IN THE SUPREME COURT OF THE STATE OF NEVADA

DAVID GARVEY, M.D., an individual.

Petitioner,

vs.

THE FOURTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA ex rel. THE COUNTY OF ELKO, AND THE HONORABLE KRISTIN N. HILL,

Respondent,

and

DIANE SCHWARTZ, individually and as Special Administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased,

Real Party In Interest.

Supreme Court No.

District Court No. : CV-C-17-439

APPENDIX OF EXHIBITS TO PETITION FOR WRIT OF MANDAMUS – VOLUME 8 OF 13

[VOLUME 1 (PAGES 1-54)]; [VOLUME 2 (PAGES 55-101)]; [VOLUME 3 (PAGES 102-143)]; [VOLUME 4 (PAGES 144-174)]; [VOLUME 5 (PAGES 175-412)]; [VOLUME 6 (PAGES 413-508)]; [VOLUME 7 (PAGES 509-568)]; [VOLUME 8 (PAGES 569-717)]; [VOLUME 9 (PAGES 718-798)]; [VOLUME 10 (PAGES 799-866)]; [VOLUME 11 (PAGES 867-959)]; [VOLUME 12 (PAGES 960-1093)]; [VOLUME 13 (PAGES 1094-1246)]

LEWIS BRISBOIS BISGAARD & SMITH LLP
KEITH A. WEAVER
Nevada Bar No. 10271
ALISSA N. BESTICK
Nevada Bar No. 14979C
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Tel. 702.893.3383
Fax 702.893.3789
Attorneys for Petitioner

CHRONOLOGICAL INDEX

Number	Document	Filing Date	Volume	Page
1	Summons	06/22/2017	1	8
2	Plaintiff's Complaint	06/22/2017	1	10
3	Acceptance of Summons and Complaint	07/13/2017	1	32
4	Plaintiff's Amended Complaint	10/20/2017	1	33
5	Plaintiff's Second Amended Complaint (Medical Malpractice and Wrongful Death)	02/12/2018	2	62
6	Errata to Plaintiffs Complaint Amended Complaint and Second Amended Complaint	09/10/2018	2	84
7	Notice of Entry of Order Denying Plaintiff's Motion for Leave to Amend Complaint (erroneously titled order denying plaintiff's motion to dismiss)	10/28/2019	2	91
8	Defendant David Garvey, M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages	07/27/2020	3 4 5	109 151 182
9	Defendant David Garvey MD;s Errata to Motion for Partial Summary Judgment	08/06/2020	6	420
10	Plaintiffs' Opposition to Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages, and All Joinders Thereto	08/18/2020	6 7 8	430 516 679
11	Defendant David Garvey, M.D.'s Motion to Strike the Declaration of Shirley Blazich, Esq.	09/08/2020	9	725

Number	Document	Filing Date	Volume	Page
12	Defendant David Garvey, M.D.'s Motion to Strike the Declaration of Seth Womack, M.D.	09/08/2020	9	757
13	Defendant David Garvey, M.D.'s Reply in Support of Motion For Partial Summary Judgment to Statutorily Limit Damages	09/08/2020	9	765
14	Plaintiffs' Opposition to: (1) Defendant David Garvey M.D.'s Motion To Strike The Declaration Of Shirley Blazich, Esq., And (2) Defendant David Garvey M.D.'s; (2) Motion To Strike The Declaration Of Seth Womack, M.D., and Any Joinders Thereto And Plaintiff's Countermotion (3) For Leave to Amend the Complaint	09/11/2020	10 11 12	806 874 1055
15	Defendant David Garvey, M.D.'s Response to Plaintiff's Improper Surreply To Partial Summary Judgment Motion and Request that the Court Disregard Plaintiff's Mislabeled and Untimely Motion For Reconsideration of this Court's October 16, 2019 Order Denying Leave to Amend With Prejudice	09/21/2020	13	1101
16	Defendant David Garvey, M.D.'s Errata to Motion for Partial Summary Judgment	04/19/2021	13	1117
17	Defendant David Garvey, M.D.'s Answer to Plaintiff's Second Amended Complaint	04/23/2021	13	1121
18	Order Granting Plaintiff's Motion for Leave to Amend Complaint	05/06/2021	13	1131

Number	Document	Filing Date	Volume	Page
19	Order Denying: 1. Defendant Phc-Elko, Inc. dba Northeastern Nevada Regional Hospital's Motion that All of Plaintiff's Claims Against Northeastern Nevada Regional Hospital Are Subject to the Requirements And Limitations of NRS 41.503 (The "Trauma" Statute) (Filed July 6,2020); 2. Defendant David Garvey, M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages (Filed July 27,2021); 3. Defendant David Garvey, M.D.'s Motion to Strike the Declaration of Seth Womack, M.D.; and 4. Defendant David Garvey, M.D.'s Motion to Strike the Declaration of Shirley Blazich,Esq.	06/03/2021	13	1135
20	Order Denying Plaintiff's Countermotion for Leave to Amend Complaint	06/03/2021	13	1141
21	Third Amended Complaint (Medical Malpractice and Wrongful Death)	06/28/2021	13	1147
22	Defendant David Garvey, M.D.'s Answer To Third Amended Complaint	07/16/2021	13	1231

ALPHABETICAL INDEX

Number	Document	Filing Date	Volume	Page
17	Defendant David Garvey, M.D.'s Answer to Plaintiff's Second Amended Complaint	04/23/2021	13	1121
6	Errata to Plaintiffs Complaint Amended Complaint and Second Amended Complaint	09/10/2018	2	84
7	Notice of Entry of Order Denying Plaintiff's Motion for Leave to Amend Complaint (erroneously titled order denying plaintiff's motion to dismiss)	10/28/2019	2	91
20	Order Denying Plaintiff's Countermotion for Leave to Amend Complaint	06/03/2021	13	1141
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18	Order Granting Plaintiff's Motion for Leave to Amend Complaint	05/06/2021	13	1131

Number	Document	Filing Date	Volume	Page
4	Plaintiff’s Amended Complaint	10/20/2017	1	33
2	Plaintiff’s Complaint	06/22/2017	1	10
5	Plaintiff’s Second Amended Complaint (Medical Malpractice and Wrongful Death)	02/12/2018	2	62
14	Plaintiffs' Opposition to: (4) Defendant David Garvey M.D.'s Motion To Strike The Declaration Of Shirley Blazich, Esq., And (2) Defendant David Garvey M.D.'s; (5) Motion To Strike The Declaration Of Seth Womack, M.D., and Any Joinders Thereto And Plaintiff's Countermotion (6) For Leave to Amend the Complaint	09/11/2020	10 11 12	806 874 1055
10	Plaintiffs’ Opposition to Defendant David Garvey M.D.’s Motion for Partial Summary Judgment to Statutorily Limit Damages, and All Joinders Thereto	08/18/2020	6 7 8	430 516 679
1	Summons	06/22/2017	1	8
21	Third Amended Complaint (Medical Malpractice and Wrongful Death)	06/28/2021	13	1147

EXHIBIT 7

NORTHEASTERN NEVADA REGIONAL HOSPITAL

Origination:	*07/1996*
Approved:	*10/2015*
Last Revised:	*10/2015*
Next Review:	*10/2017*
Owner:	*Edward Johnson: ER Director*
Policy Area:	*Provision of Care, Treatment, and Services*
References:	
Applicability:	*Northeastern Nevada Regional Hospital*

Code Blue Procedure & Crash cart maintenance

SCOPE:

House wide

POLICY:

Hospital staff will follow established guidelines for Cardiopulmonary Resuscitation.
This policy has been written to identify and designate Code Blue team members, their duties and responsibilities, and accepted procedures/protocols to follow in the event of a Code Blue. Additionally, the procedures for the utilization of crash carts are delineated.

Any person in the hospital who experiences cardiac, pulmonary or cardiopulmonary arrest will receive full resuscitative measures unless otherwise indicated by the physician in attendance or as specified by written physician's orders.

PROCEDURE:

CODE BLUE TEAM MEMBERS:

1. Physician
2. ICU RN
3. ED RN
4. Respiratory Therapist
5. Nursing Supervisor/Manager, or designee
6. Primary Nurse
7. Pharmacist

RESPONSIBILITIES:

All team members will identify themselves upon arrival to the code.

1. **Physician**: Emergency Department Physician responds to all Code Blue's unless attending or consulting physician assumes responsibility for Code Blue.
    a. Assumes medical control.

b. Interprets rhythm and orders medication and treatments as per ACLS protocol and/or other medications and treatments as deemed necessary.

c. Determines if and when life support may be stopped or discontinued.

d. Discusses patient outcome with family/S.O. as soon as possible after code terminated.

2. **ICU Nurse**

a. Directs Code Blue until arrival of physician.

b. Attaches patient to monitor equipment, obtains rhythm strips.

c. Interprets cardiac rhythms and initiates appropriate treatment per ACLS protocol or physician order.

d. Oversees the activities of other team members and coordinates fulfillment of their responsibilities.

e. Brings crash cart from second floor to third of hospital (for Code Blue in Pain Program or Sleep Medicine Program).

3. **ED Nurse**

a. Establishes an intravenous line if not already in.

b. Administers medication under direction of physician, or team leader in absence of physician.

c. Notifies recorder each time medication is given, including type of drug and dose given.

4. **Respiratory Therapist:**

a. Assumes responsibility for airway management and ventilation. Initiates and maintains ventilator assist with intubation as required.

b. Brings blood gas kits.

c. Restocks any respiratory equipment on the crash cart following the code.

5. **Nurse Manager/Supervisor or designee**

a. Aids in decreasing the number of people attending the code. Asks people to leave if duplicate service or not part of Code Blue team members.

b. Assumes responsibility to see requirements are met for nursing documentation of patient medical record.

6. **Primary Nurse**:

a. Responsible for having patient's chart, kardex, IV, and medication record at the bedside for physician in charge. Diagnosis/reason for admission should be clearly documented on kardex where applicable.

b. Assures notification of attending physician of Code Blue.

c. Assures notification of patient's family or significant others, and attends to other patients and visitors in room.

d. Coordinates patient disposition.

7. **Pharmacist**: The pharmacist will respond to Code Blue's when possible.

a. As ordered, prepares medications for administration and hands to IV Med Nurse.

b. At close of the Code Blue, initiates cart restocking process and verifies final step of drug replacement and seals/locks the cart.

ASSIGNMENT OF CODE BLUE TEAM MEMBERS:

General Code Assignments*

Physician–ED
Team Leader–ICU or ED ACLS RN
IV Med-Nurse–ED RN or ICU ACLS RN
Recorder Primary Care Nurse
Compressions–RN, LPN, CNA with current BLS
Ventilation–Respiratory Therapist as assigned each shift
Drug Supplies–Pharmacist/ Patient Care Supervisor

*Areas may be re-assigned on shift-to-shift basis as need dictates.

INITIATION OF CODE BLUE:

1. The first responder on the scene of a cardiac/pulmonary arrest will immediately call for help and initiate CPR as instructed by current CPR standards. Identify the room number or area to operator and announce Code Blue.
2. When the Code Team arrives, the team leader will initiate the appropriate current ACLS protocol in the absence of a physician. With a physician present, the team leader will follow orders as given as well as assist the physician with interpretation of rhythm, suggested ACLS protocol, etc.

PERFORMANCE IMPROVEMENT:

1. Ongoing review of the outcomes related to the processes and outcomes of resuscitation will be reviewed by the Quality Improvement Department and appropriate action taken if opportunities for improvement are identified. The findings, conclusions, recommendations, actions taken, and effectiveness of actions taken will be reported through the performance improvement program to the Emergency Department Committee, the Medical Executive Committee and Governing Board.

TRAINING, EDUCATION AND COMPETENCY

1. The hospital will identify, educate, and retrain (as appropriate) Code Blue team members.

CRASH CARTS – CHECKING AND MAINTENANCE:

There is an established mechanism to ensure the availability of emergency supplies and equipment on each nursing and specified ancillary unit.

1. General
    a. Code Carts will remain locked until Code Blue is called.
    b. Code Carts will be located in accessible, designated areas of patient care to facilitate immediate availability of necessary supplies and/or equipment in the event of patient crisis.
2. Checks (Daily/Monthly)
    a. Hospital personnel in each department where a code cart is located will be responsible for ensuring that each code cart is appropriately stocked and that all equipment is in working condition.
    b. All code carts will be checked routinely on a DAILY basis, when the department is open.

c. Nursing will check for expired items monthly for nursing supplies

d. Pharamcy will check for expired items monthly for medicaitons

e. Repiratory will check for expired items monthly for the respiratory drawer

3. 1. Free standing contents:

Supplies and equipment **not** contained within the locked elements of the cart are to be checked and re-stocked daily and as needed on all units. All Code Cart checks are to be documented.

a. Oxygen tank regulator at full

b. Integrity and functioning of defibrillator

c. Back board

a. **Internal Code Cart** contents:

a. Pharmacy is charged with control and maintenance of all code cart medications.

b. Respiratory Therapy will restock their designated drawer in all crash carts in the hospital.

c. Nursing is charged with stocking all other supplies

d. Please see attachment A for list of supplies and form to complete when stocking cart

REFERENCES:

American Heart Association

Attachments:

Crash cart stock

Approval Signatures

Approver	Date
Alice Allen: CNO	10/2015
Becky Jones: Director of Clinical Informatics and Education	10/2015
Becky Jones: Director of Clinical Informatics and Education	08/2015

TOP OF CART	AMOUNT	EXPIRES	DATE
Ambu bag Adult	2		
Ambu bag Pediatric	2		
Code Sheets			
Defib/Pacer pad Adult	2		
Defib/Pacer pad Pediatric	2		
Doppler Gel	2		
ECG Electrodes (3 pack) Pediatric	3		
ECG Electrodes (5 pack) Adult	2		
Gloves - Large	1		
Gloves - Medium	1		
Gloves - Small	1		
Monitor Paper Rolls	4		
Monitor w/Cables	1		
Nasal Cannula Adult	1		
Nasal Cannula Pediatric	1		
NRB Mask Adult	1		
Oxygen Tank	1		
Sharps Container	1		
Simple Mask Pediatric	1		
FIRST DRAWER			
MEDICATIONS	**AMOUNT**	**EXPIRES**	**DATE**
Adenosine (Adenocard) 6mg/2ml	3		
Amiodarone 150mg/3ml vial	3		
Atropine Syringe 1mg/10ml	3		
Calcium Chloride 10% 10ml vial	1		
Dextrose 5% 100ml IVPB	1		
Dextrose Syringe 50% 50ml	1		
Dopamine Drip 800mg/250ml	1		
Epinephrine Syringe 1:10000	3		
Esmolol (Brevibloc) 100mg/10ml vial	1		
Flumazenil (Romazicon) 0.5mg/5ml vial	1		
Furosemide (Lasix) 40mg/4ml vial	2		
Labetalol 100mg/20ml vial	1		
Lidocaine Syringe 100mg/10ml	2		
Magnesium Sulfate 1gm bag	1		
Naloxone (Narcan) Ampule 0.4mg/1ml	5		
Nitroglycerin Drip 50mg/250 ml IV	1		
Nitroglycerin 0.4mg table #25	1		
Sodium Bicarbonate Syringe 50mEq/50ml	2		
Sodium Chloride 0.9% Flush 10ml vial	3		
Sterile Water 10ml vial	3		
Vasopressin 20units/2ml vial	2		
Verapamil 5mg/2ml vial	1		

SECOND DRAWER			
RESPIRATORY	**AMOUNT**	**EXPIRES**	**DATE**
Primary Intubation Kit	1		
Secondary Intubation Kit	1		
Oxisensor (Disposable SpO2 probe)	1		
Sterile Suction Catheter 14fr.	1		
Tongue blades	5		
Yankaur w/Suction Tubing	1 each		
ABG Kit	2		
THIRD DRAWER			
IV SUPPLIES	**AMOUNT**	**EXPIRES**	**DATE**
Alcohol Prep pads	1 box		
Benzoine	5		
Betadine Swab Stick pack	2		
Blood Tubes			
Blue Top	1		
Green Top	1		
Purple Top	1		
Orange Top (SST)	1		
Red Top 10ml	1		
Tiger Top	1		
Blood Transfer Device	2		
Bioclusive Transparent Dressing 4 inch	2		
Bioclusive Transparent Dressing 2 inch	5		
Coban roll 2 inch	2		
Gauze Sponges			
2x2	10		
4x4	2 boxes		
IV End Cap (Heplock)	5		
IV Catheters			
24 gauge	5		
22 gauge	5		
20 gauge	5		
18 gauge	5		
16 gauge	5		
IV T-connector	5		
IV Twin Catheter			
18/20 gauge	2		
20/22 gauge	2		
Needles			
18 gauge 1 inch	10		
19 gauge 1 1/2 inch	10		
Povodine-Iodine prep pads	15		
Povodine-Iodine solution bottle	1		
Razor	1		
Three-Way Stop Cock	5		
Syringes (luer lock tip)			

3ml	5		
5ml	5		
10ml	5		
10ml prefilled Saline Flush	10		
20ml	2		
60ml	1		
Tape			
Paper 2 inch	1		
Silk 1inch	1		
Silk 2 inch	1		
Transpore 1 inch	1		
Transpore 2 inch	1		
Tournequets	3		
IV Tubing			
Blood Y Set	1		
Extension Set	2		
Nitorglycerin Non-adherent	2		
Primary Set	2		
Secondary Set	2		
BOTTOM	**AMOUNT**	**EXPIRES**	**DATE**
Central Line Kit 7fr. 20cm	1		
Central Line Kit 7fr. 16cm	1		
Doppler			
Foley Tray w/Urimeter	1		
Irrigation Kit w/60ml Piston Syringe	1		
IV Fluid			
LR 1000ml	1		
NS 1000ml	1		
NS 500ml	1		
Lubricant	3		
Manual Blood Pressure Cuff	1		
NG Tubes			
16 fr.	1		
18 fr.	1		
NG Tube Anti-Reflux Valve	1		
Pressure Bag	1		
Sterile Gloves			
6 1/2	2		
7	2		
7 1/2	2		
8	2		
8 1/2	2		
Suction Canister	1		
Suction Tubing	1		

CODE CART CHECKLIST — PEDIATRIC

TOP OF CART	AMOUNT	EXPIRES	DATE
Ambu bag Adult	1		
Ambu bag Pediatric	2		
Braslow Tape	1		
Code Sheets			
Defib/Pacer pad Adult	2		
Defib/Pacer pad Pediatric	2		
Doppler Gel	1		
ECG Electrodes (3 pack) Pediatric	4		
ECG Electrodes (5 pack) Adult	3		
Gloves - Large	1		
Gloves - Medium	1		
Gloves - Small	1		
Monitor Paper Rolls	2		
Monitor w/Cables	1		
Nasal Cannula Adult	1		
Nasal Cannula Pediatric	1		
NRB Mask Adult	1		
Oxygen Tank	1		
Sharps Container	1		
Simple Mask Pediatric	1		
FIRST DRAWER			
MEDICATIONS	**AMOUNT**	**EXPIRES**	**DATE**
Adenosine (Adenocard) 6mg/2ml	2		
Amiodarone 150mg/3ml vial	2		
Atropine Syringe 1mg/10ml	2		
Dexamethasone vial 4mg/ml 5ml	1		
Dextrose Syringe 25% 10ml	1		
Dopamine in D5 800mg	1		
D10W 500ml	1		
D5 1/4NS 500ml	1		
Epinephrine Syringe 1:10000	4		
Lidocaine syringe 2% 100mg/5ml	2		
Lidocaine vial 1%	1		
Magnesium sulfate 50% (1gm/2ml)	3		
Hydrocortisone sodium succinate/solu-cortef 100mg vial	1		
Naloxone (Narcan) Ampule 0.4mg/1ml	2		
Sodium Bicarb Syringe 4.2% 5meq/10ml	4		
Sodium Chloride 0.9% Flush 10ml vial	2		
Sodium chloride 0.9% NV 500ml	1		
Sterile Water 10ml vial	2		
OTHER ITEMS	**AMOUNT**	**EXPIRES**	**DATE**

Batteries C	2		
Batteries AA	6		
Braslow Disposable BP cuffs			
Infant-Small Child Size	1		
Small Child-Child Size	1		
Large Child-Adult Size	1		
Braslow Tape	2		
Laryngoscope Handle Large	1		
Laryngoscope Handle Small	1		
McGill Forceps Large	1		
McGill Forceps Small	1		
SECOND DRAWER			
PINK/RED Infant 3-9 kg	**AMOUNT**	**EXPIRES**	**DATE**
Alcohol Prep pads	1box		
Benzoine	2		
Bioclusive Transparent Dressing 2 inch	5		
Braslow Resuscitation Kits			
Interosseous Delivery Module Kit	1		
Intubation Module Kit	1		
IV Delivery Module Kit	1		
Oxygen Delivery Module Kit	1		
Gauze 2x2	5		
IV Catheters			
24 gauge	2		
22 gauge	2		
20 gauge	2		
18 gauge	2		
IV End Cap (Heplock)			
IV T-connector	2		
Needles			
18 gauge 1 inch	10		
19 gauge 1 1/2 inch	5		
Suction Tubing	1		
Syringes (luer lock tip)			
3ml	5		
5ml	5		
10ml	5		
10ml prefilled Saline Flush	5		
20ml	2		
60ml	1		
Tournequets	2		
Transpore Tape 1 inch	1		
Yankaur	1		
THIRD DRAWER			
PURPLE Toddler 10-11kg	**AMOUNT**	**EXPIRES**	**DATE**
Alcohol Prep pads	1box		

Benzoine	2		
Bioclusive Transparent Dressing 2 inch	5		
Braslow Resuscitation Kits			
Interosseous Delivery Module Kit	1		
Intubation Module Kit	1		
IV Delivery Module Kit	1		
Oxygen Delivery Module Kit	1		
Gauze 2x2	5		
IV Catheters			
24 gauge	2		
22 gauge	2		
20 gauge	2		
18 gauge	2		
IV End Cap (Heplock)			
IV T-connector	2		
Needles			
18 gauge 1 inch	10		
19 gauge 1 1/2 inch	5		
Suction Tubing	1		
Syringes (luer lock tip)			
3ml	5		
5ml	5		
10ml	5		
10ml prefilled Saline Flush	5		
20ml	2		
60ml	1		
Tournequets	2		
Transpore Tape 1 inch	1		
Yankaur	1		
FOURTH DRAWER			
YELLOW Small Child 12-14kg	**AMOUNT**	**EXPIRES**	**DATE**
Alcohol Prep pads	1box		
Benzoine	2		
Bioclusive Transparent Dressing 2 inch	5		
Braslow Resuscitation Kits			
Interosseous Delivery Module Kit	1		
Intubation Module Kit	1		
IV Delivery Module Kit	1		
Oxygen Delivery Module Kit	1		
Gauze 2x2	5		
IV Catheters			
24 gauge	2		
22 gauge	2		
20 gauge	2		
18 gauge	2		
IV End Cap (Heplock)			
IV T-connector	2		

Needles			
18 gauge 1 inch	10		
19 gauge 1 1/2 inch	5		
Suction Tubing	1		
Syringes (luer lock tip)			
3ml	5		
5ml	5		
10ml	5		
10ml prefilled Saline Flush	5		
20ml	2		
60ml	1		
Tournequets	2		
Transpore Tape 1 inch	1		
Yankaur	1		
FIFTH DRAWER			
WHITE Child 15-18kg	**AMOUNT**	**EXPIRES**	**DATE**
Alcohol Prep pads	1box		
Benzoine	2		
Bioclusive Transparent Dressing 2 inch	5		
Braslow Resuscitation Kits			
Interosseous Delivery Module Kit	1		
Intubation Module Kit	1		
IV Delivery Module Kit	1		
Oxygen Delivery Module Kit	1		
Gauze 2x2	5		
IV Catheters			
24 gauge	2		
22 gauge	2		
20 gauge	2		
18 gauge	2		
IV End Cap (Heplock)			
IV T-connector	2		
Needles			
18 gauge 1 inch	10		
19 gauge 1 1/2 inch	5		
Suction Tubing	1		
Syringes (luer lock tip)			
3ml	5		
5ml	5		
10ml	5		
10ml prefilled Saline Flush	5		
20ml	2		
60ml	1		
Tournequets	2		
Transpore Tape 1 inch	1		
Yankaur	1		

