were going to do. They were going to
17 do the standing orders test and I don't recall
18 what else was exactly in there. Review of the
19 standing orders and then take the standing
20 orders test. Again, this has been well over a
21 year since I looked at these documents 'cause
22 I was not involved in the investigation, sir.

23 Q: Okay. Is it your recollection that the email
24 you got from Mr. Stoller after 5:00 was the
25 first conversation you ever had with him about



1 James Davenport, or the first information you
2 knew about a QA matter with James Davenport?

3 A: To the best of my recollection. Yes, sir.

4 Q: I'm handing you Exhibit 8, Respondent's Exhibit
5 8. Does that refresh your recollection? You
6 remember getting an email from Mr. Stoller --
7 I'm sorry. I think I have you the wrong thing.

8 A: I was going to say my name's not in here
9 anywhere.

10 Q: Sorry. I gave you the wrong document. Let me
11 pull the other file. Can you give me that 8
12 back?

13 A: There you go.

14 Q: Thank you. It's actually 8a. I apologize for
15 the confusion. All right. You recognize
16 Exhibit 8a?

17 A: Yes, sir.

18 Q: Okay. It's an email you got that same day at
19 11:32 on that Friday, right?

20 A: Okay.

21 Q: And it says it's from Scott Stoller. It says,
22 Arnold I would like to enroll paramedic James
23 Davenport in the next Principles of Ethics and
24 Personal Leadership class. Thank you, Scott.
25 Right?



1 A: Yes, sir.

2 Q: Okay. Are you the registrar for the Principles
3 of Ethics and Personal Leadership class?

4 A: I am.

5 Q: Okay. How does somebody go about enrolling a
6 medic or an EMT into the PEPL class?

7 A: Into the PEPL class?

8 Q: PEPL class.

9 A: I have to go to the national NAEMT website and
10 put the person's name in. I think I put their
11 name in and perhaps an email address.

12 Q: Okay. And you responded to Mr. Stoller later
13 that day at 1:18, and said, PEPL class, it'll
14 be the first full week in June, probably at the
15 beach, right?

16 A: Yes, sir.

17 Q: Okay. It said, more details to follow later.
18 Did you ever follow later with more details to
19 Mr. Stoller about when the next PEPL class
20 would be?

21 A: Not to my recollection.

22 Q: Okay. Did you ever enroll Mr. Davenport in the
23 next PEPL class?

24 A: No. I did not.

25 **MR. ROTHSTEIN:** Your Honor, I'd like to move Exhibit



1 10 and 8a into evidence.

2 MR. WICEVIC: No objection, Your Honor.

3 (Respondent's Exhibit Number 10 was admitted into
4 evidence.)

5 (Respondent's Exhibit Number 8a was admitted into
6 evidence.)

7 MR. ROTHSTEIN: I don't know if I moved that gmail
8 email into evidence either. I'd like to make
9 sure that's Exhibit 26 into evidence.

10 THE COURT: Now which one is that?

11 MR. ROTHSTEIN: I'm sorry. Exhibit 26 is ---

12 COURT REPORTER: 27.

13 MR. ROTHSTEIN: 27. That's right. I was looking at
14 the wrong one. 27.

15 MR. WICEVIC: No objection.

16 (Respondent's Exhibit Number 27 was admitted into
17 evidence.)

18 MR. ROTHSTEIN: 26 is -- yeah, that's right.

19 THE COURT: Is it this one?

20 MR. ROTHSTEIN: Yes. And that one needs to go in
21 too, Your Honor. That's -- I just marked that
22 one. I apologize. I'm getting a little ---

23 THE COURT: Now which one are we talking about?

24 MR. ROTHSTEIN: Exhibit 27 is the gmail.

25 THE COURT: Okay.



1 **MR. ROTHSTEIN:** That one's in. And the redacted
2 version I marked it 28, Your Honor. I move
3 that into evidence as well. 28 is the redacted
4 version.

5 **THE COURT:** Okay. 27 and 28. Now I've got a
6 problem. This one does have an address on it.

7 **MR. ROTHSTEIN:** Okay. I'll redact it.

8 **THE COURT:** Yeah. I don't have a problem with it
9 going in with the address redacted.

10 **MR. ROTHSTEIN:** Is that sufficient, Your Honor?

11 **THE COURT:** That's good.

12 **MR. ROTHSTEIN:** Okay.

13 **THE COURT:** Okay. It's admitted with that change.

14 **(Respondent's Exhibit Number 28 was admitted into**
15 **evidence.)**

16 **Q:** All right. Back on track. Before Mr. Stoller
17 contacted you about the possibility of
18 enrolling Mr. Davenport into a PEPL class, did
19 you know who Mr. Davenport was?

20 **A:** I think we may have met once, probably four
21 years before this.

22 **Q:** Okay. Did Mr. Stoller ever communicate with
23 you about why he wanted to send James Davenport
24 to the PEPL class prior to this email, Exhibit
25 8a?



1 A: I'm not quite certain of the timeline. I know
2 we had talked at some point after I had
3 received the QA package that you were referring
4 to, and the findings that Dr. Kickham had had,
5 or the discussion that he had had with Dr.
6 Kickham. If there was anything else that the
7 Bureau would suggest. And I think I probably
8 suggested the only thing I could see is perhaps
9 PEPL class. I had looked at previous packages
10 that they had sent us, and other agencies, and
11 we do that on a regular basis as part of the
12 package. I, myself have taken the classes.
13 It's a professional ethics and leadership
14 class.

15 Q: It sounds like a pretty worth while class, but
16 I mean for you to evaluate whether Dr. Kickham
17 and Scott did the right thing with regard to
18 Mr. Davenport's medical care for that patient,
19 wouldn't you have to know something about the
20 medical care that was provided to that patient?
21 Or those -- there were actually three patients
22 at issue at that time, isn't that right?

23 A: I think at the time I had reviewed the package
24 and the patience care reports. Yes, sir.

25 Q: That's what I'm getting at. So you had the



1 patient care reports at the time you decided
2 this was a local problem, needed a local
3 solution, right?

4 A: Well, as far as how we determine whether it's
5 going to be through that, we look at several
6 things. First of all we try to make a
7 determination there was a compliance issue with
8 the law or the regulation. So that would
9 involve protocols, some sort of a violation of
10 a protocol whether it's minor or major. We
11 look at was there care that was less than
12 acceptable or unacceptable care. We look at
13 possible misconduct. And then any other
14 violation of the reg or the statute. We also
15 take into consideration intent. Was there an
16 intent to violate the protocol or to conduct
17 misconduct. So that comes into the
18 consideration. Sometimes that's evident on the
19 report, but many times you have to dig further.
20 So then we look at and review the investigation
21 or the QA or the review that the local agency
22 did on a particular chart or on a particular
23 individual, or particular incident. See what
24 the facts are, see what they gathered, to see
25 if it was complete. Then the next thing we



1 look at is we look at what sort of action did
2 the local agency take, was it measured, was it
3 appropriate, does it address the deficiencies.

4 Q: That sounds like a lot of stuff. You do that
5 for every QA review that comes in from an
6 agency around the State?

7 A: Well it's more or less a decision tree, like a
8 protocol. But that's the mental process I go
9 through. And then if we still can't resolve or
10 come to our conclusion, then we'll usually
11 bring in the EMT and find out their side of the
12 story. If there appears to be something that
13 was not addressed by the local Med. Control
14 Physician. We put a lot of strength or
15 authority of what the local Med. Control said.
16 It's actually hardwired into the regulation
17 that the Medical Control Physician will have
18 independent authority to oversee quality
19 patient care for an agency.

20 Q: So you give, in this case, Dr. Kickham the
21 Anderson Control Medical Control Physician the
22 deference or the -- he has the authority to
23 determine whether paramedic care under his
24 license was appropriate, right?

25 A: I don't do that. The regulation does that.



1 Q: Okay.

2 A: So ---

3 Q: When I say you I didn't mean you personally.
4 I meant DHEC does that.

5 A: Correct.

6 Q: Okay.

7 A: So, once we begin to determine what has
8 happened we look at if there's a history of
9 compliance with the agency, there's a history
10 of compliance with th department. And then we
11 determine if we're going to invest resources
12 into an investigation or if we feel that what
13 the local agency did, their actions are
14 adequate.

15 Q: Okay. So the first email you got with the QA
16 packet, you made a determination Anderson
17 County handled this appropriately, right?

18 A: Yes, sir. At that time before the video we
19 felt that there were issues, but it appeared
20 that Dr. Kickham had addressed the issues. And
21 then ---

22 Q: And you think you had all the information you
23 needed to make that determination? You had the
24 run reports for those three cases, right?

25 A: Yes, sir.



1 Q: You had some protocols that were attached in
2 the QA packet from Anderson County, right?

3 A: I don't recall if there were protocols attached
4 to that or not.

5 Q: Okay. And you had a statement from Mr.
6 Davenport's partner about the call, correct?

7 A: I don't recall if I had that or not. I
8 probably did.

9 Q: And you had a chart review done by your friend
10 Keith Eudy, right? That had a review of the
11 three cases.

12 A: I would not characterize Mr. Eudy at that point
13 as a friend.

14 Q: I'm sorry.

15 A: He was serving ---

16 Q: You had a chart review from Mr. Eudy ---

17 A: Yes, sir.

18 Q: --- of these three cases, correct?

19 A: Yes, sir.

20 Q: So you had everything you needed to determine
21 whether the medical care provided from Mr.
22 Davenport was appropriate and compliant with
23 the protocols?

24 A: Up to that point.

25 Q: And you made the determination Dr. Kickham's



1 decision looks fine to DHEC, right?

2 A: The corrective actions that he was taking to
3 the alleged protocol violations appeared to be
4 measured ---

5 Q: Okay.

6 A: --- and appeared to be appropriate. And so we
7 let his decision stand at that point.

8 Q: Okay. So at that point you knew the patient's
9 vital signs from the patient care report,
10 right? And you could tell that the patient was
11 stable?

12 A: It appeared so. Again, it's been a long while
13 since I reviewed that.

14 Q: Okay. And you knew from the narrative in the
15 patient care report and also from Ms. Aiken's
16 statement that the patient was walked out of
17 the house to the ambulance, right? You knew
18 that the patient was walked?

19 A: Yes, sir.

20 Q: Okay. You knew that Ms. Aiken, the basic on
21 the call, rode the call in the back of the
22 truck, and Mr. Davenport was the driver, right?

23 A: Yes, sir.

24 Q: Okay. You knew no IV was placed on that
25 patient, right?



1 A: Yes, sir.

2 Q: Okay. You knew no heart monitor was hooked up
3 to that patient during the call, right?

4 A: Yes, sir.

5 Q: And you knew no supplemental oxygen was
6 provided to that patient?

7 A: Yes, sir.

8 Q: Okay. Did you bother to see if this patient
9 had a good outcome when he got to the Emergency
10 Room, or did you know that?

11 A: I didn't know that at the time.

12 Q: Okay. What about the other two patients that
13 were in the packet? Based on your review of
14 the protocols and the medical evidence, it
15 appears Mr. Davenport provided good medical
16 care in accordance with what DHEC expected of
17 paramedics under their certificate?

18 A: I wouldn't characterize it good patient care.
19 There were issues. There was some slips in the
20 protocol if I recall.

21 Q: Did he deviate from what DHEC considers
22 acceptable standard of care for a South
23 Carolina paramedic or EMT?

24 A: As I said, there were issues. Again, I felt
25 that Dr. Kickham was trying to take corrective



1 action to make sure that the paramedic in
2 question had reviewed the protocols, knew of
3 sure if it was that -- the only thing we didn't
4 have at the time was intent. You're going to
5 have to take the physician's and the QA
6 Officer's word of intent, that there was no ill
7 intent. And that really kind of came to light
8 when we saw the video.

9 Q: Okay. How can you tell intent by looking at a
10 video?

11 A: The demeanor, the actions. A picture is worth
12 1,000 words. So 1,000 pictures is worth
13 multiple. There's a lot you can tell from a
14 video. Now granted, it is not perfect
15 evidence, but it was enough that we determined
16 that there were serious issues with this call.

17 Q: All right. Back to Exhibit 3 a second in the
18 receipt of your complaint. Who actually filed
19 the complaint in this case? You say that Mr.
20 Stoller filed the complaint?

21 A: He sent me the video.

22 Q: Okay.

23 A: I believe the Department started -- I guess if
24 you're going to take the video as the initial
25 complaint, Mr. Stoller would have.



1 Q: I though Mr. Wronski testified that the
2 Department doesn't file complaints against
3 paramedics.

4 A: Again, the video was, I guess you would call it
5 prima facie evidence that something had
6 occurred. And so we took that as a complaint.
7 We often get letters that are anonymous that
8 won't have a name. And there appears to be
9 some misconduct, and we have to investigate by
10 regulation.

11 Q: Okay.

12 A: All complaints and anything that comes in.

13 Q: Let's look at the regulation, Dr. Alier.
14 Section 1100, you see that?

15 A: Yes, sir.

16 Q: It's the section for revocation or suspension
17 of certificates of medical emergency
18 technicians, right?

19 A: Yes, sir.

20 Q: All right. Section A, the Department shall
21 upon receiving a complaint of misconduct as
22 herein defined initiate an investigation,
23 right?

24 A: Yes, sir.

25 Q: Item number one, the initial complaint shall --



1 what does that word shall mean to you?

2 A: It means shall.

3 Q: Okay. It's ---

4 A: It's not may, it's shall.

5 Q: Okay. It's a command, right?

6 A: Appears so. Yes, sir.

7 Q: Okay. The initial complaint shall be in the
8 form of a brief statement dated and signed by
9 the person making the complaint which shall
10 identify the person or service who is the
11 subject of the complaint and contain a summary
12 as to the nature of the complaint. Okay. Did
13 that gmail meet the regulatory definition of a
14 complaint?

15 A: If you look up further, it says the Department
16 is also authorized to initiate an investigation
17 based upon information acquired from other
18 sources.

19 Q: Okay. And I think Mr. Wronski said that the
20 Department doesn't initiate the complaint, it
21 received the complaint. Do you remember him
22 saying that?

23 A: So the complaint would, if you want to be I
24 guess literal, the video would have been the
25 complaint.



1 Q: How did you know the video wasn't doctored?
2 That's not the official body cam video, right?
3 I mean what you got was a shared Google file
4 that had a -- I don't know what computer
5 extension it has on it, but it's like a jpeg or
6 a wav video or something like that.

7 A: It's an mp4.

8 Q: Mp4. How did you know that was the actual body
9 camera footage?

10 A: We took the video at face value and then
11 requested an official copy to verify that.

12 Q: Okay.

13 A: We got the official copy, we compared the two
14 and it was a faithful copy.

15 Q: Yeah. But you had already made the decision
16 that Mr. Davenport should be either suspended
17 or revoked at that point. Isn't that right?
18 Before you even ---

19 A: No, sir. No, sir. As was said before when
20 there appears to be intent we bring the EMT,
21 the person in question in to find out their
22 side of the story.

23 Q: Okay. Well let me get back to this file. Do
24 you know what the purpose of providing the
25 paramedic, who's the subject of the complaint,



1 providing him the identity of the person making
2 the complaint, the nature of the complaint, and
3 a summary of what is being alleged against
4 them? What's the purpose of it requiring that
5 kind of information to be in a complaint
6 against a paramedic?

7 A: So they know what the complaint is about.

8 Q: Fair and due process, right? You want to
9 provide someone notice of what they're being
10 accused of, right? And an opportunity to be
11 heard to defend against what they're being
12 accused of, right? And this gmail video
13 doesn't have any of that information, does it?

14 A: No, sir.

15 Q: Okay. Were you involved in that strategy
16 meeting?

17 A: No, sir. I was in Washington.

18 Q: Okay. So you weren't involved in the first
19 time Mr. Davenport came down to the Cola Mills?

20 A: No, sir.

21 Q: Okay. Did you know what the ultimate objective
22 was at that point?

23 A: Well all our interviews, the objective is to
24 get to the facts of what actually happened.

25 Q: Didn't Mr. Stoller tell you he wanted Davenport



1 gone from Anderson County EMS?

2 A: No., sir.

3 Q: Have you been involved in -- since you've been
4 at the Department have you been involved in
5 other enforcement actions against paramedics
6 and EMT's?

7 A: Yes, sir.

8 Q: Some of those involve complaints where patients
9 were actually died in the care of paramedics or
10 EMT's?

11 A: Yes, sir. But there is a difference between
12 someone missing a skill and having a bad
13 outcome, and someone intentionally doing a bad
14 skill and having a bad outcome.

15 Q: Okay. And before you even met with Mr.
16 Davenport to get his side of the story, y'all
17 made a determination that he shouldn't be a
18 paramedic in South Carolina based on what you
19 saw in the video, isn't that right?

20 A: We did not make that determination, sir. We --

21 -

22 Q: Wasn't that the objective?

23 A: We had concerns obviously when we saw the
24 video, and that's why he was asked to come in.

25 Q: Did you compare punishments or enforcement



1 actions that DHEC had taken against other
2 paramedics in deciding what was appropriate for
3 Mr. Davenport?

4 A: I was not part of that decision making process,
5 sir.

6 Q: Did you talk about the fact that there was no
7 bad outcome in any of these three cases with
8 regard to the patients that were being
9 complained of?

10 A: At the end of the day, other than my first
11 review in which I had accepted the
12 recommendations from Dr. Kickham, I had no
13 decision making process in the case.

14 Q: Did you consider the fact that Mr. Davenport
15 had made complaints about Mr. Stoller, and that
16 Mr. Stoller might have had a motivation to get
17 rid of Mr. Davenport?

18 A: No, sir. We do not get involved in human
19 resource or personnel issues.

20 Q: Okay. So taking somebody aside and saying a
21 paramedic who used some rough language, I mean
22 would you consider that a human resources issue
23 or a local disciplinary issue?

24 A: We do not get involved in personnel issues with
25 agencies, sir.



1 Q: Okay.

2 A: And that's not just with Anderson, that's with
3 any agency. We don't get involved in billing
4 complaints. It's outside of our purview.

5 Q: Now you talked about the IRC briefly a little
6 while ago. Do you recall participating in the
7 IRC with regard to Mr. Davenport?

8 A: Very limited.

9 Q: Okay. Was that the second one that y'all had
10 done within an 18 month period, or was Mr.
11 Davenport's the first?

12 A: It was the second one.

13 Q: Second. So you had had, or at least Mr.
14 Wronski had gone through a -- so this was his
15 second rodeo so to speak, second IRC?

16 A: That would be a good characterization of that.
17 Yes, sir.

18 Q: And you learned from the experience of the
19 first IRC who made have made mistakes or done
20 things differently. So this was -- Mr.
21 Davenport's was the sort of IRC 2.0, right? I
22 mean it was the second version under Mr.
23 Wronski's leadership.

24 A: Yes, sir.

25 Q: And in that white notebook, I think it's



1 Exhibit 3 I think is the IRC. Is that right?
2 Or is it 8? Sorry, it's 8, Exhibit 8 in the
3 white notebook.

4 A: Okay. I see it.

5 Q: Before we get to that, do you recall -- on the
6 first page of Exhibit 8, it looks like the IRC
7 meeting was on June the 23rd of this year, or,
8 I'm sorry, 2016, right? Thursday, June 23rd,
9 2016.

10 A: Yes, sir.

11 Q: And the day before the IRC meeting you sent an
12 email ---

13 **MR. ROTHSTEIN:** Let me get you to mark this.

14 **(Respondent's Exhibit Number 29 was marked for**
15 **identification purposes.)**

16 Q: I'm going to hand you what's been marked as
17 Exhibit 29. Exhibit 29 is an email the day
18 before the IRC meeting, right? The first part
19 of that says -- I'll put it up on the screen.
20 The top part of it is from Arnold Alier to
21 Richard Naugler, here's the QA package that we
22 got, right?

23 A: Yes, sir.

24 Q: Okay. Have you provided the QA package to Mr.
25 Naugler prior to this?



1 A: I believe I had. I have no recollection of the
2 timeline here. I believe that was part of the
3 original package.

4 Q: Okay. That's that jdavenport.pdf that we're
5 talking about, right?

6 A: I believe so.

7 Q: Okay. And that's the thing that had the
8 patient care reports and the protocols, and Ms.
9 Aiken's statement, right?

10 A: Yes. I believe so. And I believe I had to
11 give them the password because it was password
12 protected.

13 Q: Okay. Well do you see it says, sent from my
14 iphone? You see that? Right here, sent from
15 my iphone.

16 A: Yes, sir.

17 Q: Okay. Is your iphone HIPAA compliant?

18 A: I would say not probably.

19 Q: Okay. Now let's scroll down to the prior part
20 of this email string. You sent an email on
21 your DHEC email to Mr. Wicevic and copied Mr.
22 Wronski?

23 A: Yes, sir.

24 Q: And you're forwarding summary of QA action.
25 That's the same subject line from Mr. Stoller's



1 email to you from Friday, March the 25th after
2 5:00 o'clock, right?

3 A: Where are we looking at? Okay. I see.

4 Q: Okay. And you say, here's the original package
5 that was sent to me for review 19 days or so
6 before I received the video. I took no further
7 action believing that it was a quote local
8 problem local solution handled by their Medical
9 Control and QA process, right?

10 A: Yes, sir.

11 Q: Then it says, my only verbal recommendation to
12 Scott was perhaps to include a PEPL class,
13 right?

14 A: Yes, sir.

15 Q: Okay. So let's get back to the IRC meeting a
16 second. I'm going to ask you to turn that
17 Exhibit 8 and turn to page 35, Bates page 35
18 and it's page 139 of the transcript. Okay?
19 And this is toward the end of the IRC meeting
20 and the executive session part of the IRC
21 meeting?

22 A: Yes, sir.

23 Q: Okay. And do you see on line 3, Dr. Alier, two
24 things on that. Number one, we are planning on
25 doing at least another two PEPL classes between



1 now and December. One in the Upstate early
2 while I'm here. And the second thing was if
3 you look at the original recommendations that
4 we got of the initial packet from Dr. Kickham
5 at Anderson County, one of the recommendations
6 was for him to take some kind of trauma course,
7 right?

8 A: I see that.

9 Q: Okay. And Mr. Davenport didn't mention any
10 kind of trauma remediation that Dr. Kickham was
11 requiring, did he?

12 A: If you read on further, you'll see that Dr.
13 Deschamps corrected me.

14 Q: Okay. But why were you participating in the
15 IRC meeting if you had recused yourself or you
16 felt you had to step away from this matter
17 because of whatever you felt uncomfortable with
18 in handling this investigation in light of your
19 relationship with Mr. Stoller?

20 A: I believe I was answering questions from the
21 IRC.

22 Q: Couldn't you just say to the IRC, you know I
23 don't think I should be involved in this given
24 my relationship with Mr. Stoller?

25 A: Again, I had limited responsibilities that I



1 had to fulfill. One of which was going to the
2 IRC to inform them of the package that I had
3 originally received.

4 Q: Okay. And that original recommendation from
5 Dr. Kickham didn't say anything about Mr.
6 Davenport needing trauma remediation, did it?

7 A: No, sir. That was actually in an earlier
8 package that I had received in another
9 investigation where they had recommended a
10 PHDLS class, I believe.

11 Q: Have you ever served in the military?

12 A: No, sir.

13 Q: Okay. Are you familiar with the training that
14 a Special Forces Medic is required to undergo?

15 A: No, sir. The closest I ever came, I took a
16 TCCC class.

17 Q: Okay. And Mr. Davenport taught that class,
18 didn't he?

19 A: He was one of the clinical instructors in that
20 class. Yes, sir.

21 Q: When did you take that class from Mr. ---

22 A: I believe that was July of 2013.

23 Q: Mr. Davenport seemed to know what he was doing?

24 A: Yes, sir.

25 Q: Okay.



1 MR. ROTHSTEIN: Okay. I have no further questions,
2 Your Honor.

3 THE COURT: Mr. Wicevic.

4 MR. WICEVIC: Thank you, Your Honor.

5 DR. ALIER - CROSS-EXAMINATION BY MR. WICEVIC:

6 Q: Dr. Alier, I think we skipped over your title
7 with the Department. What's your title?

8 A: I am the Director of the Division of EMS for
9 the Bureau of EMS and Trauma.

10 Q: Okay. And I think you testified you joined the
11 Department in April of 2013. Can you explain
12 your roles and responsibilities?

13 A: I am responsible for the oversight of the
14 division of EMS. That includes inspections,
15 certifications, licensing, as well as any
16 actions that the agency would take on
17 individuals as well as agencies. I also, as
18 part of my duties now, have other public
19 relations things that I do with the
20 communities, such as the LEON program and the
21 community paramedic program, several other
22 initiatives that we have started.

23 Q: Okay. Well DHEC receives a lot of information.
24 What would prompt the Department to initiate I
25 guess a formal investigation?



1 A: Kind of as I answered before. We look at the
2 possibility of infraction of the reg or
3 infraction of the statute. And then we
4 consider intent, then we consider a local
5 investigation and local actions to see if there
6 were, again I mentioned before, measured,
7 appropriate addressing the deficiency. And
8 what I mean with that, if somebody has an issue
9 with violating the protocols, we make sure the
10 protocols are reviewed, that they're tested
11 against those. If it's an issue with a skill,
12 such as one package that I had reviewed, there
13 was a missed intubation, and that individual
14 was demoted until they went through an airway
15 class. We felt that was measured and that was
16 appropriate. We read another package where
17 someone had an issue with a trauma call. And
18 in that particular case it was determined it
19 was a knowledge issue, so that particular
20 individual was sent to one of the trauma
21 classes. So we look at the actions that the
22 local Med. Control does, and if we still don't
23 have a firm grasp of what happened, then we'll
24 bring the individual in to tell his side of the
25 story. If we feel that we have not cleared



1 initial step, then there's a possibility that
2 a reg or the act was breached.

3 Q: You mentioned the Med. Control Physician's
4 responsibility or role in the decision of
5 whether or not to investigate, and how that's
6 prescribed by the regulations?

7 A: Yes, sir. The Med. Control Physician has
8 independent authority to oversee quality
9 patient care for the agency. One of my duties
10 as the Director of EMS is at least once a year,
11 sometimes twice a year, we do a workshop for
12 all new Med. Control Physicians in the State,
13 which is a requirement for them to practice as
14 such. And we go over their quality assurance
15 and their oversight duties so they fully
16 understand the gravity of what they do and
17 their responsibility. The statute and
18 regulation place a lot of responsibility on
19 local control. The State would step in if we
20 feel that, again, the actions taken were not --
21 the remediation actions by the local agency
22 were not measured or appropriate.

23 Q: How many EMT's are in the State of South
24 Carolina?

25 A: We have almost 10,000 certified. It varies



1 from day to day, but it's right around 10,000.
2 And that's all EMT's. That's basic EMT's,
3 advanced EMT's, and paramedics. Just
4 collectively they're called EMT's.

5 Q: Okay. Before we move on I want to make sure
6 we're clear about your reference to the reg.

7 MR. WICEVIC: Ms. Hazel, could I please get the
8 monitor?

9 Q: Section 402, is that what you were referring
10 to, Dr. Alier?

11 A: Yes. 402b, the Medical Control Physician shall
12 serve as the medical authority for the licensed
13 provider. C, the Medical Control Physician
14 shall have disciplinary action sufficient to
15 oversee the quality of patient care for EMT's
16 and retain other responsibilities that may be
17 negotiated agreement with the service.

18 Q: Okay. Now tell The Court what your typical
19 involvement with investigation of EMS's is.

20 A: You mean investigations of EMT's? Well it
21 depends on the source of the investigation. If
22 the individual inspector, which is usually how
23 these things come in, gets a phone call or an
24 email, or witnesses an infraction, they would
25 usually call the compliance Officer who assigns



1 it a number, and then we begin the
2 investigation. They usually inform me, we're
3 opening an investigation on such and such, and
4 this the fact gathering. If, again, it meets
5 that first criteria we talked about, something
6 that appears to be an infraction of the statute
7 of law, then we try to determine intent. If
8 there was no investigation local, if there as
9 no, because they were not aware, then we bring
10 the EMT in to get their side of the story. I
11 do sit in in most of the interviews with few
12 exceptions. If I'm away on duties or for some
13 reason I'm aware of if I had a history with
14 this individual, then I usually don't sit in on
15 those.

16 Q: Okay. And why did you not initially
17 investigate this matter when Mr. Stoller sent
18 a QA package?

19 A: Well it appeared ---

20 **MR. ROTHSTEIN:** Your Honor, I think he
21 mischaracterized -- I mean I asked him those
22 questions, and he said he reviewed the QA
23 packet. But I think Mr. Wicevic's question
24 mischaracterizes the prior testimony. It's
25 been asked and answered as well.



1 Q: Did you investigate the initial QA review?

2 A: I reviewed it and felt, again, the actions
3 taken by Dr. Kickham were consistent with the
4 regulation 402c.

5 Q: And, I mean, if you've already explained it,
6 but what tipped it over the scale after receipt
7 of the actual body cam footage?

8 A: The disturbing images, the language, all seem
9 to be consistent with ill intent. So that
10 began the process for us to get to the bottom
11 of what had actually transpired.

12 Q: Okay. And was the video the actual complaint,
13 when you refer to complaint?

14 A: I would say so.

15 Q: Okay.

16 A: And again, the video was not acquired in a
17 vacuum. It was given to Scott as I understand
18 by the Chief of Police. Once an individual
19 gets information, and this is not just talking
20 about the Department, I'm talking about in
21 general. Once an EMT or somebody that we
22 certify gets information that somebody has done
23 poor care, they have a duty to report that.
24 Otherwise they might be complicate. So I could
25 see why we got the video from Scott once he



1 received it. I'm not really certain why the
2 Police Chief didn't sent it directly to us.
3 But, again, that's outside of our control.

4 Q: Did you have concerns with authenticity of the
5 video you received from Mr. Stoller?

6 A: I did not have any questions of it, but we
7 wanted to be certain. We wanted to compare
8 with the original. And once we did that they
9 appeared to match. We didn't see where it was
10 edited or where something was muted. It
11 appeared to be a faithful copy of the original.

12 **THE COURT:** Dr. Alier, Mr. Wicevic, he is actually
13 going over testimony that we've already heard.
14 Could we move on to ---

15 **MR. WICEVIC:** Sure.

16 **THE COURT:** --- something else?

17 **MR. WICEVIC:** Sure.

18 **THE COURT:** Because we're short on time today.

19 Q: Dr. Alier, do you have Exhibit 27 up there with
20 you?

21 A: Yes, sir.

22 Q: You know there's a discussion about whether
23 that would fall into DHEC's versions of
24 misconduct, is that correct?

25 A: I'm sorry?



1 Q: Mr. Rothstein in asking questions of you ---

2 A: Yes, sir.

3 Q: --- implied that the sending of this mail was
4 a misconduct as defined by the EMS act and EMS
5 regulation?

6 A: I would not characterize that as being that.

7 Q: Well let's look at section 1100, and you tell
8 me why it would not fit with ---

9 **MR. ROTHSTEIN:** Your Honor, he's leading the
10 witness. And we've already been over this. I
11 mean I actually had him read the statute into
12 the record, or the regulation into the record.
13 This is asked and answered.

14 **MR. WICEVIC:** I don't recall him explaining why he
15 doesn't feel like this is misconduct. I can
16 move on if you don't ---

17 **THE COURT:** Yeah. I mean Mr. Stoller is not here,
18 so let's move on.

19 **MR. WICEVIC:** Okay.

20 Q: Exhibit 28, do you have that, Dr. Alier?

21 A: No. Thank you.

22 Q: Okay. And this is a redacted copy of the
23 initial summary of QA action?

24 A: Yes, sir.

25 Q: Now do you know why the Department redacts



1 certain information?

2 **MR. ROTHSTEIN:** I asked him that exact question,
3 Your Honor, about the redaction of this
4 document. And he said it was to protect the
5 identity of the paramedic, which is
6 confidential under the statute. This is asked
7 and answered.

8 Q: Are there other justifications?

9 A: If we have a public individual that wants to
10 remain anonymous. Sometimes that name will be
11 redacted.

12 Q: Are you familiar with the provisions of Freedom
13 of Information Act?

14 A: Yes, sir...

15 Q: Okay. Let's look on the screen. Can you
16 identify that statute?

17 **MR. ROTHSTEIN:** This is improper. He testified
18 about why the thing was redacted. Now Mr.
19 Wicevic ---

20 **THE COURT:** Let's let him move on.

21 **MR. WICEVIC:** Your Honor, I don't know why it was
22 brought up in the first place. I just feel
23 like I had an obligation to explain why this
24 information was redacted. It's making it look
25 like the Department's hiding information from



1 somebody under investigation. And there's
2 actually a basis for redacting such information
3 pursuant to South Carolina Code of Laws.

4 **THE COURT:** Okay.

5 **MR. ROTHSTEIN:** Well that's Mr. ---

6 **THE COURT:** Very briefly.

7 **MR. WICEVIC:** And he's not a lawyer. He doesn't
8 make these decisions ---

9 **THE COURT:** We understand. If you'll just proceed.

10 **Q:** Okay. Can you read subsection 15?

11 **A:** The identity or information tending to reveal
12 the identity of any individual when in good
13 faith makes a complaint or otherwise discloses
14 information which alleges a violation or
15 potential violation of the law or regulation to
16 a State regulatory agency. I believe part of
17 that is also in our Regulation or in our
18 statute that if a complaint comes in, that we
19 will maintain that information in
20 confidentiality.

21 **Q:** Okay. Talk about, when there's inappropriate
22 language for EMT's. When does the Department
23 get involved with conflicts such as that?

24 **A:** When it's considered battery, verbal battery
25 against the patient. Obviously.



1 **MR. ROTHSTEIN:** Your Honor, there's no such thing as
2 verbal battery. Battery is a physical touch.
3 Verbal battery -- this is

4 **DR. ALIER:** Can I finish my statement?

5 **THE COURT:** Yes. Go on.

6 **A:** Okay. Legally it might be called something
7 else. But if I were to address a patient in a
8 demeaning way, cuss them out or use
9 inappropriate language in response to either
10 their gender, their race, their sexual
11 preference, or any other thing that would be a
12 protected class, we would see that as a serious
13 infraction. We're supposed to protect those
14 who can't defend themselves. One of the
15 reasons why we do criminal background checks is
16 because we take that very seriously. Not
17 anybody can be an EMT or a paramedic in this
18 State. And so it goes to the whole general
19 conduct of an EMT. So that's, again -- in and
20 of itself, yes. Do paramedics and EMT's swear
21 or use cuss words on the scene? Yes. But when
22 they're directed at their patient, then I
23 believe it crosses a line.

24 **Q:** Okay.

25 **A:** Had I been on the scene where someone used foul



1 language? In general, yes. You work that many
2 years on the street, you see that.

3 Q: Okay. General enforcement process, what's your
4 role?

5 A: Well once an investigation is complete, usually
6 we come to an conclusion, and I usually
7 participate in generating either an emergency
8 suspension order or suspension order, a consent
9 order or an administrative order. In this case
10 I did not participate in any of those.

11 Q: Okay.

12 A: Many of the consent orders I write as a part of
13 my duties. And then they're signed by the
14 Bureau Chief and the Deputy Director.

15 Q: Okay. That's all I have. Thank you, Dr.
16 Alier.

17 MR. ROTHSTEIN: I have a couple of very brief re-
18 direct.

19 THE COURT: Okay.

20 MR. ROTHSTEIN: Less than two minutes, Your Honor.

21 DR. ALIER - RE-DIRECT EXAMINATION BY MR. ROTHSTEIN:

22 Q: Dr. Alier, did I understand you to say that you
23 may have redacted that document because Scott
24 is a public official and may have wanted to
25 remain anonymous?



1 A: I did not do the redacting on this document.
2 I'm not entirely sure who did.

3 Q: Okay. And this document wasn't redacted to
4 hide something under FOIA. I didn't make a
5 FOIA request, did I?

6 A: Again, I wasn't involved with the
7 investigation, so I'm not entirely sure what
8 you're getting at.

9 Q: Mr. Davenport didn't make a FOIA request to get
10 the information that was in the investigative
11 packet, did he?

12 **MR. WICEVIC:** Asked and answered. He doesn't know
13 what request this is.

14 A: I'm not sure.

15 **THE COURT:** He can answer. If he doesn't know he
16 can say in his answer.

17 Q: There's no evidence that Mr. Davenport treated
18 this patient the way he treated this patient
19 based on any type of discrimination, is there?
20 Like race, or religion, or gender, or other
21 protected classed that you talked about.

22 A: It appears from the video -- again, I ---

23 Q: My question was there's no evidence that Mr.
24 Davenport treated the patient in the stabbing
25 video for some discriminatory purpose, is



1 there?

2 A: You can't determine that by just looking at the
3 video. You have to talk to the individuals.

4 Q: Okay. And the word idiot is not a swear word
5 or cuss word, is it?

6 A: It's a demeaning word.

7 Q: It can also be a term of endearment, right?

8 A: Not in this context. I would never call a
9 patient ---

10 Q: I can't count the number of times my wife said,
11 you're such an idiot, to me.

12 A: But you have a relationship with that
13 individual. She's your wife.

14 Q: And you don't know what Mr. Davenport's
15 relationship with this patient is, do you?

16 A: He has a patient clinician relationship, and
17 you never call a patient an idiot. That's just
18 not appropriate.

19 Q: Now the example of the QA review that you did
20 a minute ago. You said there's a missed
21 intubation in Anderson County, right?

22 A: I believe it was Anderson County. Yes, sir.

23 Q: Okay. And there was a girl that died after a
24 fire because the paramedic didn't perform the
25 intubation properly, isn't that right?



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1 A: I believe that's correct.

2 Q: Okay. And you had all that information when
3 Mr. Stoller sent it to you, that there was a
4 paramedic that didn't have the right skills.
5 A little girl died in the fire, and you didn't
6 take any action against that paramedic's
7 license or certification, did you?

8 A: As I stated before, there was no ill intent.
9 It was a bad skill. The individual was
10 subsequently sent by Dr. Kickham to remediate.
11 She went to simulation center. Had to do a
12 comprehensive airway class one on one with
13 Aaron Dicks who does the simulations and
14 training there. She was demoted to an EMT
15 until she completed that class. I subsequently
16 contacted Aaron Dicks to find out how this
17 individual did, what was her attitude, was she
18 teachable. She was very much willing to take
19 the discipline as it came. And so we felt
20 after reviewing the remediation, after
21 reviewing the actions of Dr. Kickham and the
22 actions of the agency, we felt that was
23 measured, appropriate, and addressed the
24 deficiencies. Anybody can have a bad day and
25 miss an IV. Anybody can have a bad day and



1 miss an intubation. That does not necessarily
2 rise to misconduct.

3 Q: Anybody can have a bad day and have an off word
4 to a patient, isn't that right?

5 A: You don't demean a patient. That's the bottom
6 line.

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

9 THE COURT: Thank you. Thank you, Dr. Alier. Now
10 if anyone thinks we need additional time, I am
11 going to actually adjourn for 45 minutes. Do
12 you all think that would be sufficient to maybe
13 get something to eat?

14 MR. WICEVIC: Yes, Your Honor.

15 MR. ROTHSTEIN: Yes, Your Honor.

16 THE COURT: Okay. So let's reconvene at 12:45.

17 (Off the record from 12:06 p.m. until 1:03 p.m.)

18 THE COURT: Mr. Rothstein, are you prepared to call
19 your next witness?

20 MR. ROTHSTEIN: Yes, Your Honor. I want to make
21 sure I formally move all that evidence actually
22 into evidence.

23 THE COURT: Okay.

24 MR. ROTHSTEIN: I mean I think I want to make sure
25 Exhibit 10, Exhibit 8a, and Exhibit 28 were



1 actually formally in. Can we check with the
2 court I want to make sure they're formally
3 moved into evidence. If not, I would like to
4 hereby move ---

5 **THE COURT:** You did 10 and 8a.

6 **MR. ROTHSTEIN:** Okay.

7 **THE COURT:** Yeah. They have been admitted.

8 **MR. ROTHSTEIN:** Is ...

9 **COURT REPORTER:** 28 is what you ---

10 **MR. ROTHSTEIN:** 28. I want to make sure 28 is in,
11 and 29 Your Honor. 28 and 29. I want to move
12 them into evidence formally. 28 is the
13 redacted email ...

14 **THE COURT:** And 29 is the -- okay.

15 **MR. WICEVIC:** No objections.

16 **THE COURT:** No objections. They're admitted.

17 (Respondent's Exhibit Number 29 was admitted into
18 evidence.)

19 **MR. ROTHSTEIN:** Our next witness is Sheila Kaiser,
20 Your Honor.

21 **THE COURT:** Ms. Kaiser, if you'll go to the witness
22 box and before being seated, face the court
23 reporter, raise your right hand, he'll swear
24 you.

25 **SHEILA KAISER,** having been duly sworn, testifies as



1 follows:

2 **MS. KAISER - DIRECT EXAMINATION BY MR. ROTHSTEIN:**

3 Q: Good afternoon, Ms. Kaiser. Will you please
4 state your full name for the record?

5 A: Sheila Marie Kaiser.

6 Q: And where do you currently live?

7 A: I live in Anderson, South Carolina.

8 Q: And what do you do in Anderson?

9 A: I'm the Training Coordinator for Anderson
10 County EMS.

11 Q: How long have you been the Training Coordinator
12 for Anderson County EMS?

13 A: Since January of 2015.

14 Q: Are you currently a paramedic?

15 A: Yes.

16 Q: Okay. How long have you been a paramedic in
17 South Carolina?

18 A: Since August of 2005.

19 Q: Okay. What are your job duties as the Training
20 Officer for the Anderson County EMS Department?

21 A: I do all the in service training for -- I offer
22 in service training for the squads that attend.
23 Plus we have several EMT's that are like with
24 the fire department and the sheriff's
25 department that come to our training. I also



1 do first responder training for the sheriff's
2 department and for the fire department. And
3 CPR training around the County.

4 Q: As paramedics or certified paramedics, are you
5 required to take a certain number of continuing
6 education hours between periods of
7 certification?

8 A: Yes.

9 Q: Okay. How many hours are certified paramedics
10 required to get in a certain period of time?

11 A: It has recently just changed to where we have
12 got certain criteria in the national section
13 for recertification. So it's very broken down
14 and specified. Like there's an hour of ELVAD
15 training, there's an hour of say artificial
16 ventilation training. So it's broken down into
17 different categories. Plus there's 15 hours of
18 local subject matter and 15 hours of individual
19 subject matter every two years.

20 Q: Had Mr. Davenport ever assisted you in the in
21 service training offered through Anderson
22 County?

23 A: Yes.

24 Q: What types of courses has he helped teach other
25 paramedics?



1 A: He has taught how to teach the incident command
2 and triage, and he's also helped with, we did
3 head trauma, and he did help do that. And then
4 he also helped do multi-casualty trauma.

5 Q: Did you attend any of the trainings that Mr.
6 Davenport did on trauma?

7 A: Yes.

8 Q: And did Mr. -- or can you just explain more
9 observations of Mr. Davenport's knowledge base
10 on trauma.

11 A: He seems to be very well educated on trauma.
12 He appears to know what he's talking about very
13 well. We've had multiple conversations on
14 this.

15 Q: Does Anderson County EMS have -- we've talked
16 a lot in the trial. I know you haven't been
17 here the whole time, but a lot of discussion
18 about Anderson County protocols. I forget the
19 formal name for it. The Anderson County
20 Standards of Care and Treatment Protocols. Are
21 you familiar with that document?

22 A: Yes.

23 Q: Okay. In your role as the Training Officer, do
24 you have any insight in reviewing the
25 protocols or coming up with recommendations for



1 new protocols, and that type of thing?

2 A: I mean, the last revision that we had done --
3 well before we just recently are going through
4 this new one, and I've not been involved in the
5 changes going on now to a great extent.

6 Q: Have you ever been involved in some sort of
7 committee ---

8 A: Yes.

9 Q: --- or group that reviews protocols?

10 A: In the past we had had a committee where we got
11 together and we would go over all the protocols
12 and review them and then try to update them
13 into the new standards.

14 Q: Okay. Did Mr. Davenport have any role on the
15 protocol committee?

16 A: He had started off on that committee.

17 Q: How often would the committee meet?

18 A: It wasn't a regular meeting because it was
19 whenever Dr. Kickham was available. So
20 whenever he would call and say, get them
21 together, I'm available this day. Can you get
22 everybody, send out an email and get everybody
23 to meet. I would send out the email, so it was
24 really kind of whenever Dr. Kickham was
25 available.



1 Q: This is a diagram over here, this visual aid.
2 I don't know if you can see that from where you
3 are, but this is what's called a Venn diagram.
4 Do you recall ever seeing a Venn diagram when
5 you were in school?