SIXTH DRAWER			
BLUE Child 19-22kg	**AMOUNT**	**EXPIRES**	**DATE**
Alcohol Prep pads	1box		
Benzoine	2		
Bioclusive Transparent Dressing 2 inch	5		
Braslow Resuscitation Kits			
Interosseous Delivery Module Kit	1		
Intubation Module Kit	1		
IV Delivery Module Kit	1		
Oxygen Delivery Module Kit	1		
Gauze 2x2	5		
IV Catheters			
24 gauge	2		
22 gauge	2		
20 gauge	2		
18 gauge	2		
IV End Cap (Heplock)			
IV T-connector	2		
Needles			
18 gauge 1 inch	10		
19 gauge 1 1/2 inch	5		
Suction Tubing	1		
Syringes (luer lock tip)			
3ml	5		
5ml	5		
10ml	5		
10ml prefilled Saline Flush	5		
20ml	2		
60ml	1		
Tournequets	2		
Transpore Tape 1 inch	1		
Yankaur	1		
SEVENTH DRAWER			
ORANGE Large Child 24-28kg	**AMOUNT**	**EXPIRES**	**DATE**
Alcohol Prep pads	1box		
Benzoine	2		
Bioclusive Transparent Dressing 2 inch	5		
Braslow Resuscitation Kits			
Interosseous Delivery Module Kit	1		
Intubation Module Kit	1		
IV Delivery Module Kit	1		
Oxygen Delivery Module Kit	1		
Gauze 2x2	5		
IV Catheters			
24 gauge	2		
22 gauge	2		
20 gauge	2		

18 gauge	2		
IV End Cap (Heplock)			
IV T-connector	2		
Needles			
18 gauge 1 inch	10		
19 gauge 1 1/2 inch	5		
Suction Tubing	1		
Syringes (luer lock tip)			
3ml	5		
5ml	5		
10ml	5		
10ml prefilled Saline Flush	5		
20ml	2		
60ml	1		
Tournequets	2		
Transpore Tape 1 inch	1		
Yankaur	1		
EIGHTH DRAWER			
GREEN Adult 30-36kg	**AMOUNT**	**EXPIRES**	**DATE**
Alcohol Prep pads	1box	NA	
Benzoine	2		
Bioclusive Transparent Dressing 2 inch	5		
Braslow Resuscitation Kits			
Interosseous Delivery Module Kit	1		
Intubation Module Kit	1		
IV Delivery Module Kit	1		
Oxygen Delivery Module Kit	1		
Gauze 2x2	5		
IV Catheters			
24 gauge	2		
22 gauge	2		
20 gauge	2		
18 gauge	2		
IV End Cap (Heplock)			
IV T-connector	2		
Needles			
18 gauge 1 inch	10		
19 gauge 1 1/2 inch	5		
Suction Tubing	1		
Syringes (luer lock tip)			
3ml	5		
5ml	5		
10ml	5		
10ml prefilled Saline Flush	5		
20ml	2		
60ml	1		
Tournequets	2		

Transpore Tape 1 inch	1		
Yankaur	1		
BOTTOM DRAWER			
	AMOUNT	**EXPIRES**	**DATE**
Flowmeter	1		
Lubricant	3		
Mini-Infuser Syringe Pump	1		
Mini-Infuser Syringe Pump Tubing	2		
Irrigation Tray w/60ml Piston Syringe	1		
IV Fluids			
Dextrose 5% 1/4 NS 500ml	1		
Dextrose 500ml	1		
Dextrose 10% 500ml	1		
LR 1000ml	1		
Normal Saline 1000ml	1		
Normal Saline 500ml	1		
IV Tubing			
Buretrol Primary Set	2		
Extension Set	2		
Nitroglycerin Non-Aherent	2		
Primary Set	2		
Secondary Set	2		
Oxisensor Disposable SpO2	1		
Suction Canister	1		

EXHIBIT 8

DECLARATION FOR MEDICAL RECORDS AND MEDICAL BILLING RECORDS

STATE OF Nevada)
) ss:
COUNTY OF ELKO)

COMES NOW BEVERLEY LIGGETT, who after first being duly sworn, deposes and says:

1. That Declarant is the Custodian of Medical Records and of Medical Billing Records for **Northeastern Nevada Regional Hospital**.

2. That **Northeastern Nevada Regional Hospital** is licensed to do business in the State of NEVADA :

3. That on the 23 day of AUGUST, 2019, Declarant was served a Medical Records and Medical Billing Records Request in connection with the above-entitled cause, calling for the production of Medical Records and Medical Billing Records pertaining to: **DOUGLAS SCHWARTZ**.

4. That Declarant has examined the original of both those Medical Records and Medical Billing Records and has made or has caused to be made a true and exact copy of them, and that the reproduction of them attached hereto is true and complete.

5. That the original of both those Medical Records and Medical Billing Records were made at or near the time of the act, event, condition, opinion, diagnosis recited therein by or from information transmitted by a person with knowledge, in the course of a regularly conducted activity of Declarant or **Northeastern Nevada Regional Hospital**.

6. That the services provided were reasonable and necessary and the amounts charged for the services were reasonable and necessary at the time and place that the services were provided.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 27 day of AUGUST, 2019

Beverley Liggett
DECLARANT

NORTHEASTERN NEVADA REGIONAL HOSPITAL

User: MQI6948
Hospital: 26

Clinical View Notes Report

Date Range: 06/22/16 21:10 - 06/23/16 06:05

Date: 8/27/19
Time: 12:32

Patient Name:	**SCHWARTZ DOUGLAS R**	Room / Bed:	/	HSV:	**ED**
Patient #:	**6139781**	DOB:	**06/02/1958**	Admitted:	**06/22/16 21:10**
Medical Record	**330967**	Age / Sex:	**58 M**	Discharged:	**06/23/16 06:05**

Date	Time	By / Note Text

Patient has no notes.

Patient . . . : SCHWARTZ DOUGLAS R (6139781) Room/Bed:
History Number: 330967 DOB . . .: 06/02/1958 Age . . : 61 Y (As of: 06/23/2016)
Height: Weight:
IBW . : 0 lb 0.00 oz / 0.000 kg BSA . . .: 0.0000 CrCL. . :
Admit Date. . : 06/22/2016 Discharge Date: 06/23/2016
Physician: GARVEY DAVID J MD
Diagnosis: AUTO VS PEDESTRAIN
Allergies: Allergies Unknown

DISCHARGE MEDICATIONS:

Discharge Reconciliation has not been completed or still in progress

Admission/Discharge/Transfer:

Physician: Date: _____ Time: _____ Signature: _____

Attending Physician: Date: _____ Time: _____ Signature: _____

_ Please ask the Attending Physician to review the patients meds at next visit within 24 hours

Nurse. . : Date: _____ Time: _____ Signature: _____

* * * * END OF REPORT * * * *

PATIENT: 6139781 SCHWARTZ DOUGLAS R SEX: M DATE OF BIRTH: 6/02/58 ADMIT DATE: 6/22/16
PHYSICIAN: 02818 GARVEY DAVID J MD ROOM/BED:
MED REC #: 000330967

I N T A K E S

DATE	TIME	TOTAL																	
	SHIFT:0																		
	TOTAL:																		

O U T P U T S

DATE	TIME	TOTAL																	
	SHIFT:0																		
	TOTAL:																		

Fluid Balance for 6/22/16 is .0

NORTHEASTERN NEVADA REGIONAL HOSPITAL

User: MQI6948
Hospital: 26

Assessment/Flowsheet Report

Page: 1

		Date: 08/27/2019	**Time:** 12:32		
Patient Name:	SCHWARTZ DOUGLAS R			Room/Bed:	/
Patient Number:	6139781	Gender:	M	HSV Code:	ED
MR Number:	330967	Age:	58 Y	Date of Birth:	06/02/1958

Question / Answers	Comment
No Assessment Data Found.	

Patient Name: SCHWARTZ DOUGLAS R
Patient #: 6139781 **Med Rec #:** 330967

Age/Cd/Sex: 58 / Y / M **Attending:** GARVEY DAVID J MD
Room/Bed: **Admitted:** 6/22/16 21:10

Date	Time	By	Title	Discipline

*** No Notes Exist ***

NORTHEASTERN NEVADA REGIONAL HOSPITAL

PATIENT: SCHWARTZ DOUGLAS R

PATIENT#: 6139781 MR#:000330967
DATE : 8/27/19
DSCHG DX: CARDIAC ARREST, CAUSE UNS
ATT PHYS: GARVEY DAVID J MD

DISCHARGE INSTRUCTIONS

==========

PHYSICIAN: _____

NURSE SIGNATURE: _____

PATIENT/DESIGNATE SIGNATURE: _____

==========

PATIENT : SCHWARTZ DOUGLAS R
PATIENT#: 6139781
DSC DATE: 6/23/16
DSC TIME: 06:05

NORTHEASTERN NEVADA REGIONAL HOSPITAL
2001 ERRECART BLVD.
ELKO NV 89801
775-738-5151

PATIENT: 6139781 SCHWARTZ DOUGLAS R SEX: M DATE OF BIRTH: 6/02/58 ADMIT DATE: 6/22/16
PHYSICIAN: 02818 GARVEY DAVID J MD MED REC #: 000330967 ROOM/BED: -

DATE TIME Unit/Measure								

NORTHEASTERN NEVADA REGIONAL HOSPITAL

Facesheet

MEDICAL RECORD NUMBER	MRSA	VRE	PATIENT ACCOUNT NUMBER
000330967			6139781

PATIENT (Name, Address, Phone)	BIRTH DATE	AGE	BIRTH PLACE	SOCIAL SECURITY NUMBER
SCHWARTZ DOUGLAS R [redacted] [redacted]	06/02/1958	58		[redacted]

SEX	RACE	M/S	ED CD	PREV ADM	REL	ADMITTED BY
M	W	M		07/22/14	R	LUE

ADMIT DATE & TIME	DISCHARGE DATE & TIME	SERVICE	ROOM / BED NO.
06/22/16 21:10	06/23/16 06:05	ED	/

PATIENT EMPLOYER (Name, Address, Phone, Occ.)	EMERGENCY CONTACT (Name, Address, Phone, Rel.)	REFERRAL SOURCE / AGENCY / TEAM MEMBER
ELKO FEDERAL CREDIT MOUNTAIN CITY HWY ELKO NV 898010000 PHONE: (775)738-4083 OCC: EXEC VICE PRES	SCHWARTZ DIANE [redacted] REL: Spouse	PHONE: CONTACT NAME:

GUARANTOR (Name, Address, Phone)	GUARANTOR EMPLOYER (Name, Address, Phone)	FINANCIAL CLASS
SCHWARTZ DOUGLAS R [redacted] PHONE: (702)373-2436 REL: Patient is insured	ELKO FEDERAL CREDIT MOUNTAIN CITY HWY ELKO NV 898010000 PHONE: (775)738-4083	04 WORKERS COMP **ATTENDING PHYSICIAN** GARVEY DAVID J MD 2818 **ADMISSION STATUS** / **DISCHARGE STATUS** 20

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
WC FIRSTCOMP PO BOX 3188 OMAHA NE 681030188 PHONE: (888)500-3344 POLICY# 518864393 GROUP #: GRP NAME: AUTH#: NR/ER SCHWARTZ DOUGLAS R DOB: 06/02/1958 SEX: M REL: Patient is insured	BCBS PREFIX YF PO BOX 5747 DENVER CO 802175747 PHONE: (877)833-5742 POLICY# YFO841M50938 GROUP #: A46847 GRP NAME: AUTH#: NR/ER SCHWARTZ DOUGLAS R DOB: 06/02/1958 SEX: M REL: Patient is insured	PHONE: POLICY# GROUP #: GRP NAME: AUTH#: DOB: SEX: REL:

CHIEF COMPLAINT

ENCOUNTER FOR EXAM AND OBS FOLLOWING TRANSPORT ACC Z041

COMMENTS:

2242 ALL PAPERWORK SIGNED COPY OF INS CARD AND ID CONSENTS SCANNED PT WAS HI

T BY A CAR HIT AND RUN GAVE PT MRA PACKET NO PAYMENT OR DISCOUNT OFFERED

04

NORTHEASTERN NEVADA REGIONAL HOSPITAL
Clinical History Profile Report

Patient Name: SCHWARTZ DOUGLAS R
Patient Number: 6139781
Chart Number: 330967
Room/Bed: /
Date of Birth: 6/02/1958
Age: 61 Y
HSV Code: ED

CURRENT:

		Date	Time	User ID
Medical Condition:				
Admitting Diagnosis:	ENCOUNTER FOR EXAM AND OBS FOLLOWING TRANSPORT ACC	06/24/16	08:13	CRO9538
Current Diagnosis:				
Height:				
Weight:				
BSA:				
BMI:				

PATIENT PROBLEMS:

ALLERGIES:

	Date	Time	User ID
No Historical Data			

Allergy	Symptoms	Severity	Type	Date	Time	User ID

General Comments:	Date	Time	User ID

Review of allergies:	Date	Time	User ID

UNIVERSAL:

	Date	Time	User ID
Advance Directive:			
Copy on Chart:			
DNR:			
Oxygen:			
Ventilator:			
Monitor:			
IV:			
Mobility:			
Transportation:			
Isolation:			
Other Remarks:			
Past Med/Surg Proc:			
Special Needs:			

ADVANCE DIRECTIVE:

Date	Time	User ID

HOME MEDICATIONS:

Date	Time	User ID

DIETARY:

Date	Time	User ID

SPECIAL:

Date	Time	User ID

DRUG RESISTANT INFECTIONS:

Date	Time	User ID

IMMUNIZATIONS:

WELLNESS:

CRO9538-ANGELA BARRETT - HIM, HIM

** End of Report **

Encounter: 6139781 SCHWARTZ DOUGLAS R
Date of Birth: 6/02/1958

Order Type: All
Sequenced by: Entered Date

6/23/16 9:21 Pharmacy Order#: 1704021 Discontinued
sodium chloride 0.9% SOLN Dose: 18 mL
Route: IV FLUSH Frequency: ONE TIME ONLY
Drip rate: 0.75 ML Per: Hour IV type: IV
Start: 6/22/16 09:21 End: 6/22/16 09:21 # of Days: 1
D/C'd by: Vicki Childs Pharm Tech CPhT 6/23/16 11:23
D/C Order Origin:
Order Origin:
Ordering Physician: GARVEY DAVID J MD
Entered by: VICKI CHILDS

6/22/16 21:02 Ancillary Order#: 1000
Desc: CT ABD PELVIS IV ONLY Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Ancillary Instructions: Bed Name: 12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

6/22/16 21:02 Ancillary Order#: 900
Desc: CT CHEST W Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Comments: Chest Pain with Trauma/Injury
Ancillary Instructions: Bed Name: 12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

6/22/16 21:02 Ancillary Order#: 800
Desc: CT THORACIC WO Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Comments: Pain with Trauma/Injury
Ancillary Instructions: Bed Name: 12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

6/22/16 21:02 Ancillary Order#: 700
Desc: CT C SPINE WITHOUT Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Comments: Pain with Trauma/Injury
Ancillary Instructions: Bed Name: 12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

Encounter: 6139781 SCHWARTZ DOUGLAS R
Date of Birth: 6/02/1958

Order Type: All
Sequenced by: Entered Date

6/22/16 21:02 Ancillary Order#: 600
Desc: CT BRAIN HEAD WO Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Comments: Swelling with Trauma/Injury
Ancillary Instructions: Bed Name: 12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

6/22/16 21:02 Ancillary Order#: 500
Desc: UA - URINALYSIS Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Source: Urine
Ancillary Instructions: Bed:12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

6/22/16 21:02 Ancillary Order#: 400
Desc: LIPASE Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Ancillary Instructions: Bed:12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

6/22/16 21:02 Ancillary Order#: 300
Desc: AMYLASE Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Ancillary Instructions: Bed:12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

6/22/16 21:02 Ancillary Order#: 200
Desc: CMP-COMPLETE METABOLIC PANEL Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Ancillary Instructions: Bed:12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

NORTHEASTERN NEVADA REGIONAL HOSPITAL
All Orders History
All Dates for Encounter

Encounter: 6139781 SCHWARTZ DOUGLAS R
Date of Birth: 6/02/1958

Order Type: All
Sequenced by: Entered Date

6/22/16 21:02 Ancillary Order#: 100
Desc: CBC WITH DIFF
Start: 6/22/16 21:02
Priority: Stat Frequency: ONE TIME Occurrences: 1
Ancillary Instructions: Bed:12
Order Origin: eOrder
Ordering Physician: GARVEY DAVID J MD
Electronically Signed by: GARVEY DAVID J MD 6/22/16 21:02
Entered by: GARVEY DAVID J MD

Encounter: 6139781 SCHWARTZ DOUGLAS R
Date of Birth: 6/02/1958

Order Type: All
Sequenced by: Entered Date

Legend:

D/C = Discontinue
WBD-BSA = Weight based dose - Body Surface Area
WBD-IBW = Weight based dose - Ideal Body Weight
WBD-Weight = Weight based dose - Weight
INFO = Informational Message

Providers:

GARVEY DAVID J MD (2818)
Vicki Childs Pharm Tech CPhT (IEQ7724)
VICKI CHILDS (VCHILDS)

*** End of Report ***

NORTHEASTERN NEVADA REGIONAL HOSPITAL
PHYSICIAN ATTESTATION

Date: 8/27/19
Time: 12:33:00

PATIENT NAME: SCHWARTZ DOUGLAS R AGE: 58 SEX: MALE
PATIENT NO: 6139781 CHART NO: 000330967 HISTORY NO: 000330967
ADMISSION DATE: 06/22/16 DISCHARGE DATE: 06/23/16
FC: 04 SRV:008 EMERGENCY DEPARTMENT
PHYSICIAN: 02818 DISCHARGE STATUS: 20 EXPIRED OR DID NOT R

FINAL DIAGNOSES		POA	ICD CODE
Coded by	CRO9538		
Finalized by	CRO9538		
PRINCIPAL DIAGNOSIS			
CARDIAC ARREST, CAUSE UNSPECIFIED			I469
SECONDARY DIAGNOSES			
TRAUMATIC PNEUMOTHORAX, INITIAL ENCOUNTER			S270XXA
FLAIL CHEST, INITIAL ENCOUNTER FOR CLOSED FRA			S225XXA
FOOD IN RESPIRATORY TRACT, PART UNSPECIFIED C			T17920A
CONTUSION OF LUNG, UNSPECIFIED, INITIAL ENCOU			S27329A
UNSPECIFIED INJURY OF OTHER INTRA-ABDOMINAL O			S36899A
PEDESTRIAN ON FOOT INJURED IN COLLISION WITH			V0390XA
ACTIVITY, UNSPECIFIED			Y939
UNSPECIFIED STREET AND HIGHWAY AS THE PLACE O			Y92410
UNSPECIFIED EXTERNAL CAUSE STATUS			Y999
ESSENTIAL (PRIMARY) HYPERTENSION			I10

CPT-4 PROCEDURES	CPT-4 CODE
INCISION OF WINDPIPE	31605
INSERT EMERGENCY AIRWAY	31500

Patient: 6139781 SCHWARTZ DOUGLAS R
Admit / Discharge Date: 6/22/16 - 6/23/16

Type	Date	User	Activity
CIS	0/00/00		No records found
HIM	6/24/16	CRO9538	M 81159 NNRHCODER1 Adm Dx10 added Z041
HIM	6/24/16	CRO9538	M 81159 NNRHCODER1 Prin Dx10 added I469
HIM	6/24/16	CRO9538	M 81331 NNRHCODER1 FINALIZED BY CRO9538
HIM	7/08/16	DVI8604	O 91811 NNRHMRS2B Encounter checked out
MNL	0/00/00		No records found
PA1	6/22/16	LUE7964	6 000000000 Added Payor:MRA AUTO LIABILITY
PA1	6/22/16	LUE7964	6 000000000 Added Payor:MRA AUTO LIABILITY
PA1	6/22/16	NNRHDAYEND	F 000000000 Chrg 0103396 pstd FC 99/94
PA1	6/23/16	LUE7964	# 000000000 NPP received 06/22/2016
PA1	6/23/16	LUE7964	F 000000000 F/C CHG FROM 99 TO 94
PA1	9/02/16	CIJ9874	F 000000000 FC CHANGE 94 TO 04 PATIENTS
PA1	9/02/16	CIJ9874	1 000000000 PAYOR CHG: E/B Bills Deleted
PA1	9/02/16	CIJ9874	1 000000000 IN1 120/316 TO 300/090 ARSM(01
PA1	9/02/16	CIJ9874	1 000000000 IN1 120/316 TO 300/090 ARSM(02
PA1	9/02/16	CIJ9874	1 000000000 INS1 120/316 TO 300/090 PATIEN
PA2	0/00/00		No records found
RRX	0/00/00		No records found
TR	0/00/00		No records found
TRX	0/00/00		No records found

```
********************************   LEGEND   ************************************
*  CIS - DATE, USER, TIME, GROUP, TAB, OVR AUT, PRINT, OUTQ, ORDER #           *
*  HIM - DATE, USER, TRAN TYPE, TIME, WORKSTATION, DESCRIPTION                 *
*  ROI - DATE, USER, TRAN TYPE, TIME, WORKSTATION, DESCRIPTION                 *
*  MNL - DATE, USER, TRAN TYPE, TIME, WORKSTATION, DESCRIPTION                 *
*  PA1 - DATE, USER, TRAN TYPE, AMOUNT, DESCRIPION                             *
*  PA2 - DATE, USER, OLD HSV, NEW HSV, NEW F/C, F/C#1, F/C#2, F/C#3, F/C#4     *
*  RRX - DATE, USER, TIME, JOB NAME, SPLF NAME, RECIPIENT, FAX #               *
*  TR  - DATE, USER, TIME, DOC NAME, ACT CODE, ACT DESC, NET ID                *
*  TRX - DATE, USER, TIME, DOC NAME, RECIPIENT, FAX #                          *
*******************************************************************************
```

BT0R15A

NORTHEASTERN NEVADA REGIONAL HOSPITAL
Medication Administration Record

Page: 1
Date: 8/27/19
Time: 10:32:20

User: MQI6948
Order By: admin by, admin date,admin time Administered: ALL
Patient: SCHWARTZ DOUGLAS R Patient No.: 6139781 Sex: M Admit Date: 6-22-2016
Physician: Location:

Order No: 0000000

***** No Records found with selected criteria. *****

***** End of Report *****

Patient . . . : SCHWARTZ DOUGLAS R (6139781) Room/Bed:
History Number: 330967 DOB . . .: 06/02/1958 Age . . : 61 Y (As of: 06/23/2016)
Height: Weight:
IBW . : 0 lb 0.00 oz / 0.000 kg BSA . . .: 0.0000 CrCL. . :
Admit Date. . : 06/22/2016 Discharge Date: 06/23/2016
Physician: GARVEY DAVID J MD
Diagnosis: AUTO VS PEDESTRAIN
Allergies: Allergies Unknown

PROFILE MEDICATION ORDERS:

Order#	Medication	Dose/UOM	Route	Start/Stop Date	OrderStatus Sts @Disch	Continue Ord? (Circle One)
1704021	SALINE FLUSH 0.9 % SOLN SALINE 0.9% Frequency: ONE TIME ONLY Drip Rate: 0.75 ML/HR	18 mL	IVFLUSH	6/22/16 9:21 6/22/16 9:21	D/C 6/23/16	Yes / No
Changes:						
1703807	KETALAR (ketamine hcl) 100 MG/ KETALAR (ketamine) 100 MG/ML IN Frequency: ONE	100 MG	IV PUSH	6/23/16 :05 6/23/16 :05	D/C	Yes / No
Changes:						
1703806	DIPRIVAN (propofol) 10 MG/ML E DIPRIVAN (propofol) 1000 MG VIA Frequency: ONE	1000 MG	IV	6/23/16 :05 6/23/16 :05	D/C	Yes / No
Changes:						
1703797	ZOFRAN (ondansetron) 4 MG/2ML ZOFRAN (ondansetron) 4 MG/2 ML Frequency: ONE	4 MG	IV PUSH	6/22/16 23:04 6/22/16 23:04	D/C	Yes / No
Changes:						
1703786	DILAUDID (HYDROmorphone) 1 MG/ DILAUDID (HYDROmorphone)1 MG/ML Frequency: ONE	1 MG	IV PUSH	6/22/16 22:24 6/22/16 22:24	D/C	Yes / No
Changes:						
1703785	ZOFRAN (ondansetron) 4 MG/2ML ZOFRAN (ondansetron) 4 MG/2 ML Frequency: ONE	4 MG	IV PUSH	6/22/16 22:24 6/22/16 22:24	D/C	Yes / No