6 A: I don't remember.

7 Q: And I kind of created this, so it's a little
8 odd looking, but the green circle was intended
9 to represent protocols, okay? It's just sort
10 of a visual representation of protocols, all
11 right? And then I used this little red circle
12 as orders. Do you understand the -- or in your
13 training experience, do you understand the
14 difference between general protocols and
15 physician orders?

16 A: Yes.

17 Q: Okay. Explain to The Court what the
18 distinction between a protocol and an order is.

19 A: My understanding, like a standing order would
20 be if a diabetic has a blood sugar below 60,
21 you will give 25 grams of D-50. It's very
22 specific, in this situation you will do this.
23 Whereas protocols are guidelines. So you'll
24 place the patient in the position of comfort is
25 a protocol. Well there's some room for



1 interpretation. Yes, you will place them in a
2 position of comfort. It could be sitting up,
3 it could be leaning back slightly. The same
4 standard's there, you want to place them in a
5 position of comfort, but there's a little bit
6 of leeway as to, you know, what's their
7 position of comfort. It leaves a little bit of
8 room for that interpretation.

9 Q: Okay. Well other than the standing orders, are
10 their other times when paramedics either ask
11 for or receive physician orders?

12 A: Yes. Especially there are certain drugs where
13 you have to call in and get direct online
14 medical control order before you can
15 administer. Or if you're not sure if what
16 you're doing, if you're ever unsure, you know,
17 should I or should I not, you can always call
18 in and ask the doctor, what do you think,
19 should I? And the doctor will give you direct
20 online medical control orders on yes do this or
21 do that.

22 Q: Okay. And I have over here SO for standing
23 orders in red within the limits of the
24 protocols. You see that?

25 A: Uh-huh.



1 Q: And then the OL is for online physician orders.
2 And those are things that are outside the
3 protocols that you have to call and ask for
4 help. Is that a fair representation of how you
5 understand? Some orders are not in the
6 protocols, but some orders are in the
7 protocols. Is that ---

8 A: Not really because even your online orders are
9 within your protocols because I can call the
10 doctor and he can give me online orders to give
11 100 milligrams of morphine. That doesn't mean
12 I can give it. I still have guidelines that I
13 can't go outside of. So I still can't give 100
14 milligrams of morphine even if a doctor tells
15 me, give that. I still can only give what's
16 within that guideline. So even with online
17 orders, you still have to stay within ---

18 Q: Well let me ask you this. What if you come up
19 on a scene and there doesn't appear to be a
20 protocol in the book about how to handle that
21 particular patient. Is there a mechanism that
22 you could call the Emergency Department or call
23 the Medical Control Physician and say, here's
24 what I've got. Can you help me through ---

25 A: Yes.



1 Q: Okay. Is that a type of an online order if the
2 doctor tells you what to do?

3 A: Yes.

4 Q: And if you'll look at exhibit -- there's a
5 white exhibit notebook binder. That's it. If
6 you'll look at Exhibit 1. Do you recognize
7 that, I mean we've been using them, do you
8 recognize that as the Anderson County Standards
9 of Care and Treatment Protocols with a revision
10 date of 2013?

11 A: Yes.

12 Q: Okay. And I think it's already been
13 established that that was the set of protocols
14 that was in existence as of the date of Mr.
15 Davenport's suspension in March of 2016.

16 A: Yes.

17 Q: Did that document include a set of protocols
18 for how to handle penetrating abdominal
19 traumas?

20 A: Not specifically, no.

21 Q: Okay. After Mr. Davenport's incident, have the
22 protocols been revised?

23 A: Yes.

24 Q: Okay. Did the revised protocols include
25 guidance or protocol on how to handle



1 penetrating abdominal trauma?

2 A: Yes.

3 Q: Have you ever heard the new protocols for that
4 penetrating abdominal trauma referred to sort
5 of colloquially as the Davenport Protocol?

6 A: I have not heard them called that.

7 Q: Now as the In Service Training Officer for
8 Anderson County, are you also involved in the
9 quality assurance or QA process?

10 A: Sometimes.

11 Q: Okay. Are you familiar with the QA process in

12 ---

13 A: Yes.

14 Q: --- Anderson County? At the time, Dr. Kickham,
15 or whoever the new Medical Control Physician is
16 now, do they regularly meet with QA Officers
17 from the different agencies or rescue squads
18 within Anderson County?

19 A: Yes. They meet every other month.

20 Q: Okay. Do you attend those meetings?

21 A: Yes.

22 Q: Before Mr. Davenport's separation or
23 suspension, did he occasionally attend those QA
24 meetings?

25 A: Yes, he has.



1 Q: Have you ever seen a representative of DHEC, or
2 the Department of Health and Environmental
3 Control attend one of those QA meetings?

4 A: I don't recall seeing them at a QA meeting.

5 Q: Have you ever seen Keith Eudy attend a QA
6 meeting?

7 A: I don't recall seeing him at one.

8 Q: Do you know who Keith Eudy is?

9 A: Yes.

10 Q: Okay. Is Keith Eudy on the payroll at Anderson
11 County?

12 A: Yes.

13 Q: Have you regularly seen him in the office at
14 the Anderson County EMS Department?

15 A: No.

16 Q: Okay. Do you know if he receives a regular
17 paycheck from Anderson County?

18 A: I don't know if it's a regular paycheck.

19 Q: Well have you seen paychecks ---

20 A: Yes.

21 Q: --- in the stack of paychecks ---

22 A: Yes.

23 Q: --- for the Anderson County EMS Department made
24 payable to Mr. Eudy?

25 A: Yes.



1 Q: Okay. Do you see the stack of payroll checks
2 from time to time ---

3 A: Yes.

4 Q: --- in the office? How close is your office at
5 Anderson County EMS to Mr. Stoller's office?

6 A: Down the hall.

7 Q: At one point, was Mr. Davenport, did he also
8 have an office in that building in that same
9 area?

10 A: Yes.

11 Q: Okay. How close was Mr. Davenport's office to
12 your office?

13 A: His was next door. We had a connecting door.

14 Q: Would you describe Mr Stoller as having a
15 somewhat vindictive personality?

16 A: He can.

17 Q: Okay. Do you have any experiences where you
18 observed him displaying what you thought was a
19 somewhat vindictive personality?

20 A: I think the relationship deterioration between
21 Scott and James has caused quite a bit of
22 trying to turn opinions with comments. For
23 instance, telling me that my husband did not
24 like James, or telling me that James thinks I
25 dress sloppy, or trying to turn my opinion.



1 Q: Okay. Do you consider yourself a friend of Mr.
2 Davenport's?

3 A: Yes. I do.

4 Q: Okay. Do you believe that your late husband
5 was a friend of Mr. Davenport's?

6 A: My husband committed suicide, so obviously I
7 don't know everything he thought. But in my
8 understanding, I thought he was.

9 Q: Okay. I know that's a touch subject for you,
10 but can you tell The Court when your husband
11 committed suicide?

12 A: January 22nd of 2016.

13 Q: Was Mr. Davenport supportive of you and your
14 family after that? And I don't mean
15 financially, but emotionally supportive of you
16 and your family after that?

17 A: That night -- well my husband shot himself at
18 the house. So obviously when we went to the
19 hospital we couldn't go back home because our
20 house became a crime scene. And James and his
21 wife opened -- it was after midnight at that
22 point and he opened his house and let me and my
23 kids spend the night. And him and another
24 friend of mine got together and got me and my
25 kids, like tooth brushes, tooth paste, a change



1 of clothes and everything because we couldn't
2 go home anything that night until they had gone
3 through my house to find -- because my husband
4 had a gun that I wasn't aware of, and they had
5 to go through the house and find the ammunition
6 and everything, and clear my house from being
7 a crime scene first. And he allowed us to stay
8 there have a place to stay that night. And in
9 the time after that he's been there repeatedly,
10 both emotionally plus he helped me lay floors
11 in my house and different things at the house
12 to help try and fix my house up.

13 Q: In your experience would you describe Mr.
14 Davenport as a compassionate person?

15 A: In my experience he has been.

16 Q: Okay. Now I think you talked about some type
17 of deterioration in the relationship between
18 Mr. Stoller and Mr. Davenport. Did you witness
19 any change in their relationship?

20 A: Yes.

21 Q: Okay. When did you start to notice a change in
22 the relationship between Mr. Stoller and Mr.
23 Davenport?

24 A: They began having arguments over James's
25 beliefs that Scott was -- he would argue with



1 Scott over whether or not he felt EMS money was
2 spent appropriately or whether or not a vehicle
3 should have been used as a QRV or whether it
4 should have been used as his vehicle. And then
5 James would make up policies and then Scott
6 would argue against them. So it became more
7 and more they became divisive on issues. And
8 they became more and more -- the whole
9 relationship began to suffer from these
10 divisiveness.

11 Q: What time frame would you say the relationship
12 started to sour between Mr. Davenport and Mr.
13 Stoller?

14 A: I think it started, I'm wanting to say it was
15 like maybe September, August, September of 2015
16 is when I noticed that it was starting and
17 progressively getting worse.

18 Q: Okay. At some point did Mr. Stoller ask you to
19 write an incident report that was negative
20 toward Mr. Davenport?

21 A: Yes.

22 Q: Okay. Can you describe to The Court what
23 happened in that event?

24 A: James and I would get into discussions about
25 things. And both of us are a little stubborn



1 and both of us are very passionate. We had
2 gotten into one and evidently it had gotten
3 overheard or something. I'm not sure.

4 Q: Did your voice and Mr. Davenport's voice get
5 somewhat elevated?

6 A: Yeah.

7 Q: Okay. Were there any curse words exchanged ---

8 A: No.

9 Q: --- between the two of you? Never?

10 A: No.

11 Q: But it just sort of got loud?

12 A: Yeah. We both were very stuck on our side of
13 the discussion.

14 Q: You remember what even the topic of that
15 discussion was?

16 A: I really don't at this point.

17 Q: Did you have any like problems with the way Mr.
18 Davenport conducted himself in that discussion?

19 A: No.

20 Q: Okay. Do you believe that you acted, even
21 though you were passionate and loud, you
22 believe that you acted appropriately as well?

23 A: Yeah. It was after working hours. We were at
24 the office, but it was after working hours. We
25 were just passionately -- I mean, yeah we got



1 loud and we probably shouldn't have.

2 Q: Do you know how that came to the attention of
3 Mr. Stoller?

4 A: I am not sure.

5 Q: Okay. And what did Mr. Stoller do, or what did
6 he request of you or ask of you after that loud
7 discussion?

8 A: He asked me to write an incident report about
9 it, and I told him that I didn't believe that
10 it was warranted. And ---

11 Q: How many times did Mr. Stoller ask you to write
12 an incident report about Mr. Davenport?

13 A: Several times.

14 Q: Okay. And what was your repeated response to
15 Mr. Stoller?

16 A: I just didn't feel comfortable because I didn't
17 feel that it was worth an incident report. I
18 finally did write the incident report.

19 Q: How soon prior to Mr. Davenport's suspension
20 did you write the incident report?

21 A: It was actually after.

22 Q: Okay.

23 A: It took several months for me to finally write
24 the incident report.

25 Q: Okay. Did Mr. Stoller ask you to write the



1 incident report before Mr. Davenport was
2 suspended?

3 A: Yes.

4 Q: Okay. And this altercation obviously Mr.
5 Davenport was in the office with you after
6 work, that was prior to his being suspended ---

7 A: Yes.

8 Q: --- is that right? Okay. At some point did
9 you discover a listening device had been placed
10 in your office?

11 A: It was a camera. I'm not sure if it was able
12 to listen or not, but it was a camera hidden
13 behind my bookshelf.

14 Q: I'm going to show you Exhibit 14. Do you
15 recognize that photograph?

16 A: Yes.

17 Q: And could you tell The Court what that
18 phonograph is?

19 A: That is the camera that was behind my
20 bookshelf.

21 Q: Okay. And who discovered or noticed that
22 camera?

23 A: I'm a little bit OCD, and I noticed that my
24 bookshelf was crooked, and couldn't figure why
25 my bookshelf was crooked. And so I went to go



1 straighten my bookshelf up against the wall
2 because I have it flush with the wall, and it
3 was pulled back on side. And when I went to --
4 it wouldn't push back against the wall, and I
5 could figure why it wouldn't. So I looked, and
6 that's when I found the camera behind the
7 bookshelf is why it wouldn't push back against
8 the wall in that corner. There was a camera
9 back there. And so I'm the one that discovered
10 it.

11 Q: Is Exhibit 14 a fair and accurate
12 representation of what you saw where the camera
13 was placed?

14 A: Yes.

15 Q: Okay.

16 **MR. ROTHSTEIN:** Your Honor, I move Exhibit 14 into
17 evidence.

18 **MR. WICEVIC:** And, Your Honor, you know my
19 objection. I object on relevance.

20 **THE COURT:** What's the relevance of that camera?

21 **MR. ROTHSTEIN:** Well this was very shortly before
22 Mr. Davenport was suspended. I think Ms.
23 Kaiser actually made a complaint about it. I
24 think somebody actually -- Mr. Stoller a couple
25 days later came in and actually retrieved the



1 item from her office. I mean I think it is
2 relevant to show that Mr. Stoller at the time
3 was sort of looking for information to use
4 against Mr. Davenport to get rid of him.

5 **THE COURT:** I'm going to allow it.

6 **MR. ROTHSTEIN:** Thank you.

7 **THE COURT:** It's admitted.

8 **(Respondent's Exhibit Number 14 was admitted into**
9 **evidence.)**

10 Q: Was the camera, could you tell from the
11 position of the camera, could you describe
12 what's on the photograph what's to the right of
13 the camera? The brown piece?

14 A: The brown piece would be the bookshelf.

15 Q: Okay. And what's the white piece on the left
16 side?

17 A: That's the wall.

18 Q: And was that the position the camera was in
19 when you found it?

20 A: Yes.

21 Q: Okay. Was the camera pointed at anything that
22 you could tell in the room?

23 A: There's a cabinet that has got some of my
24 training supplies in it. It was pointed
25 towards that cabinet.



1 Q: Okay. Did that cabinet have a lock on it?

2 A: No.

3 Q: Okay. Was there anything valuable or secret
4 that was kept in that cabinet?

5 A: Well let me rephrase. On the bottom cabinet
6 there's no lock. On the top cabinet there is
7 a lock. The bottom cabinet had some like old
8 ET tubes, they're expired because I use them
9 for training. So they're of no value. The top
10 cabinet I think had some uniform t-shirts in it
11 to give to people if they come up to the office
12 asking for a uniform, and that's not really
13 locked. And so there's nothing of real value
14 there. So there's nothing in the cabinet of
15 any ...

16 Q: Did you complain to anybody after you found the
17 camera in your office?

18 A: Yeah. I was kind of freaked out. I didn't
19 know who had put it there. I didn't know where
20 it had come from. Scott was not in the office
21 at the time. Taylor Jones was.

22 Q: Who is Taylor Jones?

23 A: He was the Emergency Manager at the time.

24 Q: Okay.

25 A: And we were in the same building as him. And



1 he was the highest ranking person that was
2 there. And I went and said something to him
3 because I asked him if he knew the camera was
4 there and why.

5 Q: What was his response?

6 A: That no he didn't know it was there, and how
7 long had it been there? And I'm like, I just
8 found it. I don't know. I don't think it had
9 been there long because I'm pretty OCD about
10 things like that, and I notice when people move
11 stuff in my office. So I don't think it had
12 been there long. And then he came and looked
13 and he said, well I need to know is there any
14 chance, have you changed clothes or anything in
15 this office? And I'm like, no. And he's like,
16 okay so he could not have seen you undress or
17 anything. And I'm like, no. And I'm like, I
18 don't know where it came from.

19 Q: At some -- I'm sorry.

20 A: He said he thought he did.

21 Q: Taylor said he thought he knew where it came
22 from?

23 A: (Nods head.)

24 Q: Okay what happened next with regard to the
25 camera?



1 A: A couple days later Scott came in and ---

2 **THE COURT:** Ms. Kaiser, I do need you to give verbal
3 responses to the question. I think you nodded
4 and it was a yes to the last question.

5 **MR. ROTHSTEIN:** I'm sorry. Thank you, Your Honor.

6 **MS. KAISER:** I'm sorry.

7 Q: So, what happened next with regard to the
8 camera?

9 A: Scott came in and took the camera out of my
10 office.

11 Q: Okay. Were you in the office when Mr. Stoller
12 took the camera?

13 A: Yes

14 Q: Did he say anything to you?

15 A: He just said that he had been called and tolled
16 to take it out of my office, and I said, well
17 I didn't know who had put it there. And he
18 said, well I put it there. I was wanting to
19 put it on that cabinet because I was thinking
20 of putting narcotics in that cabinet. And I
21 said, oh, I said, I didn't know because I just
22 saw the camera, and nobody said anything, and
23 I didn't know who had put it there.

24 Q: Do you know --

25 A: -- They were already taking it out.



1 Q: Do you know if that cabinet would meet DHEC
2 regulation for storing narcotics?

3 A: Not in the way it is now.

4 Q: Okay.

5 A: To store narcotics it has to be double locked,
6 and it is currently just a single lock.

7 Q: Did anything occur that led you to believe that
8 Mr. Stoller may have been listening to
9 conversations in your office with that camera?

10 A: We had talked about the fact that James had
11 been over at my house doing another project of
12 ours to lay flooring in my house, and Scott did
13 come into my office and said something about
14 the fact that he had been at my house that
15 weekend.

16 Q: That James had been at you house?

17 A: That James had been at my house that weekend.

18 Q: Okay. Was Mr. Stoller part of the conversation
19 where you were discussing Mr. Davenport and the
20 flooring?

21 A: Now, I'm not positive he heard it on the -- I
22 mean he could have been outside in the hallway
23 and heard it, but he wasn't in my office when
24 we were talking about it.

25 Q: Have you ever seen the body camera video



1 footage with Mr. Davenport's interaction with
2 the stabbing patient and the rescue squad?

3 A: During the deposition, I was showed a couple
4 minutes.

5 Q: Okay. Prior to the deposition -- Who at the
6 deposition showed you that body camera footage?

7 A: One of the lawyers for DHEC. I forget her
8 name.

9 Q: Okay. Have you ever seen the entire video, or
10 the entire camera, or just snippets by the DHEC
11 lawyer?

12 A: No, I have not seen the entire video.

13 Q: Okay. Has Mr. Stoller ever offered to show you
14 the entire video footage?

15 A: He's offered, but I refused to see it.

16 Q: Okay. Tell me about his offer. What did he
17 say to you when he offered for you took look at
18 the video?

19 A: He just said that I -- that he would show me
20 that, because it was worse than what James had
21 told me, and I was like I'm not involved in it,
22 and we are friends, therefore I don't need to
23 see it. To me I don't think it's appropriate.
24 I'm already biased anyway, because James and I
25 are friends anyway, and I like Scott, and I'm



1 trying to stay out of the middle of it. I
2 don't want to be in the middle of the whole
3 thing, so I really didn't to see it, and I
4 wasn't involved in the QA, I wasn't involved in
5 any of it, so there was no reason for me to see
6 it.

7 Q: Okay. Is Mr. Stoller still your supervisor at
8 Anderson county EMS?

9 A: Yes he is.

10 Q: Okay, and has he been your supervisor sense you
11 been the training Officer at Anderson County
12 EMS?

13 A: Yes.

14 Q: Do you know if Mr. Stoller has shown the video
15 to other -- the body camera video of the
16 stabbing to other people outside of the EMS
17 department?

18 A: There are two people that have told me that
19 they have seen it.

20 Q: Who are those people?

21 A: James Howard Murphy, and Zan Taylor Jones.

22 Q: Okay, and Taylor Jones is the Emergency Manger,
23 is that his position?

24 A: It was.

25 Q: OKay. What does he do now?



1 A: I think he is now an RN at the Emergency Room.

2 Q: Okay. Do you know when he left Anderson?

3 A: January of 2016.

4 Q: Okay. So. That was --

5 A: Or 2017, my apologies.

6 Q: 2017. Okay, do you know if Mr. Stoller him the
7 video before or after he left his employment at
8 Anderson County?

9 A: Before.

10 Q: Okay. One the other person you mentioned,
11 Howard I'm sorry I missed the last name.

12 A: Howard Murphy.

13 Q: Howard Murphy. What is Howard Murphy's
14 position in Anderson County?

15 A: He's a paramedic with us. He is also a
16 professor at Anderson University, and I think
17 he works part time with the Emergency
18 management also.

19 Q: Okay. Have these three cases, the stabbing
20 case, and the two cases of pediatric seizure
21 case, and the nursing of a patient case, have
22 these ever been discussed at any of the regular
23 QA meetings, at Anderson county?

24 A: No.

25 Q: Do you have any military service?



1 A: Yes.

2 Q: Okay. How long were you in the military?

3 A: Two years.

4 Q: And what branch of the service were you in?

5 A: Navy.

6 Q: Okay. In your experience in the military, have
7 you had an occasion observe or hear your co
8 service people engage in what you thought was
9 sort of rude or offensive language?

10 A: Yes.

11 Q: Was that a fairly common occurrence in the
12 military, in your experience?

13 A: Yes. Military people tend to cuss a lot.

14 Q: Okay. What about an emergency serviceman?
15 Have you had occasion to see either paramedics
16 or EMT's or fire-fighters, Police Officers
17 engage in somewhat I guess offensive or rude
18 behavior, language?

19 A: Yes.

20 Q: Have you yourself in your career as a paramedic
21 used what you thought was I guess was an
22 unfortunate choice of words?

23 A: Unfortunately, yes.

24 Q: Okay. Have you done that in connection with
25 the care of a patient?



1 A: Unfortunately, yes.

2 Q: Okay. Are there instances you can think of in
3 your career that you wouldn't want somebody to
4 see on a body camera video footage in a
5 courtroom?

6 A: I'm sure there are.

7 Q: I don't think I have any further questions,
8 Thank you Sheila.

9 **MS. KAISER - DIRECT EXAMINATION BY MR. WICEVIC:**

10 Q: I just have a couple questions for you, and
11 we'll get you out of here. You mentioned that
12 you're a friend of Mr. Davenport, and you're a
13 biased party, and that's why you didn't decide
14 to review the boy cam footage when Shawn --
15 excuse me, when Mr. Stoller offered it to you?

16 A: That's correct.

17 Q: I believe during your deposition, Mr. Rothstein
18 asked you how you would rate Mr. Davenport as
19 far as the medics at Anderson County, and you
20 said top five percent, something like that?

21 A: I believe my statement was, I would trust him
22 to treat my family.

23 Q: Was it within the top five percent?

24 A: I don't recall using a percentage. If I did,
25 I don't recall using that. I'm not saying I



1 didn't, but I don't remember.

2 Q: Well, would you characterize him as being in
3 the probably top five percent, top ten percent?

4 A: I think with his experience, especially with
5 trauma, he's probably got more experience
6 dealing with that than most medics in Anderson
7 County.

8 Q: Okay, fair enough. This is in spite of never
9 being on an actual patient care call, is that
10 correct?

11 A: That's correct.

12 Q: Mr. Rothstein mentioned you saw a portion of
13 the body cam footage at the deposition with
14 Mrs. Nelson, is that correct?

15 A: That's correct.

16 Q: Okay. For this particular patient based upon
17 what you did observe, you did indicate that you
18 would have established IV access correct?

19 A: May have. It was hard for me to tell with the
20 portion I saw, I could not see the knife that
21 everybody's referring to. I did not see
22 enough. I've heard testimony about him walking
23 the patient, I did not see that, so I did not
24 see enough of the video for that. I saw enough
25 to see him walking in, he bent down, I could



1 not tell what exactly he was doing. His back
2 was to the camera, so I'm not sure, because I
3 believe it was asked, would I have done things
4 differently, and like I said in the deposition,
5 without having all the details of the call,
6 because I've never seen the patient care
7 report, I haven't seen all the vital signs, I
8 haven't seen how the patient was, the complete
9 surroundings or anything. I can't say with any
10 definitive answer what I would have done.

11 Q: Well do you recall being shown the video and
12 answering the question whether you would
13 establish an IV?

14 A: I recall being shown the little bit of video,
15 yes.

16 MR. WICEVIC: Can we pull up on the monitor, Ms.
17 Hazel?

18 Q: Can we back up a little bit? Were you deposed
19 by the department on June 19, 2017?

20 A: Yes.

21 Q: Ms. Kaiser, I'm going to read page 56. It
22 says, question, do you think that protocols
23 addressed whether to start an IV on a trauma
24 patients? Answer, it depends on the level
25 trauma? You've got to know -- with a sprained



1 ankle you don't start an IV. It's kind of your
2 discretion as to level of trauma. Question, do
3 you think the protocols address whether to
4 start an IV on a patient with this type of
5 trauma, with penetrating abdomen trauma?
6 Answer, for me, I would. Was that your answer
7 during the deposition?

8 A: Obviously so, and if so then I probably would.

9 Q: Okay. And, I think you said you'd have an IV,
10 but you wouldn't bolus the fluids, because if
11 there were some kind of internal bleeding we
12 didn't want to bust any clots loose, and make
13 their internal bleeding any worse. Is that
14 correct?

15 A: Yea, if you've got an abdominal wounds, you do
16 not want to bolus any kind of fluids at all.
17 You only want to maintain a blood pressure of
18 about 90 because you can make bleeding worse
19 into the belly.

20 Q: Right, I think you mentioned something about
21 keeping the IV open at a keep open rate? Is
22 that correct terminology?

23 A: Probab- -- Yeah, that sounds.

24 Q: Okay, and you said it was also important to
25 start an IV in transit because if there was



1 something you needed to give blood or fluids at
2 the hospital you'd already have the IV started,
3 correct?

4 A: If it is a critical trauma, yes.

5 Q: Is that what you indicated at the deposition?

6 A: I believe I was asked very critical trauma, if
7 I would, and I believe that I said yes. I
8 believe if I remember correctly, all of this
9 was with a critical trauma.

10 Q: Right, like the patient you saw during the
11 video, correct?

12 A: If you will back up, I believe we had some
13 discussion on the fact I could not say with any
14 definitive answer on whether I didn't have
15 enough details to say whether this was a
16 critical patient or not, because I don't know.
17 Nobody would answer, I've not seen the patient
18 care report, I don't have vitals, I didn't see
19 the skin, I didn't even see the wound well.

20 Q: Well let me ask you this. A patient with
21 penetrating knife wound to the stomach, with an
22 unknown length.

23 A: An unknown length of the knife?

24 Q: Yes ma'am, would that be a critical trauma?

25 A: If the patient appears critical then it would.



1 Now, would it be something that I would be
2 concerned with, yes. If I don't know the
3 length of the knife, then yes I would be
4 concerned, and yes I would treat with an IV, I
5 would.

6 Q: Okay, and then if the patients blood pressure
7 began to drop, then you would have that ability
8 to get the fluids, correct?

9 A: Yes.

10 Q: And get the pressure to rise, the blood
11 pressure to rise again?

12 A: Yes.

13 Q: Additionally, again I know you don't know all
14 of the details, but as a paramedic, you
15 probably would have ridden the call for this
16 type of patient, correct?

17 A: Without knowing all the details which you're
18 giving me, then yes.

19 Q: And I think you characterized Mr. Davenport's
20 language as being a bit rough, was that correct?

21 A: It appeared to be, yes.

22 Q: Okay.

23 A: What I saw of it.

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



1 THE COURT: Okay. Re-direct?

2 MR. ROTHSTEIN: Just a few questions, Your Honor.

3 MS. KAISER - RE-DIRECT EXAMINATION BY MR. ROTHSTEIN:

4 Q: Ms. Kaiser, just because you might have done
5 something differently doesn't mean it's the
6 only way to do it, right?

7 A: No.

8 Q: Would you agree that there's more than one way
9 to practice good medicine?

10 A: There's different levels of experience. So my
11 experience differs from say James.

12 Q: Okay.

13 A: Obviously he's got more experience dealing with
14 trauma than I do.

15 Q: Are you trained as a paramedic and do you train
16 other paramedics on how to recognize if a
17 patient is heading toward shock?

18 A: Yes.

19 Q: Okay. Is blood pressure a good indication of
20 whether a patient is heading toward shock?

21 A: Kind of a late sign.

22 Q: Okay. What do you mean?

23 A: You will actually see change in mental status
24 before. You will see a change in mental
25 status, you'll see a an increase in heart rate



1 way before even a drop in blood pressure. So
2 there will be changes. You'll start seeing,
3 you know, the skin get pale.

4 Q: Are you trained as a paramedic to recognize
5 those signs of a patient heading towards shock?

6 A: Yes.

7 Q: Is shock something that just happens like
8 stable, stable, suddenly you just drop off the
9 table and you're in shock?

10 A: Not in the adult normal.

11 Q: Okay. Thank you.

12 **THE COURT:** Thank you, Ms. Kaiser.

13 **MR. ROTHSTEIN:** Your Honor, if we could take a brief
14 break to let Mr. Davenport run to the restroom.
15 He'll be our final witness.

16 **THE COURT:** He's your final witness? Okay.

17 **MR. ROTHSTEIN:** I'll keep it short.

18 **THE COURT:** Okay. We'll take a ten minute break.

19 (Off the record from 1:45 p.m. until 1:58 p.m.)

20 **THE COURT:** Okay. If everyone is ready, we'll call
21 the hearing back to order. And please, take
22 you seats. Okay. We're ready for your next
23 witness.

24 **MR. ROTHSTEIN:** Your Honor, Mr. Davenport's our last
25 witness. As you know he's already been sworn



1 ---
2 **THE COURT:** Right.

3 **MR. ROTHSTEIN:** --- and is recalled to the stand.

4 **THE COURT:** Okay. Very good.

5 **MR. ROTHSTEIN:** May it please The Court?

6 **THE COURT:** Yes.

7 **MR. DAVENPORT - DIRECT EXAMINATION BY MR. ROTHSTEIN:**

8 Q: James, yesterday when your team leader, former
9 team leader, Deek Crus was on the stand, he
10 told a story about how the two of y'all first
11 met. Was he completely -- I mean did he tell
12 the truth, the whole truth, and nothing but the
13 truth on that story?

14 A: I think he cut out a word or two, but.

15 Q: What did you actually say to Mr. -- or what was
16 your recollection of that meeting like?

17 A: When I graduated from the Special Forces
18 qualifications course after being there a while
19 and had volunteered for a deployment right out
20 of the course, or out of the gate as some
21 people say. I had taken a week of leave after
22 graduating to spend some time with family
23 before disappearing for 9 months, and so I
24 returned to Fort Bragg as those guys were
25 showing up, getting ready to leave country.



1 And so never having met Deek, or Master
2 Sergeant Crus at the time, I was new guy to the
3 team and there's a lot of initiation. And you
4 know, so people call it hazing but we call it
5 just paying your dues, so I was handing out
6 pillows and pillow cases and I hear from the
7 doorway of the supply room, you must be
8 Sergeant Davenport, and I said well that's what
9 the fucking name tag says, and I looked up and
10 there he stood, and he goes well I'm Master
11 Sergeant Crus, I'm your new team Sergeant, and
12 I'm like, can I back up about 30 seconds and
13 start this all over again? And he was like, no
14 you'll do just fine, and I mean so --

15 Q: Did you realize at the time he said that, that
16 he was your new team leader?

17 A: I didn't know when he called my name that
18 that's who that was, no.

19 Q: Did your mouth almost get you in trouble on
20 that, or did you think your mouth had gotten
21 you in trouble in that situation?

22 A: Well, there would be some hazing that go along
23 with my comments, but most, and by most I mean
24 I can't think of one SF Soldier that doesn't
25 say what he means, and means what he says, and



1 sometimes you know, we let our common
2 vernacular on the team slip out in situations
3 when it shouldn't.

4 Q: Now Dr. Deangelo was here, and has talked
5 extensively about what the training and
6 selecting process is for Special Forces team
7 members and medics. I won't go through all
8 that, but as part of that, can you give the
9 court an idea of I think Dr. Deangelo didn't
10 have it figured, but how -- what's the washout
11 rate of someone who comes in the Army and
12 applies, they say do you want to be in the
13 Special Forces, and puts their name in the hat?
14 What's the process from there?

15 A: Well, our Special Forces assessment and
16 selection class, we class up to 495 guys. It's
17 a 24 day selection process, that covers
18 everything from your mental aptitude, your
19 physical aptitude, your team work skills, your
20 ability to problem solve, think on your feet,
21 your ability to work under pressure, work while
22 sleep deprived, hungry, hurt, you know, and
23 they're really adept at putting you in every
24 one of those situations. So, we start with 495
25 guys, and there was 106 guys that were selected



1 to move forward from that class.

2 Q: What's next after they've cut down that first
3 selection class by about 75 percent or 80
4 percent don't make it, right?

5 A: Yea, about that much. It's about an 80 percent
6 wash out rate at selection alone, then you have
7 a litany of academic courses from, well while
8 you're at selection you also get tested for a
9 -- to see if you can learn to speak a foreign
10 language, if you can't, if you don't have the
11 ability to pick up a foreign language, you
12 don't get selected no matter how well you do.
13 So, moving forward from there, there's a bunch
14 of leadership courses that you have to attend.
15 They teach you how to be a leader, if you will.
16 A combat leader, a professional leader, how to
17 counsel people that may need improvement, how
18 to conduce investigations, how to as someone
19 else said today, fact find, and then council
20 soldiers moving forward at the end of the end
21 of the day an Sf guy, an SF soldier or Green
22 Beret is a leader of soldiers, and if you can't
23 address soldiers in how to make them better,
24 you can't do your job.

25 Q: At the initial 24 day selection process, is



1 there another weed out period after that?

2 A: Well, throughout the course as a whole, you're
3 constantly being evaluated, either by the
4 students or by the cadre. You know, you have
5 small unit tactics, which is like radings and
6 ambushes, you know, learning to, if you will,
7 hunt humans, and then as a medic then you, once
8 you're done with that, you go to language
9 school, you'll pick up at least one language.

10 Q: Why sir, why is that important in the selection
11 process, or training process for a medic, a
12 foreign language?

13 A: My job overseas is to teach unconventional
14 warfare and a foreign internal defense to the
15 host nation soldiers like working with the
16 Afghan population. If you can't speak their
17 language, you can't teach them; and my job in
18 Afghanistan, aside from you being on patrols,
19 and hunting down enemies of our nation, is to
20 teach their soldiers to somewhat take care of
21 their own country, so we can one day stop
22 policing up their own problems. And, if you
23 can't speak their language, you can't do that
24 skill.

25 Q: How many languages have you picked up or



1 learned, or become fluent in during your
2 Special Forces career?

3 A: In addition to English, I speak 4 languages.

4 Q: And what languages are those?

5 A: French, Spanish, Aerobic, and Pashto.

6 Q: Okay. In your language training, did they ever
7 teach you how to speak sensitively or
8 courteously to someone?

9 A: That's not usually a part of it. It's -- you
10 know, when you're in combat, there's not any
11 mincing words in those situations, and you kind
12 of have to speak directly to the point.

13 Q: Okay, and during this weed out, or selection
14 qualification process, is there any level of
15 etiquette that you have to demonstrate, or
16 politeness that you have to demonstrate to get
17 past, to move on to the next round?

18 A: No, that is not something that is assessed for.
19 They consider that a weakness. In training
20 that is.

21 Q: And I know we've gone over a lot of stuff, in
22 your earlier testimony, and I'm not going to
23 rehash that, but can you tell us why you first
24 decided to go into the armed services, or into
25 the Army?



1 A: My wife was 9 months pregnant on 9/11.
2 Sensitive subject. And, I would have a
3 daughter born on the 29th of September.

4 Q: When did you decide to enlist?

5 A: 9/11.

6 Q: Okay. Where were you the day after 9/11
7 occurred?

8 A: Recruiters office.

9 Q: What did you sign up for?

10 A: I sign up for the infantry initially, because
11 it would, you know, get me into combat
12 quickest.

13 Q: And through your infantry training, did you
14 catch the attention of any recruiters, or you
15 trained the direction of how you wanted to go
16 in the military.

17 A: Well, my goal was always to be an SF guy. For
18 a number of reasons. I don't want to talk
19 about here, but while I was in my basic
20 Airborne course at Fort Benning, Georgia, which
21 is after infantry school, there were a couple
22 of us that caught the attention of the SF
23 recruiter, and he offered us a path to you know
24 kind of skipping going to the infantry, and
25 going straight to Fort Bragg, to begin SF



1 training, or to go straight to selection at
2 least, and if I hadn't made it through
3 selection I'd just go back to the infantry. As
4 luck had it, and getting selected is about 75
5 percent luck, well luck, and not getting
6 injured, I got picked up to be an SF Medic.

7 Q: And what was your role on that, or what was
8 your, I guess is it MOS, is that the right
9 acronym?

10 A: Military Occupational Speciality.

11 Q: Okay. What was your MOS on the Special Forces
12 team?

13 A: I was an 18-Delta, or Special Forces Medical
14 Sergeant.

15 Q: And, I know Dr. DeAngelo went through a lot of
16 it, but training, clinical training, is there
17 sort of a continuing education, or making sure
18 your skills continued to be maintained at the
19 cutting edge level as part of being an SF
20 medic?

21 A: Yes, every year we have to attend both trauma
22 and non trauma modules. The non trauma modules
23 consist of like dental medicine, OBGYN, vet
24 medicine, radiology, lab, I think I said OBGYN
25 once, sports medicine or orthopedics,



1 respiratory, cardiac, ENT, I mean it's a litany
2 of rotations that we have to go through in a
3 variety of different hospitals across the U.S.,
4 and then you know, trauma modules consist of
5 pretty much the same thing. You work in a
6 level one trauma center with the trauma surgery
7 team. They bring patients into the ER, you
8 scrub in just like a surgeon, and you're in th
9 OR scrubbed in just like a 3rd year resident,
10 doing everything a 3rd year resident would do.

11 Q: Have you been involved in actually performing
12 surgery in the United States for the military?

13 A: Yes.

14 Q: How many surgeries would you say you have
15 scrubbed in on, and actually put your hands
16 inside of patients?

17 A: Well I was at Walter Reed for 14 months,
18 healing from my own injuries, and was in the OR
19 59 times in 14 months, just doing surgery, from
20 finishing amputations, to loop colostomies,
21 suprapubic cath placement, arteriovenous shunt
22 placement, which is where you, at the end of an
23 amputation, they have to make a loop where the
24 artery and the veins still have to connect, so
25 blood doesn't just squirt out the end of the



1 limb, and so it's called arteriovenous shunt,
2 completing those. I was never the primary
3 surgeon of course, but any time you're in
4 trauma surgery there's a team of surgeons that
5 will work and each one has a little bit of a
6 specialty. So, you may have, and it really
7 depends on the case but, orthopaedics are
8 working on the orthopedic injuries, like
9 amputations, the trauma surgeons are more
10 working on the core of the body or the trunk.
11 Anything from the neck to the groin, unless
12 it's gastrourinary, or reproductive in nature.
13 And then there's a urologist that takes care of
14 those parts, but. So, I've removed items from
15 people, close people, put in drains, wound
16 vacs, taking people to the OR electively while
17 doing rounds on the floor. It's pretty
18 intense. I mean you don't, I mean, you know
19 the word Special Forces denoted that you aren't
20 an average kind of, you pick up stuff on an
21 average pace, so.

22 Q: Is part of your training as an SF Medic involve
23 anatomy and physiology?

24 A: You can say that, yes.

25 Q: How did your training in the SF, in terms of



1 anatomy and physiology compare to your
2 previously service as a, and I didn't get to
3 that, but you were a paramedic before you went
4 in to the Army, is that right?

5 A: That's correct. From 1995 until 2002.

6 Q: And I think Mr. Wicevic covered all that, but
7 how did the training in anatomy and physiology
8 compare to your paramedic, between your
9 paramedic training and your SF Medic training?

10 A: The vast majority of paramedic training is all
11 about acting with respect to anatomy and
12 physiology, and by the majority, I mean, there
13 are some places that do gross anatomy labs
14 where you work on cadavers, and some places
15 just rely completely on didactic, but the SF
16 medic course is 80 percent hands on and 20
17 percent didactic. Teaching you from a book
18 doesn't give you experience on where organs lie
19 on the body, and for you to be proficient at
20 opening people up, and taking things out of
21 them, or putting things back in them, you have
22 to have in depth working knowledge of what's in
23 the body, not just a round about, I think it's
24 in that part of the body.

25 Q: Are there more than 3 organs in the left upper



1 quadrant of the abdomen?

2 A: Yes.

3 Q: Have you ever been taught in your anatomy or
4 physiology that the internal organs of the body
5 are just sort of floating freely inside the
6 body cavity?

7 A: No, that's a bit of a misnomer. All the organs
8 are attached in the body by ligaments. I mean
9 if all your organs were just kind of in a sack,
10 they'd end up in your suprapubic area, and you
11 know, you'd kind of be built like an apple.
12 So, every one of them are suspended by
13 ligaments in different places inside of the
14 thorax or, which is the chest, or abdominal
15 cavity, or pelvic cavity.

16 Q: As part of your training in trauma, are you
17 trained on how to recognize the symptoms of a
18 patient going into shock?

19 A: Yes.

20 Q: Do you teach people how to recognize the signs
21 and symptoms of shock when you teach trauma
22 courses?

23 A: Yes. I do.

24 **MR. ROTHSTEIN:** Okay. Can we get the screen over
25 here on my computer please?



1 Q: Mr. Davenport, I put a -- this is just for
2 demonstrative purposes. Have you ever used
3 something similar to this in terms of teaching
4 people the signs and symptoms of shock?

5 A: Yes, sir. I have.

6 Q: Have you ever taught somebody that shock, it
7 goes from a patient begin stable and then they
8 just drop off the table?

9 A: That's ridiculous. The body doesn't function
10 in that manner.

11 Q: Can you explain to The Court what happens if a
12 patient who's stable starts to head toward
13 shock?

14 A: Sure. So, you have a patient that is
15 completely stable, meaning their blood
16 pressure's within normal limits, their heart
17 rate's within normal limits, their respiratory
18 rate their breathing is within normal limits,
19 their skin color, condition, and temperature
20 are all within normal limits for that patient.
21 And then as you begin losing blood, your body
22 begins to compensate for that blood loss in one
23 of several areas. I'll leave the chemistry
24 part out of it. Just to say, you know, the
25 first thing that happens is you go into



1 compensatory shock, patient gets anxious, your
2 pulse rate begins to climb a little bit, the
3 blood is shunted from your extremities, and so
4 your extremities begin to get cold and clammy
5 like a chilly sweat like you maybe get in the
6 middle of the night when you have like a flu or
7 a stomach bug kind of thing. If the problem
8 isn't remedied it will sometimes continue, not
9 all the time but some of the times continue
10 through compensatory into decompensatory or
11 progressive shock. And then you end up in
12 irreversible shock and die. But the idea that
13 you go from being completely fine one minute to
14 your heart stops the next, if that happens it
15 wasn't a shock problem it's a cardiac issue.
16 But that's not caused by blood loss, it's due
17 to another factor.

18 Q: If you're treating a patient, and there's a
19 concern about shock and their blood pressure
20 starts to drop, is that the first indication
21 you're going to see that that patient's going
22 into shock?

23 A: Absolutely not. Your blood pressure dropping
24 -- well, let me say your body's going to
25 compensate to a certain point and maintain a



1 normally high blood pressure, or within normal
2 limits. And then as your body gets to the
3 point where it's lost so much blood and it can
4 no longer compensate, then the heart rate will
5 start to drop and the blood pressure will start
6 to drop with it. If you're waiting until the
7 blood pressure starts to drop, you're way
8 behind the eight ball. But that isn't a reason
9 to just, you know, stack eight balls on top of
10 each other to try to get in front of it.
11 There's plenty of other things that you can do
12 for a patient that has nothing to do with
13 trying to treat shock.

14 Q: Okay. Is installing just a IV port or I think
15 a hepwell is what we talked about, is that a
16 way to prevent shock?

17 A: Absolutely not. There's plenty of literature
18 speaking of -- you asked earlier about what we
19 do to maintain currency or move medicine
20 forward. On of the other things is we're as SF
21 Medics, we're required to do a research topic
22 once a year on a topic that is assigned by like
23 say Dr. DeAngelo our group or battalion
24 surgeon. So it's not -- we don't get to choose
25 based on what we want to write about. We



1 choose based on what those that are trying to
2 teach us think we need to learn based on where
3 our short comings are individually through
4 counseling soldiers and being around them,
5 through training exercises. So with that
6 there's a lot of literature that talks about
7 how bad it is for penetrating trauma patients
8 to have IV fluid in the pre-hospital setting.
9 And survival rates are better when the patient
10 doesn't have IV fluid in the pre-hospital
11 setting than it is if they get IV fluids in the
12 pre-hospital setting. The body doesn't bleed
13 saline, it bleeds blood. And by feeding -- the
14 misnomer is well I can put saline in and just
15 fill the container up, but all you're doing is
16 diluting the red blood cells that are currently
17 in the container. I'm trying not to talk in
18 too great of detail chemistry wise. But
19 there's a litany of problems with just putting
20 fluid in people for, a, the sake of putting
21 fluid in them and raising their blood pressure,
22 and b, it's diluting the red blood cells which
23 are carrying the oxygen. They're also what's
24 carrying the clotting factors in your blood.
25 So if you get the clotting factors to the site



1 of the bleed and they start to work and the
2 blood pressure's dropping a little bit, that's
3 not necessarily a bad sign. That can be better
4 for the patient than just letting them maintain
5 a, you know -- then just pumping their body
6 back full of saline. I mean that's the simple
7 approach to it. But the idea that when a
8 patient starts to compensate you immediately
9 have to fill them fluid is just ridiculous. It
10 isn't founded in medicine. Trauma surgeons
11 will tell you that that's not the way they
12 operate in that OR. If you bring a patient to
13 the OR, they may hang blood on that patient,
14 but there's a huge difference between putting
15 blood in somebody and putting saline. I mean,
16 it's just been proven that it's not good for
17 the body. And hospital stays -- I'm sorry.