HOME MEDICATIONS:

Medication	Dose/UOM	Route	Ordered By Physician	Ordered At Discharge	Imported

DISCHARGE MEDICATIONS:

Discharge Reconciliation has not been completed or still in progress

TRANSFER MEDICATIONS:

Continued on next page

Patient . . . : SCHWARTZ DOUGLAS R (5139781) Room/Bed:
History Number: 330967 DOB . . .: 06/02/1958 Age . . : 61 Y (As of: 06/23/2016)
Height: Weight:
IBW . : 0 lb 0.00 oz / 0.000 kg BSA . . .: 0.0000 CrCL. . :
Admit Date. . : 06/22/2016 Discharge Date: 06/23/2016
Physician: GARVEY DAVID J MD
Diagnosis: AUTO VS PEDESTRAIN
Allergies: Allergies Unknown

HOME MEDICATIONS:

Medication	Dose/UOM	Route	Ordered By Physician	Ordered At Discharge	Imported

Admission/Discharge/Transfer:

Physician: Date: _____ Time: _____ Signature: _____

Attending Physician: Date: _____ Time: _____ Signature: _____

_ Please ask the Attending Physician to review the patients meds at next visit within 24 hours

Nurse. . : Date: _____ Time: _____ Signature: _____

Patient .: Date: _____ Time: _____ Signature: _____

* * * * END OF REPORT * * * *

Order By: admin by, schedule date,schedule time Administered: ALL
Patient: SCHWARTZ DOUGLAS R Patient No.: 6139781 Sex: M Admit Date: 6-22-2016
Physician: Location:

Order No: 0000000

***** No Records found with selected criteria. *****

***** E n d o f R e p o r t *****

RR0R11 C U M U L A T I V E R E P O R T Page: 1
0026 ** F I N A L ** Print date: 8/27/19
Printed by: MQI6948 Time: 10:32
NORTHEASTERN NEVADA REGIONAL HOSPITAL LABORATORY2 CLIA#29D0058654
2001 ERRECART BLVD. GEORGE MARDINI, M.D.
ELKO NV 89801

NAME: SCHWARTZ DOUGLAS R DOB: 6/02/58 STATUS : O/P / ED
PAT#: 6139781 AGE: 58 ADM DATE: 6/22/16
MR# : 000330967 SEX: M DSCHG DT: 6/23/16
ADM PHYS: GARVEY DAVID J MD

*******CHEMISTRY*******

COLLECT DT / TM	06/22/16 21:36	06/22/16 21:36	06/22/16 21:36	REFERENCE LOW - HIGH	UNITS
SODIUM			134 L	136 - 148	mmol/L
K			3.4 L	3.5 - 5.2	mmol/L
CHLORIDE			100	98 - 108	mmol/L
BICARB			25.1	21 - 32	mmol/L
ANIONGAP			8.9	6 - 18	
GLUCOSE			127 H	70 - 100	mg/dl
BUN			15	7 - 24	mg/dl
CREAT			1.3	0.6 - 1.3	mg/dl
BUN/CREA			11.5 L	12.0 - 20.0	ratio
EGFR			60 L	70	mL/min/1.73m
SGOT-AST			301 H	9 - 35	U/L
CA			8.3 L	8.8 - 10.5	mg/dl
ALBUMIN			4.1	3.4 - 5.0	g/dl
PROTEIN			7.4	6.4 - 8.2	g/dl
GLOBULIN			3.3	2.3 - 3.5	
A/GRATIO			1.2	1.1 - 1.9	
T BIL A			0.4	0.0 - 1.0	mg/dl
ALK PHOS			55	46 - 116	U/L
AMYLASE		87		25 - 115	U/L
SGPT-ALT			226 H	23 - 65	U/L
LIPASE	397 H			73 - 393	U/L
REPORTED DT / TM	06/22/16 21:57	06/22/16 21:57	06/22/16 21:57		

NAME: SCHWARTZ DOUGLAS R
PAT#: 6139781
MR# : 000330967

DOB: 6/02/58
AGE: 58
SEX: M

STATUS : O/P / ED
ADM DATE: 6/22/16
DSCHG DT: 6/23/16
ADM PHYS: GARVEY DAVID J MD

*******HEMATOLOGY********

		REFERENCE LOW - HIGH	UNITS
COLLECT DT	06/22/16		
TM	21:36		
WBC	13.0 H	4.8 - 10.8	X 10(3)
NEUTS	64.3	41.7 - 82.3	%
LYMPHS	27.2	15.0 - 51.1	%
MONOS	6.0	0.0 - 11.7	%
EOSINS	1.7	0.0 - 5.5	%
BASOS	0.2	0.0 - 3.0	%
NE#	8.4	2.5 - 9.0	X 10(3)
LY#	3.5	0.9 - 4.8	X 10(3)
MO#	0.8	0.1 - 0.9	X 10(3)
EO#	0.2	0.0 - 0.7	X 10(3)
BA#	0.0	0.0 - 0.2	X 10(3)
RBC	4.89	4.7 - 6.1	X 10(6)
HGB	15.5	14.0 - 18.0	GM/DL
HCT	42.8	42.0 - 54.0	%
MCV	87.5	80.0 - 99.0	FL
MCH	31.7	27.0 - 34.0	PG
MCHC	36.2 H	31.0 - 36.0	G/%
RDW	12.1	11.5 - 15.2	%
PLATELET	234	140 - 440	X 10(3)
MPV	10.1	6.5 - 12.0	FL

REPORTED DT 06/22/16
TM 21:42

RR0R11
0026
Printed by: MQI6948
NORTHEASTERN NEVADA REGIONAL HOSPITAL
2001 ERRECART BLVD.
ELKO NV 89801

C U M U L A T I V E R E P O R T
** F I N A L **

Print date: 8/27/19
Time: 10:32
LABORATORY2 CLIA#29D0058654
GEORGE MARDINI, M.D.

NAME: SCHWARTZ DOUGLAS R
PAT#: 6139781
MR# : 000330967

DOB: 6/02/58
AGE: 58
SEX: M

STATUS : O/P / ED
ADM DATE: 6/22/16
DSCHG DT: 6/23/16
ADM PHYS: GARVEY DAVID J MD

******URINALYSIS********

		REFERENCE LOW - HIGH	UNITS
COLLECT DT	06/22/16		
TM	23:17		
COLOR	YELLOW		
CLARITY	CLEAR		
UR GLUC	NEGATIVE	NEG	
UR BILI	NEGATIVE	NEG	
UR KETON	NEGATIVE	NEG	
UR PH	5.5	5.0 - 8.0	
UR PROT	TRACE	NEG	
UROBILIN	0.2	NORM	MG/DL
NITRITE	NEGATIVE	NEG	
BLOODHGB	3+	NEG	
LEUK EST	NEGATIVE	NEG	
UR DIP	NO	.....	
UR WBC	0-2		PER HPF
UR RBC	20-30		PER HPF
MUCUS	TRACE		PER HPF
REPORTED DT	06/22/16		
TM	23:30		

SOURCE INFORMATION:
6/22/16 21:02 UA Urine clean catch

NAME: SCHWARTZ DOUGLAS R
PAT#: 6139781
MR# : 000330967

DOB: 6/02/58
AGE: 58
SEX: M

STATUS : O/P / ED
ADM DATE: 6/22/16
DSCHG DT: 6/23/16
ADM PHYS: GARVEY DAVID J MD

*******SEROLOGY*********

		REFERENCE LOW - HIGH	UNITS
COLLECT DT 06/22/16 TM 23:17			
URINE SG	1.010	1.005 - 1.030	
REPORTED DT 06/22/16 TM 23:30			

SOURCE INFORMATION:
6/22/16 21:02 UA Urine clean catch

NORTHEASTERN NEVADA REGIONAL HOSPITAL

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

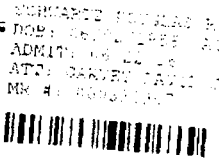
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer's or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.



8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS / OTHER HEALTH CARE PROVIDERS:** I understand that most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (P.A.'s), Nurse Practitioners (N.P.'s), and Certified Registered Nurse Anesthetists (C.R.N.A.'s) are independent contractors and are not employees, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

    I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

    ☐ I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize Northeastern Nevada Regional Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

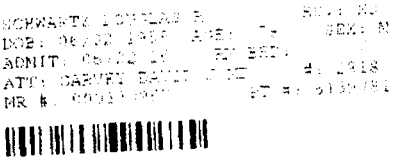
12. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

13. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

    ☐ I object to having my name, location and general condition listed in the facility directory.

14. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

15. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.



16. **CONSENT TO PHOTOGRAPH:** I consent to photographs, video or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of your medical record.

17. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

- ☐ I have executed an Advance Directive
- ☐ I have not executed an Advance Directive
- ☐ I would like to formulate an Advance Directive and receive additional information

18. **OTHER ACKNOWLEDGEMENTS:**

a. **Personal Valuables:** I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables and that the hospital shall not be liable for the loss of such valuables unless deposited with the hospital for safekeeping. The liability of the hospital for loss of personal property that is deposited for safekeeping is limited to $5000 or the maximum required by law. I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/Pods and all other such devices.

b. **Smoke Free Facility Policy:** The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

c. **Weapons / Explosives / Drugs:** I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

19. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

20. **KENTUCKY ONLY:** In compliance with KRS 214, the undersigned has received AIDS information. ☐ Yes ☐ No

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Duane Schwartz 6/22/16

Signature of Patient or Legal Representative for Health Care if Other Than Patient — Date / Time

Relationship of Representative

Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent

Signature of Witness — Date / Time 6/22/16

Northeastern Nevada Regional Hospital
2001 Errecart Blvd. • Elko, Nevada 89801

CARDIAC ARREST RECORD

WHITE - CHART COPY
YELLOW - CHARGE COPY
PINK - COURM COPY

PATIENT NAME: Douglas R. Schwartz PAGE ____ OF ____

DATE: 06-23-16 TIME OF ARREST: 0035 CPR INITIATED BY: ____ LOCATION OF ARREST: NNRH ER-Bed 12 DIAGNOSIS: Cardiac Arrest due to Asphyxiation

ED ARRIVAL TIME: 6-22-16 2353 ATTD PHYS NOTIFIED TIME ____ BY ____ FAMILY NOTIFIED TIME: 0145 BY: Dr. Garvey

TEAM MEMBERS (Name and Title)
1) David Garvey, MD 2) Donna Kevitt, RN 3) Sue Olson, RN 4) Cyndy Fus RN
5) Nancy Abrahms, ER Tech 6) Bonnie, RN-REACH Air 8) Barry RN-REACH 7) Tom R.T. Paul EMS Ward

TYPE OF ARREST (CHECK ALL APPROPRIATE)
☐ RESPIRATORY ☐ V-FIB
☐ CARDIAC ☐ ASYSTOLE
☐ WITNESSED ☐ EMD
☐ UNWITNESSED ☐ OTHER
☐ ECG MONITORED
☐ V/TACH.

INITIAL ASSESSMENT
RESPIRATIONS
☐ PRESENT ☐ ABSENT ☐ AGONAL
CAROTID PULSE
☐ PRESENT ☐ ABSENT

INTUBATION
SIZE: ____ FIO$_2$ ____
TIME: ____
BY WHOM: ____
BILAT BS: ☐ PRESENT ☐ ABSENT

☒ IV PRESENT - Site 20g (R) hand
☒ IV STARTED - Site 20g (R) wrist
NEEDLE SIZE: ____
SOLUTION: NS
BY WHOM: EMS (1) / Paramedic Student (1) (Kristina)

TIME	RESPIRATION	PULSE	RHYTHM	BP	JOULES	EXTERNAL PACING	EPI IV or ETT	ATROPINE IV or ETT	LIDOCAINE			DOPAMINE (mg/min)			PH	PO$_2$	PCO$_2$	COMMENTS/LAB
0018	Ketamine 180 mg IVP, Rocuronium by Reach air nurse Bonnie RN																	
0020	ET tube attempted / unsuccessful Started bagging 7.5 tube by Barry RN																	
0033	" " " / unsuccessful " " 7.5 tube / 9 tube by Barry RN																	
0035	CPR in progress. HR 36 O_2 sat 37% while bagging Brady																	
0036	King airway placed 225/136 O_2 sat to 79% King placed by Barry RN																	
0040	HR 120 O_2 sat 82% 249/140																	
0044	ET tube attempted by Dr Garvey / unsuccessful / started bagging																	
0047	" " " " " / " " / started bagging																	
0050	O_2 sat 65% CPR continues asystole																	
0052	ET tube insertion attempted by Barry (Reach) unsuccessful 55-60% O_2 sat / bagging																	
0053	O_2 sat 50% unsuccessful c̄ ET tube insertion CPR continue																	
0054	HR 147 42% O_2 while bagging 221/148																	
0057	NPA placed by Dr. Garvey																	
0058	O_2 sat 69% c̄ NPA CPR continues asystole																	
0102	75% O_2 sat HR 122																	
0104	65% O_2 sat 202/143 121 HR																	
0108	Cric attempted by Dr. Garvey																	
0113	O_2 sat 60% asystole continuing CPR																	

continuing throughout the code

OUTCOME
☐ SUCCESSFUL DISPOSITION
☒ UNSUCCESSFUL Code Terminated At 0133 (time)
BY WHOM: Garvey MD

SIGNATURE OF RECORDER X Silvia Wines EMT
SIGNATURE OF MED NURSE X Donna Kevitt, RN
SIGNATURE OF MD IN CHARGE X [signature]

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

CQI/RM COPY

SUMMARY OF CQI/RM MONITORING AND EVALUATION

Findings: What did you see (find)? What are the statistical numbers?
Conclusions: What decisions did you make from the findings? What stories do the finding tell us?
Recommendations: What do you think needs to be done? Actions: How are you going to make improvements?
Follow-up: What did you find when reviewing this at a later date? What did you do to make sure the actions were implemented.

ASPECT OF CARE /SERVICE (INDICATOR/STUDY)	% THRESHOLD DESIRED	% THRESHOLD ATTAINED	FINDINGS-CONCLUSIONS	RECOMMENDATIONS-ACTIONS	FOLLOW-UP
CODE BLUE 1.Supplies and equipment are immediately available and operational 2.Code response immediate by at least four qualified personnel 3.ACLS protocol followed	100% 100% 100%				

CONFIDENTIAL: NOT PART OF MEDICAL RECORDS

DEPARTMENT _____ DATE _____ REVIEWER _____

WHITE - CHART COPY
YELLOW - CHARGE COPY
PINK - CQI/RM COPY

PATIENT NAME Douglas R. Schwartz

PAGE ______ OF ______

DATE 06-23-16 TIME OF ARREST: ______ CPR INITIATED BY: ______ LOCATION OF ARREST: ______ DIAGNOSIS: ______

ED ARRIVAL TIME: ______ ATTD PHYS NOTIFIED TIME ______ BY ______ FAMILY NOTIFIED TIME ______ BY ______

TEAM MEMBERS (Name and Title)

1) ______ 2) ______ 3) ______ 4) ______

5) ______ 6) ______ &) ______ *) ______

TYPE OF ARREST (CHECK ALL APPROPRIATE)

☐ RESPIRATORY ☐ V-FIB
☐ CARDIAC ☐ ASYSTOLE
☐ WITNESSED ☐ EMD
☐ UNWITNESSED ☐ OTHER
☐ ECG MONITORED
☐ V/TACH.

INITIAL ASSESSMENT

RESPIRATIONS
☐ PRESENT ☐ ABSENT ☐ AGONAL
CAROTID PULSE
☐ PRESENT ☐ ABSENT

INTUBATION

SIZE: ______ FIO_2 ______
TIME: ______
BY WHOM: ______
BILAT BS: ☐ PRESENT ☐ ABSENT

☐ IV PRESENT - Site ______
☐ IV STARTED - Site ______
NEEDLE SIZE: ______
SOLUTION: ______
BY WHOM: ______

TIME	RESPIRATION (S= Spontaneous, A=Assisted)	PULSE (S= Spontaneous, A=Assisted)	RHYTHM	BP	JOULES	EXTERNAL PACING	SINGLE DOSES: EPI IV or ETT	ATROPINE IV or ETT	LIDOCAINE			DRIP MEDS: DOPAMINE (mcg/min)			ABG: PH	PO_2	POC_2		COMMENTS/LAB
0116	O2 sat 37% HR 81 BP 126/95																		
0117	CPR started no pulse O2 44% HR 33																		
0119	O2 sat 36%																		
0120	Asystole. No O2 cyanotic																		
0122	52% O2 sat. CPR still in progress.																		
0124	61% O2 sat. CPR still in progress Gastric expansion.																		
0125	49% O2 sat. CPR continues																		
0128	64% O2 sat. CPR continues																		
0129	Needle decompression - Right																		
0131	Needle decompression - Left/Right chest																		
0133	Stop compressions time of death 0133																		

During procedure - suctioning performed. Copious amounts of vomitus from posterior pharynx.

OUTCOME

☐ SUCCESSFUL DISPOSITION ______

☒ UNSUCCESSFUL Code Terminated At 0133 (time)

BY WHOM: Garvey MD

SIGNATURE OF RECORDER X Sylvia Wines, EMT
SIGNATURE OF MED NURSE X [illegible], RN
SIGNATURE OF MD IN CHARGE X [illegible]

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

NNRH Northeastern Nevada Regional Hospital
2001 Errecart Blvd. • Elko, Nevada 89801

CARDIAC ARREST RECORD

CQI/RM COPY

SUMMARY OF CQI/RM MONITORING AND EVALUATION

Findings: What did you see (find)? What are the statistical numbers?
Conclusions: What decisions did you make from the findings? What stories do the finding tell us?
Recommendations: What do you think needs to be done? Actions: How are you going to make improvements?
Follow-up: What did you find when reviewing this at a later date? What did you do to make sure the actions were implemented.

ASPECT OF CARE /SERVICE (INDICATOR/STUDY)	% THRESHOLD DESIRED	% THRESHOLD ATTAINED	FINDINGS-CONCLUSIONS	RECOMMENDATIONS-ACTIONS	FOLLOW-UP
CODE BLUE					
1.Supplies and equipment are immediately available and operational	100%				
2.Code response immediate by at least four qualified personnel	100%				
3.ACLS protocol followed	100%				

CONFIDENTIAL: NOT PART OF MEDICAL RECORDS

DEPARTMENT _____ DATE _____ REVIEWER _____

ID: Patient 0207
Patient Mode: Adult
06/23/2016 01:58:07AM
Dept:
Unit:
S/N: AI11K001505
SW Rev: 02.01.27.00

TREND SUMMARY REPORT
Name:
ID: Patient 0206
Patient Mode: Adult
Start Time:
06/23/2016 12:06:14AM
Total Trend Events: 27
Dept:
Unit:
S/N: AI11K001505
SW: 02.01.27.00

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FiCO2 mmHg
01:45	???	???	OFF	???	???	???
01:40	???	???	OFF	???	???	???
01:35	???	???	OFF	???	???	???
01:32	134	49	149/55(88)	---	0	0
01:30	---	60	OFF	---	0	0
01:25	---	64	OFF	---	0	0
01:20	36	39	OFF	---	0	0
01:15	119	46	126/95(106)	---	0	0
01:15	123	41	OFF	---	0	0

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FiCO2 mmHg
01:14	124	60	202/125(150)	---	0	0
01:10	126	52	OFF	---	0	0
01:05	120	71	OFF	---	0	0
01:00	121	62	207/143(165)	---	0	0
01:00	124	69	OFF	---	0	0
00:55	128	43	OFF	46	OFF	OFF
00:50	126	62	OFF	57	OFF	OFF
00:45	118	73	221/148(173)	23	OFF	OFF
00:45	119	75	OFF	30	OFF	OFF

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M
00:41	125	81	249/140(178)	31
00:40	111	77	OFF	34
00:35	36	37	OFF	35
00:30	124	76	225/136(166)	57
00:30	127	76	OFF	57
00:25	108	92	OFF	27
00:20	97	83	OFF	22
00:15	73	99	OFF	19
00:10	66	97	OFF	17

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

TREND SUMMARY REPORT

Name:
ID: Patient 0206
Patient Mode: Adult
Start Time:
06/23/2016 12:06.14AM
Total Trend Events: 27
Dept:
Unit:
S/N: AI11K001505
SW: 02.01.27.00

TIME 24HR	HR/PR BPM	SpO2 %	NIBP mmHg	BR/RR Br/M	EtCO2 mmHg	FiCO2 mmHg
01:45	???	???	OFF	???	???	???
01:40	???	???	OFF	???	???	???
01:35	???	???	OFF	???	???	???
01:32	134	49	149/55(88)	---	0	0
01:30	---	60	OFF	---	0	0
01:25	---	64	OFF	---	0	0
01:20	36	39	OFF	---	0	0
01:15	119	46	126/95(106)	---	0	0
01:15	123	41	OFF	---	0	0
01:14	124	60	202/125(150)	---	0	0
01:10	126	52	OFF	---	0	0
01:05	120	71	OFF	---	0	0
01:00	121	62	207/143(165)	---	0	0
01:00	124	69	OFF	---	0	0
00:55	128	43	OFF	46	OFF	OFF
00:50	126	62	OFF	57	OFF	OFF
00:45	118	73	221/148(173)	23	OFF	OFF
00:45	119	75	OFF	30	OFF	OFF
00:41	125	81	249/140(178)	31		
00:40	111	77	OFF	34		
00:35	36	37	OFF	35		
00:30	124	76	225/136(166)	57		
00:30	127	76	OFF	57		
00:25	108	92	OFF	27		
00:20	97	83	OFF	22		
00:15	73	99	OFF	19		
00:10	66	97	OFF	17		

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

Organ and Tissue Notification:

Intermountain Organ Recovery System Must be notified of
ALL Deaths at 1-800- 83-DONOR

Spoke with : Elizabeth Gill
Time: 0324 – returned call at 0335
Date: 3-26-16

Contacted by: _____ (Staff Signature)

IORS rules medically eligible: ____ YES ✓ NO

Explain: pt not eligible, would like to see heart, lung investigation

The option of Organ and Tissue Donation has been presented:

N/A Family wishes to pursue option of donation

Family declines option of donation

Next of Kin signature: N/A Relationship: N/A

Completed by: _____ (Staff signature)

Northeastern Nevada Regional Hospital
2001 Errecart Blvd, Elko, NV 89801

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
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MR #: 000330967 PT #: 6139781

NORTHEASTERN NEVADA REGIONAL HOSPITAL

PATIENT TRANSFER

Name: SCHWARTZ DOUGLAS R Patient Number: 6139781

Age: 58 Date of Birth: 06/02/1958 Sex: M MR No.: 000330967

Date: 6.22.16

Section: Patient Consent (This section must be signed by the patient and / or responsible party.)

I acknowledge the patient will be transferred to: University of Utah
The risks and benefits involved in the transfer have been explained to me, as well as the risks and benefits of foregoing this transfer, and I accept full responsibility for such transfer. I acknowledge that I have received a medical screening for my condition. I give consent to this hospital to release all of my medical records and x-ray films, including information related to HIV, drug / alcohol abuse, or psychiatric treatment.

Transported Via: ☐ ALS ☐ BLS ☐ POV Against Medical Advice
☒ ~~Air~~ Evacuation ☐ POV Reach Air

I elect to provide my own transportation and decline medical transportation for the transfer. I am aware of the risks and release the physician, this hospital, and its agents from any liability related to transportation to the receiving facility.

n/a	n/a	
Patient / Responsible Party's Signature	Relationship	Date

Summary of Risks and Benefits:

Risk of Transfer:

☒ Worsening of medical condition including risk to unborn/ newborn in the case of pregnancy. Disease specific risks: Death

☒ Transportation Risks plane crash

☐ Other: _____

Benefits of Transfer:

☒ Immediate access to specialized practitioner / equipment / monitoring, specifically: Trauma

☐ Bed capacity that is not currently available at this facility.

☒ ~~Continuity of care~~

☐ Other: _____

I release the physician, this hospital and its agents from any liability as a result of this transfer.

X Diane Schwartz	Spouse	6.22.16
Signature of Responsible Party	Relationship	Date
[illegible], RN	Nurse	6.22.16
Signature of Witness	Relationship	Date

Section II: Patient Refusal for Transfer

This risk and benefits involved in the transfer have been explained to me, as well as the risks and benefits of foregoing this transfer, and I have decided to decline the transfer. I accept full responsibility for this decision. I release the physician, this hospital, and its agents from any liability as a result of **NOT** being transferred.

Signature of Responsible Party N/A	N/A	Date
Signature of Witness	Relationship	Date

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 ROOM/BED /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PAT #: 6139781

SUMMIT AIR AMBULANCE

Flight # 16-14083 (16-14060)

Transport Info

Sending Facility _____

Unit _____ Bed _____

Physician _____

Receiving Facility _____

Bed _____

Physician _____

Patient _____

Weight 92 CODE STATUS _____

Chief complaint _____

Called back with "GO" _____

Depart /arrive sending 1145-1155

Arrive bedside 1157

Called for ambulance _____

Ambulance arrives _____

Walk out of referring _____

Loaded and leaving referring _____

Arrive airport _____

Lift off from airport _____

Destination airport _____

Loaded and leaving dest. airport _____

Arrived receiving _____

Arrive bedside / handoff _____

Depart receiving _____

Past Medical History _____

Allergies: _____

Time	Drug / Fluids	Dose
	Dilaudid	

Time	Drug / Fluids	Dose

Time	HR	B/P	Sat	Pain

10% Albumin 97%

REACH Flight Crew
Elko EMS
David Garvey, MD
Donna Keuith, RN
Sue Olson, RN
Tom Evers, RT

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

deal Bodyweight vT calc: male: 50 + 2.3 for every inch > 60 inches. Female: 45.5 + 2.3
T calc: 6-8ml's / kg of ideal BW, 5ml/kg for sepsis.
'ent Check: Turn on > clear alarm > Select & scroll to "Vent Check" > select.
'ressure Cntl Setup: Mode - SIMV, Breath Type - Pressure, PC = 15, PS = 10, PEEP = 5. Add the
'C and PEEP together and that should ~ equate to PIP. This is a safe starting point for adults
nd peds. Adjust fIO2 and/or PC up or down PRN to increase sPO2 or change ETCO2.
'o increase sPO2 add more PC. To maniplute ETCO2 manipulate PC.
iPAP Setup: On > select New Pt. > select Pt. Size > select Intubate > Breath Mode =CPaP + PS
reath Type = Pressure > Adjust PS and PEEP to desired values > select ventilate.
Jarms: Set high 10 point above PIP and low 10 points below PIP.

Epi 1mg
Keta
RoC

Keta RoC

0018 0018

Tube 0020 - No

0023, unsuccessful

0033 unsuccessful 7.5

0033 unsuccessful 9.

0035 CPR

0036 king 1057 225/136 47% 79% (Paul)
resp O_2

0040 1457 $82O_2$ Resp25 249/140

0044 unsuccessful

0047 unsuccessful

0050 O_2 65%

0052 unsuccessful 2 55% , 60%

0053 50% O_2 unsuccessful

0054 127% $42O_2$ 221/148

NPA 0057 (69% 0058)

0102 ♡172
75%

0104 suctions 65 O_2 207/143 121♡

0108 Crik in prog.

0113 O_2 60 (gone up)

0116 $37O_2$ 81♡ 126/95

0117 CPR started no pulse
$44 O_2$ 33♡

0119 360_2

0120 asystoly - no O_2 cyanotic

0122 52 CPR still in progress

0124 610_2 CPR still gastric extention

0125 490_2 CPR

0128 640_2

0129 needle right no output

0131 decompression L & R ← little air

0133 stop compressions

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

SUMMIT AIR AMBULANCE

Flight # 16-14083 (16-14060)

Transport Info

Sending Facility _____

Unit _____ Bed _____

Physician _____

Receiving Facility _____

Bed _____

Physician _____

Patient _____

Weight 92 CODE STATUS _____

Chief complaint _____

Called back with "GO" _____

Depart /arrive sending ~~1132~~ 1145-1155

Arrive bedside 1157

Called for ambulance _____

Ambulance arrives _____

Walk out of referring _____

Loaded and leaving referring _____

Arrive airport _____

Lift off from airport _____

Destination airport _____

Loaded and leaving dest. airport _____

Arrived receiving _____

Arrive bedside / handoff _____

Depart receiving _____

Past Medical History _____

Allergies: _____

Time	Drug / Fluids	Dose
	Dilaudid	

Time	Drug / Fluids	Dose

Time	HR	B/P	Sat	Pain

10% Nrebulo = 97%

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

Ideal Bodyweight vT calc: male: 50 + 2.3 for every inch > 60 inches. Female: 45.5 + 2.3
T calc: 6-8ml's / kg of ideal BW, 5ml/kg for sepsis.
Vent Check: Turn on > clear alarm > Select & scroll to "Vent Check" > select.
Pressure Cntl Setup: Mode - SIMV, Breath Type - Pressure, PC = 15, PS = 10, PEEP = 5. Add the
PC and PEEP together and that should ~ equate to PIP. This is a safe starting point for adults
nd peds. Adjust fIO2 and/or PC up or down PRN to increase sPO2 or change ETCO2.
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reath Type = Pressure > Adjust PS and PEEP to desired values > select ventilate.
Alarms: Set high 10 point above PIP and low 10 points below PIP.

Epi 1mg
Keta
RoC

Keta 180mg
RoC

0018 0018

Tube 0020 - No

0023 unsuccessful

0033 unsuccessful 7.5

0033 unsuccessful 9.

0035 CPR

0036 King 1057 225/136 47% 79% (Paul)
Resp O2

00[illegible] 1[illegible]07 82% Resp25 249/140

0044 unsuccessful

0047 unsuccessful

0050 O_2 65%

0052 unsuccessful 2 55% , 60%

0053 50% O_2 unsuccessful

0054 127♀ 42% O_2 221/148

NPA 0057 (69% 0058.)

0102 ♥172
75%

0104 suctions 65% O_2 207/143 121♥

0108 Crik in prog.

0113 O_2 60 (gyrus up)

PHYSICIAN/QUALIFIED MEDICAL PERSONNEL STATEMENT
MEDICAL NECESSITY AND REASONABLENESS FOR AIR MEDICAL TRANSPORT

As the medical professional involved in the air ambulance transport provided by _____ (Air ambulance supplier)

Please complete this form in its entirety in order to justify why air transportation was required instead of ground transport.
(This information will be provided to third party payors.)

Patient Data

Please Complete Each Sec

SCHWARTZ DOUGLAS R HSV: ED
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MR #: 000330967 PT #: 6139781

Call # _____ Patient Name _____

Date of Service _____ Date of Birth _____

Diagnosis or Potential Diagnosis of Patient _____

Requesting Source

Requested By (full name and title) DR David Garvey

Requesting Entity (name and contact) NNRtt

Accepting-Receiving Hospital University of Utah

Requesting Air Transport General Criteria

- ☐ The Patient's condition is too critical to allow for longer transport time by ground
- ☐ Patient requires higher level of care ☐ Facility on Divert
- ☐ Weather / road conditions prohibit ground transport
- ☑ The patient's condition is too unstable for a ground unit and requires critical care abilities of the air ambulance transport team.

Specify care:

☐ Intubated ☐ ETCO2 Monitoring ☐ TPA Infusion ☐ EKG ☐ IABP ☐ Fetal Monitoring ☐ Neonatal Isolette ☐ Glidescope Intubation

☐ Other _____ ☐ IV Medications, titrated drips (specify medications) _____

Mechanism of Injury

☑ Patient requires immediate and rapid transport due to the nature and or severity of the illness / injury
(Please check the Mechanism(s) of Injury)

- ☐ Vehicle rollover / ejection / high speed collision
- ☑ Vehicle striking pedestrian > 10 mph
- ☐ Falls from > 15 feet
- ☐ Motorcycle victim ejected at > 20 mph
- ☐ Near drowning injuries
- ☐ Major crush injuries
- ☐ AMI / Chest pain
- ☐ Other (specify) _____
- ☐ Symptomatic hypotension
- ☐ High-risk obstetrical conditions
- ☐ Penetrating trauma
- ☐ Spinal Cord / spinal column injury
- ☐ Partial or total amputation
- ☐ 2 or more long bone fx. Pelvic fx,
- ☐ Altered level of consciousness
- ☐ Patient experiencing neurological impairment (CVA, Stroke, Seizures)
- ☐ Symptomatic hypertension
- ☐ Major burns of the body surface area; burns involving the face, hands, feet, perineum; burns with significant respiratory involvement; major electrical or chemical burn
- ☐ Same vehicle fatality

Specialty Care Required

☐ Specialty Care likely required for this patient's immediate care. **(Please check the appropriate physician consultation or skill likely required)**

- ☐ Cardiologist
- ☐ Cardiothoracic Surgeon
- ☐ Vascular Surgeon
- ☐ Neurologist
- ☐ Neurosurgeon
- ☐ Neuroradiologist
- ☐ Pulmonologist
- ☐ Gastroenterologist
- ☐ Neonatologist
- ☐ Pediatric Intensive Care Specialist
- ☐ Burn Specialist
- ☐ Trauma Surgeon
- ☐ ICU Not Available at referring
- ☐ Other (specify) _____

I order/certify that this patient's condition requires Air Ambulance Transportation due to the time or geographical factors. Such certification is to the best of my professional ability. By so certifying, I am NOT assuming any financial responsibility for the transportation services provided by: _____ (Air ambulance supplier)
The ambulance supplier agrees that it will bill only the patient or any applicable third party payor for any transportation cost.

Signature/Date X Dsmith RN Name (print) Donna Hewitt RN

☐ EMT ☐ Paramedic ☐ Trained First Responder ☐ Physician ☐ Physician Assistant ☑ Nurse Practitioner ☐ R.N. per VO/TO of Dr. _____

Do you (requesting source) have a financial/employment relationship with the ambulance supplier transporting patient?
Please Indicate ☐ Yes ☑ No

Revision Date 1/1/2013

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

Patient Nam **ervices Signature form**

Transport Date: _____ **Transport #:** _____

Privacy Practi signer acknowledges that **REACH Air Medical Services, LLC. (REACH)** provided a copy of its Nc r party with instructions to provide the Notice to the patient. ***A copy of this form is valid as an ori**

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: If the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by **REACH** now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by **REACH**, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to **REACH** any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to **REACH**. I authorize **REACH** to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to **REACH** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by **REACH**, now, in the past, or in the future.

If the patient signs with an "X" or other mark, a witness should sign below

X _____ _____ X _____ _____
Patient Signature or Mark | Date | Witness Signature | Date

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section only if the patient is physically or mentally incapable of signing.

On the line below, explain the circumstances that make it impractical for the patient to sign:

Patient unable to Sign Multi Trauma

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to the patient by **REACH** now or in the past, (or in the future, where permitted). By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include only the following individuals:

- ☐ Patient's legal guardian
- ☑ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges for the patient's treatment or exercise other responsibility for the patient's affairs
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services or sending facility) but furnished other care, services, or assistance to the patient

x Diane Schwartz 6/22/16 Diane Schwartz
Representative Signature | Date | Printed Name

Printed Address of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section only if: (1) the patient was physically or mentally incapable of signing, and (2) No authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)
My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

On the line below, explain the circumstances that make it impractical for the patient to sign:

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____ _____ _____ _____
Signature of Crewmember | Title | Date | Printed Name of Crewmember | Title of Crewmember

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility at the date and time indicated above. **My signature is not an acceptance of financial responsibility for the services rendered to this patient.**

X _____ _____ _____ _____ _____
Signature of Receiving Facility Representative | Title | Date | Printed Name of Receiving Facility Representative | Title

Elko County Ambulance Physician Certification for Transport

SCHWARTZ DOUGLAS R HSV: ED
DOB: 06/02/1958 AGE: 58 SEX: M
ADMIT: 06/22/16 RM/BED: /
ATT: GARVEY DAVID J MD #: 2818
MR #: 000330967 PT #: 6139781

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport: (Indicate number of trips on this date and for all repetitive trips in the 60-day range as noted below.)

Origin: University of Utah

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: Multi System

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

Multi System TRAUMA

2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair

3) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement
☐ Danger to self/others ☐ IV meds/fluids required ☐ Patient is combative ☐ Need or possible need for restraints
☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self administer
☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport
☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked,** I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:***

_____

Signature of Physician* or Healthcare Professional

6.22.16
Date Signed
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

Donna Lovitt RN
Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☒ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner

Attestation Statement – Authorized PCS Signers

Name of Patient: _____ Patient ID Number: _____

"I, _____[print full name of the physician/practitioner that signed the PCS or other document in question], hereby attest that the document dated _____[date of signing PCS or other document in question] accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D., D.O., RN, etc.] when I certified that the above listed Medicare beneficiary required ambulance transport. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Signed

Donna Kevitt

Printed Name

10-22-16

Date

statrad®
Leading Teleradiology

Northeastern Nevada Regional Hospital

Patient:	**SCHWARTZ, DOUGLAS (Male)**	DOB:	06/02/58
MR #:	**330967**	Status:	ER
Date:	06/22/16 22:37	Slices:	0
History:	Study: CT BRAIN HEAD WO Reason: Swelling with Trauma/Injury		
Priors:			
Tech:	Exam request generated by HL7 interface		
Exams:	CT HEAD Without Contrast		
Contrast:			

Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900, 61397810001000

Final Report

EXAM: CT head without contrast.

CLINICAL INDICATION: Auto versus pedestrian with blunt force trauma to the head.

TECHNIQUE: Multiple contiguous axial images were obtained from skull base to vertex without the use of intravenous contrast.

COMPARISON: None.

FINDINGS: The ventricular system is normal in size and configuration without midline shift or ventriculomegaly. Symmetrical hyperdensity along the bilateral tentorium may represent hemoconcentration. Trace subdural blood products would be considered much less likely but not entirely excluded. There is no CT evidence of acute cortical infarction. The bilateral orbital contents are grossly unremarkable. Scattered paranasal sinus mucosal thickening is present with possible trace right maxillary sinus fluid level. Evaluation for facial fracture is limited with the provided technique. There is no significant mastoid or tympanic cavity fluid. There is no depressed calvarial fracture.

IMPRESSION:

1. Symmetrical hyperdensity along the bilateral tentorium likely reflects hemoconcentration/dehydration. Trace subdural blood products would be considered much less likely. If indicated, followup head CT could be performed to assess for stability.

2. No midline shift or depressed calvarial fracture.

3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

Study ready at 22:40 and initial results transmitted at 23:29

Critical Value Communications

Clear Time	Type	Notes
06/22/16 23:48	Verify Receipt	Verified receipt with Dr. Garvey on 06/22 23:47 (-07:00)

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Leading Teleradiology

Northeastern Nevada Regional Hospital

Patient:	**SCHWARTZ, DOUGLAS (Male)**	DOB:	06/02/58
MR #:	**330967**	Status:	ER
Date:	06/22/16 22:22	Slices:	0
History:	Study: CT THORACIC WO Reason: Pain with Trauma/Injury		
Priors:			
Tech:	Exam request generated by HL7 interface		
Exams:	CT T SPINE		

Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900, 61397810001000

Final Report

EXAM: CT thoracic spine

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the chest and back, back pain.

TECHNIQUE: Helical CT was performed through the thoracic spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS: Thoracic alignment is anatomic without spondylolisthesis and the thoracic vertebral body heights are generally well preserved with the exception of mild ventral wedging at T12. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformities. Acute nondisplaced pedicle fractures not excluded. Consider MRI for further evaluation as indicated. The thoracic facets articulate normally. Multilevel mild loss of intervertebral disc space height with small central disc protrusions are noted without significant bony spinal canal stenosis. Prominent ventral osteophytosis is present at T9/T10 on the right. Heterotopic ossification is seen within the interspinous ligament in the mid/lower thoracic spine.

Please see CT chest report for further detail regarding intrathoracic findings.

IMPRESSION:

1. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformity. Acute nondisplaced pedicle fractures not entirely excluded. Correlate for tenderness to palpation at this level. MRI could further evaluate as indicated.

2. Mild thoracic spondylosis without significant spinal canal stenosis.

3. Mild ventral wedging of T12 is likely chronic/physiologic.

4. Please see CT chest report for further detail.

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

Study ready at 22:27 and initial results transmitted at 23:16

Critical Value Communications

Clear Time	Type	Notes
06/22/16 23:48	Verify Receipt	Verified receipt with Dr. Garvey on 06/22 23:47 (-07:00)

statrad®
Leading Teleradiology

Northeastern Nevada Regional Hospital

Patient:	**SCHWARTZ, DOUGLAS (Male)**	DOB:	
MR #:	**330967**	Status:	ER
Date:	06/22/16 22:19	Slices:	0
History:	Study: CT ABD PELVIS IV ONLY		
Priors:			
Tech:	Exam request generated by HL7 interface		
Exams:	CT ABDOMEN & PELVIS With Contrast		
Contrast:			

Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900, 61397810001000

Final Report

EXAM: CT abdomen and pelvis with contrast.

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the abdomen/pelvis, abdominal pain.

TECHNIQUE: Contrast-enhanced helical CT was performed through the abdomen and pelvis following the administration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

Please see separate CT chest report for further detail regarding intrathoracic findings.

The liver is enlarged with the right hepatic lobe measuring 19.9 cm. No hypoenhancement is present to suggest hepatic contusion or laceration. A small amount of hyperdense free fluid is seen adjacent to the inferior portion of the right hepatic lobe. The gallbladder is nondistended and the common bile duct is normal in caliber. The pancreas enhances uniformly without evidence for laceration. Small calcifications are seen within the spleen and there is no definite splenic laceration allowing for limitations of streak artifact related to arms down scanning technique. The bilateral adrenal glands are normal. The bilateral kidneys enhance uniformly without evidence for contusion or laceration and there is no hydroureteronephrosis. The small bowel loops are nondilated and there is no mesenteric hematoma. No free air is present within the abdomen. Atherosclerotic plaquing is seen within the infrarenal abdominal aorta and mild ectasia is present without aneurysmal dilatation or dissection. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes.

Small hyperdense fluid is seen within the mid and inferior portion of the left paracolic gutter. There is a 7.6 mm focus of hyperenhancement within the periphery of the prostate on the right. No significant free fluid is seen collecting within the rectovesical pouch. The urinary bladder is grossly unremarkable. No colonic wall thickening is evident. A small fat-containing umbilical hernia is present.

Soft tissue stranding and induration is seen overlying the left gluteal region compatible with contusion. There is no definite proximal left femoral fracture. Degenerative change in the bilateral hips is noted with marginal osteophytosis and joint space narrowing. No acute displaced pelvic fracture is clearly evident. Multilevel lumbar degenerative disc disease is present most pronounced at L2-3 and L5-S1. Lower lumbar facet arthropathy is also noted. A hypoplastic rib is present on the right at L1. Evaluation for nondisplaced transverse process fracture is limited with the provided technique. There is no clear CT evidence of acute lumbar fracture allowing for limitations of routine CT abdomen/pelvis technique.

IMPRESSION:

1. Trace hyperdense free fluid adjacent to the inferior right hepatic lobe as well as within the mid and caudal left paracolic gutter. No clear CT evidence for splenic or hepatic contusion/laceration, however, finding should be considered to reflect trace hemoperitoneum in the setting of significant trauma. Low-grade solid organ injury is not excluded. Surgical consultation, close clinical, and as needed imaging followup recommended.

2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.

3. No free air to suggest visceral perforation.

4. Lumbar spondylosis without clear CT evidence of acute lumbar fracture. As above, if there is concern for lumbar spine fracture, dedicated lumbar spine CT could enter evaluate.

5. Also noted: Atherosclerosis without aneurysm/dissection, hepatomegaly, fat-containing umbilical hernia, splenic calcification, degenerative change of the bilateral hips, and 7.6 mm hyperenhancing right prostate lesion. Followup recommended.

6. Please see CT chest report for further detail regarding intrathoracic findings.

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

Study ready at 22:24 and initial results transmitted at 22:54

Critical Value Communications

Clear Time	Type	Notes
06/22/16 23:07	Verify Receipt	Verified receipt with Cheryl in the ER for Dr. Garvey on 06/2 23:07 (-07:00)

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Northeastern Nevada Regional Hospital

Patient:	**SCHWARTZ, DOUGLAS (Male)**	DOB:	06/02/58
MR #:	**330967**	Status:	ER
Date:	06/22/16 22:20	Slices:	0
History:	Study: CT CHEST W Reason: Chest Pain with Trauma/Injury		
Priors:			
Tech:	Exam request generated by HL7 interface		
Exams:	CT CHEST With Contrast		
Contrast:			

Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900, 61397810001000

Final Report

EXAM: CT chest with contrast.

CLINICAL INDICATION: Auto versus pedestrian, one force trauma to the chest, chest pain, increased difficulty breathing.

TECHNIQUE: Contrast-enhanced helical CT was performed through the chest following the ministration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

The heart is normal in size and there is no pericardial effusion. Trace atherosclerosis is present without thoracic aortic aneurysm or dissection. The origins of the great vessels are unremarkable with the exception of mild atherosclerotic plaquing in the left subclavian artery. Trace gas within the main pulmonary artery is likely related to peripheral IV access. No mediastinal hematoma is present. The visualized aerodigestive tract is unremarkable.

There is a small, less than 10%, right pneumothorax. Prominent pleural fat is present without definite pleural effusion. Bibasilar opacities and right perihilar opacity may reflect atelectasis, contusion, or the sequela of aspiration. There is no left-sided pneumothorax or pleural effusion. Prominent left pleural fat is also present. There is a 4.9 mm noncalcified left upper lobe subpleural pulmonary nodule.

There are acute anterolateral fractures of the right fourth through seventh ribs with the fourth and sixth ribs fractured in 2 places (nondisplaced posterior fractures also noted). Comminution and displacement of the seventh rib fracture is present. No acute displaced sternal fracture. Please see separate CT thoracic spine report for further detail.

IMPRESSION:

1. Small right anterior pneumothorax (less than 10%). Surgical consultation and followup

recommended.

2. Prominent right pleural fat without definite pleural effusion.

3. Acute fractures of the right fourth through seventh ribs as described above. Please note that the fourth and sixth ribs are fractured in 2 places.

4. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or the sequela of aspiration.

5. Mild atherosclerosis without evidence for traumatic aortic injury.

6. Please see CT thoracic spine report for further detail.

7. 4.9 mm left upper lobe pulmonary nodule. Followup per Fleischner Society criteria recommended.

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

Study ready at 22:24 and initial results transmitted at 23:08

Critical Value Communications

Clear Time	Type	Notes
	Verify Receipt	

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Northeastern Nevada Regional Hospital

Patient:	**SCHWARTZ, DOUGLAS (Male)**	DOB:	06/02/58
MR #:	**330967**	Status:	ER
Date:	06/22/16 22:38	Slices:	0
History:	Study: CT C SPINE WITHOUT Reason: Pain with Trauma/Injury		
Priors:			
Tech:	Exam request generated by HL7 interface		
Exams:	CT C SPINE		
Contrast:			

Accession Numbers: 61397810000600, 61397810000700, 61397810000800, 61397810000900, 61397810001000

Final Report

EXAM: CT cervical spine.

CLINICAL INDICATION: Auto versus pedestrian, trauma to the neck and cervical spine, upper back pain.

TECHNIQUE: Helical CT is performed through the cervical spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS:

Cervical alignment is anatomic without spondylolisthesis and there is preservation of the cervical lordosis. The visualized vertebral body heights are preserved without evidence for compression deformity. No acute cervical fracture is evident by CT. The atlantooccipital and atlantoaxial articulations are intact. The odontoid process is normal. The cervical facets articulate normally bilaterally without dislocation or subluxation. There is no prevertebral soft tissue thickening.