18 Q: No, no. Go ahead.

19 A: I've gotten on a tangent. Not a tangent but on
20 the topic. But hospital stays have been shown
21 to be shorter with patients where IV fluids are
22 restricted to the patient than when they get
23 them in the pre-hospital setting because once
24 you get into the hospital they have to fix all
25 of the acid base balance issues that take place



1 in the body because once you start putting
2 saline in and you displace blood with saline,
3 now you're changing the body's PH level, and
4 that causes all kind of problems.

5 Q: Now, I think there was a term used earlier or
6 maybe late yesterday afternoon called an IV
7 lifeline. Have you ever heard that term
8 before?

9 A: Yesterday's the first time I heard that
10 silliness.

11 Q: Okay. Is there such a thing as an IV lifeline?

12 A: No. There's not.

13 Q: Okay.

14 A: There's a surgeon lifeline but not an IV
15 lifeline.

16 Q: In your experience in pre-hospital medicine, is
17 our job in the field to install an IV that's
18 going to be used at some point in the actual
19 surgery itself?

20 A: No. As a matter of fact, most
21 anesthesiologists that I've worked with and
22 worked around, as soon as that patient gets to
23 the ER or through the trauma bay going to the
24 OR, those IV's get replaced because they're not
25 trusted for a number of reasons. Aseptic



1 technique is one of the biggest ones. I mean
2 you don't want anymore of an infection hazard
3 than the patient already has. And that's one
4 other route to get antibodies into the body.

5 Q: Okay. Let's talk about this stabbing call on
6 March the 19th, 2016 when you were working at
7 the Iva Rescue Squad. Tell me what you can
8 recall about that particular day. Do you know
9 how long you had been on duty at the time the
10 call went out?

11 A: Yeah. I was working the backside of a 36 hour
12 shift.

13 Q: Okay. And when the call came out, do you
14 recall who was driving the ambulance on the way
15 to the call?

16 A: I don't. I mean we changed that up. I mean,
17 there's not one of us that drives anymore than
18 the other one on the way to a call. It just,
19 you know -- if I was closer to the truck and my
20 partner's in the kitchen or out in the bay or
21 something, you know, doing laundry, whatever
22 the case may be, the first one in the truck
23 usually starts the truck and is ready to go by
24 the time the other person hops in the truck.

25 Q: How would you assess your driving ability



1 compared to Ms. Aiken's driving ability of the
2 ambulance itself?

3 A: I'd say they're equal.

4 Q: Okay. Now when you got to the scene that
5 night, what's the first thing you can recall.
6 I mean, I know you've seen the video before.
7 Tell me -- walk the Judge through what was
8 going in your mind set as you first came up to
9 assess that patient.

10 A: Well it was ---

11 Q: Was the patient awake at ---

12 A: Sorry. I was trying to figure out what to call
13 him. The patient.

14 Q: The patient.

15 A: He was sitting in a semi-Fowler's position,
16 kind of slouched down on the couch, awake and
17 alert, talking to the law enforcement Officer.
18 I was, you know, I mean it had just been
19 recently that quite honestly James Kaiser had
20 taken his own life very unannounced. I mean,
21 Sheila talked about it earlier. And you know,
22 we were still as friends dealing with helping
23 her deal with her loss, which is not something
24 that I took lightly.

25 Q: Do you know how long the patient had been



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1 sitting on that couch before you all arrived?

2 A: The Officer said 20 minutes.

3 Q: Okay. And when you first got there, was the
4 patient alert and oriented, or did he appear to
5 be alert and oriented?

6 A: He appeared to be alert and oriented. He was
7 speaking to the Officer. I walked in, stood
8 there for a few seconds, watched the patient,
9 watched the knife, made an unfortunate comment
10 that, you know, everybody that's asked me, I've
11 said I regret it. I mean, I don't know how
12 much more I can get beat up over that. But,
13 you know, I regret my choice of words, but ---

14 Q: How long did it take you to figure out that
15 that patient was stable when you got onto the
16 scene?

17 A: About 15 seconds.

18 Q: Okay. And how did you make that determination
19 by observing the patient?

20 A: His skin was warm and dry, he had a strong
21 pedal pulse, his respiratory rate was normal.
22 He was awake and alert and answering questions.

23 Q: What did you decide to do -- I mean, did you
24 notice any blood from the wound or much blood?

25 A: So the blood coming from the wound was dripping



1 straight down his body. I shouldn't say drip.
2 I misspoke, but I mean it was pretty much dried
3 on his abdomen. It looked like he maybe lost
4 two to three CC's of blood, or milliliters.

5 Q: Did you see the photographs that came in during
6 Ms. Aiken's testimony, the first witness?

7 A: I did.

8 Q: Have you ever seen those photographs before?

9 A: I have not.

10 Q: Based on looking at the photographs of the
11 linoleum floor and the couch, can you estimate
12 how much blood that patient lost?

13 A: Less than five milliliters.

14 Q: Okay. How much blood -- if I'm going to go
15 down today to the Red-Cross and donate blood,
16 how much blood is coming out of my body?

17 A: About 500 CC's.

18 Q: How did that compare to the amount of blood
19 that you saw on the floor and on the couch?

20 A: I mean it's infinitesimal based on -- I mean,
21 in the grand scheme of things. I mean the
22 average guy cuts himself shaving probably as
23 bad.

24 Q: I'm sure you've given blood before.

25 A: I have.



1 Q: But after you lose 500 CC's -- is it CC's?

2 A: 500 CC's.

3 Q: Do people start an IV on you to start saline
4 after you've ---

5 A: Absolutely not.

6 Q: All right. So getting back to the scene. Had
7 you had a previous, or have you had previous
8 encounters with this particular gentleman?

9 A: Yes.

10 Q: Okay. And was he -- have you seen him out and
11 about in the community?

12 A: Absolutely.

13 Q: Have you discussed this particular gentleman
14 with other fellow members of the Rescue Squad
15 at Iva?

16 A: Yes.

17 Q: Okay. And you'd been out to this gentleman's
18 house, I think your earlier testimony was on
19 one prior occasion?

20 A: One prior occasion, I was in the ambulance.

21 Q: Did you actually go into the house on that
22 occasion?

23 A: No. The patient met us at the front door.

24 Q: Okay. Now when you said to the patient, did
25 anybody ever tell you you're an idiot, what was



1 going through your mind when you made that
2 comment?

3 A: Well a whole bunch of things. One, I was
4 certainly still thinking about my friend Ms.
5 Kaiser and that unfortunate circumstance. And
6 then, I mean, there was a litany of other
7 things that were running through my mind.
8 Scene safety, you know, whether I thought that
9 guy had the ability to get up off the couch and
10 do harm to somebody with the Officer standing
11 right next to him.

12 Q: Once you determined that the patient seemed to
13 be stable, what was your next most important
14 thing to do?

15 A: Stabilizing the object in his abdomen.

16 Q: How did you go about stabilizing the object in
17 his abdomen?

18 A: Used a couple pieces of tape and horseshoe
19 around the object itself so that that object,
20 the handle couldn't tilt forward or backward,
21 then put bulky dressing around it and tape that
22 down.

23 Q: Okay. Prior to you taping that down, did you
24 observe the handle, the knife handle or did you
25 watch the knife handle as the patient was



1 breathing and sitting there on the couch?

2 A: Yeah. So, there was some testimony earlier in
3 the week about that knife handle. The handle
4 was perpendicular to the body's surface, well
5 mostly perpendicular. He was kind of a -- had
6 a round belly. But the knife handle was
7 sticking straight out of the body, not at an
8 angle. If it had been either in the diaphragm,
9 which is the muscle that helps you breath,
10 drops down is helping you inhale air, relaxes
11 pushes air back out of your lungs. Had the
12 knife penetrated the diaphragm, every time the
13 patient breathed the knife handle would move,
14 regardless of whether it was still suck in the
15 diaphragm, it's irregardless to it moving. If
16 it was in the path of the diaphragm the handle
17 would have moved every time the patient
18 breathed, all right? The knife doesn't, you
19 know -- if the knife penetrated the diaphragm,
20 as it's dropping, when it relaxes and comes up
21 and pulls away from the knife, when it goes
22 back down it's going to touch the knife blade
23 again and cause the handle to move. The knife
24 doesn't magically displace itself when it's
25 done in the diaphragm. If it was in the aorta,



1 which it can't get to due to the placement of
2 the aorta vice the trajectory of the blade and
3 the handle, there would be a ticking motion
4 every time the heart beat there would be a tick
5 of that handle. And the reason I know both of
6 those things is 'cause I've treated patients
7 with impaled objects in their diaphragm,
8 impaled objects in their aorta, pieces sticking
9 completely through both of those items. It's
10 not hard to tell when once of those items is
11 injured. It's just hard to associate it when
12 you haven't seen it.

13 Q: Okay. I think you were talking about you put
14 horseshoe tape around the handle. What else
15 did you do to secure the knife in place?

16 A: Took a couple rolls, not rolls but a couple
17 pieces of what we call AB pads, or like five by
18 nine inch pads. I rolled them up, laid them
19 adjacent to the blade of the knife, taped those
20 down in place to provide some bulky dressing
21 around the handle so that it was less apt to be
22 moved.

23 Q: Okay. Did you believe that you brought into
24 that scene all the equipment that you were
25 going to need to treat that patient based on



1 what the call was reported to be?

2 A: Absolutely.

3 Q: Have you ever taken all of the equipment off of
4 the truck and brought it into a house at a
5 scene?

6 A: I know that's what the protocol says, but
7 that's a virtual impossibility. I mean it
8 would take -- by the time I got all the
9 equipment off of the truck and into the house
10 for any given emergency, because you don't know
11 what you have, so just because dispatch says
12 you have one thing doesn't mean you'll always
13 have that. Dispatch could say a patient's
14 complaining of a headache and go in there and
15 the patient's in cardiac arrest. Or the
16 patient has a broke toe and you go in there and
17 the patient's lying in between the toilet and
18 the tub with a broke neck. It's somewhat of a
19 crap shoot. But the point is, there comes a
20 point where you have to go in, assess the
21 patient, decide what you need, and then bring
22 those extra supplies to the patient. You know,
23 trying to take a stretcher, a stair chair, a
24 spine board, a scoop stretcher, all the
25 equipment out of the truck, which includes a



1 drug bag, a heart monitor, a suction unit,
2 oxycaddy, I mean does all the equipment include
3 all the equipment cabinets too? I mean all the
4 four by fours, all the extra oxygen cylinders.
5 I mean it's a bit ---

6 Q: If you brought all that stuff into the house,
7 you can't just leave it in the house, right?

8 A: No.

9 Q: What would you have to do?

10 A: Well eventually you'll have to take it and put
11 it back in the truck.

12 Q: Would that affect your scene time and your
13 ability to get the patient to where he needs to
14 go?

15 A: Absolutely.

16 Q: Now after you got the knife stabilized in
17 place, what was your next major concern with
18 this patient?

19 A: How we were going to move him.

20 Q: Okay. Did that present any particular
21 challenges to you?

22 A: Yeah, several. One, you have a person that has
23 an object impaled in them. Then you have the
24 structure of the house itself, doorway sizes,
25 how the door swings, if there's a railing on



1 the steps, how secure the steps are, whether
2 the steps are secure, but they're not on a firm
3 foundation if you will. Then there's the move
4 from the house to the truck. Is it over
5 gravel, is it over sand, is it mud, grass. I
6 mean there's a litany of things that have to be
7 considered when you're moving a patient. The
8 most important one is the patient themselves.

9 Q: How quickly did you decide the best way to get
10 that patient out of the house was to try and
11 gingerly stand him up and walk him to down the
12 stairs?

13 A: How quickly?

14 Q: Yes.

15 A: It was a thought process from the time I
16 started stabilizing the object in his abdomen.

17 Q: Okay. Did you have any doubt in your mind that
18 walking that patient out of the house at that
19 time was the best way to get him out under the
20 circumstances?

21 A: Absolutely not.

22 Q: Okay. Did you give any consideration to the
23 protocols that say don't ambulate the patient
24 to the ambulance?

25 A: You mean should not?



1 Q: Should not. I'm sorry, should not.

2 A: Well you shouldn't just blow off the protocols,
3 but there's no chance that those pieces of
4 paper can take into account every instance that
5 you could possibly come across. I mean they
6 just can't.

7 Q: Could you get that stretcher into the house,
8 the stretcher from the ambulance into the house
9 up the stairs?

10 A: I wouldn't not even attempt that.

11 Q: Okay. How heavy is the stretcher?

12 A: About 130 pounds.

13 Q: Okay. And I think some of the medical records
14 said that patient was about 160 pounds?

15 A: Yeah, that's a little light for him, but ...

16 Q: Okay. So with his weight and the stretcher's
17 weight, that's about what, close to 300 pounds?

18 A: Yes, sir.

19 Q: Okay. And do you often go to calls where it's
20 just you and your partner on the truck?

21 A: We do.

22 Q: Okay. Is it feasible for two people, you and
23 Ms. Aiken to carry a 300 pound stretcher out of
24 the house and down a set of stairs?

25 A: No. Not the two of us.



1 Q: Okay. What about with four other people, like
2 Police Officers or other first responders on
3 the scene? Does that increase or decrease the
4 danger in moving a patient having more people
5 helping?

6 A: Anytime you have more moving pieces, there's
7 more complexity to it. And there's a chance
8 that something is going to go wrong the more
9 pieces you add. I mean I know that there's a
10 call for help, but just because you're getting
11 more people doesn't necessarily mean you're
12 getting more help or better help for that
13 matter. So ...

14 Q: If you have say four people carrying that
15 stretcher, and the patient down those stairs,
16 somebody's got to be going backwards down the
17 stairs. Is that right?

18 A: You'd either have to be going backwards -- I
19 mean if it's two of you, somebody's going to
20 have to go backwards and hopefully somebody
21 would be standing at the bottom trying to spot
22 you. But dropping that patient was the greater
23 concern of anything else that was going on at
24 that time.

25 Q: How quickly did it take you to stand that



1 patient up, gingerly walk him down the stairs,
2 and get him to the ambulance if you had to
3 estimate that to the nearest three seconds?

4 A: I'd say about 45 seconds.

5 Q: Okay. How long would it have taken you to go
6 back to the rig, get the stair chair, bring the
7 stair chair into the house, and get that
8 patient back to the ambulance. I don't
9 remember the stair chair being on that truck.
10 For some reason I remembered that that truck
11 had just returned from service and there was an
12 issue with it, and so it was off the truck.
13 Regardless of it being on the truck, I still
14 wouldn't have used it. The type that we have
15 does not have tracks on the back of it. It's
16 a set of wheels that would require you to load
17 the patient on it, strap him down, and then try
18 to either walk him supporting his entire body
19 weight with him in a upright position hoping
20 that he doesn't feel like off balance and reach
21 for something and throw us off balance, or you
22 have to kind of roll the wheels off a step and
23 let it fall down on the next step which is not
24 an option. I mean that is worse for the
25 patient than everything except for just



1 dropping him right on the knife.

2 Q: Once you get him down, if you got him down the
3 stairs, out of the house and down the stairs,
4 what was the ground like between the bottom of
5 the stairs, and the back of the ambulance?

6 A: It's grass.

7 Q: Okay. How would you get the patient, if you
8 used the stair chair, from the bottom of the
9 stairs to the back of the ambulance?

10 A: You could either transfer the, if you were
11 going to use a stair chair, you could either
12 transfer the patient directly to the stretcher
13 there, or continue to carry slash roll the
14 stair chair to the back of the ambulance, and
15 then you would transfer to the back of the
16 ambulance.

17 Q: Now when you decided to stand the patient up,
18 did you mean, or did you deliberately try to
19 cause him the maximum amount of pain in moving
20 him?

21 A: I know that's been a discussion. If I wanted
22 to cause him the maximum amount of pain, I
23 would have done a crappy job of stabilizing the
24 knife. That way, it provided the most
25 opportunity for that thing to move. That's not



1 what I did. I might have been short with
2 patient, given some issues that a friend of
3 mine was in her resent past, and made some
4 inappropriate comments, but that guy has done
5 nothing to me, despite me being upset at his,
6 what I considered, his silliness of attempting
7 suicide. I mean I have had people laterally
8 shoot me, not shoot at me, but put holes in me,
9 and me end up treating them afterwards, because
10 it's the humane thing to do. I mean, if
11 anybody I was going to let die, or cause pain
12 to, it would be somebody that just tried to
13 kill me. But, back to that patient, no I did
14 not. If you'll see the video, when we stood
15 him, we lifted him, I didn't tell him to stand
16 on his own. I mean I could have said, hey man,
17 get up of the couch, we're going to walk you
18 outside, and just let him try to stand on his
19 own, alright. An Officer was on one side, I
20 was on the other, I grabbed him by the wrist,
21 and underneath the arm, and lifted as much of
22 his body weight off of him as possible to get
23 him in an upright position. There is
24 absolutely nothing wrong with that move. I
25 understand that paramedics are cautious about



1 it, but that's because they don't have, and I
2 hope this doesn't, at the risk of sounding
3 arrogant, they don't have the experience moving
4 patients by foot that I do, or with impaled
5 objects in them.

6 Q: Now, when you were lifting that patient up,
7 what were you doing, or where were you looking
8 or where were you focused when that patient
9 started to move?

10 A: That knife blade, or the knife handle.

11 Q: And as the patient got up and walked what,
12 about 3 or 4 steps to the door --

13 A: Yep.

14 Q: Did you just leave him and walk down th steps?

15 A: No, when we opened the door, I turned with my
16 back to the steps, and walked down the steps
17 side by side, sideways holding him, in the
18 event that he lost his footing, I would be
19 there to catch him, but he's a pretty sure
20 footed individual from what I've seen.

21 Q: I noticed you went out the steps first, and
22 kind of hoped down the steps. Can you tell the
23 court why you had to hop down the steps?

24 A: I can't take pain meds when I work, so I
25 experience a fair amount of pain from my combat



1 injuries, on a daily basis.

2 Q: So, you went down first, pivoted around, and
3 did you watch the patient come down the steps?

4 A: Yes.

5 Q: Okay. What was your -- Why did you go down
6 first instead of letting the cop go down first?

7 A: Because if he fell, I wanted to be there to
8 catch him.

9 Q: Okay.

10 A: Or support him.

11 Q: Did you have any trouble getting the patient
12 down the steps?

13 A: Nope.

14 Q: Okay.

15 A: We -- if I may.

16 Q: Yeah, go ahead.

17 A: So, I mean Leo hit on this a little bit
18 yesterday, Mr. Deason. Patients know what
19 hurts them, you know. Us moving a patient, we
20 can't feel what that patient feels. Anytime
21 we're manipulating a patient that is in pain,
22 we risk the chance of causing them more pain,
23 because we are not feeling what they're
24 feeling. If we allow them to manipulate
25 themselves, there's a lot less pain involved.



1 They can stop when they feel pain, alright, or
2 discomfort. One of the best examples of that
3 is for years we put a C collar, if I may use an
4 example, we put a C collar on a patient's neck
5 in a car accident. We sit there and hold their
6 head, in an effort to keep their neck from
7 moving. Put a collar on them, and then we put
8 this, either what's called Kendrick Extrication
9 Device, KED, around them to prevent movement,
10 and then turn them and lay them down. What the
11 National Association of Athletic Trainers has
12 found, through a bunch of research that's
13 available online, is that if you let the
14 patient get out of the car themselves, there's
15 a lot less movement of their C spine, because
16 they can stabilize themselves in their position
17 of comfort, instead of us trying to put them in
18 the position that we think their comfortable.

19 Q: Now before you got out of the house, there was,
20 I think, some testimony earlier about after you
21 made the comment, I think it was, does anybody
22 ever tell you you're an idiot.

23 A: Yes.

24 Q: Did the patient stop interacting with you after
25 you made that comment?



1 A: No, he did not.

2 Q: Okay. Now There was also a comment about I
3 think some discussions between you and the
4 Police Officer, and the patient about you know,
5 why he did what he did or what he was trying to
6 accomplish, and he indicated he was hoping to
7 bleed out, he wanted to stab himself in the
8 heart, and hoped to bleed out. And you made a
9 comment to the affect of, man that's not where
10 your heart is. What was your intention in
11 making that comment?

12 A: To relieve any anxiety he had over where he put
13 the knife. I mean, if he thought that his
14 heart was there, and he was going to die, and
15 that's why he called 9-1-1, I wanted him to
16 know that he wasn't even near where his heart
17 was, and he would be ok. I mean, I'll agree
18 that just like the first comment I made to him,
19 I was rough about it. And, I mean, I'm happy
20 to talk about that later, but it wasn't a
21 comment that was meant to suggest that he was
22 an idiot and didn't do it right.

23 Q: Were you trying to coach him how to do it next
24 time in the right way?

25 A: I don't even know that that deserves an answer.



1 Q: Okay. You also told the patient at one point,
2 or sort of asked him, why he did it, and he
3 said he's got it so bad, his nerves are shot,
4 his wife's got an oxygen or depressed or
5 whatever, and you made a comment to the affect,
6 man I don't want to hear that. I stepped on a
7 IED in Afghanistan and blew my nuts off. What
8 was your thought process or your intentions in
9 conveying that information to the stabbing
10 patient?