The intervertebral disc spaces are generally well preserved. Small ventral osteophytes are present at C4, C5, and C6. A partially calcified right paracentral disc protrusion is present at T1/T2. Right greater than left facet arthropathy is present most pronounced at C4-5. There is no significant bony spinal canal stenosis. Minimal foraminal stenosis is present on the left at C4-5.

Please see CT chest for further detail regarding intrathoracic findings.

IMPRESSION:

1. No CT evidence of acute cervical fracture or traumatic subluxation.

2. Very mild cervical and upper thoracic spondylosis as described above.

3. Please see CT chest report for further detail.

Radiologist: Max Pollock, M.D. Phone: 858-626-8106

Study ready at 22:40 and initial results transmitted at 23:38

Physician Documentation
Northeastern Nevada Regional Hospital
Name: Douglas Schwartz
Age: 58 yrs
Sex: Male
DOB: 06/02/1958
MRN: 330967
Arrival Date: 06/22/2016
Time: 20:51
Account#: 6139781
Bed 16
Private MD:
ED Physician Garvey, David
HPI:
06/22
21:15 This 58 yrs old White Male presents to ER via EMS with complaints of pedestrian versus djg/jkp
auto.
21:15 The patient was a pedestrian struck by a moving vehicle, and thrown approximately 10 djg/jkp
feet. Onset: The symptoms/episode began/occurred just prior to arrival. Associated
injuries: The patient sustained injury to the head, abrasion, injury to the chest,
specifically the right lateral posterior chest, pain with breathing, pain with movement, right bicep, right elbow and right knee, abrasion. Associated signs and
symptoms: Loss of consciousness: the patient experienced loss of consciousness, that
was brief. Severity of symptoms: At their worst the symptoms were moderate, in the
emergency department the symptoms are unchanged. The patient has not experienced
similar symptoms in the past. The patient has not recently seen a physician.

Historical:
Allergies: Lortab;
PMHx: Hypertension;
PSHx: None;
Exposure Risk/Travel Screening:: Patient has not been out of the country in last 30
days. Have you been in contact with anyone who is ill that has traveled outside of
the country in the last 30 days? No.
Social history:: Tobacco Status: The patient states he/she has never used tobacco.
The patient/guardian denies using alcohol, street drugs, IV drugs, The patient lives
with family, The patient's primary language is English. The patient's preferred
language is English.
Tuberculosis screening:: No symptoms or risk factors identified.
Family history:: Not pertinent.
The history from nurses notes was reviewed: and I agree with what is documented up to
this point.

ROS:
21:18 Constitutional: Negative for body aches, chills, fatigue, fever. Eyes: Negative for djg/jkp
blurry vision, visual disturbance, the patient's right contact lens was lost during the
accident. ENT: Negative for drainage from ear(s), nasal discharge. Neck: Negative for
stiffness, swelling. Cardiovascular: Positive for chest pain, of the right lateral
posterior chest, Negative for palpitations. Respiratory: Negative for hemoptysis,
shortness of breath. Abdomen/GI: Negative for nausea, vomiting. Back: Positive for pain
at rest, of the left scapular area and left subscapular area. MS/extremity: Positive
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

Legally authenticated
for abrasion. Skin: Negative for diaphoresis, pallor. Neuro: Negative for dizziness,
gait disturbance, headache. Psych: Negative for anxiety, depression.

Exam:
21:20 Constitutional: The patient appears awake, in obvious pain, uncomfortable. djg/jkp
21:20 Head/face: Noted is abrasion(s), that are mild, of the forehead.
21:20 Eyes: Pupils: equal, round, and reactive to light and accomodation.
21:20 ENT: TM's: are normal, no hemotympanum, Nose: is normal, no bleeding, no clotted blood,
no drainage.
21:20 Neck: External neck: is normal, C-spine: Nexus Criteria: Nexus criteria: no cervical
midline tenderness, patient is not intoxicated, mental status is normal, no focal/neurologic deficits, and no painful distracting injuries are present.
21:20 Chest/axilla: Inspection: normal, Palpation: tenderness, that is moderate, of the
right lateral posterior chest.
21:20 Cardiovascular: Rate: normal, Rhythm: regular.
21:20 Respiratory: the patient does not display signs of respiratory distress, Respirations:
normal, Breath sounds: are normal, clear throughout.
21:20 Abdomen/GI: Inspection: abdomen appears normal, Bowel sounds: normal, active, all
quadrants, Palpation: abdomen is soft and non-tender, in all quadrants.
21:20 Back: pain, that is moderate, of the left scapular area and left subscapular area.
21:20 Musculoskeletal/extremity: Extremities: grossly normal except: noted in the right knee
and right elbow and right bicep: abrasion, ROM: intact in all extremities, Circulation
is intact in all extremities. Sensation intact.
21:20 Skin: Appearance: normal except for affected area.
21:20 Neuro: Orientation: is normal, to person, place & time. Memory: immediate memory is
intact, remote memory is intact. recent memory is impaired.
21:20 Psych: Behavior/mood is pleasant, cooperative.

Vital Signs:
20:53 BP 162 / 96; Pulse 69; Resp 20; Temp 98.4(T); Pulse Ox 94% on 4 lpm NC; Weight 92.99 dk
kg; Height 5 ft. 10 in. (177.80 cm); Pain 5/10;
20:53 BP 162 / 96 (auto/); Pulse 71 MON; Pulse Ox 83% ;
dk
20:55 Pulse 69 MON; Resp 18; Pulse Ox 94% ;
dk
23:17 BP 116 / 75 (auto/);
dk
23:17 Pulse 67 MON; Resp 16; Pulse Ox 91% ;
dk
23:27 BP 115 / 74 (auto/);
dk
23:27 Pulse 67 MON; Resp 17; Pulse Ox 91% ;
dk
23:30 BP 120 / 78 (auto/);
dk
23:30 Pulse 67 MON; Resp 18; Pulse Ox 92% ;
dk
23:45 BP 114 / 73 (auto/);
dk
23:45 Pulse 68 MON; Resp 18; Pulse Ox 91% ;
dk
06/23
00:10 Pulse 66; Resp 17; Pulse Ox 97% on 15% Non-rebreather mask;
dk
00:15 Pulse 73; Resp 19; Pulse Ox 99% on 15% Non-rebreather mask;
dk
00:20 Pulse 97; Resp 22; Pulse Ox 83% ;
dk
00:25 Pulse 108; Pulse Ox 76% ;
dk
00:30 BP 225 / 136; Pulse 127; Pulse Ox 76% ;
dk
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

00:35 Pulse 36; Pulse Ox 37% ;
dk
00:40 Pulse 111; Pulse Ox 77% ;
dk
00:41 BP 249 / 140; Pulse 125; Pulse Ox 81% ;
dk
00:45 BP 221 / 148; Pulse 119; Pulse Ox 75% ;
dk
00:50 Pulse 126; Pulse Ox 62% ;
dk
00:55 Pulse 128; Pulse Ox 43% ;
dk
01:00 BP 207 / 143; Pulse 124; Pulse Ox 69% ;
dk
01:05 Pulse 120; Pulse Ox 71% ;
dk
01:10 Pulse 126; Pulse Ox 52% ;
dk
01:14 BP 202 / 125; Pulse 124; Pulse Ox 60% ;
dk
01:15 BP 126 / 95; Pulse 119; Pulse Ox 46% ;
dk
01:20 Pulse 36; Pulse Ox 39% ;
dk
01:25 Pulse Ox 64% ;
dk
01:30 Pulse Ox 60% ;
dk
01:32 BP 149 / 55; Pulse 134; Pulse Ox 49% ;
dk
06/22
20:53 Body Mass Index 29.41 (92.99 kg, 177.80 cm)
dk

Glasgow Coma Score:
02:29 Eye Response: spontaneous(4). Verbal Response: oriented(5). Motor Response: obeys djg
commands(6). Total: 15.

Procedures:
05:04 Performed Cricothyrotomy performed due to inability to orally intubate patient. djg
Initially the small trach tube that came with kit was placed - it quickly became
occluded with gastric contents. The tube became dislodged while attempting to clear the
obstruction, and after repositioning it, development of SQ air in the neck was noticed.
The trach tube was removed and replaced with a 5-0 ET tube. The pt was very difficult
to ventilate thru the crich tube with most of the bagged air expelled from the mouth,
but there was chest rise and equal air movement with bagging thru the cric and occluding the mouth and nose. O2 sats however did not improve and the patient went into
full cardiac arrest and CPR was restarted. .

MDM:
06/22
20:52 MSE Initiated by Provider.
djg
06/23
02:05 ED course: Discussed with Dr Ray at U of U who excepted pt in transfer. He requested djg
that a chest tube be placed and possibly intubation prior to air medical transport due
to flail segment, pulmonary contusions, low O2 sats and a traumatic R pneumothorax.
Plan was discussed with pt and his wife. Reach critical care transport team arrived
just after the discussion with patient and family. Plan was to sedate the patient with
Ketamine. I would place the CT while the Reach crew performed the intubation. The pt
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

was give Rocuronium and Ketamine with appropriate sedation and paralysis. The initial
attempt at intubation was unsuccessful. The pt was bagged for a few mins and a 2nd
attempt was made. During the 2nd attempt the pt vomited and aspirated a large amount of
gastric contents. Suctioning was difficult due to large food particles occluding the
suction. I attempted the 3rd attempt at intubation w/o success - mainly due to a very
anterior larynx and vomitus in the airway that couldn't be completely cleared. The pt
bradied down due to low O2 sats and CPR was begun while the pt was bagged. The O2 sats
improved and the pt regained a strong pulse. Several more attempts at intubation were
made by myself and the Reach team, and although each time it was felt that the ET tube
was properly placed, large amts of gastric contents continued to fill the ET tube and
each time the tube was pulled and the patient bagged. At the point when bagging did not
achieve adequate oxygenation, a cricothyrotomy was performed. Again there was a
significant amt of vomitus plugging the small ET tube used for the cric. Bilateral
needle thoracostomies were also done. The patient could not be adequately ventilated,
even through the cric tube and again bradyed down to full arrest and CPR was restarted.
The patient did not respond to CPR efforts and the code was called and the pt
pronounced at 0133. I informed the pt's wife and friends of the occurrences in the ED..
Data reviewed: vital signs, nurses notes, EMS record, lab test result(s), radiologic
studies, CT scan.
04:20 I have reviewed and agree with the scribe's documentation on my behalf.
djg
05:21 ED course: Note: after the pt's initial regurgitation and aspiration, a patent airway djg
was never secured - multiple oral ET attempts with direct and video fiberoptic
laryngoscopes, bougie and King airway. Some of the initial ETT placements may have been
in the trachea, but because of the large amt of gastric contents filling the tube with
each placement and poor ET CO2 readings, all placed tubes were pulled, and the pt was
bagged via BVM until the cric was placed. But, even with the cric the pt could not be
adequately ventilated or oxygenated. .
21:55 I have reviewed and agree with the scribe's documentation on my behalf.
djg

06/22
21:02 Order name: Cbc W/ Auto Diff; Complete Time: 23:42
djg
06/22
21:02 Order name: CMP; Complete Time: 23:42
djg
06/22
21:02 Order name: Amylase; Complete Time: 23:42
djg
06/22
21:02 Order name: Lipase; Complete Time: 23:42
djg
06/22
21:02 Order name: Urinalysis; Complete Time: 23:42
djg
06/22
21:02 Order name: Ct Brain Head Wo; Complete Time: 03:18
djg
06/22
21:02 Order name: CT C Spine Wo; Complete Time: 23:42
djg
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

06/22
21:02 Order name: CT T Spine W/O; Complete Time: 03:18
djg
06/22
21:02 Order name: Ct Chest W; Complete Time: 03:18
djg
06/22
21:02 Order name: CT Abd/Pelvis IV Only; Complete Time: 23:42
djg
06/22
21:02 Order name: Dilaudid 1 mg IVP once
djg
06/22
21:02 Order name: Zofran - Ondansetron 4 mg IVP once; over 2 minutes
djg
06/22
23:18 Order name: Zofran - Ondansetron 4 mg IVP once; over 2 minutes
dk
06/23
04:29 Order name: Ativan 2 mg PO once; 2 mg Ativan given to wife at 0225h
djg
06/22
21:02 Order name: Urine, Obtain; Complete Time: 23:19
djg
06/22
21:02 Order name: NS saline lock; Complete Time: 21:33
djg

Dispensed Medications:
06/22
22:33 Drug: Dilaudid 1 mg Route: IVP; Site: left hand;
dk
23:17 Follow up: Response: No adverse reaction; Pain is decreased
dk
22:33 Drug: Zofran - Ondansetron 4 mg Route: IVP; Site: left hand;
dk
23:18 Follow up: Response: No adverse reaction; Nausea is decreased
dk
23:19 Drug: Zofran - Ondansetron 4 mg Route: IVP; Site: left hand;
dk
23:53 Follow up: Response: No adverse reaction; Nausea is decreased
dk
06/23
02:25 Drug: Ativan 2 mg Route: PO;
dk
03:20 Follow up: Response: No adverse reaction
dk

Disposition:
02:29 Electronically signed by Garvey, David, MD at 02:29 on 06/23/2016.
djg

Disposition:
Patient pronounced on 06/23/16 01:33 by Garvey, David. Impression: Multiple Trauma -
Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary Contusions, Closed
Head Injury with LOC, R Pneumothorax, Hemoperitoneum, Cardiac arrest - Due to Asphyxiation .

Critical care time excluding procedures:
02:29 Critical care time: Bedside Care excluding time for separrate services.: 2.5 minutes. djg
Total time: 2 minutes
02:29 Critical care time: Consultation: 10 minutes, Family Intervention: 15 minutes. Total djg
time: 25 minutes

Signatures:
Dispatcher MedHost EDMS
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

Legally authenticated

Garvey, David, MD MD djg
Kevitt, Donna dk
Price, Julia jkp

Corrections: (The following items were deleted from the chart)
05:46 06/22 21:02 IV saline lock ordered. djg
dk

****
****

Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

Nurse's Notes
Northeastern Nevada Regional Hospital
Name: Douglas Schwartz
Age: 58 yrs
Sex: Male
DOB: 06/02/1958
MRN: 330967
Arrival Date: 06/22/2016
Time: 20:51
Account#: 6139781
Bed 16
Private MD:
Diagnosis: Multiple Trauma - Multiple R Rib Fractures (4-7) with Flail Segment, R Pulmonary
Contusions, Closed Head Injury with LOC, R Pneumothorax, Hemoperitoneum;Cardiac
arrest-Due to Asphyxiation

Presentation:
06/22
20:53 Presenting complaint: EMS states: right sided rib pain, right knee pain, right dk
shoulder. Hit by car going approx 35-40 mph. Possible loss of consciousness. Alert/oriented at time EMS arrive. VSS during transfer. A/O at this time. EMS administered 100 mcg Fentanyl and 4 mg Zofran in the field. Airway is patent with good
air movement. The patient is breathing without difficulty. The patient is pink,warm and
dry. Heart rate is within normal limits. Pain: Complains of pain in right supraclavicular area, diaphragm and right breast. Influenza risk: Fever: The patient
has no complaints of fever. Suicide Screening: Have you recently had thoughts about
hurting yourself or others? No.
20:53 Acuity: Emergent (2)
dk
20:53 Care prior to arrival: Medication(s) given: See presentation complaint for treatment dk
and medications given prior to arrival.
20:53 Compressions began at 00:35.
dk

Historical:
Allergies: Lortab;
PMHx: Hypertension;
PSHx: None;
Exposure Risk/Travel Screening:: Patient has not been out of the country in last 30
days. Have you been in contact with anyone who is ill that has traveled outside of
the country in the last 30 days? No.
Social history:: Tobacco Status: The patient states he/she has never used tobacco.
The patient/guardian denies using alcohol, street drugs, IV drugs, The patient lives
with family, The patient's primary language is English. The patient's preferred
language is English.
Tuberculosis screening:: No symptoms or risk factors identified.
Family history:: Not pertinent.

Screening:
21:05 Fall Risk: History of Falls: No (0 points): The patient does not have a history of dk
falls. Secondary Diagnosis: No (0 points): The patient has no chronic conditions.
Ambulatory Aids: None (0 Points): The patient uses no ambulatory aids. IV or IV Access:
Yes (20 points): The patient has IV access or infusion therapy. Gait: Impaired (20
points): The patient has difficulty rising from a chair, head is down, or watches the
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

ground, grabs walking aids or others for support, or cannot walk without assistance.
Mental Status: Oriented (0 pts): The patient can recall their ability to ambulate and
acknowledges limitations per medical order. Sedated or Mind altering medications: No
Total Points: Med. Risk (25-44); Implement universal fall prevention interventions.
Abuse Screen: Patient verbally denies physical, verbal and emotional abuse/neglect.
Cultural/Spirit Needs: There are no cultural/spiritual considerations for care needed
for this patient.
21:05 Nutritional Screening: No deficits noted.
dk

Assessment:
20:52 visited this patient and evaluated for pain, information needs and comfort. djg
21:02 Mechanism of Injury: Auto vs Ped Vehicle was traveling approximately 35 mph. hit approx dk
35-40 mph. Thrown up and over vehicle. The level of pain that is acceptable is 0 out of
10 on a pain scale. General: Appears well developed, well nourished, well groomed,
uncomfortable, Behavior is appropriate for age, cooperative, pleasant. Neuro: No
deficits noted. EENT: No deficits noted. Cardiovascular: No deficits noted. Heart tones
present. Respiratory: Breath sounds are diminished in right posterior middle lobe and
right posterior lower lobe. GI: No deficits noted. Bowel sounds present X 4 quads. GU:
No deficits noted. Sepsis Screening: Sepsis screening negative at this time.
21:02 Method Of Arrival: EMS: Elko EMS
dk
21:13 Neuro: Level of Consciousness is awake, alert, unknown LOC at time of injury. A/O at dk
this time. . Oriented to person, place, time, Grips are equal bilaterally Moves all
extremities. Speech is normal, Facial symmetry appears normal.
21:21 Derm: Abrasions noted to Right scalp area, outer right arm, right elbow and right knee. dk
Injury Description: Abrasion Auto vs. Ped. Vehicle traveling approx 35-40 on impact. Pt
hit right drivers door and was thrown up over vehicle. Unknown LOC at scene. EMS
reported pt A/O on their arrival. Pt is alert and oriented at time of arrival to NNRH.
21:31 visited this patient and evaluated for pain, information needs and comfort. dk
23:17 visited this patient and evaluated for pain, information needs and comfort. dk
23:27 visited this patient and evaluated for pain, information needs and comfort. dk
23:31 visited this patient and evaluated for pain, information needs and comfort. dk
23:36 Injury Description:.
dk
06/23
00:35 CPR assessment: unresponsive, no respiratory effort, mechanical ventilation, Ambu dk
ventilation, cyanotic, pulses absent w/ compressions.
00:35 Cardiac rhythm is asystole.
dk
06/24
00:37 visited this patient and evaluated for pain, information needs and comfort. kp

Vital Signs:
06/22
20:53 BP 162 / 96; Pulse 69; Resp 20; Temp 98.4(T); Pulse Ox 94% on 4 lpm NC; Weight 92.99 dk
kg; Height 5 ft. 10 in. (177.80 cm); Pain 5/10;
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

Legally authenticated

20:53 BP 162 / 96 (auto/); Pulse 71 MON; Pulse Ox 83% ;
dk
20:55 Pulse 69 MON; Resp 18; Pulse Ox 94% ;
dk
23:17 BP 116 / 75 (auto/);
dk
23:17 Pulse 67 MON; Resp 16; Pulse Ox 91% ;
dk
23:27 BP 115 / 74 (auto/);
dk
23:27 Pulse 67 MON; Resp 17; Pulse Ox 91% ;
dk
23:30 BP 120 / 78 (auto/);
dk
23:30 Pulse 67 MON; Resp 18; Pulse Ox 92% ;
dk
23:45 BP 114 / 73 (auto/);
dk
23:45 Pulse 68 MON; Resp 18; Pulse Ox 91% ;
dk
06/23
00:10 Pulse 66; Resp 17; Pulse Ox 97% on 15% Non-rebreather mask;
dk
00:15 Pulse 73; Resp 19; Pulse Ox 99% on 15% Non-rebreather mask;
dk
00:20 Pulse 97; Resp 22; Pulse Ox 83% ;
dk
00:25 Pulse 108; Pulse Ox 76% ;
dk
00:30 BP 225 / 136; Pulse 127; Pulse Ox 76% ;
dk
00:35 Pulse 36; Pulse Ox 37% ;
dk
00:40 Pulse 111; Pulse Ox 77% ;
dk
00:41 BP 249 / 140; Pulse 125; Pulse Ox 81% ;
dk
00:45 BP 221 / 148; Pulse 119; Pulse Ox 75% ;
dk
00:50 Pulse 126; Pulse Ox 62% ;
dk
00:55 Pulse 128; Pulse Ox 43% ;
dk
01:00 BP 207 / 143; Pulse 124; Pulse Ox 69% ;
dk
01:05 Pulse 120; Pulse Ox 71% ;
dk
01:10 Pulse 126; Pulse Ox 52% ;
dk
01:14 BP 202 / 125; Pulse 124; Pulse Ox 60% ;
dk
01:15 BP 126 / 95; Pulse 119; Pulse Ox 46% ;
dk
01:20 Pulse 36; Pulse Ox 39% ;
dk
01:25 Pulse Ox 64% ;
dk
01:30 Pulse Ox 60% ;
dk
01:32 BP 149 / 55; Pulse 134; Pulse Ox 49% ;
dk
06/22
20:53 Body Mass Index 29.41 (92.99 kg, 177.80 cm)
dk

Glasgow Coma Score:
02:29 Eye Response: spontaneous(4). Verbal Response: oriented(5). Motor Response: obeys djg
commands(6). Total: 15.

ED Course:
06/22
20:51 Patient arrived in ED.
dk
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

20:51 Patient moved to Waiting
dk
20:51 Patient moved to 12
dk
20:52 Garvey, David, MD is Attending Physician.
djg
20:58 Triage completed.
dk
21:08 Kevitt, Donna is Primary Nurse.
dk
21:20 Maintain field IV. Dressing intact. Good blood return noted. Site clean & dry. Gauge & dk
site: 20g left wrist. Oxygen administration via nasal cannula @ 4L/min.
21:20 Cardiac monitor on. Pulse ox on. NIBP on. Warm blanket given.
dk
21:25 Patient has correct armband on for positive identification. Placed in gown. Bed in low dk
position. Call light in reach. Side rails up X2. Adult w/ patient.
21:29 Awaiting Per MD- hold medication administration at this time due to meds given by EMS. dk
OK to wait on urine at this time until after CT completed.
21:32 Inserted peripheral IV: 20 gauge left hand blood drawn and sent to lab per order. dk
21:33 Patient moved to CT.
hr
21:33 Patient moved to CT Scan
hr
21:33 Lipase Sent.
dk
21:33 Amylase Sent.
dk
21:33 CMP Sent.
dk
21:33 Cbc W/ Auto Diff Sent.
dk
21:40 Patient moved to CT.
dk
23:00 Patient moved back from CT.
hr
23:00 Patient moved to 12
hr
23:37 Pt placed on 40% Venti mask per respiratory. Pt sats: 92-93%.
dk
23:51 Oxygen administration via non-rebreather mask @ 15L/min.
dk
06/23
01:45 Wife notified of patient's death by Dr. Garvey. Dr. John Patton, friend of family at dk
wife's side. Wife moved to Triage room. Assisted Dr. Patton in calling family members.
Sons DJ, Taylor, and Mitchell notified. Called family friend Todd Robinson @ 0220.
Continuing to comfort wife. 0225am 2 mg po Ativan given to wife per MD order.
02:14 Patient moved to 16
so
02:30 Garvey, David, MD is Pronouncing Provider.
djg
02:40 Wife escorted to room 16 via wheelchair. Friend John Patton at side.
dk
03:06 Patient moved to D1
na
03:06 Patient moved to 16
na
04:10 Awaiting Call to donor line. Case #: 10402647.
dk
04:13 Awaiting Elizabeth Gill with Donor line called. Release to coroner.
dk
04:25 Gastric tube NGT removed.
dk
05:46 Custody of body released to Elko Co. Sheriff Officer Coroner.
Transported by Burn's dk
Funeral home.
05:50 Assist provider with intubation Unsuccessful attempts. See Code sheet.
dk
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

Administered Medications:
06/22
22:33 Drug: Dilaudid 1 mg Route: IVP; Site: left hand;
dk
23:17 Follow up: Response: No adverse reaction; Pain is decreased
dk
22:33 Drug: Zofran - Ondansetron 4 mg Route: IVP; Site: left hand;
dk
23:18 Follow up: Response: No adverse reaction; Nausea is decreased
dk
23:19 Drug: Zofran - Ondansetron 4 mg Route: IVP; Site: left hand;
dk
23:53 Follow up: Response: No adverse reaction; Nausea is decreased
dk
06/23
02:25 Drug: Ativan 2 mg Route: PO;
dk
03:20 Follow up: Response: No adverse reaction
dk

Intake:
01:33 1000 plus ml from suctioning during event. Copius amounts of vomitus from posterier dk
pharynx using 2 suctions simutaneously.

Output:
01:33 Gastric: 1000ml (NGT); Total: 1000ml.
dk
01:33 1000 plus ml from suctioning during event. Copius amounts of vomitus from posterier dk
pharynx using 2 suctions simutaneously.

Outcome:
05:00 Outcome Patient expired
dk
05:00 Patient expired: Time of death 01:33 Pronounced by David Garvey MD Body released to ME
Organ Donation no
05:00 Condition: expired
dk
05:00 Discharge Assessment: Patient Pt expired @ 0133
dk
06:05 Patient left the ED.
dk

Signatures:

Garvey, David, MD	MD	djg
Rangel, Hannah		hr
Abrams, Nancy, PCA	PCA	na
Olson, Sue		so
Kevitt, Donna		dk
Price, Julia		jkp
Payne, Kimber		kp

Corrections: (The following items were deleted from the chart)
06/22
21:20 20:53 Presenting complaint: EMS states: right sided rib pain, right knee pain, right dk
shoulder. Hit by car going approx 35-40 mph. Possible loss of consciousness. Alert/oriented at time EMS arrive. VSS during transfer. A/O at this time. dk
06/23
05:19 04:37 Wife was notified by Dr. Garvey. Dr John Patton, friend of family at wife's side. dk
Wife moved to Triage room. Assisted Dr. Patton in calling family members. Sons DJ,
Taylor, and Mitchell notified. Called family friend Todd Robinson @ 0220. Continuing to
comfort wife. 0225 2 mg by mouth Ativan given to wife per MD Order. dk
05:24 01:45 Wife was notified by Dr. Garvey. Dr John Patton, friend of family at wife's side. dk
Wife moved to Triage room. Assisted Dr. Patton in calling family members. Sons DJ,
Legally authenticated by David J. Garvey, MD 2016-06-24 06:05:01

Legally authenticated

Taylor, and Mitchell notified. Called family friend Todd Robinson @ 0220.
Continuing to
comfort wife. 0225 2 mg by mouth Ativan given to wife per MD Order. Body was
released
to Coroner transported by Burns Funeral home. . dk
05:54 05:53 Discharge Assessment: Pt expired at 0133 dk
dk
05:55 05:55 Instructed on dk
dk

****
****

Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT ABD PELVIS IV ONLY
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT abdomen and pelvis with contrast.

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the abdomen/pelvis, abdominal pain.

TECHNIQUE: Contrast-enhanced helical CT was performed through the abdomen and pelvis following the administration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

Please see separate CT chest report for further detail regarding intrathoracic findings.

The liver is enlarged with the right hepatic lobe measuring 19.9 cm. No hypoenhancement is present to suggest hepatic contusion or laceration. A small amount of hyperdense free fluid is seen adjacent to the inferior portion of the right hepatic lobe. The gallbladder is nondistended and the common bile duct is normal in caliber. The pancreas enhances uniformly without evidence for laceration. Small calcifications are seen within the spleen and there is no definite splenic laceration allowing for limitations of streak artifact related to arms down scanning technique. The bilateral adrenal glands are normal. The bilateral kidneys enhance uniformly without evidence for contusion or laceration and there is no hydroureteronephrosis. The small bowel loops are nondilated and there is no mesenteric hematoma. No free air is present within the abdomen. Atherosclerotic plaquing is seen within the infrarenal abdominal aorta and mild ectasia is present without aneurysmal dilatation or dissection. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes.

Legally authenticated by POLLOCK MAX MD 2016-06-22 22:54:44

Small hyperdense fluid is seen within the mid and inferior portion of the left paracolic gutter. There is a 7.6 mm focus of hyperenhancement within the periphery of the prostate on the right.

No significant free fluid is seen collecting within the rectovesical pouch. The urinary bladder is grossly unremarkable. No colonic wall thickening is evident. A small fat-containing umbilical hernia is present.

Soft tissue stranding and induration is seen overlying the left gluteal region compatible with contusion. There is no definite proximal left femoral fracture. Degenerative change in the bilateral hips is noted with marginal osteophytosis and joint space narrowing. No acute displaced pelvic fracture is clearly evident. Multilevel lumbar degenerative disc disease is present most pronounced at L2-3 and L5-S1. Lower lumbar facet arthropathy is also noted. A hypoplastic rib is present on the right at L1. Evaluation for nondisplaced transverse process fracture is limited with the provided technique. There is no clear CT evidence of acute lumbar fracture allowing for limitations of routine CT abdomen/pelvis technique.

IMPRESSION:

1. Trace hyperdense free fluid adjacent to the inferior right hepatic lobe as well as within the mid and caudal left paracolic gutter. No clear CT evidence for splenic or hepatic contusion/laceration, however, finding should be considered to reflect trace hemoperitoneum in the setting of significant trauma. Low-grade solid organ injury is not excluded. Surgical consultation, close clinical, and as needed imaging followup recommended.

2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.

3. No free air to suggest visceral perforation.

4. Lumbar spondylosis without clear CT evidence of acute lumbar fracture. As above, if there is concern for lumbar spine fracture,

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Legally authenticated
dedicated lumbar spine CT could enter evaluate.

5. Also noted: Atherosclerosis without aneurysm/dissection, hepatomegaly, fat-containing umbilical hernia, splenic calcification, degenerative change of the bilateral hips, and 7.6 mm hyperenhancing right prostate lesion. Followup recommended.

6. Please see CT chest report for further detail regarding intrathoracic findings.

Critical Value Communications

Verify Receipt

Dictating Radiologist: Pollock, Max M.D.
Electronically Signed by: Pollock, Max M.D. 06/22/2016 22:54
StatRad Exam Id: 2154859

Legally authenticated by POLLOCK MAX MD 2016-06-22 22:54:44

Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT ABD PELVIS IV ONLY
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT abdomen and pelvis with contrast.

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the abdomen/pelvis, abdominal pain.

TECHNIQUE: Contrast-enhanced helical CT was performed through the abdomen and pelvis following the administration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

Please see separate CT chest report for further detail regarding intrathoracic findings.

The liver is enlarged with the right hepatic lobe measuring 19.9 cm. No hypoenhancement is present to suggest hepatic contusion or laceration. A small amount of hyperdense free fluid is seen adjacent to the inferior portion of the right hepatic lobe. The gallbladder is nondistended and the common bile duct is normal in caliber. The pancreas enhances uniformly without evidence for laceration. Small calcifications are seen within the spleen and there is no definite splenic laceration allowing for limitations of streak artifact related to arms down scanning technique. The bilateral adrenal glands are normal. The bilateral kidneys enhance uniformly without evidence for contusion or laceration and there is no hydroureteronephrosis. The small bowel loops are nondilated and there is no mesenteric hematoma. No free air is present within the abdomen. Atherosclerotic plaquing is seen within the infrarenal abdominal aorta and mild ectasia is present without aneurysmal dilatation or dissection. There are no pathologically enlarged mesenteric or retroperitoneal lymph nodes.

Legally authenticated by POLLOCK MAX MD 2016-06-22 22:54:44

Legally authenticated
Small hyperdense fluid is seen within the mid and inferior portion of the left paracolic gutter. There is a 7.6 mm focus of hyperenhancement within the periphery of the prostate on the right.

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Soft tissue stranding and induration is seen overlying the left gluteal region compatible with contusion. There is no definite proximal left femoral fracture. Degenerative change in the bilateral hips is noted with marginal osteophytosis and joint space narrowing. No acute displaced pelvic fracture is clearly evident. Multilevel lumbar degenerative disc disease is present most pronounced at L2-3 and L5-S1. Lower lumbar facet arthropathy is also noted. A hypoplastic rib is present on the right at L1. Evaluation for nondisplaced transverse process fracture is limited with the provided technique. There is no clear CT evidence of acute lumbar fracture allowing for limitations of routine CT abdomen/pelvis technique.

IMPRESSION:

1. Trace hyperdense free fluid adjacent to the inferior right hepatic lobe as well as within the mid and caudal left paracolic gutter. No clear CT evidence for splenic or hepatic contusion/laceration, however, finding should be considered to reflect trace hemoperitoneum in the setting of significant trauma. Low-grade solid organ injury is not excluded. Surgical consultation, close clinical, and as needed imaging followup recommended.

2. Soft tissue contusion overlying the left hip as described. No definite CT evidence of acute proximal left femoral or left hemipelvis fracture allowing for limitations of routine CT abdomen/pelvis technique. If there is clinical suspicion for pelvic or femoral fracture, dedicated CT could be performed for further evaluation.

3. No free air to suggest visceral perforation.

4. Lumbar spondylosis without clear CT evidence of acute lumbar fracture. As above, if there is concern for lumbar spine fracture,

Legally authenticated by POLLOCK MAX MD 2016-06-22 22:54:44

Legally authenticated
dedicated lumbar spine CT could enter evaluate.

5. Also noted: Atherosclerosis without aneurysm/dissection, hepatomegaly, fat-containing umbilical hernia, splenic calcification, degenerative change of the bilateral hips, and 7.6 mm hyperenhancing right prostate lesion. Followup recommended.

6. Please see CT chest report for further detail regarding intrathoracic findings.

Critical Value Communications

Verify Receipt

********** ADDENDUM
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CR

Critical Value Communications

06/22/16 23:07 Verify Receipt Verified receipt with Cheryl in the ER for Dr. Garvey on 06/22 23:07 (-07:00)

Electronically Signed and Reported by: Pollock, Max M.D. 06/22/2016 22:54
StatRad Exam Id: 2154859

Legally authenticated by POLLOCK MAX MD 2016-06-22 22:54:44

Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT CHEST W
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT chest with contrast.

CLINICAL INDICATION: Auto versus pedestrian, one force trauma to the chest, chest pain, increased difficulty breathing.

TECHNIQUE: Contrast-enhanced helical CT was performed through the chest following the ministration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

The heart is normal in size and there is no pericardial effusion. Trace atherosclerosis is present without thoracic aortic aneurysm or dissection. The origins of the great vessels are unremarkable with the exception of mild atherosclerotic plaquing in the left subclavian artery. Trace gas within the main pulmonary artery is likely related to peripheral IV access. No mediastinal hematoma is present. The visualized aerodigestive tract is unremarkable. There is a small, less than 10%, right pneumothorax. Prominent pleural fat is present without definite pleural effusion. Bibasilar opacities and right perihilar opacity may reflect atelectasis, contusion, or the sequela of aspiration. There is no left-sided pneumothorax or pleural effusion. Prominent left pleural fat is also present. There is a 4.9 mm noncalcified left upper lobe subpleural pulmonary nodule.

There are acute anterolateral fractures of the right fourth through seventh ribs with the fourth and sixth ribs fractured in 2 places (nondisplaced posterior fractures also noted). Comminution and displacement of the seventh rib fracture is present. No acute displaced sternal fracture. Please see separate CT thoracic spine

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:08:08

report for further detail.

IMPRESSION:

1. Small right anterior pneumothorax (less than 10%). Surgical consultation and followup recommended.
2. Prominent right pleural fat without definite pleural effusion.
3. Acute fractures of the right fourth through seventh ribs as described above. Please note that the fourth and sixth ribs are fractured in 2 places.
4. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or the sequela of aspiration.
5. Mild atherosclerosis without evidence for traumatic aortic injury.
6. Please see CT thoracic spine report for further detail.
7. 4.9 mm left upper lobe pulmonary nodule. Followup per Fleischner Society criteria recommended.

Critical Value Communications

Verify Receipt

Dictating Radiologist: Pollock, Max M.D.
Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:08
StatRad Exam Id: 2154862

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:08:08

Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT THORACIC WO
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT thoracic spine

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the chest and back, back pain.

TECHNIQUE: Helical CT was performed through the thoracic spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS: Thoracic alignment is anatomic without spondylolisthesis and the thoracic vertebral body heights are generally well preserved with the exception of mild ventral wedging at T12. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformities. Acute nondisplaced pedicle fractures not excluded. Consider MRI for further evaluation as indicated. The thoracic facets articulate normally. Multilevel mild loss of intervertebral disc space height with small central disc protrusions are noted without significant bony spinal canal stenosis. Prominent ventral osteophytosis is present at T9/T10 on the right. Heterotopic ossification is seen within the interspinous ligament in the mid/lower thoracic spine. Please see CT chest report for further detail regarding intrathoracic findings.

IMPRESSION:

1. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformity. Acute nondisplaced pedicle fractures not entirely excluded. Correlate for tenderness to palpation at this level. MRI could further evaluate as indicated.
2. Mild thoracic spondylosis without significant spinal canal stenosis.

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3. Mild ventral wedging of T12 is likely chronic/physiologic.

4. Please see CT chest report for further detail.

Critical Value Communications

Verify Receipt

Dictating Radiologist: Pollock, Max M.D.
Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:16
StatRad Exam Id: 2154865

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Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT BRAIN HEAD WO
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT head without contrast.

CLINICAL INDICATION: Auto versus pedestrian with blunt force trauma to the head.

TECHNIQUE: Multiple contiguous axial images were obtained from skull base to vertex without the use of intravenous contrast.

COMPARISON: None.

FINDINGS: The ventricular system is normal in size and configuration without midline shift or ventriculomegaly. Symmetrical hyperdensity along the bilateral tentorium may represent hemoconcentration. Trace subdural blood products would be considered much less likely but not entirely excluded. There is no CT evidence of acute cortical infarction. The bilateral orbital contents are grossly unremarkable. Scattered paranasal sinus mucosal thickening is present with possible trace right maxillary sinus fluid level. Evaluation for facial fracture is limited with the provided technique. There is no significant mastoid or tympanic cavity fluid. There is no depressed calvarial fracture.

IMPRESSION:

1. Symmetrical hyperdensity along the bilateral tentorium likely reflects hemoconcentration/dehydration. Trace subdural blood products would be considered much less likely. If indicated, followup head CT could be performed to assess for stability.
2. No midline shift or depressed calvarial fracture.
3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:29:57

Critical Value Communications

Verify Receipt

Dictating Radiologist: Pollock, Max M.D.
Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:29
StatRad Exam Id: 2154893

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:29:57

Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT C SPINE WITHOUT
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT cervical spine.

CLINICAL INDICATION: Auto versus pedestrian, trauma to the neck and cervical spine, upper back pain.

TECHNIQUE: Helical CT is performed through the cervical spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS:

Cervical alignment is anatomic without spondylolisthesis and there is preservation of the cervical lordosis. The visualized vertebral body heights are preserved without evidence for compression deformity. No acute cervical fracture is evident by CT. The atlantooccipital and atlantoaxial articulations are intact. The odontoid process is normal. The cervical facets articulate normally bilaterally without dislocation or subluxation.

There is no prevertebral soft tissue thickening.

The intervertebral disc spaces are generally well preserved. Small ventral osteophytes are present at C4, C5, and C6. A partially calcified right paracentral disc protrusion is present at T1/T2. Right greater than left facet arthropathy is present most pronounced at C4-5. There is no significant bony spinal canal stenosis. Minimal foraminal stenosis is present on the left at C4-5.

Please see CT chest for further detail regarding intrathoracic findings.

IMPRESSION:

1. No CT evidence of acute cervical fracture or traumatic subluxation.

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:38:13

Legally authenticated

2. Very mild cervical and upper thoracic spondylosis as described above.

3. Please see CT chest report for further detail.

Dictating Radiologist: Pollock, Max M.D.
Electronically Signed by: Pollock, Max M.D. 06/22/2016 23:38
StatRad Exam Id: 2154896

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:38:13

Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT CHEST W
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT chest with contrast.

CLINICAL INDICATION: Auto versus pedestrian, one force trauma to the chest, chest pain, increased difficulty breathing.

TECHNIQUE: Contrast-enhanced helical CT was performed through the chest following the ministration of 125 cc Isovue-370 iodinated intravenous contrast. Two-dimensional coronal and sagittal reformatted images were generated for review.

COMPARISON: None.

FINDINGS:

The heart is normal in size and there is no pericardial effusion. Trace atherosclerosis is present without thoracic aortic aneurysm or dissection. The origins of the great vessels are unremarkable with the exception of mild atherosclerotic plaquing in the left subclavian artery. Trace gas within the main pulmonary artery is likely related to peripheral IV access. No mediastinal hematoma is present. The visualized aerodigestive tract is unremarkable. There is a small, less than 10%, right pneumothorax. Prominent pleural fat is present without definite pleural effusion. Bibasilar opacities and right perihilar opacity may reflect atelectasis, contusion, or the sequela of aspiration. There is no left-sided pneumothorax or pleural effusion. Prominent left pleural fat is also present. There is a 4.9 mm noncalcified left upper lobe subpleural pulmonary nodule.

There are acute anterolateral fractures of the right fourth through seventh ribs with the fourth and sixth ribs fractured in 2 places (nondisplaced posterior fractures also noted). Comminution and displacement of the seventh rib fracture is present. No acute displaced sternal fracture. Please see separate CT thoracic spine

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:08:08

report for further detail.

IMPRESSION:

1. Small right anterior pneumothorax (less than 10%). Surgical consultation and followup recommended.
2. Prominent right pleural fat without definite pleural effusion.
3. Acute fractures of the right fourth through seventh ribs as described above. Please note that the fourth and sixth ribs are fractured in 2 places.
4. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or the sequela of aspiration.
5. Mild atherosclerosis without evidence for traumatic aortic injury.
6. Please see CT thoracic spine report for further detail.
7. 4.9 mm left upper lobe pulmonary nodule. Followup per Fleischner Society criteria recommended.

Critical Value Communications

Verify Receipt

********** ADDENDUM
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CR

Critical Value Communications

06/22/16 23:48 Verify Receipt Verified receipt with Dr. Garvey on 06/22 23:47 (-07:00)

Electronically Signed and Reported by: Pollock, Max M.D. 06/22/2016 23:08
StatRad Exam Id: 2154862

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:08:08

Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT BRAIN HEAD WO
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT head without contrast.

CLINICAL INDICATION: Auto versus pedestrian with blunt force trauma to the head.

TECHNIQUE: Multiple contiguous axial images were obtained from skull base to vertex without the use of intravenous contrast.

COMPARISON: None.

FINDINGS: The ventricular system is normal in size and configuration without midline shift or ventriculomegaly. Symmetrical hyperdensity along the bilateral tentorium may represent hemoconcentration. Trace subdural blood products would be considered much less likely but not entirely excluded. There is no CT evidence of acute cortical infarction. The bilateral orbital contents are grossly unremarkable. Scattered paranasal sinus mucosal thickening is present with possible trace right maxillary sinus fluid level. Evaluation for facial fracture is limited with the provided technique. There is no significant mastoid or tympanic cavity fluid. There is no depressed calvarial fracture.

IMPRESSION:

1. Symmetrical hyperdensity along the bilateral tentorium likely reflects hemoconcentration/dehydration. Trace subdural blood products would be considered much less likely. If indicated, followup head CT could be performed to assess for stability.
2. No midline shift or depressed calvarial fracture.
3. Mild scattered paranasal sinus mucosal thickening and possible low-density fluid level in the right maxillary sinus most suggestive of inflammatory sinus fluid rather than acute hemorrhage.

Legally authenticated by POLLOCK MAX MD 2016-06-22 23:29:57

Critical Value Communications

Verify Receipt

********** ADDENDUM
****

CR

Critical Value Communications

06/22/16 23:48 Verify Receipt Verified receipt with Dr. Garvey on

06/22 23:47 (-07:00)

Electronically Signed and Reported by: Pollock, Max M.D. 06/22/2016 23:29
StatRad Exam Id: 2154893

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Legally authenticated

Northeastern Nevada Regional Hospital
2001 Errecart Boulevard, Elko, Nevada 89801
Phone: 775-738-5151 Fax: 775-748-2031

Radiology Report

Patient Name: SCHWARTZ, DOUGLAS
Date of Birth: 06/02/1958
Gender: Male
Exam Date: 06/22/2016
Medical Record #: 330967
Account Number: 6139781
Exam Description: CT THORACIC WO
Ordering Physician: GARVEY, DAVID

StatRad Final Report

EXAM: CT thoracic spine

CLINICAL INDICATION: Auto versus pedestrian, blunt force trauma to the chest and back, back pain.

TECHNIQUE: Helical CT was performed through the thoracic spine with two-dimensional coronal and sagittal reformatted images generated for review.

COMPARISON: None.

FINDINGS: Thoracic alignment is anatomic without spondylolisthesis and the thoracic vertebral body heights are generally well preserved with the exception of mild ventral wedging at T12. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformities. Acute nondisplaced pedicle fractures not excluded. Consider MRI for further evaluation as indicated. The thoracic facets articulate normally. Multilevel mild loss of intervertebral disc space height with small central disc protrusions are noted without significant bony spinal canal stenosis. Prominent ventral osteophytosis is present at T9/T10 on the right. Heterotopic ossification is seen within the interspinous ligament in the mid/lower thoracic spine. Please see CT chest report for further detail regarding intrathoracic findings.

IMPRESSION:

1. Irregularity of the right T10 and T11 pedicles may reflect chronic fracture deformity. Acute nondisplaced pedicle fractures not entirely excluded. Correlate for tenderness to palpation at this level. MRI could further evaluate as indicated.
2. Mild thoracic spondylosis without significant spinal canal stenosis.

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3. Mild ventral wedging of T12 is likely chronic/physiologic.

4. Please see CT chest report for further detail.

Critical Value Communications

Verify Receipt

********** ADDENDUM
****
CR

Critical Value Communications

06/22/16 23:48 Verify Receipt Verified receipt with Dr. Garvey on

06/22 23:47 (-07:00)

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EXHIBIT 9

IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA

IN AND FOR THE COUNTY OF ELKO

---o0o---

DIANE SCHWARTZ, individual and as Special Administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased,

Plaintiff,

vs. Case No. CV-C-17-439

DAVID GARVEY, M.D., an individual; BARRY BARTLETT, et al., Dept. No. 1

Defendants.
_____/

VIDEOTAPED DEPOSITION OF BARRY AMOS RAY BARTLETT

DECEMBER 20, 2019

RENO, NEVADA

Reported by: JULIE ANN KERNAN, CCR #427, RPR

Job No. 581741

APPEARANCES

For the Plaintiff: CLAGGETT & SYKES LAW FIRM
By: Jennifer Morales, Esq.
4101 Meadows Lane
Suite 100
Las Vegas, Nevada 89107

For the Defendants Reach Air Medical Services, LLC: KIRTON McCONKIE
Attorneys at Law
By: James T. Burton, Esq.
36 S. State Street
Suite 1900
Salt Lake City, Utah 84111

For the Defendants Global Medical Response, Reach Air: ELLEN HARMON, JD, MBA, RN
Associate General Counsel
1001 Boardwalk Springs Place
Suite 250
O'Fallon, MO 63368
TODD ROMKEMA, ESQ.