11 A: SO, I believe I testified, that or I'm going
12 crazy, while Mr. Wicevic was questioning me
13 earlier in the week, that when I was healing
14 from my injuries, I worked as part of the Force
15 Preservation Director down at Seven Special
16 Forces Group in Elgin Airforce Base where I was
17 stationed, and a part of my duties was taking
18 care of wounded soldiers, and these are Special
19 Forces soldiers not unlike myself that were
20 greatly injured, and a lot of them weren't
21 doing nearly as well as I was. Multiple
22 amputations, a bunch of dudes with their faces
23 almost blown off, or shot off, and so, we had
24 a rise in suicides. And, SF dudes don't talk
25 about doing anything, they just do it. To be



1 honest with you, we're not the type to ask for
2 help a lot of times. You know, we're kind of
3 self sufficient in that area, or at least we
4 think we are. Whether it's emotionally,
5 physically, whatever the case may be, and so,
6 what we found was there was not a lot of
7 hinting around about guys who were going to
8 commit suicide. And so, the courser that we
9 took, was a, how to recognize it, and b, how to
10 treat it in other guys, or other soldiers.
11 And, you know, attacking is not the right word,
12 but talking around the problem, sugar coating
13 things, holding people's hands, and while I
14 agree, certain people need their hand held if
15 you will, not everybody's like that. And so,
16 coddling people doesn't get you the results
17 that you think it's going to get you, and like
18 I said, we were taught to not sugar coat
19 things, and talk right at them. Again I agree
20 that I could have chosen better words, and
21 maybe changed my tone a little bit, but I meant
22 that man no harm.

23 Q: And you recall in the video, and you were
24 there, you saw the Officer Boucher say
25 something to the affect of, don't make me be



1 bad guy.

2 A: Condescending?

3 Q: Yeah, is it appropriate to talk to a patient
4 with baby talk? I mean does that show
5 compassion and care when you talk to someone
6 with baby talk?

7 A: No, it does not.

8 Q: Okay. Now, as you were performing these
9 procedures, and stabilizing, did you tell the
10 patient what you were going to do for him?

11 A: No, I --

12 Q: Did you tell him you were going to tape the
13 knife into place when you taped the knife into
14 place?

15 A: I don't recall.

16 Q: Okay. Do you recall telling him that he's
17 going to have to go to the Operating Room to
18 have the knife --

19 A: Yes, yes.

20 Q: Why did you tell him he was going to have to go
21 to the Operating Room?

22 A: Because I wanted to prepare him for what was
23 about to happen to him, so that it wasn't a
24 surprise. He had previous encounters, with EMS
25 crews, had noted that he changed en route to



1 the hospital, and decided he didn't want to go,
2 so he was going to put up a fight. I would
3 rather it had started there while I had plenty
4 of help, rather than him being in the
5 ambulance, and I say, or Km says something to
6 the affect of you're going to have to go the
7 OR, and then he not have that in mind, and
8 start fighting someone in the back of the
9 truck.

10 Q: Okay. There was some interaction, again this
11 is after the idiot comment was made, right? I
12 mean this was a couple minutes after. There's
13 a comment about, you mean I got to go to the
14 hospital to get that taken out, you can't take
15 that knife out. And what was your response to
16 that?

17 A: I said, I could, but I'd lose my job.

18 Q: And what did you mean that you would lose your
19 job if you tried to take that knife out?

20 A: Well, it's out of a paramedic's scope of
21 practice.

22 Q: If that patient had the same knife wound in
23 Afghanistan, could you have taken the knife out
24 and fixed him?

25 A: Absolutely.



1 Q: Okay, but if you try to do that in Iva of South
2 Carolina, that's way out here beyond the scope
3 of practice of a civilian paramedic, you agree
4 with that?

5 A: Yeah, I completely agree. That's why I didn't
6 take it out right there. That and it not being
7 sterile.

8 Q: Alright, so you get the patient out the back of
9 the truck and I do remember when he stood up,
10 he kind of grimaced with a little bit of pain.
11 Was that normal to experience pain as you stand
12 up with an impaled object in your stomach?

13 A: Yes, anywhere in your body it's going to hurt.
14 I mean it could be in your foot, and you could
15 put pressure on it it's going to hurt.

16 Q: Did you disregard that complaint of pain, or is
17 that something you expected to see as you
18 lifted ---

19 A: It was an expectation.

20 Q: And when you got the patient in the back of the
21 truck and helped him, you said put your butt
22 right there, were you being mean to the patient
23 when you told him where to put his rear end?

24 A: No, I just wanted him to put his butt, where I
25 told I wanted him to put his butt.



1 Q: Okay. He put his butt there, and he got sort
2 of turned up on to the gurney, and he expressed
3 a little bit more pain, right?

4 A: Yes.

5 Q: Is that something you would expect to see
6 again, as you're manipulating that patient into
7 that position? For those stomach muscles to
8 tense up and for him to experience some pain?

9 A: So, sense you brought up stomach muscles.
10 Anytime you move your core, your stomach
11 muscles, your core has to be engaged to make
12 that motion, so whether he moved himself, or I
13 moved him, his body is still going to tense,
14 because he's going to think it's going to hurt,
15 and try to anticipate the pain that might be
16 coming. So the idea that you could move
17 somebody with an injury of any type, and never
18 cause no pain, is just not so. I mean,
19 sometimes you have to cause people a little
20 pain to help them, you know. Setting bones, I
21 mean, if you go to the hospital for sutures,
22 the doctor, or PA or nurse practitioner, or SF
23 medic, if you're around an Army base, that's
24 going to suture you has to stick a needle in
25 you to numb the area where he's going to suture



1 you. So, the mere fact that the patient hurt
2 a little, isn't indicative of someone trying to
3 hurt him. It's just a fact of trying to care
4 for him.

5 Q: Okay. Then the patient got on, and he looked
6 like he was a little too far toward the head of
7 the stretcher, and he had to kind of get moved
8 down to the back. How did you go about moving
9 the patient down a little bit?

10 A: I grabbed his belt, below the site of the
11 wound, and drug him down slightly, so he didn't
12 have to move himself.

13 Q: Okay, and I think when that happened, he said
14 ouch ouch. Did you do that internally or
15 deliberately to hurt him?

16 A: No.

17 Q: Okay. What was your purpose in moving him down
18 the stretcher?

19 A: Because his head was, I believe, about to hang
20 off the top of the stretcher, or it was at the
21 top of the stretcher.

22 Q: Now, I think at some point the -- I think it
23 was Kim's husband said, hey man, you want to
24 sit up some or something. Do you remember
25 that?



1 A: Yes I do.

2 Q: Okay. Was it -- is it your understanding he's
3 an EMT basic?

4 A: That's correct.

5 Q: Was it his place to tell you how to carry that
6 patient into the hospital?

7 A: No.

8 Q: Okay. Why did you lay the patient down flat on
9 the stretcher?

10 A: So when the patient was in the house, if you
11 see from the video, when the patient's in the
12 house, and he's kind of in that slouched down
13 position. His heads craned forward a little
14 bit, and he's constantly looking at that knife.
15 It's like dangling something in front of a
16 kid's face. He won't, you know -- it caught
17 his attention, and he kept reaching for it.
18 The Officer of course told him several times to
19 leave it alone. It was my intention that if
20 he's laying down flat, and looking at the
21 ceiling, to see the knife, he'd have to lift
22 his head and then reach for it, as opposed --
23 I mean, somebody with an object in their
24 stomach just is not going to wave at they're
25 abdomen and hope that they get it. I mean that



1 would be causing a bunch of pain to himself.
2 But, anyway, my intention that laying him flat,
3 which is the same position they put him in the
4 ER, and it was the position he was going to be
5 in the OR with the knife being removed. That
6 he would look up at the ceiling, or look at Kim
7 sitting over beside, or me sitting on one side,
8 whoever was going to end up in the back with
9 him, and be less apt to just reach for the
10 knife. And by doing that, not end up having to
11 try to wrestle him down to restrain him for
12 causing himself more harm.

13 Q: And there was some talk about restraints. Did
14 you give some consideration to physically
15 restraining that person's arms or legs to the
16 stretcher?

17 A: About a nanosecond.

18 Q: Okay, and what are the risks involved in trying
19 to forcibly restrain a patient, especially one
20 with a knife in the belly?

21 A: So, with any patient you're going to restrain,
22 much less one with a knife in his belly,
23 especially a psych patient who we end up
24 restraining most of the time, unless it be
25 somebody that's inebriated, that's wanting to



1 fight with you. But, you often times end up in
2 a scuffle. The patient with a knife sticking
3 out of his belly is not the guy I want to
4 scuffle with in the back of the truck, or in
5 his house for that matter. So, the longer we
6 could go without that problem presenting
7 itself, the better off he was, and by virtue of
8 that, the better off Kim and I would be.

9 Q: After the patient gets into the back of the
10 truck, I know there was a comment about I think
11 one of the cops asked you, hey man you doing
12 ok, and you said, you kind of expressed some
13 frustration, you said, F'ing stupid people.

14 A: Yes.

15 Q: Was the door to ambulance almost, or on the way
16 to being closed at that point?

17 A: Yes.

18 Q: Okay. Did you curse at that patient at anytime
19 during your encounter with him?

20 A: No, I did not curse at him, I cursed in his
21 presence.

22 Q: And what did the Police Officer say when you
23 said that, what was his reaction?

24 A: Oh he said he was -- Kim made a comment about
25 going to check on the wife who has significant



1 medical history as well, and they, the rescue
2 squad had been out there numerous times for her
3 as well. That she needed to be checked on, I
4 think she was making a motion for Eric to go do
5 it afterwards, her husband, but TJ Boucher the
6 Officer in the case, said he was 1086, which is
7 crazy in ten codes.

8 Q: And the Judge can look at the video, but I
9 think that actually happened before you made
10 the comment about F'ing stupid people.

11 A: I don't remember.

12 Q: Okay, but do you remember Boucher laughing and
13 saying, man I couldn't agree with you more.

14 A: Yes.

15 Q: Okay. In your experience in emergency
16 medicine, and interacting with firefighters and
17 paramedics, and Police Officers, is that a
18 fairly stressful environment?

19 A: It is.

20 Q: Okay. Is sort of a little comradery between
21 the first responders and police, you're the
22 guy, you see pretty tough situations from time
23 to time, isn't that right?

24 A: Well, public safety has a dark sense of humor
25 to begin with. I you know, all of us blow off



1 steam -- I shouldn't say all of us. That's a
2 gross generalization, but the vast majority
3 that I have come across, public safety, law
4 enforcement, fire, police, have a dark sense of
5 humor, and often times we blow off steam in the
6 same way. It's no different than doing it in
7 th OR, and it happens in the OR too. You know
8 surgeons fixing people that have done stuff to
9 themselves, get called all kinds of stuff while
10 their asleep. But, I'm not excusing it, I'm
11 just saying that it does happen, and it's a way
12 of you know -- I mean it's a very stressful
13 jobs, and it's the way guys bond, and the way
14 people relieve stress.

15 Q: And I know, when you look at the video, I sure
16 you've seen it hundreds of times, I mean if it
17 was that -- first of all were you aware that,
18 or did you pay attention to whether the Police
19 Officer was running a body cam at the time of
20 the call?

21 A: No, I didn't notice.

22 Q: Okay.

23 A: Wasn't paying any attention, the patient was my
24 focus.

25 Q: And I know you've expressed regret several



1 times about how you sort lost, not lost your
2 cool, but you had sort of a short tolerance
3 with this particular patient.

4 A: Yes.

5 Q: Did that affect in any way, the level of care
6 that you provided to this patient?

7 A: Absolutely not.

8 Q: And did you ever do anything malicious to try
9 intentionally or deliberately and harm that
10 patient?

11 A: No.

12 Q: Okay.

13 A: I mean, on that note, I mean if you watch the
14 video as we were loading him in the truck he
15 sat up, like he tried to sit his head up as we
16 started to push the stretcher into the
17 ambulance. I mean I gently put my hand on his
18 forehead and said, whoa, and just gently guided
19 his head back to the stretcher. There were
20 plenty of opportunities I had to hurt that guy
21 if I wanted to hurt him. Making him stand on
22 his own would have been one. Walking him
23 unassisted in any means. Making him move
24 himself on the stretcher. I mean there's a
25 litany of other means and ways I could have



1 harmed that patient if I had wanted to do him
2 harm. That wasn't my goal. Like you said, I
3 admit that I was short with him. Given, like
4 I said, the recent history that we had had in
5 Anderson with another paramedic. I was short
6 with him.

7 Q: Have you ever heard the term BS meter?

8 A: Oh yeah, yeah.

9 Q: How was your BS meter reading about that time?

10 A: It was pegged.

11 Q: Okay.

12 A: I mean, you know, it just ...

13 Q: Did that have any impact at all on the level of
14 care that you provided for this patient?

15 A: No more than it affected any of the guys I
16 treated in combat that tried to do me harm.

17 Q: Now Deek told a story yesterday about a guy
18 jumping off of a -- I think y'all were chasing
19 and he jumped off like a three story building
20 and landed on a pavement. What happened to
21 that patient?

22 A: We went on a mission to capture Abraham Al
23 Badgadi who's the progenitor of ISIS who just
24 got killed. But the guy that started ISIS. We
25 were after his number two man in Iraq. And we



1 had gotten into a short firefight. He ran out
2 of ammo and took off up the stairs and ended up
3 trying to jump between roofs but didn't quite
4 get there. His Spiderman skills weren't quite
5 as good as Spiderman. He jumped and ended up
6 falling, you know, three stories, landed on
7 both feet, well landed on one foot and one
8 tibia 'cause he rolled his ankle, inverted his
9 ankle, like when you roll your ankle and
10 fractured his ankle and the bone protruded out
11 the end and into the asphalt.

12 Q: Was that a pretty gruesome injury?

13 A: It was painful. I don't know that I'd call it
14 gruesome, but I'm sure he did.

15 Q: I mean this is a guy from Al Qadea that was
16 shooting at you until he ran of ammunition?

17 A: Yes. Al Qadea in Iraq.

18 Q: Did you render medical care or medical
19 attention to that person?

20 A: I did. I was on the second floor of the
21 building. I was finishing what we call
22 tactical interrogation, and I got a call over
23 the radio that there was a downed bad guy. So
24 I came back outside and he was thrashing around
25 on the ground. The guys were standing around



1 him, you know, kicking him as he did it. Not
2 our guys, the Iraqi SF guys. Ran them off,
3 stabilized the fracture.

4 Q: Give any pain medicines?

5 A: Oh yeah. I did a regional nerve block and
6 killed all the pain from his knee down on that
7 side. Took him back to my clinic, put him in
8 the OR, set the bone, cast him, and then we
9 kept him in the holding area for about a week,
10 and then I released him to the Iraqis once I
11 was sure that infection was not going to be an
12 issue in that leg.

13 Q: Did that patient's race or religion or the fact
14 that he had been shooting at you affect the
15 level of care that you provided for that
16 patient?

17 A: No, sir.

18 Q: Okay. Did the stabbing patient in Iva, South
19 Carolina, did any of those socio-economic
20 conditions race, religion, color, any
21 discrimination factor play any part of your
22 treatment to that patient?

23 A: No.

24 Q: Okay. When you hear somebody like Dr. Alier
25 say that that was a concern of theirs, how does



1 that make you feel?

2 A: Well, like I said, when I was interrogated the
3 first time -- I'd hardly call that an
4 investigation or fact finding mission, but I
5 told them then that I can't make an excuse or
6 a reason, I have no excuse for the way I talked
7 to the patient. He needed to be talked to
8 directly. The words I chose were poor. I had
9 a bad day. Everybody has a, you know? But the
10 patient's alive, which is a lot more than I can
11 say for paramedics who suck at their skills and
12 can't seem to intubate people. But I just have
13 no -- I apologize. I don't know how many more
14 times I can apologize for being short with him.
15 But my medical care was not affected by -- or
16 the care I provided him was in no way affected
17 by what I thought of him at the time.

18 Q: Now after you get the patient in the back of
19 the compartment, there's some discussion on the
20 video that you have with Ms. Aiken about who's
21 going to ride the call in. Do you recall that?

22 A: I do.

23 Q: Okay. Did you ever tell Ms. Aiken, this call
24 is your call to ride in?

25 A: No. I did not.



1 Q: Okay. What was the language you actually used
2 with Ms. Aiken?

3 A: So, a little back story. Ms. Aiken had had her
4 backside chewed into by Mr. Stoller on a couple
5 of occasions and she was hesitant sometimes to
6 ride calls because she just didn't want that to
7 happen again. It had nothing to do with
8 patient care or her ability to care for
9 somebody. She's just not a very strong
10 personality. I mean she'll admit that herself,
11 said so in her deposition. And she just tries
12 to avoid conflict at all cost, and that really
13 bothered her when Scott lit into her. I was
14 trying to assure her that it was not going to
15 be an issue moving forward that if it was I
16 would talk to Scott and everything would be
17 okay.

18 Q: When I was questioning Ms. Aiken I think it was
19 my paraphrasing, when I said, it's your call.
20 And the Judge has the video in evidence. But
21 were you basically conveying to Ms. Aiken that
22 it was up to her to let you know whether she
23 was comfortable enough to ride the call in?

24 A: It's always up to the EMT whether they want to
25 ride a call or not. I mean, I've said this to



1 more than one partner on more than one
2 occasion. Regardless of whether it's a toenail
3 that's torn off or a fracture, regardless of
4 how insignificant the injury might be. If she
5 doesn't or he doesn't feel like they are
6 comfortable riding it -- but they have to speak
7 up. Like I don't read soft language well, and
8 I gave her plenty of opportunities to say, I do
9 not feel comfortable riding this call, and she
10 never said that. She just worried that she was
11 going to get in trouble.

12 Q: Okay.

13 A: Which obviously has not happened.

14 Q: Compared to the other basic partners that
15 you've had at the Iva Rescue Squad, would you
16 describe Ms. Aiken as a real go getter?

17 A: Define go getter.

18 Q: I mean is she chomping a the bit to increase or
19 learn her skills?

20 A: No. She's a little hesitant sometimes.

21 Q: Okay. As the senior medic on the team, the
22 partners you get assigned -- this wasn't your
23 partner all the time, right?

24 A: No. I worked there part-time.

25 Q: Okay. When you're assigned with an EMT basic,



1 do you view part of your role as to try and
2 help educate the other EMT's on the rescue
3 squad about how to do things or why you did
4 certain things?

5 A: Absolutely. Every call is a teachable moment.
6 If I'm not learning something myself, I'm
7 trying -- and or trying to teach my partner
8 something that I may have learned a long time
9 ago or something changed that I've relearned or
10 readdressed in training. Every shift, the ride
11 back from the hospital with every partner I
12 have is a discussion about patient care in some
13 form or fashion. Why I did something, why I
14 didn't do something, why you should do
15 something, why you shouldn't do something. I
16 mean if you're not trying to pass on your
17 knowledge, then you're missing opportunities to
18 -- especially at my age. I'm 45 years old, and
19 as busted up as I am, I don't have a lot of
20 career left in the field. And it's my
21 responsibility, just like it was on the SF team
22 to train my junior medic. It's also my
23 responsibility to ensure that the people that
24 come up behind me don't just have book
25 knowledge to run off of because that's bad



1 medicine.

2 Q: Did you or Ms. Aiken ever just abandon that
3 patient at the scene of the stabbing?

4 A: No. I've heard that said several times,
5 abandon or, there was another word,
6 discontinued care. That's no more
7 discontinuing care than if a doctor comes in
8 your hospital room, assesses you and he walks
9 back out of the hospital room, goes down the
10 hallway, and sits down to look up your labs or
11 your x-rays or anything else. He has left
12 where you currently are but that doesn't mean
13 he's discontinued care. If that patient had
14 had any issues whatsoever, that or any other
15 patient. I won't even get into the silliness
16 of that patient crashing. But you could have
17 a patient in the back with a broken ankle on
18 the way to the hospital, and that patient could
19 go into cardiac arrest. You just pull over
20 switch places. Now I agree that it's not
21 optimal, but had I thought for a second that
22 that patient was going to need anything more
23 than what he currently had, Kim wouldn't have
24 been in the back of that ambulance with that
25 patient.



1 Q: Okay. The video shows Officer Burns inside the
2 rig taking the still photographs. I guess
3 Officer Boucher standing in the doorway 'cause
4 he's got the camera on, right?

5 A: Well he stepped up inside the ambulance and
6 turned so you could see, from his view you see
7 the back of the ambulance. You see Burns, you
8 see the bench on the left, you see the
9 stretcher and the cabinets on the right. And
10 then the back doors obviously. Burns is
11 standing right beside the patient stretcher
12 taking photos down. I mean, could he have fit
13 two more people in the back of the ambulance?
14 Absolutely. But that patient has an issue with
15 authority as it is, now you're going to put
16 four authority figures in a confined space with
17 him? That's a receipt for disaster.

18 Q: Was the side door of the ambulance open ---

19 A: Yes, it was.

20 Q: --- at Officer Boucher's back?

21 A: Yes, sir. It was open.

22 Q: Were you and Kim doing anything at that time?

23 A: We were having a conversation outside the
24 ambulance.

25 Q: Okay. And what were y'all talking about? I



1 know the video doesn't pick it up that well,
2 but what can you recall talking about?

3 A: That's when I told her that it's up to her.
4 She had made some comment about the wife, and
5 I said, well we need to get on the road. Are
6 you sure that you're comfortable with this.
7 And she said, I'll be fine.

8 Q: About the tenth time I listened to the video I
9 hear the phrase BLS call about that time when
10 Officer Burns is finishing up his photographs.
11 Have you ever heard that?

12 A: Basic life support.

13 Q: Okay. I mean do you recognize -- did you hear
14 that on the video as well?

15 A: Yes.

16 Q: Okay. Who's voice was that that said BLS call?

17 A: I don't remember.

18 Q: Okay. So Ms. Aiken gets in the back of the
19 truck, y'all go to the hospital. Did you view
20 this as such an emergency that you went blaring
21 down the highway lights and sirens?

22 A: No.

23 Q: Okay. Why did you decide not to do that?

24 A: Because that wasn't critical. It wasn't a
25 critical injury, one. And two, the risk to



1 benefit of getting there two minutes faster
2 running lights and sirens, it wasn't worth the
3 risk to the patient, risk to the crew, risk to
4 the system having an ambulance out if we'd had
5 an accident on the way to the hospital. I mean
6 we could have had an accident anyway, but
7 anytime you turn the red lights and siren on,
8 the likelihood that you're going to be in an
9 accident increases dramatically.

10 Q: Is it disconcerting to the patient to hear the
11 lights and sirens going off on the way to the
12 hospital?

13 A: Well yeah, they think that the situation is far
14 worse than what it really needs to be. The
15 patient was completely stable. There was no
16 impending issue with that patient despite, you
17 know, he had a knife in his belly. Mr. Deason
18 mentioned yesterday about a thumb tack, and I'm
19 not equating a thumb tack to a knife in the
20 belly. But both of those are penetrating
21 trauma to the belly. Just because you have
22 something in the abdomen does not make it
23 critical.