For the Defendant PHC-Elko, Inc.: HALL PRANGLE & SCHOOVELD, LLC
By: Jennifer Ries-Buntain, Esq.
200 South Wacker Drive
Suite 3300
Chicago, Illinois 60606

For the Defendant Dr. Garvey: LEWIS, BRISBOIS, BRISGAARD & SMITH, LLP
Attorneys at Law
By: Keith A. Weaver, Esq.
6385 S. Rainbow Blvd.
Suite 600
Las Vegas, Nevada 89118

For the Defendants Crum, Stefanko & Jones, LLC, dba Ruby Crest Emergency Medicine: CARROLL KELLY TROTTER FRANZEN
MCBRIDE & PEABODY
Attorneys at Law
By: Chelsea R. Hueth, Esq.
8329 W. Sunset Road
Suite 260
Las Vegas, Nevada 89113

The Videographer: STEWART CAMPBELL
Sunshine Litigation Services

I N D E X

WITNESS: BARRY AMOS RAY BARTLETT

PURSUANT TO NOTICE AND STIPULATION, and on Friday, the 20th day of December, 2019, at the hour of 9:11 a.m. of said day, at the offices of Sunshine Litigation Services, 151 Country Circle Estates, Reno, Nevada, before me, Julie Ann Kernan, a notary public, personally appeared BARRY AMOS RAY BARTLETT.

---o0o---

VIDEOGRAPHER: This is the beginning of media one in the deposition of Barry Bartlett in the matter of Schwartz versus Garvey, held at Sunshine Litigation Services on December 20th, 2019. The time is approximately 9:11 a.m. The court reporter is Julie Kernan. I am Stewart Campbell, the videographer, an employee of Litigation Services.

This deposition is being videotaped at all times unless specified to go off the video record.

Would all present please identify themselves beginning with the witness.

THE WITNESS: My name is Barry Bartlett.

MS. MORALES: Jennifer Morales on behalf of the Plaintiff Diane Schwartz and estate.

MR. BURTON: James Burton on behalf of Defendant Reach.

MS. HARMON: Ellen Harmon on behalf of defendant

Reach.

MR. ROMKEMA: Todd Romkema on behalf of Defendant Reach.

MR. WEAVER: Keith Weaver on behalf of Mr. David Garvey.

MS. RIES-BUNTAIN: Jennifer Ries-Buntain on behalf of Northeastern, Northwestern Nevada Hospital.

MS. HUETH: Chelsea Hueth on behalf of Ruby Crest Emergency Medicine.

VIDEOGRAPHER: Will the court reporter please swear in the witness.

REPORTER: Raise your right hand, please.

BARRY AMOS RAY BARTLETT,
called as a witness herein, being first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. MORALES:

Q Can you please state your full name for the record?

A My full name is Barry Amos Ray Bartlett.

Q Okay. And Mr. Bartlett, have you ever had your deposition taken prior to today?

Page 6

A I have.
Q On how many occasions?
A Four.
Q And when is the last time you had your deposition taken?
A In 2017.
Q Okay. I'm going to go over admonitions of having your deposition taken since it has been a few years. If you have any questions, just feel free to ask me as we go through them, okay?
A Uh-hum.
Q You understand that you just took an oath, and the oath carries with it the same penalties of perjury as if you were sitting in trial. Do you understand that?
A I understand that.
Q Okay. As you can see we have a court reporter here taking down everything that you say and that we say in a question and answer format so it's important that we get verbal responses. And it's also important that you answer yes or no instead of uh-huh or huh-uh. Okay? Do you understand that?
A I understand that.
Q Okay. There is a lot of attorneys in this room today, as well as Chelsea remotely. Everyone has -- all the attorneys have the right to make objections, however,

Page 7

unless your counsel instructs you not to answer I will ask -- that's just to preserve the record, I will ask that you answer the question. Okay?
A Yes.
Q Do you understand the difference between an estimate and a guess?
A Why don't you explain it to me.
Q Okay. So the common example is as we sit here today, and the reason I'm asking you this is we are entitled to your best estimate, however, no one in this room wants you to guess at anything. So one of the examples everyone uses is as you sit here today you could probably estimate for us the length of this conference table. However, if I asked you what the size of a conference table in my office was, you've never been there so that would be a guess. Do you understand?
A I understand that.
Q Okay. If for any reason you need to take a break, you just let us know, however, if there is a question pending I will ask that you answer the question before you go out on break. Okay?
A Yes.
Q All right. I may have forgotten something and if I did, and as we move along I will caution you as such. Okay?

Page 8

A Right.
Q Have you taken any medications that could affect your credibility today or your testimony?
A I have not.
Q Okay. Have you drank any alcohol within the last 24 hours?
A I have not.
Q You testified a few minutes ago that you've had your deposition taken four times, the last was in 2017. What was that deposition pertaining to?
A It was pertaining to a gentleman that was suing Amazon Corporation out of Tracy, over a pipe that had fallen from the ceiling and supposedly it struck him, which it had not.
Q And how were you -- how were you a witness in that case?
A I was the transporting paramedic.
Q Okay. And prior to 2017 when did you have your deposition taken?
A In 2003.
Q And was that also in the capacity as a paramedic?
A Yes, it was.
Q And do you recall the facts of that case?
A That involved a situation with a helicopter that

Page 9

was not air worthy that the company kept putting up, and having a team fly in. It also involved the death of a patient in that aircraft.
Q And was the death of a patient a result of something that was wrong with the helicopter? Was there a crash?
A That was one of the factors involved in the death of the patient.
Q Was there actually a crash of the --
A There was not. There --
Q -- helicopter?
A There were several near misses.
Q And what company was that that you worked for at the time?
A That was Air Med Team.
Q And were you personally named in that lawsuit?
A I was one. Yes, I was.
Q And what were the allegations against you?
A Actually, the allegations were not against me. We were the ones pursuing the lawsuit.
Q Oh, okay.
A I apologize.
Q That probably was a poor question. So you were a plaintiff in that lawsuit?
A Yes.

Page 10

Q And what were your allegations against the company?
A The allegations were that we were constructively terminated because we were whistleblowers regarding the incident.
Q And did that -- did that case resolve or what was the disposition of the case? Did it resolve or settlement, or did you go to trial?
A It was through arbitration.
Q And was there a finding on your behalf?
A Not on our behalf. We lost that, that case.
Q Okay. And what's the third deposition that you've had taken?
A Going back in ancient history here. That was in regards to a call at another flight team I was in, I worked for.
Q Okay. And do you recall the facts of that case?
A Yes, I do.
Q Okay. Were you personally named in it?
A I was not.
Q And what company did you work for at that time?
A I was Medaflight of Northern California.
Q And do you recall what the allegations were in that case?
A There really weren't allegations. It was more

Page 11

of a situation where Medaflight -- Air Med team was a new program, and Medaflight was trying to serve an injunction to stop the program.
Q Okay.
A And -- and so it really wasn't -- I guess what you would call a case where there was money involved.
Q Okay. And last but not least, what was the other deposition that you had taken?
A That was a deposi -- that was a call that we were involved in in -- it was a patient that we transported from a mountain area down to doctor's medical center.
Q A mountain area from where?
A Calaveras County.
Q Where is that?
A In California.
Q Oh, okay.
A Yes.
Q And how long ago was that?
A I can't recall that.
Q Okay. And were you personally named in that lawsuit?
A I was not.
Q Have you ever been personally named in a lawsuit besides this lawsuit?
A I have not.

Page 12

Q And then the one that we -- where you were a plaintiff.
A I have not.
Q Okay. Can you tell me your current address?
A It is 1790 Empire Road, Reno, Nevada.
Q And how long have you lived there?
A Since 2013.
Q And what is a telephone number for you?
A 775 433-7017.
Q And who resides with you at that residence?
A My wife.
Q Can you give me a brief synopsis of your educational history?
A It is brief. I went to high school and graduated. And I got my paramedic certification in 1985 at Delta College. And I've had various classes at Community colleges for an A.A. degree which I never finished.
Q Okay. So you graduated high school in 1985. Where -- where did you graduate high school?
A Actually, I graduated in 1978.
Q Oh, I'm sorry.
A Yeah.
Q Well, you should have gone along with the 1985.
A Yeah.
Q 1978?

Page 13

A No, I take that back. No, 1982 was when I graduated. Now I'm getting mixed up on numbers here. I started in '78.
Q Okay. So 1982 you graduated.
A Uh-hum.
Q And where -- what high school did you?
A It was Edward Reed High School, in Sparks, Nevada.
Q And then where did you get your training to become a paramedic?
A At Delta College in Stockton, California.
Q And do you recall the year?
A 1985.
Q There's --
A There's '85.
Q There's '85. Okay. And how -- how long was the training at Delta College?
A Twelve months.
Q What organization -- well, strike that. What licenses do you currently hold?
A I have a paramedic license.
Q And what organization regulates your license to practice?
A California.
Q And is there a governing board?

Page 14

A That would be the California EMS agency in Sacramento.
Q Have you ever had your license revoked or suspended?
A I have not.
Q Have you ever had any lapses in your license?
A I have not.
Q Have you ever been contacted by the board for any letters of concern regarding your care?
A I have not.
Q What certifications do you hold?
A Paramedic certification.
Q Do you have a BLS -- do you have a BLS certification?
A Yes, I do.
Q And do you know when you first got the BLS?
A When I was in the Navy in 1982.
Q And have you maintained that certification since 1982?
A Yes, I have.
Q Any lapses?
A No.
Q What about ACLS?
A Yes, ACLS.
Q And when did you get your ACLS certification?

Page 15

A In 1983.
Q Any lapses in that certification?
A Never.
Q Are there different rankings for paramedics?
A There are not.
Q Can you tell me five years prior to 2016 where you worked as a paramedic?
A American Medical Response.
Q Anywhere else?
A No.
Q So you went from AMR to Reach Air? Or were you working for both?
A I was working for both.
Q How long did you work for both companies?
A For AMR, close to 19 years. And for Reach, close to six months.
Q When did you begin working for Reach Air?
A In March or April, 2016.
Q And how did you come to find Reach Air or did they find you?
A I forged around and Reach, since they were a new program in California, I worked with a lot of their crew members because many of them worked on our team.
Q And back in June of 2016, what -- can you tell me what your schedule looked like between the two

Page 16

companies?
A The -- I was a full timer at Reach so we went out as hardship base. We went out, I believe, ten days at a time, and then I just picked up part-time shifts with AMR in between my rotations in Elko.
Q And so what did it look like to be full time at Reach? Was it certain days that you worked?
A Well, yeah, we went in for a certain group of days, right, we went -- it was a continuum. We'd work one shift. We were one shift off and then on shift, and you were there the whole time because it was a hardship base. It's not where you can work a shift and go all the way home--
Q Okay.
A -- so.
Q And how long were the actual shifts?
A They were 24 hours.
Q And so did you stay -- you would stay in Elko then and then travel back to Reno?
A That is correct. They had an apartment for us so when you're off you went to the apartment --
Q Okay.
A -- until your next shift.
Q Did anyone at Reach Air reach out to you for the position or did you just apply?

Page 17

A I just applied for the position.
Q Okay. And at the time that you were hired at Reach Air, do you recall what documentation or information that you had to provide to them for employment?
A We had to get all of my certifications and my paramedic license.
Q And how long from the time that you applied were you hired?
A Approximately four to six weeks.
Q Okay. And after you were hired were you required to take any type of training courses?
A Within the program.
Q And when you say within the program what do you mean by that?
A They have a -- they have an internship for a certain amount of months when you go there.
Q And do you recall how many months that was?
A It lasts approximately six months.
Q Did you have -- was there classroom training, any type of classroom training or testing that you had to do before you actually went out with a crew?
A There's a two-week training academy in Santa Rosa that's a very intensive academy, I might add, before they let you loose.
Q Okay. And when -- do you recall if you started

Page 18

in April when did you attend the training academy in Santa Rosa?
A It was in April, to the best of my recollection.
Q And what did that training academy consist of?
A It consisted of the basic parameters of prehospital care, emergency medicine, very intensive, so we had many different specialists who would come in for neonatal care, cyclical care, heavy emphasis on rapid sequence intubations in surgical airways.
Q And how much of the time would you estimate was dedicated to the rapid sequence intubations and surgical airways?
A I would estimate three to four days.
Q And can you give us just a description of what those three to four days looked like? Was it hands on, like, with a manikin, was it testing, written tests for --for that specific for rapid sequence intubation and surgical airways?
A It was a combination of didactic work and work on manikins. And also they brought in lungs of, I believe, pigs. We hooked them up -- yeah, I know, it's gross. And we -- for our ventilation, you know, we put ventilators on and we could actually see what the ventilator was doing at the level of the IV line. Very interesting. Very hands on, very intensive.

Page 19

Q And was there also a written portion of that part of the test? I mean, part of the training?
A There was a final test that had all the different subjects, not just RSI.
Q Was it pass/fail or was it graded?
A It was graded.
Q Okay. And do you recall what grade you got on it?
A I do not.
Q Okay. So after -- well, strike that. So prior to attending this two-week training academy you hadn't gone out with the crew for Reach Air? You had to do this first?
A That is correct.
Q And so during -- you only worked for Reach Air for six months. Correct?
A Approximately.
Q And so during that six months that you worked for Reach Air you were still in your internship?
A That is correct.
Q And what was your guidelines or understanding as an intern of Reach Air what you were allowed to do versus being a full crew member?
A You're allowed to do everything within your scope of practice of whatever respective state you're

Page 20

working in.
Q Were you supposed to be or was there supposed to be oversight by anyone since you were still an intern?
MR. WEAVER: Object as to form.
MR. BURTON: Join. You can answer.
BY MS. MORALES:
Q On your crew?
A Yes. They put you with a partner that's already a full-fledged crew member on their own, they're a field training officer, if you will.
Q And who was your training officer?
A I had two of them. One was -- her name was Tamara, I can't remember her last name, in Stockton.
Q I'm sorry, did you say Tamara?
A Tamara, right. Because I was at the Stockton base for a few weeks before I went to Elko. And Elko is Ron Lyons.
Q And Mr. Lyons was a registered nurse. Correct?
A Yes, he was.
Q And what about Tamara, do you know what -- is --
A She's a registered nurse.
Q Can you estimate -- can you estimate for us when -- approximately when you started going out with a crew?
MR. BURTON: Which crew?
BY MS. MORALES:

Page 21

Q The Reach Air.
A As soon as I finished the academy. So I'm estimating May.
Q And as an intern was there any kind of documentation that you would have to submit to your supervising preceptor, Mr. Lyons?
A We had daily evaluations.
Q And can you explain to us what was included in those daily evaluations?
A Basic overall performance.
Q And would -- on those evaluations is that something that you would see? Would he share with you how he was evaluating you?
A Yes. We went through the entire evaluation together.
Q Can you explain to us how that would work? Was it, like, at the end of each shift or the beginning of the next shift that, you know, he would -- what would he go over with you?
A No, it was at the end of every shift.
Q Okay. And do you recall what subjects were on that daily evaluation?
A I don't recall exact subjects.
Q Is it something that you had to sign off on?
A Yes.

Page 22

Q Did you keep a copy of those evaluations?
A I did not.
Q Where -- what would happen after you would sign off on those evaluations?
MR. BURTON: Objection as to form.
MS. MORALES: Yeah.
THE WITNESS: Could you --
MS. MORALES: Yeah. To your --
THE WITNESS: -- rephrase that?
BY MS. MORALES:
Q Yeah. To your knowledge, did you have to submit those evaluations that you signed off onto Reach Air? What would you do once you signed off on them?
A They were kept in a binder at the base. And then at the end of the internship it would be submitted to -- to Santa Rosa.
Q Do you recall ever having any criticisms by Mr. Lyons of your -- during your internship?
A I do not.
Q Why did you -- why did you leave Reach Air before -- I mean right after you -- well, strike that.
Did you complete your internship?
A I did not.
Q And why didn't you complete it?
A Because I resigned my position.

Page 23

Q And why did you resign?
A I resigned because I had decided to leave Reach within about four months of employment because of the insurance. Medical insurance was not what I thought it was.
Q Any other reasons?
A That's the only reason.
MS. MORALES: I heard that. It's being videoed.
BY MS. MORALES:
Q So after you decided to leave Reach Air where did you start working?
A I went back full time to AMR in Stockton.
Q Now, when you're licensed in California as a --as a paramedic is there, like, reciprocity so you can work in other states, is that how it works?
A There is not.
Q And so do you have to be licensed in the state of Nevada?
A You do.
Q And were you licensed in the state of Nevada at the time that you provided care to -- in 2000 -- June of 2016?
A Yes, I was.
Q And how long had you had your license in the state of Nevada?

Page 24

A Approximately three months.
Q Three months from when? What -- what was the date that you got your license?
A I -- I can't remember that.
Q Did you have it before you started at Reach Air?
A I did not.
Q Did you have it in June of 2016?
A I did.
Q Did you have it at the time that you attended the training courses in Santa Rosa?
A I did not.
Q Did you do any intern, part of your internship with Reach Air prior to -- with the crew prior to getting your Nevada license?
A I did.
Q For approximately how long?
A Approximately four weeks.
Q And what was your scope of practice during that four weeks of time that you were on the crew with Reach Air without a license in Nevada?
A I was actually at the time operating at the Stockton base in California, so I was operating under the California State Paramedic scope of practice.
Q Did you go with any of the flight crews in Nevada during that period of time?

Page 25

A I did not.
Q And when you say you were operating out of Santa Rosa can you explain that for us?
A Actually, it was out of Stockton.
Q I'm sorry, Stockton.
A Yeah, it was the Stockton base that they sent me to because I was -- I did not have my license in Nevada yet.
Q And how long did you stay there?
A Approximately four weeks.
Q And do you recall what month that was?
A The month of May.
Q So then you obtained your Nevada license sometime in June of 2016?
A It was in May.
Q Do you still hold a Nevada license?
A I do not.
Q Is there a reason for that?
A I don't work in the state.
Q Did you ever have that license revoked or suspended?
A I did not.
Q Do you still talk with Mr. Lyons?
A I do not.
Q Did you get along with him when you worked with

Page 26

him?
MR. BURTON: Object as to form. Go ahead.
THE WITNESS: I did.
BY MS. MORALES.
Q Did you socialize with him outside of work?
A I did not.
Q Who was your -- who was your -- besides Mr. Lyons did you have any other supervisors at Reach Air that you had to directly report to?
A Yes, but I can't remember his name. No, actually, it was Chris Giller. Chris Giller.
Q And do you know what his position was?
A I don't remember the exact title.
Q And have you spoke with him since you stopped working at Reach Air?
A I have not.
Q When you resigned did you -- did you provide any type of resignation letter?
A I did.
Q And do you recall the reasons, if any, that you cited in the resignation letter for leaving?
A Yes.
Q And what did you put in the letter?
A Because of lack of medical insurance, or the poor medical insurance.

Page 27

Q When you worked -- when you went back to work for AMR did you ever work for AMR in Nevada?
A I did not.
Q And how did you go from -- how did you wind up in Dubai?
A I have not.
Q I mean, not Dubai, I'm sorry. Kuwait, right? Or Iraq, somewhere around there.
A Right. I'm employed by a private military contractor.
Q And what's the name of that contractor?
A I can't tell you that.
MR. BURTON: And just so that you know, and I don't want to cloud your transcript, a lot of what he's doing is classified.
MS. MORALES: Okay.
MR. BURTON: And so I don't have a problem, obviously, if you ask questions, just a heads up you'll probably get a lot of he can't disclose because of classified information stuff.
BY MS. MORALES:
Q So it's not for the government, it's a private contractor?
A They work with the government.
Q And how long have you held that position?

Page 28

A Since August of last year.
Q And when you went to the Middle East is that the first time that you had gone for this company?
MR. BURTON: Objection to form. Go ahead and answer it.
THE WITNESS: That's correct.
BY MS. MORALES:
Q And how long were you there?
A I was there -- actually I never deployed at that -- Middle East with this particular company. And I had been to the Middle East before.
Q Were you doing work for this company at any time since you worked for them in the Middle East?
A I have not. I have not.
Q Was there ever a time that you were residing in a state other than Nevada?
A Yes.
Q Okay. And when was that?
A When was that?
Q During this -- so let me -- let me make it easier.
A Uh-hum.
Q So from 2016 to the present have you resided in any state beside -- or any state or country besides here, or in Reno area?

Page 29

A Yes, I have.
Q Okay. And where did you reside?
A California.
Q Okay. Anywhere else?
A No.
Q Any idea why counsel was trying to schedule your deposition to be taken in Dubai?
MR. BURTON: And just don't disclose anything that we talked about, but you can answer the question.
THE WITNESS: There were just miscommunications.
BY MS. MORALES:
Q I'm sorry?
A There were miscommunications between us. I had multiple false deployment dates. And I did not make that clear.
Q And when you resided in California when was that, from 2016 to the present?
A July of this year. I had dual residence, so.
Q Does your -- does the regulating board for paramedics require that you take a certain number of continuing education credits every year?
A That is correct. Every -- every two years.
Q And how many do you have to take?
A Forty-eight.
Q And have you always taken the required number of

Page 30

credits?
A Yes, I have.
Q Okay. And where or who are those classes offered through that you have to take?
A American Heart Association mostly. And also the International Board of Specialty Certifications for my flight paramedic certification.
Q This Chris Geller that you identified earlier, did you have any knowledge one way or another if he still works for Reach Air?
A I do not.
Q Do you know what his position was at Reach Air at the time that you worked there?
A I -- He was an administrator. I don't know the exact title.
Q What was your understanding as far as how he was to oversee you or supervise you?
A He was -- I believe more of a -- like a regional manager. He had several bases under his command. He was up in the food chain.
Q If you had any questions, concerns or issues as an intern for Reach Air, who would you address those with?
A It depends on what the situation was.
Q Okay. Did you ever have any while you were interning?

Page 31

A No.
Q How many times -- how many times prior to the date that you provided medical treatment to Mr. Schwartz had you been to -- is it Northeastern, North?
MS. RIES-BUNTAIN: It's so funny. I double-checked it, it's Northeastern.
THE WITNESS: Yeah.
MS. RIES-BUNTAIN: It's obvious that I'm not from here. yeah.
BY MS. MORALES:
Q So Northeastern Hospital. Had you been to Northeastern Hospital before the day that you provided medical care to Mr. Schwartz?
A Multiple times.
Q Okay. And was that with Reach Air that you had been there?
A That is correct.
Q And when you say multiple times this is where that estimate comes into play. Can you give us an estimate?
A Probably, like, two times a shift, every shift, on the average.
Q Had you worked with Dr. Garvey prior to the day that you provided medical care to Mr. Schwartz?
A I have.

Page 32

Q Approximately how many occasions?
A Two to three.
Q And had you been introduced to him previously before that date that you rendered medical care to Mr. Schwartz as -- as working for Reach Air as a director?
A That is correct.
Q Did Dr. Garvey provide any of the training that you received in Santa Rosa?
A He did not.
Q How did you first come to meet Dr. Garvey?
A It was during a -- our CTAK training, I believe they called it, it's coordinated training we had to do, and he was involved in that.
Q And where was that training held?
A It was in Reno, Nevada.
Q And what's it called, C?
A It's -- I'm not doing it justice. It's -- it's an acronym for the training that they do. It's very intensive, actually, and they do it every -- I believe every four months.
Q Okay.
A The entire Reach program.
MS. RIES-BUNTAIN: I'm sorry, I must have misheard you. Did you say CPAP?
THE WITNESS: CTAK. It's CTAK, I believe.

Page 33

MS. RIES-BUNTAIN: CTAK. It's an acronym of some type.
THE WITNESS: Right. And that's wrong I'm gonna tell you right now.
MS. RIES-BUNTAIN: All right.
BY MS. MORALES:
Q Okay. And what do you recall, Dr. Garvey, did he teach the entire course?
A He did not.
Q Okay. And what do you recall his participation being in that course?
A He and another representative from Reach, I believe she's a registered nurse, were giving us scenarios. They're very interactive and.
Q And do you -- did you have an understanding of what his position was at Reach Air?
A Yes.
Q And what was your understanding?
A He was a medical director.
Q And how long did that CTAK or whatever it's called training last in Reno?
A Approximately eight hours. A full day.
Q And do you know approximately when that training occurred in relation so this incident happened in June of 2016?

Page 34

A Approximately a month before the incident.
Q Had you already been going out with the flight crew at the time that you took this training or did you take the training before you went out?
A No, I was already with the flight crew.
Q And prior to rendering medical care to Mr. Schwartz you -- how many times had you worked with Dr. Garvey in the emergency room?
A Approximately two to three times.
Q Two to three times?
A Oh, right.
Q And were those for transports?
A They were.
Q Flight transports?
A Yes.
Q Did you ever have to intubate any of those patients?
A I did not.
Q Had you ever performed an intubation for Reach Air prior to Mr. Schwartz?
A I did not.
MS. MORALES: Can we take a quick break?
MR. BURTON: You bet.
VIDEOGRAPHER: We are going off the video record. The time is approximately 10:05 a.m.