24 Q: Did the exact length of that knife blade inside
25 that man's belly matter to you in determining



1 whether the patient was stable or not?

2 A: No. Not in it's exactivness. The length of
3 the knife blade has no bearing on his
4 stability.

5 Q: So whether the knife blade was two and a half
6 inches long or seven inches long, would that
7 have affected your assessment of this patient
8 in terms of whether he was stable or not?

9 A: No. Seven inches long it still can't get to
10 his aorta.

11 Q: And is Ms. Aiken trained on how to monitor the
12 vital signs of the patient on the way to the
13 hospital?

14 A: Yes, she is. That diagram of the signs of
15 shock is taught from EMT basic all the way
16 through paramedic. I mean the renin and all
17 that stuff, all the chemistry part of it, all
18 that stuff is not taught at the basic level I
19 don't think because it does them no good to
20 know it. You're taught from the time you start
21 EMT school how to recognize shock. Starting
22 IV's on people doesn't fix shock. It doesn't
23 fix blood loss. If the patient's bleeding
24 internally the worst thing for that patient is
25 more fluid. So as long as that patient's



1 sitting upright talking to me, he's still not
2 getting fluids. Ms. Aiken, we've had several
3 discussions about the presentation of shock and
4 the most reliable signs of picking up on it.
5 I mentioned earlier that skin color, condition,
6 and temperature, the pulse rate, and the
7 patient's alertness or anxiety level are the
8 three best indicators of a patient that is
9 going into shock. That doesn't mean that they
10 will ever be in shock. That just means that
11 they lost blood. So ...

12 Q: How did you find out that you were being
13 suspended from Anderson County or at least
14 having your medical controls suspended?

15 A: Scott Stoller walked into my office on Tuesday
16 morning and handed me a piece of paper, told me
17 to get my stuff, and that Sheila Kaiser would
18 take me home, and she would be retrieving my
19 keys, radio, and all of my County equipment.

20 Q: Let me show you Respondent's Exhibit 4. Do you
21 recognize that document?

22 A: That would be what Mr. Stoller gave me.

23 Q: Okay. Did Mr. Stoller tell you what specific
24 calls you were being investigated for?

25 A: He did not.



1 Q: Did Mr. Stoller tell you anything? I mean what
2 was his demeanor like toward you when he said,
3 you're being suspended?

4 A: He was pretty rude.

5 Q: Did he tell you to take any personal belongings
6 out of your office?

7 A: Yeah. He told me that I could take all my
8 military awards that were hanging on the wall
9 and memorabilia with me. That I might not be
10 coming back.

11 Q: What's the next interaction you had about this
12 investigation that Mr. Stoller and Dr. Kickham
13 were supposedly conducting?

14 A: He contacted me to set up a time for us to
15 meet. And then we met on the 25th, Friday
16 morning about 10:30 maybe.

17 Q: Let me show you Respondent's Exhibit 12.

18 **MR. ROTHSTEIN:** And, Your Honor, I'm going to move 4
19 into evidence.

20 **MR. WICEVIC:** And, Your Honor, the same relevance
21 objection about this one.

22 **THE COURT:** Okay. It's admitted.

23 **(Respondent's Exhibit Number 4 was admitted into**
24 **evidence.)**

25 Q: Okay. Do you recognize Exhibit 12?



1 A: Yeah. That's a list of text messages between
2 Kim and I the afternoon after I was suspended.

3 Q: Okay. After you were suspended, how did you
4 get home that day?

5 A: Sheila drove me home I my County issued
6 vehicle, and then I gave her my keys, my badge,
7 and all of my medical gear that wasn't in the
8 vehicle. And then she drove it back to Scott.

9 Q: Okay. Did you contact Ms. Aiken about your
10 suspension?

11 A: I did. I tried to call her first. So as I was
12 leaving the building I ran into somebody that
13 told me what it was about. And I want to say
14 it was Taylor Jones' secretary at the time who
15 worked for the Sheriff's Office.

16 Q: What did she tell you?

17 A: That it was about a stabbing patient.

18 Q: Okay. And does this set of text messages,
19 Exhibit 12 accurately reflect the text
20 communication you had with Ms. Aiken over
21 whether or not she filed a complaint in the
22 stabbing call?

23 A: That's the text messages. I drove down to Iva
24 and we met that next day I want to say. Yeah,
25 I want to say it was the next day I drove down



1 to Iva to get copies of that run report. Had
2 no idea what the other two were about for it
3 seems like a day or so. I don't remember how
4 I learned about the other two, but it wasn't
5 directly from Scott.

6 Q: At some point in your discussions over then
7 next couple days after you were suspended, did
8 you come to find out how the complaint was sort
9 of generated about the stabbing call?

10 A: I confronted Scott the morning of the 25th at
11 the meeting, and he said a complaint -- well he
12 told me initially that a complaint was filed
13 anonymously and that he couldn't get into the
14 details. Of course I told him that I had a
15 right to face my accuser and he told me in
16 certain words not to worry about it. That it
17 wasn't germane to the investigation.

18 MR. ROTHSTEIN: Your Honor, I move Exhibit 12 into
19 evidence.

20 MR. WICEVIC: Your Honor, the same objections,
21 relevance.

22 THE COURT: Thank you. It's admitted.

23 (Respondent's Exhibit Number 12 was admitted into
24 evidence.)

25 Q: James, hang on to that. Can you look at page



1 2 of Exhibit 12?

2 A: Absolutely.

3 Q: At some point did you have some concerns about
4 whether the Iva Police Department was actually
5 the source of the complaint against you?

6 A: Yes.

7 Q: And can I clarify one thing. On that document,
8 are the green bubbles your communications or
9 Ms. Aiken's communications?

10 A: The green is me, the white is Ms. Aiken, or
11 grey.

12 Q: And halfway down the second page of the text
13 messages, what did she mean by the PD can't do
14 anything can they? I mean they don't do PT
15 care. What does that mean?

16 A: So, we had talked about, on the way out of the
17 building when ---

18 Q: Taylor Jones' secretary?

19 A: Yeah. The secretary, I stopped back by her
20 office while Sheila was collecting up her
21 things so that she could take me home. And she
22 said that she heard that it was somebody from
23 the Iva PD. And that's why the comments about
24 the PD.

25 Q: And what was your response to Ms. Aiken's



1 comment about whether the PD could do anything?

2 A: Say that again.

3 Q: How did you respond to Ms. Aiken's text about
4 the PD can't do anything can they. I mean they
5 don't do patient care.

6 A: Well I guess she thought that the PD wouldn't
7 have filed the complaint 'cause they wouldn't
8 have had a reason to. But that's when I said
9 the supposedly called Scott with concerns
10 according to Scott.

11 Q: Okay. And what was Ms. Aiken's response to
12 that?

13 A: She obviously wanted to know if her report got
14 pulled. I mean she said that she was fine
15 riding it, the patient was stable the whole
16 ride. And then she said she called Tim who is
17 the Captain at the Iva Police Department. And
18 he said he didn't know anything about it.

19 Q: What report was Ms. Aiken referring to with,
20 did he pull my report? Was that the patient
21 care report?

22 A: Patient care report I assume.

23 Q: Okay. What does soft abdomen mean?

24 A: That he didn't have a rigid abdomen. That he
25 wasn't bleeding into his abdomen and there was



1 no abdominal contents that were spilling into
2 the abdomen. If a patient's bleeding into
3 their abdomen, the body doesn't like blood
4 outside the vasculature. Especially inside the
5 abdominal cavity and so it'll get rigid. The
6 same thing will happen if you penetrate an
7 organ in the abdomen or the hollow organs in
8 the abdomen and spill bowel or abdominal
9 contents into the peritoneal cavity. It get's
10 really irritated, will get rigid, and you'll be
11 able to feel it. Aside from that, it get's
12 very painful.

13 Q: Are EMT basics trained on how to recognize the
14 signs of a rigid abdomen?

15 A: Absolutely.

16 Q: Okay.

17 A: Again, it's part of the national curriculum.

18 Q: Okay. The next sentence on her text says --
19 did you interpret that to mean stable the whole
20 time?

21 A: Yeah. Stable.

22 Q: Okay. All right, so you get the notice from
23 Mr. Stoller that you're being suspended on
24 Tuesday. What happened on Friday?

25 A: I sat down with Dr. Kickham. We had a meeting.



1 I ---

2 Q: Who was in that meeting?

3 A: Scott -- Mr. Stoller, Dr. Kickham, and myself.

4 Q: Okay. And what can you recall about the
5 meeting?

6 A: It wasn't very long. They had some questions
7 about the first two non-trauma related calls.

8 Q: When were those in relation to the stabbing
9 call, when were the other two calls run?

10 A: More than a month earlier.

11 Q: Okay.

12 A: So I explained myself about them. Dr. Kickham
13 kind of, you know, was basically like whatever.
14 And then there was no protocols in front of
15 him. Like we didn't go through the protocols,
16 and he go, James this is what you did, this is
17 what you should have done. It was more of a
18 discussion about it says this is what you did
19 on the report, can you explain to me why you
20 did it, you know, justification. And I
21 justified my actions, and for all three calls.
22 He had some concerns over the elderly gentleman
23 with the low blood pressure. But once I
24 explained the history behind that all, he said
25 that makes perfect sense. The patient was in



1 the ER for about an hour and then returned to
2 the nursing home where he started. There was,
3 you now, nothing to that one. I really didn't
4 know why those two were, you know, pulled at
5 all. And then we got to talking about the
6 stabbing patient. We talked about my clinical
7 decision making, why I made the decisions I
8 did, the basis for the decisions I made. We
9 left that meeting and it was my understanding
10 that Dr. Kickham, while he -- I don't even know
11 how to word it. We left the meeting and he's
12 like, okay we'll be in touch in a little bit.
13 And there was not, this is what you did, this
14 is what you should have done. This is what the
15 policy says, this is what you should do. So
16 ...

17 Q: Let me show you Respondent's Exhibit 5. You
18 recognize Exhibit 5?

19 A: Yes.

20 Q: What is Exhibit 5?

21 A: Exhibit 5 is Dr. Kickham returning me to duty
22 after the investigation if that's the right
23 word, and Scott stating that Dr. Kickham wanted
24 me to take a protocol test and the PEPL class.

25 Q: Okay. Did you in fact take the protocol test?



1 A: I did. Well ... Yes, I took it.

2 Q: Okay. Did you go down to talk to Mark
3 Henderson about scheduling a protocol test?

4 A: I called Mark on the phone the afternoon after
5 I got this. He said he would be out of town
6 for a few days. And so it took me about I
7 think right at a week. It would have been the
8 next Friday I believe that I took the protocol
9 test. Passed it as always, and he passed the
10 results to Scott, or Mr. Stoller.

11 Q: And, James, there's a date of March 22nd on the
12 top of that letter. When did you actually
13 receive that letter?

14 A: It should say the 25th. I believe there's an
15 email between Mr. Stoller and the
16 administration at Iva Rescue Squad where Scott
17 states in the email that despite it saying the
18 22nd, it was a typo. He just erased the
19 irrelevant portions of the email, and just used
20 the email from the 22nd that we had a few
21 minutes ago as the basis for this one. So he
22 forgot to change the date.

23 Q: After you got this letter, did you submit
24 anything in writing or email to Dr. Kickham or
25 Mr. Stoller asking for more detailed



1 explanation of why they think you had done
2 something improper?

3 A: So after I got this, Scott and I had a
4 conversation on the phone, and I was trying to
5 figure out why I need to take a protocol test
6 when I had just taken one seven months earlier.
7 And I basically got a bunch of words from Scott
8 that were not expressed by Dr. Kickham in the
9 meeting. So I sent Scott an email trying to
10 clarify what he had said, you know, in hopes
11 that I would get a return in email or in
12 writing according to the policy. I felt that
13 I had explained myself, and Scott kind of
14 conflated things to the point where -- Scott
15 made some inaccurate statements, so I was
16 asking for clarification.

17 Q: If you turn in the white notebook to the last
18 exhibit in the white notebook ...

19 A: 14?

20 Q: That's right.

21 MR. ROTHSTEIN: And, Your Honor, I move Exhibit 5
22 into evidence, by the way.

23 MR. WICEVIC: Same objection, Your Honor.

24 THE COURT: Same objection, okay. It's admitted.

25 (Respondent's Exhibit Number 5 was admitted into



1 evidence.)

2 MR. ROTHSTEIN: Is 14 already in evidence? DHEC 14?

3 MR. WICEVIC: I believe it is.

4 MR. ROTHSTEIN: Okay.

5 Q: James, do you recognize Exhibit 14 as the email
6 you sent to Mr. Stoller asking for some
7 additional explanation?

8 A: Say that one more time. Sorry. State the
9 question again, David. I'm sorry.

10 Q: Yeah. Do you recognize Exhibit 14 as the email
11 you sent to Mr. Stoller on March the 30th
12 asking for some additional explanation for what
13 policies you violated or how you violated
14 County protocols?

15 A: Yes.

16 Q: Did you ever receive a response to the March
17 30th email, Exhibit 14?

18 A: I never received anything.

19 Q: Okay. Did Mr. Stoller after that point
20 schedule you for any shifts on the QRV?

21 A: I want to say it was Saturday. I may have
22 worked the QRV, but I think that was scheduled
23 before the email was sent. I want to say I
24 think that shift was scheduled before I took
25 the protocol test pending me passing the test.



1 But this was sent the Wednesday two days prior
2 to taking the protocol test.

3 Q: Did you run any shifts on an Iva County Rescue
4 Squad ambulance after your Medical Control was
5 restored by Dr. Kickham?

6 A: I have not.

7 Q: To this date, has Dr. Kickham told you that
8 your Medical Control has been suspended again?

9 A: No. He has not.

10 Q: Okay. Now after this occurred did you sort of
11 put that stabbing call out of your mind?

12 A: Yeah. I thought it was done.

13 Q: What was the next interaction you had with
14 anybody about the stabbing call?

15 A: I received a phone call from either Sandy
16 Sutherland or Tommy Miller from the Iva Rescue
17 Squad letting me know that Mr. Naugler was
18 trying to contact me. I don't remember which
19 one it was that contacted me. They passed me
20 Mr. Naugler's cell phone number I believe. And
21 I proceeded to call Mr. Naugler.

22 Q: Okay. What did Mr. Naugler tell you when you
23 called him back?

24 A: He said they were finishing up just a
25 systematic chart review. I don't remember the



1 exact word. But he wanted to know if I would
2 be willing to come down and answer a couple
3 questions so they could close the case and put
4 it behind them or something to that effect.

5 Q: Did Mr. Naugler identify himself as a DHEC
6 inspector?

7 A: I don't remember him using the word inspector.
8 I remember him saying -- he represented himself
9 as Richard Naugler from DHEC. But I don't
10 remember him saying that he was an inspector.
11 I'm not saying he did not. I just don't recall
12 him saying he was.

13 Q: Did he tell you that a formal complaint had
14 been filed against you at DHEC?

15 A: No. He did not.

16 Q: Did he ever tell you he was investigating a
17 complaint of potential misconduct by you for
18 DHEC?

19 A: No. He did not.

20 Q: Did he ever indicate to you that the purpose of
21 the interview with you was to determine whether
22 or not to revoke your paramedic certificate?

23 A: Absolutely not.

24 Q: Okay. Did you cooperate with Mr. Naugler's
25 request to come down to Columbia for an



1 interview?

2 A: Yes, sir. To the best of my recollection it
3 was like maybe a day later, two days at the
4 most it seems. I had something on my schedule.
5 I cleared it to go.

6 Q: And you heard the snippets at the end of it.
7 Obviously you remember that interview. What
8 was your demeanor like or what were your
9 expectations when you first got to the meeting
10 about what they were going to do?

11 A: I thought it was just answer, you know -- like
12 he said, chitchat. And, you know, ask some
13 questions about a few things and that was it.
14 I didn't think much about it.

15 Q: Going into that meeting, were you aware that
16 the body cam video footage had been forwarded
17 to DHEC?

18 A: No, I was not.

19 Q: Okay. Did Mr. Naugler explain to you on the
20 phone when he first called you and asked you to
21 come down there, that they saw something on the
22 body cam video that they wanted you to explain?

23 A: He did not.

24 Q: When you got to the meeting in Columbia, did
25 they tell you this was sort of a routine chart



1 review?

2 A: Something to that effect, yes.

3 Q: Okay. And that they had gotten a statement or
4 they were forwarded a statement from your
5 partner on one of the calls ---

6 A: That came out some point in the discussion. It
7 wasn't up front.

8 Q: Okay. And they said to complete their file or
9 close their they wanted to get your side of the
10 case, is that right?

11 A: That's correct.

12 Q: Did you cooperate with them during that
13 meeting?

14 A: Yes, sir.

15 Q: Okay. How many calls were discussed? Was it
16 more than just the stabbing call that was
17 discussed during the meeting?

18 A: No. That was the last one we discussed.

19 Q: Okay. Which ones did they discuss before they
20 got to the stabbing call?

21 A: The pediatric seizure and the older gentleman
22 with low blood pressure.

23 Q: Okay. At the time of that interview, did they
24 have the Anderson County protocols in front of
25 them?



1 A: No.

2 Q: Okay. Did they disclose to you that there was
3 a chart review done by Keith Eudy?

4 A: I didn't see that until we did discovery.

5 Q: Okay. Did they say anything about your care
6 other than O2, IV, and monitor on all three
7 patients?

8 A: No. Not much.

9 Q: Okay. And about half way through that meeting,
10 did the tone of the meeting change?

11 A: Yes.

12 Q: Okay. What happened?

13 A: I thought the meeting was over. Everybody had
14 made comments. I'd pushed my chair back from
15 the table a little bit, was getting ready when
16 I thought we were going to adjourn. And then
17 Mr. Wronski made some comment about from time
18 to time they get forwarded information or they
19 try to collect as much information as possible
20 when they're making decisions, and then put the
21 video on.

22 Q: Okay. And how did the room change or the
23 attitude in the room toward you change at that
24 point?

25 A: They became adversarial.



1 Q: Okay. Did you feel like you were being
2 ambushed?

3 A: Yeah. I don't appreciate that a whole lot.

4 Q: Okay. Have you ever been ambushed as a Special
5 Forces person?

6 A: Yes.

7 Q: Is that a good feeling?

8 A: No.

9 Q: Okay. Was your level of cooperation and
10 friendliness, did it continue after they
11 started to attack you?

12 A: No.

13 Q: Okay. At some point did they start to discuss
14 with you whether or not they wanted to go after
15 your paramedic credentials?

16 A: Yes.

17 Q: Okay. And at some point did they offer you a
18 consent order? Not necessarily in the meeting.

19 A: Yeah. We discussed what it was I believe. But
20 there wasn't -- they told me what a consent
21 order was vice an administrative order, and
22 that they try to solve them through consent
23 orders as much as possible, but it was my
24 choice. Made some comment about public record
25 or the video being seen or something



1 derogatorily trying to force my hand into -- I
2 felt like they were trying to coerce me into
3 signing whatever it was that they put in front
4 of me.

5 Q: Okay. At that point did you seek legal
6 representation?

7 A: I did.

8 Q: Okay. If you knew what the meeting was --
9 before you went into that meeting, if you knew
10 what was going to happen, would you have
11 brought an attorney with you to the meeting?

12 A: Absolutely.

13 Q: Okay. Let me show you Respondent's Exhibit 2.
14 I'm about finished. You recognize Respondent's
15 Exhibit 2?

16 A: Yeah. That would be the grievance that I filed
17 with the County Administrator against Mr.
18 Stoller. Or against his actions.

19 Q: And I know that grievance was filed after the
20 meeting you had at DHEC. But had you raised
21 the issues that are set forth in that grievance
22 with Mr. Stoller prior to the stabbing call on
23 March the 19th?

24 A: Mr. Stoller and I had what I would have
25 considered to be a friendship up to a certain



1 level prior to that. He offered me a job when
2 I returned from -- while I was healing from
3 surgeries. So I worked in the office a large
4 part of the time because I was still healing
5 from continuous surgeries. I've had 79 since
6 October 2012, and so I would work for a period
7 of time while I was healing between surgeries,
8 and I'd go have surgery, come back home. And
9 in those times I would work on various projects
10 that Scott had going on, or that he wanted me
11 to work on. A policy manual, changing dispatch
12 policy and protocol, the mass casualty plan for
13 the entire County to name a few of what I
14 worked on. And then as our relationship
15 developed he ended up relying on my more as an
16 Operations Officer for the organization. I
17 made a lot of day to day operational decisions
18 even as a part-time paramedic. And in that
19 capacity, I gained a lot more knowledge about
20 some things that were going on in the
21 organization that I couldn't turn a blind eye
22 to.

23 Q: Did you confront Mr. Stoller about those items?

24 A: Oh yes. On several occasions we had
25 discussions about -- almost everything in this



1 grievance we talked about at one time or
2 another. Several of them on multiple occasions
3 and when he couldn't get me to agree to certain
4 things he would go to other people and try to
5 get their agreement. Sheila for one, a couple
6 of the other more senior paramedics in the
7 organization.

8 Q: At some point in the early 20' or mid 2016 time
9 frame, was Anderson County EMS planned to have
10 a consultant come in and sort of do an
11 evaluation of the EMS system?

12 A: I believe that started near the end of '15.
13 They were collecting all the data from dispatch
14 and I facilitated most of the data that they
15 asked for. And then that consultant was
16 supposed to show up, I want to say about May
17 time frame it seems like, to do interviews with
18 certain individuals, all the rescue squad
19 Chiefs, the Dispatch Coordinator, 9-1-1
20 Coordinator, County Fire Chief, Sheriff, I mean
21 a bunch of people.

22 Q: Were you supposed to be one of the ones that
23 was going to be interviewed?

24 A: Yes.

25 Q: Okay. How many times had you been offered a



1 consent order in this case to turn in your
2 paramedic credentials?

3 A: Twice.

4 Q: Have they ever offered you anything that didn't
5 include turning in your paramedic credentials?

6 A: No.

7 Q: Okay. Why have you chosen to file this request
8 for contested case hearing?

9 A: Because I feel that the way I was treated when
10 I showed up to DHEC was wrong. It robbed me of
11 my due process rights. And if as squeaky a
12 wheel as I am, if they'll do it to me, there's
13 no telling how many other people they've pushed
14 into one over fear of them not having a job.
15 Fact of the matter is I do this because I want
16 to. I make a fairly good living on my military
17 disability and retirement. So I don't have to
18 be a paramedic. But I have a set of skills in
19 a community that could certainly utilize those
20 skills. And it seemed to me to be a waste to
21 just sit at home and not use them. But I was
22 not going to tolerate people telling me that
23 the medicine that I provided that gentleman
24 because their knowledge of the body or up to
25 date medicine, they can't keep up with it, is



1 bad medicine because it saved hundreds of lives
2 overseas. And it's founded on science and
3 evidence, not on old time and not wanting to
4 change and being stuck in old ways. It was a
5 direct attack on my credentials or on my
6 credibility and on my integrity. And that's
7 not one of those things that I'm accustomed to
8 turning a blind eye to.

9 Q: About a year ago there was a tragic shooting in
10 Anderson County, a little town called Townville
11 I think it was. I'm sure you're familiar with
12 that.

13 A: Yes, sir.

14 Q: Okay. The little boy, Jacob, that lost his
15 life when a bullet went through his femoral
16 artery, have you seen that kind of injury
17 before in your experience as an SF Medic?

18 A: Yeah. I suffered nearly the same injury, or
19 pretty close to the same injury.

20 Q: Given your training as an SF Medic, do you
21 believe that if you were on the scene providing
22 primary care to that patient, that you could
23 have saved that boy's life?

24 A: Absolutely.

25 Q: Okay. Would you have gotten out the protocol



1 book to put that patient on a spine board
2 first?

3 A: Absolutely not.

4 Q: Would you have gotten the protocol book out and
5 started an IV on that patient?

6 A: Absolutely not.

7 Q: But that's what the protocol says you're
8 supposed to do.

9 A: Well the protocols, especially with the IV
10 portion says assess patient for indications.
11 Until you get bleeding stopped there's not an
12 indication for an IV. Saline doesn't save
13 lives. There's no lifeline to a bag of saline.
14 If it was then when we give transfusions, we'd
15 get transfused with saline, not blood. While
16 it's a volume expander, meaning it can be used
17 in the short term to replace a little bit, that
18 little boy needed a surgeon. The wound should
19 have been packed ---

20 Q: Is that ---

21 A: --- appropriately.

22 Q: --- how you were saved in Afghanistan?

23 A: Yes.

24 Q: Okay. And who saved you in Afghanistan?

25 A: My team Sergeant.



1 Q: How did they know how to do that in
2 Afghanistan?

3 A: Over training that I provided..

4 Q: Could your team mates in Afghanistan have saved
5 that boy's life in Townville?

6 A: Yes.

7 Q: If you had trouble stopping the bleeding at
8 Townville with trying to pack the wound, could
9 you have done that surgically?

10 A: Yes, I could have..

11 MR. WICEVIC: Your Honor, this is going on very far.
12 I just don't understand the relevance.

13 MR. ROTHSTEIN: Well, Your Honor, part of this case
14 is DHEC has this obligation to protect the
15 public. And that's what we're here about
16 today: And Mr. Davenport's skills as a medical
17 technician have been attacked. And I'm just
18 trying to show that the interest of the public
19 is served by him having a paramedic license and
20 being allowed to get in the field, rather than
21 having his paramedic license revoked
22 permanently and voided.

23 THE COURT: And I've got that, but I don't think we
24 need to proceed on down the subject.

25 Q: Thank you, James.



1 MR. ROTHSTEIN: And, Your Honor, that rests our
2 case.

3 THE COURT: Okay.

4 MR. WICEVIC: Your Honor, can I take a quick break.
5 I really gotta use the restroom?

6 THE COURT: Okay. We'll do a ten here.

7 MR. ROTHSTEIN: And I think he's already, I mean he
8 took his cross-examination first. I don't
9 think he gets another bite at the apple.

10 THE COURT: Well

11 MR. WICEVIC: It won't take long. I promise you
12 that.

13 THE COURT: Okay. Well we'll take a ten minute
14 break before.

15 (Off the record from 3:46 p.m. until 4:01 p.m.)

16 THE COURT: If everyone's ready I'll reconvene the
17 hearing. And, Mr. Wicevic, Mr. Rothstein is
18 correct that you did do your cross initially.
19 But I am going to allow you to do a short ...

20 MR. WICEVIC: Yes, Your Honor.

21 THE COURT: Yeah. Recross. But just make sure you
22 keep it short and narrowly tailored.

23 MR. WICEVIC: Yes, Your Honor.

24 MR. DAVENPORT - RECROSS-EXAMINATION BY MR. WICEVIC.

25 Q: Mr. Davenport, you refused to take that



1 Principles of Ethics and -- PEPL leadership
2 course, isn't that correct?

3 A: That's not true. I never refused to take it.

4 Q: Didn't you say in the interview, I won't be
5 coming to that class?

6 A: Yeah, in June.

7 Q: Okay. So you were going to take it later?

8 A: Yes.

9 Q: And have you?

10 A: No. Because this thing hasn't been settled
11 yet.

12 Q: Well you understand that you're still
13 authorized to practice?

14 A: No. I did not.

15 Q: Mr. Rothstein didn't ---

16 A: No, no. I ---

17 MR. ROTHSTEIN: Your Honor, I'm going to object to
18 anything that I discussed with Mr. Davenport.
19 That's clearly ---

20 THE COURT: Right.

21 MR. ROTHSTEIN: --- attorney client privilege.

22 THE COURT: Right. It is.

23 MR. ROTHSTEIN: That's clearly an improper question.

24 Q: All right. Well let me ask you this. Do you
25 understand that the PEPL class is aimed at



1 improving communication skills?

2 A: I'm sorry.

3 Q: The PEPL class is ---

4 **MR. ROTHSTEIN:** Your Honor, the PEPL class has
5 nothing to do with why we're here today. The
6 PEPL class was never imposed as a condition by
7 DHEC. This was a condition that Dr. Kickham at
8 Anderson imposed. The class wouldn't have been
9 scheduled till two months down the road. So,
10 I mean, this has nothing to do with the
11 hearing.

12 **THE COURT:** I mean I think he's already testified
13 that he didn't refuse to take the PEPL class.

14 **MR. WICEVIC:** Right. He also testified about his
15 communication skills, and I think the PEPL
16 class is specifically aimed at improving those
17 communication skills people skills.

18 **THE COURT:** But he stated that he did not refuse to
19 take it.

20 **MR. WICEVIC:** Right. Well I was asking him if he
21 was aware of the aims of that class.

22 **THE COURT:** Okay. I'm going to allow you to ask
23 your question.

24 **MR. WICEVIC:** I'll move on

25 **THE COURT:** Okay.



1 Q: Okay. There was some discussion in your direct
2 testimony or I guess it's cross about organs
3 being suspended by ligaments, is that correct?

4 A: Yes.

5 Q: But you do understand that when you do move,
6 whether it's standing up, walking, sitting
7 down, that those organs are moving?

8 A: Yes.

9 Q: Is that correct?

10 A: Yes. To a degree. I mean your liver can't end
11 up in your pelvis.

12 Q: Right. And they're not going to come through
13 your throat?

14 A: Yes. I mean the amount that each organ moves
15 is completely dependant upon that organ itself.

16 Q: Right.

17 A: And where it's attached inside the body.
18 There's not a uniform degree to which each
19 organ moves inside the body. Everything is a
20 little different.

21 Q: But the principle that as you move your organs
22 move, you'd say that's correct?

23 A: Yes.

24 Q: Okay. Let's talk about blood pressure not
25 being an early sign on shock. Is that what



1 you're testimony was?

2 A: I said it is not the most reliable indicator of
3 a patient going into shock.

4 Q: But in your diagram here, that's the first
5 thing listed as an early sign of shock,
6 correct?

7 A: What are you talking about?

8 Q: The ten milliliters of mercury from baseline?

9 A: You see where it says map?

10 Q: Yes, sir.

11 A: You know what that means? That's mean arterial
12 pressure. Do you now how that's calculated?

13 Q: I'm not testifying. You can explain for the
14 record.

15 A: But you can't measure that in the field.

16 Q: Okay. But does that mean blood pressure's
17 going down?

18 A: Just because the map changes doesn't mean the
19 systolic blood pressure changes.

20 Q: Does that mean the blood pressure's going down?

21 A: No.

22 Q: Okay.

23 A: Again, just because the map changes doesn't
24 mean the systolic blood pressure necessarily
25 changes.



1 Q: Okay. You also testified about 500 CC's of
2 blood being I guess lost for this particular
3 patient?

4 MR. ROTHSTEIN: That's not what he ---

5 A: No. We were making an analogy about giving
6 blood.

7 THE COURT: No. I remember the testimony. That's
8 not what he testified.

9 MR. WICEVIC: Okay. I must have been mistaken.

10 THE COURT: I believe his testimony was that when
11 you donate blood, that's generally the amount
12 of blood that's removed.

13 Q: Well let me ask you this, do you know how much
14 blood this patient lost?

15 A: Do I have an estimate, a total estimate? Yeah.
16 Probably somewhere in the neighborhood of -- I
17 mean are you talking about operatively or are
18 you talking about in the field?

19 Q: I'm talking about in the field when you rode
20 him.

21 A: I have an estimation of what was visible, yes.

22 Q: Okay. And what was that estimation?

23 A: About 5 CC's.

24 Q: 5 CC's. I'm sorry. Do you acknowledge that,
25 you know, there was a discussion about bringing



1 the required equipment to the scene?

2 A: Uh-huh.

3 Q: And you're not going to carry the whole truck.
4 That's common sense. There are two EMT's on
5 the truck, correct?

6 A: Yes.

7 Q: And y'all both can take equipment. You can
8 take the equipment bag, correct?

9 A: Yes.

10 Q: Ms. Aiken could take the carrying device,
11 correct?

12 A: Depends on what carrying device is needed. You
13 don't know that until you get to the patient.
14 You can take a carrying device and then have to
15 go back and get a different one 'cause the one
16 you brought is the wrong one. So why not just
17 cut that right out, assess what you have, and
18 begin treating.

19 Q: Fair enough.

20 A: Can't treat it until you assess it.

21 Q: Okay. So this patient is sure footed. You
22 know he's surefooted with a knife in his
23 stomach?

24 A: I watched him ambulate.

25 Q: When did you watch him ambulate?



1 A: When he was ambulating.

2 Q: When you were assisting him?

3 A: Yes.

4 Q: Okay. Stomach muscles are engaged whenever you
5 move?

6 A: Yes.

7 Q: So when you're walking, the logical following
8 would be those muscles and your abs are moving
9 then too.

10 A: That's correct. They're also engaged when
11 you're being moved.

12 Q: And when you're sitting or standing still, or
13 laying down?

14 A: They're always moving. They're always engaged.
15 Unless you're completely relaxed.

16 Q: If you're in a static position?

17 A: Not necessarily. Just because you're -- I mean
18 you're in a static position right now.

19 Q: Okay. What I'm getting at is when you're
20 seated, there's less of a chance of those
21 muscles moving, correct?

22 A: That's all dependant on the patient.

23 Q: Okay.

24 A: It isn't a they are or aren't. It's
25 situationally dependent.



1 Q: Would you say this particular patient had
2 issues with getting along with Officer Boucher?

3 A: That' patient -- so first of all he has an
4 extensive psycho-social history. Who he gets
5 along with is dependent on the day of the week.

6 Q: From your observation at this particular scene?

7 A: Yes. He seemed to get along with Officer
8 Boucher fine.

9 Q: Officer Boucher's in a position of authority,
10 correct?

11 A: Yes.

12 Q: Okay. And you agree there's a difference
13 between sugar coating something and treating
14 somebody with respect, correct?

15 A: I would not categorize the way Officer Boucher
16 talked to that patient anymore respectful than
17 I did.

18 Q: Well I wasn't asking that. I was asking if you
19 consider a distinction between sugar coating
20 and treating somebody respectfully?

21 A: Yes.

22 Q: Okay. The consent orders that were offered by
23 the Department, they weren't offered on a take
24 it or leave it basis.

25 A: It said do your suspension or I could appeal.



1 Q: After that?

2 A: Then it was a year or I could appeal. But
3 after that there wasn't ---

4 Q: Well if there was a subsequent offer it wasn't
5 a take it or leave it basis, correct?

6 A: What do you mean subsequent offer?

7 Q: There's two consent orders?

8 A: Yes. The first one after we met, and then the
9 one after the IRC.

10 Q: Right. And I just want to be clear that the
11 proposed consent orders were not to revoke your
12 certificate.

13 A: If I'm not practicing, it may as well be. It's
14 just a difference in time.

15 Q: Right. So the suspension. Those were ---

16 A: Still can't practice.

17 Q: Correct.

18 A: So it's a matter of semantics at that point.

19 Q: Okay. And am I correct that you haven't
20 practiced as a paramedic since this incident?

21 A: I have not practiced on an ambulance since this
22 incident in South Carolina.

23 Q: I think that's all I have for you. Thank you,
24 Mr. Davenport.

25 **THE COURT:** Mr. Wicevic, let me correct myself. He



1 did not testify about the 5 CC's. He said 500
2 CC's was the amount that's normally extracted
3 during blood donation. I think that's all
4 we've got. Mr. Davenport, thank you.

5 **MR. DAVENPORT:** Thank you, Your Honor.

6 **THE COURT:** Mr. Rothstein, that's your last witness?

7 **MR. ROTHSTEIN:** Yes, Your Honor. We rest.

8 **THE COURT:** Okay. Thank you. Do you have anything
9 in this ---

10 **MR. WICEVIC:** No, Your Honor.

11 **THE COURT:** Okay. Good. Okay. I think we're ready
12 for closing. It's been a long week.

13 **MR. ROTHSTEIN:** I do have just a housekeeping
14 matter. I think there was some confusion about
15 exhibits. I think the court reporter said that
16 14 was in, but he was looking at the
17 Department's 14 and not my ---

18 **THE COURT:** Not the Respondent's 14.

19 **COURT REPORTER:** Were you asking about yours or ---

20 **MR. WICEVIC:** I think you were asking about DHEC's.

21 **MR. ROTHSTEIN:** I want to make sure DHEC 14 ---

22 **THE COURT:** Yeah. I thought we ---

23 **COURT REPORTER:** Right. That one is in. I don't
24 have it checked.

25 **MR. ROTHSTEIN:** Yeah. I guess it was DHEC 14 that I



1 wanted to make sure was in.

2 **THE COURT:** Okay.

3 **MR. ROTHSTEIN:** And then I also want to make sure
4 Respondent's exhibit 2 is formally moved into
5 evidence. That was the grievance complaint.

6 **MR. WICEVIC:** Your Honor, the same objection that we
7 continuously logged.

8 **THE COURT:** What's the purpose of the, what
9 relevance does the grievance complaint, since
10 it was filed after ---

11 **MR. ROTHSTEIN:** Well I think he testified that it
12 reflects things that he had brought up before.
13 I don't need the document in. I mean I'm happy
14 to withdraw if that'll make it easier.

15 **THE COURT:** Okay. I'm not inclined to ---

16 **MR. ROTHSTEIN:** Thank you, Your Honor.

17 **THE COURT:** --- admit that. Okay. Does that -- all
18 the evidentiary issues are dealt with?

19 **MR. ROTHSTEIN:** Yes, ma'am.

20 **THE COURT:** Okay. Good. Now we're ready to move
21 onto closing statements. And let's keep the
22 closing statement's brief because y'all
23 presented a lot. So we've got a lot to
24 consider in this case.

25 **MR. WICEVIC:** Yes, Your Honor.



CLOSING STATEMENT BY MR. WICEVIC:

1. **MR. WICEVIC:** Your honor, it's a touch decision to
2. revoke a certificate or license. It's probably
3. the harshest sanction the Department has. It
4. often includes somebody's likelihood, often
5. includes their passion. And I know Your Honor
6. doesn't take it lightly. I know our staff
7. doesn't take it lightly. However, we
8. considered the facts of this case, previous
9. endorsements that we've taken, and we took the
10. recommendation of the IRC, and determined that
11. revocation was the most appropriate action
12. here. The Department's charged with protecting
13. the public health, and without any kid of
14. assurance from Mr. Davenport regarding this
15. incident, we have some significant concerns.
16. We have a serious fear that something will
17. happen again. And while this case didn't
18. result in any adverse outcome's, our fear is
19. that the next one will. Mr. Rothstein
20. mentioned during his motion for directed
21. verdict that the Department doesn't understand
22. what a de novo hearing is. I suggest that we
23. do. And we fully understand that Your Honor
24. acts as the fact finder. That's correct. The
25.



1 Court does not owe deference to our factual
2 findings. Instead the Department's charged
3 with producing the evidence to support our
4 allegations. And I think we have produced
5 enough evidence in this matter to support the
6 findings of misconduct and unacceptable medical
7 treatment. Beginning with the first one,
8 disregarding an appropriate order by a
9 physician concerning emergency treatment.
10 There's a preponderance of evidence in the
11 record that supports finding that Mr. Davenport
12 failed to comply with the orders prescribed by
13 the Anderson County Standards of Care Treatment
14 protocols. We had Dr. Deschamps and Mr.
15 Wronski testify about the distinctions between
16 orders and protocols. Protocols guide
17 decisions, criteria for diagnosis, and
18 management of patients. Standing order on the
19 other hand is a specific policy that prescribes
20 a definitive action taken in a particular
21 condition or situation. I think an additional
22 guiding principle is interpreting the Anderson
23 County Standards of Care through the mind of an
24 EMT. This Court knows by now EMT's receive
25 specialized education by where they learn



1 technical terms, and they use those technical
2 terms in their industry. They learn and
3 understand pre-hospital care terminology, and
4 there is significant decision making in the
5 practice of EMS. There's a lot of going back
6 and forth between standards of care and
7 protocols. That's how the practice works.
8 It's not cookbook medicine, it's not monkey
9 medicine. I suggest to you Mr. Davenport's
10 reading of this completely removes orders from
11 the Anderson County Standards of Care
12 protocols. And that's absurd. It's one of
13 many fallacies in his case. Mr. Davenport is
14 accustomed to the practice of a Special Forces
15 Medic, and he has apparent problems with taking
16 orders from his Med. Control Physician,
17 considers himself on par with these physicians,
18 and PA's, and surgeons. And while he may have
19 specialized form of training and education, and
20 that's more than an ordinary South Carolina,
21 he's still constrained by the same practice as
22 any other South Carolina paramedic. So these
23 are the final orders that we determined that
24 he, Mr. Davenport violated. GP-18, demonstrate
25 professionalism and courtesy. The body cam



1 speaks volumes. Mr. Davenport's
2 characterization, his words and behaviors, and
3 being terse and matter of fact I think just
4 shows a general disconnect from the truth. GP-
5 16, patient should not ambulate to the
6 ambulance or transport. All patients need an
7 appropriate carrying device. Again, the body
8 cam testimony showed this improper transfer.
9 He failed to use a carrying device. Trauma
10 protocols, the patient's injury was critical
11 trauma that any EMT using rational judgement
12 would now triggers the trauma protocols. T-2
13 specifically lists penetrating abdominal
14 injuries as traumatic injuries. Circumstances
15 of this case, not knowing the length of the
16 knife blade would lead a prudent paramedic to
17 precaution proceeding with this injury and
18 acting as if it were a multiple trauma injury.
19 Further, the characteristics of this injury
20 would also lead a prudent paramedic to proceed
21 with the thought that shock was a substantial
22 possibility. Mr. Davenport failed to recognize
23 these concepts. Furthermore, because of the
24 serious traumatic injury, the patient needed IV
25 therapy. There's multiple protocols and orders



1 within Exhibit 1 that require IV therapy. T-3
2 requires initiate IV access in route to ED.
3 Also says initiate IV access protocol. T-1
4 says that all IV lines will be established en
5 route. Finally GP-3, intravenous protocol
6 directs IV access and normal saline solution
7 are appropriate for these types of trauma
8 patients. Mr. Davenport points out some absurd
9 examples of trauma injuries, a broken toe or
10 broken pinky. I think a little common sense
11 tells you that those injuries don't require
12 IV's. This goes back to the basic principle,
13 using some reasonable pre-hospital educated
14 judgement in this case. Dr. Deschamps, Mr.
15 Douglas, and Mr. Wronski all testified about
16 this approach. Because of this injury, the
17 patient also require oxygen therapy. Mr.
18 Davenport failed to provide that. The protocol
19 specifically orders trauma mechanism of injury
20 and or severe trauma specifically listed in G-
21 3, specifically ordered. It's not a trauma
22 patient with respiratory distress and a trauma
23 patient. It's not a certain pulse oximetry
24 level. Simply to say, it's trauma. Again,
25 EMT'S are expected to use their education and



1 training in reading these various protocols and
2 orders. Finally, last thing, patient required
3 cardiac monitor as specified in T-3.
4 Specifically directs paramedics to initiate
5 cardiac monitor lead two. Now whether an EMT
6 agrees with Medical Control Physician's
7 protocols is not significant. Whether the
8 Physician's protocols and orders are based on
9 the latest needs based medicine is not
10 significant either. The EMT's operating under
11 that Med. Control Physician's license and is
12 therefore bound to that direction. It's just
13 the nature of being a civilian EMT here in
14 South Carolina. Mr. Davenport signed up for
15 it, signed the Medical Control Agreement, he
16 attested in the Anderson County Standards of
17 Care and Treatment protocols are medically
18 acceptable as testified by Dr. Deschamps, if
19 you don't exceed the State protocol ceilings.
20 Therefore Mr. Davenport needs to comply with
21 them and he failed to do so. Second
22 misconduct, after initiating care, he
23 discontinued such care without the patient's
24 consent without providing further
25 administration of care by an equal or higher



1 medical authority. Similarly, there's some
2 evidence in the record finding that he did
3 this. He transferred care to Ms. Aiken, a
4 lower level provider without the patient's
5 consent. Despite Mr. Davenport's independent
6 determination to the contrary, this patient
7 required advanced life support, notably the
8 establishment of IV access, supported by the
9 protocols, supported by emergency medical
10 standards. Mr. Davenport knew this patient was
11 going to surgery. A trauma alert was called
12 by the hospital nearly the same time that he
13 arrived. Against all odds, he still maintained
14 with basic life support. Notably Mr.
15 Davenport's action of transferring this care to
16 Ms. Aiken also violated Anderson County's
17 policies regarding management of care. She
18 wasn't reasonably -- she wasn't qualified to
19 meet the patients reasonably perceived needs.
20 The patient himself was ineligible because of
21 his injuries, required ALS intervention, there
22 was a possibility of multiple trauma, and
23 because Ms. Aiken expressed apparent discomfort
24 whether it's not verbal, with riding the call.
25 The patient was ineligible for transfer. Mr.