Page 35

(Short break.)
VIDEOGRAPHER: We are going back on the video record. The time is approximately 10:18 a.m.
BY MS. MORALES:
Q How many intubations have you performed in your career as a paramedic?
A Approximately 1,500.
Q And that's a specific number. How'd you come up with that?
A I used to keep a record.
Q I'm sorry?
A Used to keep a record.
Q Do you still have that record?
A I do not.
Q And what was the purpose of keeping the record?
A Just have a record how many intubations I've done.
Q And when did you stop keeping record?
A Fifteen years ago.
Q Have you ever performed a cric procedure before?
A I have.
Q How many?
A Five.
Q How many had you performed before Mr. Schwartz?
A Four.

Page 36

Q And as a -- does your license as an EMT allow you to do cric procedures?
A In the state of Nevada.
Q What about in California?
A No.
Q When prior to -- strike that. Did you perform the cric procedures while a crew member for Reach Air, prior to Mr. Schwartz's other four?
A No.
Q Where did you perform those?
A In California.
Q And how did you perform those if your licensure didn't allow you to do it?
A It was actually assisting of the surgical cric with the flight nurse.
Q So you didn't actually do one yourself.
A No.
Q So prior to Mr. Schwartz you'd never yourself performed a cric procedure. Correct?
A Not on a human being.
Q What's your understanding as an EMT as to when a cric procedure should be performed?
A When you're in a crash airway situation you can not orally intubate the patient.
Q And can you explain to us a little bit more what

Page 37

-- how do you define a crash airway situation?
A When you have a patient that's not able to ventilate, you're not able to ventilate through the BLS measures or through direct oral and tracheal intubation.
Q How many attempts should be made before you -- before you do the cric procedure, how many failed intubations?
MR. BURTON: Object as to form.
THE WITNESS: On the average, three.
BY MS. MORALES:
Q And in Nevada as an EMT are you allowed to make the call whether or not to start a cric procedure or does that have to be ordered by a doctor, supervising physician?
A It depends on the environment that you're in.
Q Can you explain that to us?
A If we're in the field, me and the flight nurse, we can make that decision on our own.
Q And in a situation such as Mr. Schwartz's, who makes that decision?
A A medical doctor.
Q As an EMT you can certainly make that recommendation. Correct?
A That is correct.
MR. BURTON: Object to form. Sorry.
BY MS. MORALES:

Page 38

Q Sorry?
A That is correct.
Q Do you consider a patient who has just had a steak dinner just prior to presenting to a hospital a high-risk intubation?
MR. GARVEY: Object to form.
MR. BURTON: Join.
MR. WEAVER: Jen, so are you okay with one objection?
MS. MORALES: Yeah, yeah, that's fine.
THE WITNESS: Any patient requires intubation is a risk.
BY MS. MORALES:
Q Okay. Do you consider a patient who has just eaten a dinner a higher risk?
MR. WEAVER: Object as to form.
MR. BURTON: Join.
THE WITNESS: Yes.
BY MS. MORALES:
Q Were you made aware at the time that you presented to the hospital that Mr. Schwartz had just had a meal prior to presentation to the hospital?
MR. WEAVER: Form.
MR. BURTON: Join.
THE WITNESS: Yes.

Page 39

BY MS. MORALES:
Q And you agree that it's important to know whether the patient is a higher risk before intubating. Correct?
MR. BURTON: Object as to form.
THE WITNESS: That is correct.
BY MS. MORALES:
Q And you agree that -- strike that. You agree that Dr. Garvey as a medical director of Reach Air and an emergency room physician has more experience and -- or is more qualified than you to perform intubations. Correct?
MR. WEAVER: Object as to form.
MR. BURTON: Join.
MS. HUETH: Join.
THE WITNESS: I don't know about his experience.
BY MS. MORALES:
Q Generally you would agree that a director in a position for Reach Air as well as AN emergency room doctor with 30-plus years' experience is gonna have more experience than you in performing intubation. Correct?
MR. WEAVER: Object as to form.
MR. BURTON: Join.
THE WITNESS: No.
BY MS. MORALES:
Q Why not?

Page 40

MR. BURTON: Make sure your give us a chance to -- to chime in.
THE WITNESS: Because I don't know how many intubations they have. We usually have a lot more intubations in the field.
BY MS. MORALES:
Q And you had an understanding that Dr. Garvey actually taught for Reach Air, correct, intubations?
MR. BURTON: Objection. It mischaracterizes the testimony. Go ahead and answer.
THE WITNESS: Yes.
BY MS. MORALES:
Q Have you ever witnessed Dr. Garvey perform an intubation prior to his assistance with Mr. Schwartz?
A I have not.
Q To your knowledge have you ever performed an intubation on a patient who had a full meal prior to intubating?
A Yes.
Q Have you ever had a patient die during your attempt to intubate?
MR. BURTON: Object as to form.
THE WITNESS: Never.
BY MS. MORALES:
Q Have you ever witnessed anyone else -- well,

Page 41

strike that.
Have you ever witnessed any -- the other EMT that you worked with have a patient die trying to intubate?
MR. BURTON: Object as to form.
THE WITNESS: No.
BY MS. MORALES:
Q How many intubations had you performed for Reach Air while a patient was in the hospital versus in route to a hospital?
A None.
Q Had you ever in any of your positions as an EMT intubated a patient in a hospital setting versus being in route to a hospital?
A Yes.
Q On how many occasions?
A I can't even approximate.
Q You can't give an estimate for that?
A No.
Q When is prior to Mr. Schwartz do you recall the last time that you had intubated a patient in a hospital setting?
A In 2009, 2010.
Q And was that in California?
A Yes, it was.
Q And was that in an emergency room?

Page 42

A Yes, it was.
Q Would you estimate that you've intubated a patient in an emergency room setting more or less than 50 times?
A I would say more.
Q Is there a reason the last time that you had done it in California was approximately six years before Mr. Schwartz's intubation, attempted intubation?
A In 2009, 2010, yes.
Q Is there a reason that you hadn't done it for that six-year period of time?
A Are you talking about in-house intubation or intubation?
Q In-house. I'm talking about in an emergency room setting.
A Yeah, it was approximately -- was there a reason for it?
Q Yeah.
A Yes, because most of the intubations we do are in the field.
Q Can you estimate for me appro -- by percentages, like 95 intubations that you do in the field, more or less? Is it more or less than 95 percent?
MR. BURTON: Object to form.
THE WITNESS: I'd say more.

Page 43

MR. BURTON: Sorry.
BY MS. MORALES:
Q How about 99 percent?
MR. BURTON: Object to form.
THE WITNESS: I can't guess on a percentage to that exact degree.
BY MS. MORALES:
Q And what company did you work for when you're performing intubations in the emergency room setting?
A American Medical Response.
Q And to your knowledge, do they have any policies or procedures one way or the other whether or not that's allowed?
A That I'm not aware of.
Q So you're not aware if they have policies or procedures whether you should be doing that but you actually had; is that correct?
MR. BURTON: Object to form.
THE WITNESS: That is correct.
BY MS. MORALES:
Q Would you estimate that you've intubated a patient in an ER setting for ARM more or less than ten times?
A Less.
Q How about five times?

Page 44

A Less.
Q How about three times?
A Less.
Q One?
A One.
Q And when was that prior? Was that back in 2006 or 2 -- I'm sorry, 2000 -- 2009 time period?
A Correct.
Q And what were the circumstances of that case and the reason why you intubated a patient in the ER?
A I was there to transport another patient and I came in and the crew had a pediatric patient that was a drowning, and the ER doc and the respiratory therapist could not intubate the patient, and the ER doctor asked me if I would do the intubation.
Q So in that situation there was already failed attempts by the ER doc and the nurse, correct?
A They were a respiratory therapist, correct.
Q A respiratory therapist, yeah. And were you able to successfully intubate that patient?
A Yes, I was.
Q During your training at Reach Air did they train you that you're only to intubate patients in route?
A No, they did not.
Q Did they have any specifics of whether or not

Page 45

you should be intubating a patient in an emergency room setting?
MR. BURTON: Objection to form.
THE WITNESS: The criteria for intubation is the whether a patient -- regardless of where they are is whether the patient needs that at that time.
BY MS. MORALES:
Q I'm sorry?
A Whether they need the intubation at the time, or to secure an airway before transport.
Q Have you ever had any discussions regarding your experience, training, or education with Dr. Garvey prior to attempting to intubate Mr. Schwartz?
A I did not.
Q So to your knowledge he had no idea what your training or experience was, correct?
MR. WEAVER: Object as to form.
MR. BURTON: Join.
THE WITNESS: I -- no.
BY MS. MORALES:
Q Did anyone from Reach Air ask you why you were the one to attempt to intubate Mr. Schwartz instead of Dr. Garvey?
MR. BURTON: So I'm going to object to the extent any of that was with in-house counsel or any lawyers on

Page 46

behalf of Reach, don't answer that, but if it's anyone who's not a lawyer, you can go ahead answer.
THE WITNESS: Answer the question?
MR. BURTON: Just as long as it doesn't disclose any discussions that you may have --
THE WITNESS: Oh, okay.
MR. BURTON: -- had with lawyers. Sorry.
THE WITNESS: And I'm sorry, could you just retell me the question again?
MS. MORALES: Can you repeat that?
REPORTER: Yes.
(Question read.)
MR. BURTON: And so my objection is if anyone -- if you had that discussion with anyone who's an attorney, including anybody in this room, don't disclose that, but if it was anybody else, you're free to answer.
THE WITNESS: No.
BY MS. MORALES:
Q Let me show you the records here from Reach Air. Does everyone have a copy?
MR. BURTON: I think I'd like an exhibit just to make sure we're talking about the same thing, if you have enough.
MS. MORALES: Yeah, I had some made, but I'll go ahead we'll mark this as the first exhibit. I have a

Page 47

couple copies.
MS. RIES-BUNTAIN: I'll take one if you have extra.
MS. MORALES: Keith, do you have one?
MR. WEAVER: I'm good, thanks.
REPORTER: Exhibit 1.
(Exhibit 1 is marked.)
MS. MORALES: I have a couple of copies.
BY MS. MORALES:
Q Okay. So if you can go to, if you look, it's kind of small, but in the right-hand corner Schwartz 000187.
MR. WEAVER: So Jen, in that case do you have an extra copy? Just because mine are different Bates-stamped numbers. If not, it's okay, I'll find it.
MS. MORALES: We can --
MR. WEAVER: It's okay, go ahead. I'll find it.
MS. MORALES: Are you sure?
MR. WEAVER: Yeah.
MS. RIES-BUNTAIN: I'll show you.
MR. BURTON: It's that. Oh, yeah, I bet you have it in front of you.
MR. WEAVER: Got it. Thank you.
BY MS. MORALES:
Q Okay. Thank you. Okay. According to -- so if

Page 48

-- are you with me on page 187?
A Yes, I am.
Q And if you look in the left-hand side here it identifies -- sorry, my eyes are starting to go now for reading close-up. So the response mode, no lights and sirens; is that correct?
A Yes.
Q Okay. And just so the jury is clear, does that mean as you were heading over to the hospital to provide transport to Mr. Schwartz that the lights and sirens were not on the ambulance. Correct?
A We did not go over in an ambulance.
Q Okay. How are you -- how do you transport over to the hospital?
A We have a van, and the pilot drives us over.
Q Okay. And does the van have lights or sirens?
A It does not.
Q Okay. So I guess that's always filled out no lights and sirens; is that correct?
A That is correct, yeah.
Q Okay. All right. It says here that if you look on the response times, you were notified at 23:36; is that correct?
A No, we were not notified at 23:36.
Q Okay. Can you tell me what that means then?

Page 49

A That's when dispatch was notified.
Q Okay. Dispatch was notified.
A Yeah.
Q Okay. So the unit, are -- is your team the unit?
A That is correct.
Q Okay. So the unit was dispatched at 23:41. Correct?
A That is correct.
Q And you arrive at -- on scene -- and I assume on scene means at the hospital; is that right?
A That is correct.
Q So you arrive on scene at 23:55. True?
A True.
Q Okay. And at the patient's bedside at 23:57. Correct?
A Correct.
Q Okay. Now, if you turn to the next page. And before we get here can you tell me what you do before presenting to the patient's bedside? Do you get any information before you actually go to the patient's bedside?
A We get that information via dispatch.
Q Okay. And do you recall in this case what information you were provided?

Page 50

A That we're going to be transporting a gentleman that had been -- it was an auto/ped and had a small flail segment and a small pneumothorax.

Q And so when it says "The Reach team arrives at 23:57 to find Dr. Garvey speaking with the receiving physician on the phone", were you part of that team that arrived when he was on the phone?

A I was part of that team.

Q Okay. And do you recall and do you have a recollection of Dr. Garvey being on the phone?

A Yes, from a distance.

Q Were you able to overhear anything that he was saying on the phone?

A Not me.

Q The next line there says that "Dr. Garvey reports Mr. Schwartz has an approximately ten percent pneumothorax on the right side of his chest with a flail segment but is tolerating it well at this time."

Did Dr. Garvey report that to you and your crew at the time of presentation?

A Not to me.

Q Okay. Did you overhear him talking to Mr. Lyons?

A I did not.

Q And at the time that you presented to Mr.

Page 51

Schwartz' room was his family still in the room?

A Yes, they were.

Q And did you have any discussions with any of the family in the room?

A I did not.

Q And were you present when Dr. Garvey had any discussions with Diane for -- Diane is Ms. Schwartz, for the need to insert a chest tube?

A Yes, I was.

Q And what do you recall of that discussion?

A That he was gonna be putting in a chest tube because of a collapsed lung, and also be putting in an airway.

Q And who -- where did this discussion take place?

A In the emerg -- in the room where he was, the trauma room.

Q And who was in the room at the time that this discussion took place?

A Myself, Dr. Garvey, Ron Lyons, Mrs. Schwartz, obviously Mr. Schwartz, and another gentleman there that I assume was a family friend.

Q And when Mr. -- what Dr. Garvey actually said is that he might need to intubate the patient; isn't that correct?

MS. MORALES: Form.

Page 52

MR. BURTON: Join.

THE WITNESS: No, he did not.

BY MS. MORALES:

Q What did you hear him tell Ms. Schwartz?

A That he needed to be intubated because he needed to protect the airway for the flight.

Q And did he discuss with Ms. Schwartz any potential risks or complications associated with intubating Mr. Schwartz?

A Yes.

Q What did he explain?

A Explained that it was very common procedure, and for all intents and purposes a safe one but that there were possibilities of issues with the intubation and anesthesia.

Q And did he give her any alternative treatment options besides intubation?

A I don't recall that.

Q Did he explain that there was a higher risk to intubate this patient because he had just eaten prior to presentation to the hospital?

A No.

Q Do you recall Diane, anything that Diane said to Dr. Garvey after this discussion?

A No.

Q And I'm sorry, I'm gonna skip around a little

Page 53

bit. In preparation for your deposition today did you -- what did you review?

A I reviewed this chart and Dr. Garvey's deposition.

Q And when you say "this chart", just a Reach Air chart?

A That is correct, this chart that's in front of us.

Q Did you review any medical records from Northeastern hospital?

MS. RIES-BUNTAIN: You know, do you refer to it as NNRH? I feel like some people do.

THE WITNESS: Yes, NNRH.

MS. RIES-BUNTAIN: That might be easier for everybody, right?

THE WITNESS: I did not.

BY MS. MORALES:

Q At Reach Air, do you. Does Reach Air have any type of consent forms that are normally signed for intubation?

MR. BURTON: Object as to form.

THE WITNESS: Not that I can recall.

BY MS. MORALES:

Q Did you personally try to get informed consent from Ms. Schwartz to perform the intubation on her husband?

Page 54

MR. BURTON: Object as to form.
THE WITNESS: I did not.
BY MS. MORALES:
Q The Reach Air medical record describes that the team included a respiratory therapist, six ER nurses, a paramedic, and attendants. Do you recall who was in the room that day with you?
A B name?
Q Yeah. Who can you recall by name?
A The transporting team, Silvia, EMT, I believe, and Paul is the transporting paramedic.
Q And did they both work for Reach Air?
A They do not. Or did not at the time.
Q Do you associate or socialize with either of these individuals outside of the work area?
A I do not.
Q Do you have any knowledge one way or the other if these two individuals are still working as an EMT and paramedic?
A I do not.
Q So Silvia and Paula and Mr. Lyons; is that correct?
A That's correct. It is Paul, not Paula.
Q Oh, okay. And was Mr. Lyons in the room as well?

Page 55

A Yes, he was.
Q Did you have any discussions with Mr. Schwartz before you attempted to intubate him?
A Yes.
Q And what do you recall discussing with Mr. Schwartz?
A I talked to him briefly, I introduced myself. He told me his name. And I told him I was gonna do a quick assessment and put him on our monitor, which I did.
Q And when you introduce yourself what do you say?
A I said "Hello my name's Barry, I'm a fleet paramedic with Reach Air."
Q And what kind of assessment do you do?
A I do a -- in his particular case listen to his breath sounds, was observing his level of consciousness just by talking to him.
Q And what do you recall -- well, strike that. Do you document your assessment any way, anywhere in the record?
A It's in the flow chart with the vital signs.
Q What do you recall about his assessment that you did?
A He was on a nonrebreather, I remember his saturations were in the 96, 97th percentage, his blood pressure and his pulse were stable, as was his level of

Page 56

consciousness. It's normal.
Q So his blood pressure was -- his blood pressure, pulse, and what about respiratory rate, that was normal too, correct?
A It was slightly elevated.
Q What's a normal respiratory rate?
A Sixteen to twenty for an adult.
Q And what do you recall his being?
A I don't recall.
Q And he was able to talk to you. Correct?
A He was.
Q Anything else about the discussion that -- with Mr. Schwartz that we haven't discussed already?
A Not that I can recall.
Q And so at the time that you got to the room he had what type of mask on?
A I believe it was a nonrebreather. It has a full bag.
Q And is that the mask that you put on to preoxygenate the patient?
A That is correct.
Q And was a mask, to your knowledge, was a mask put on in preparation to preoxygenate the patient?
A Yes, it was.
Q And can you explain to us and -- and the jury

Page 57

what it means to preoxygenate a patient?
A It's to supersaturate a patient before rapid sequence induction intubation.
Q And to your knowledge, and education and experience as an EMT, what's the purpose of preoxygenation of a patient prior to rapid induction?
A There's gonna be a time when the patient is not breathing, and the cells need to be supersaturated.
Q And what's your understanding of how long the patient should be preoxygenated before performing an intubation?
MR. BURTON: Object to form.
THE WITNESS: Approximately five, eight minutes.
BY MS. MORALES:
Q Now, is there a setting that -- of the amount of oxygen that should be given?
A Yes.
Q And what is that?
A On a nonrebreather, anything above eight liters, permanent.
Q And so here in this record that I'm going back to this 1888, at the time that you arrived to the hospital it's fair to say that Mr. Schwartz was tolerating the pneumothorax and flail segment. Correct?
MR. WEAVER: Object as to form.

Page 58

MR. BURTON: Join.
THE WITNESS: Tolerating. Why don't you rephrase that. What do you mean by tolerating?
BY MS. MORALES:
Q I'm getting it straight from the record from Reach Air. So he was stable at the time that he got to the hospital. Correct?
MR. WEAVER: Object as to form.
MR. BURTON: Join.
MS. RIES-BUNTAIN: Join.
THE WITNESS: I wouldn't say he was stable.
BY MS. MORALES.
Q Okay. And why wouldn't you say he was stable?
A Because he is at 97 percent oxygen saturation and he's on a 15-liter nonrebreather.
Q Okay.
A And your average person would be at 99 percent at room air.
Q And do you know what it meant when it said that he was tolerating these conditions well?
A No.
Q And his vital signs were normal. Correct?
A His blood pressure and his pulse.
Q And can you look at the record and tell me what his respirations were?

Page 59

A I can not.
Q Okay. We'll go ahead and give you more records, then maybe you can tell us.
So this is -- okay. So we'll mark this as the next exhibit.
So these are records -- got pen all over me.
MR. BURTON: Do you have a copy that we can --
MS. MORALES: Yeah. I think these are the records from the hospital.
MS. HARMON: NNRH?
MS. MORALES: Yeah. I'm, like, I put it on the other sheet so I wouldn't get that wrong so much. Okay. So I have one more.
Keith, I'm not trying to leave you out.
MR. WEAVER: No, I don't need any. Thank you.
MS. RIES-BUNTAIN: Yeah, we can share --
MS. MORALES: Okay.
MS. RIES-BUNTAIN: -- too. I appreciate the paper. Thank you.
BY MS. MORALES:
Q Okay. And so you said the normal respir -- respirations for an adult is between 16 and 20. Correct?
A That is correct.
Q And if you turn to page 34, it looks like that's an automatic reporting there of his vitals. And the timing

Page 60

that we're looking at, you arrived at 23:57. So at 23:45 his respirations were 18, correct?
A That's what the chart says.
Q Okay. Do you have any reason to dispute that?
A No, I don't.
Q Okay. And then at ten minutes after midnight his respirations are 17, correct?
A That is correct.
Q And then 15 minutes after midnight his respirations are 19, correct?
A Yes, that is correct.
Q And then 20 minutes after midnight is when his respirations go to 22, correct?
A That is correct.
Q Okay. And do you know if that's a time that you attempted to intubate?
A I don't recall when the time was, intubation.
Q And, in fact, the pulse oxy at that point had dropped to 83 percent. Right?
A That's what the chart indicates, yes.
Q Okay. So we'll go back and look at what time you intubated.
So it's fair to say before 20 minutes after midnight his respirations were normal, correct?
MR. WEAVER: Object as --

Page 61

BY MS. MORALES:
Q Within normal limits.
A Per what the monitor says, that's correct.
MR. BURTON: Join the objection.
BY MS. MORALES:
Q And do you have evidence that they were anything other than what's documented here by the monitor?
A I do not.
Q And those are all within normal limits, right?
A That is correct.
Q Okay. And so just so we're clear, then, his blood pressure was within normal limits, the respirations were within normal limits, and what was the other one that we talked about earlier? Didn't you name three? The pulse, pulse oxy.
Do you recall from your, and I'm going to look for it here, but from your review of the records in preparation for your deposition what time you attempted the intubation?
A I do not.
MS. MORALES: Okay. And then I apologize, I need more of these, then I need to make copies because --
MS. RIES-BUNTAIN: I have it.
MR. WEAVER: May I have it, too?
MS. MORALES: Okay. So this is Schwartz 0000060,

Page 62

and we can mark this as the next exhibit.
(Exhibit 3 is marked.)
BY MS. MORALES:
Q Can you look at that record and tell me at what time you attempted the intubation?
MS. HARMON: What did you just provide him?
MR. BURTON: Yeah.
MS. MORALES: It was -- it's a medical record, I believe, from -- oh, it's from the hospital.
MR. BURTON: Yeah. You're not asking him to rely upon what's stated in this record?
MS. MORALES: Well, I'm asking him to look at that. He's the one that performed the intubation, or attempted it.
THE WITNESS: Did you guys want a copy of this before we -- I go forward? Want to make a copy of this?
MS. MORALES: Yeah, sure. Can we go off the record for a moment? Sorry.
VIDEOGRAPHER: We are going off the video record. The time is approximately 11:05 a.m.
(Short break.)
(Exhibit 2 is marked.)
VIDEOGRAPHER: We are going back on the video record. The time is approximately 11:08 a.m.
BY MS. MORALES:

Page 63

Q Okay. So now you're looking at what we marked as the next exhibit, which is -- are we going numbers or Letters here? Letters?
REPORTER: Numbers. Number 3.
MS. MORALES: Okay. That's fine. Number 3.
BY MS. MORALES:
Q Number 3. Have you had an opportunity to review this record?
A Just right now.
Q Yeah.
A Yes.
Q Okay. And so this isn't one of the records that you reviewed in preparation for your deposition?
A No, it was not.
Q Okay. And according to this record, what time did you attempt to intubate the patient?
MR. BURTON: Object to form.
THE WITNESS: Zero --
MR. BURTON: Go ahead.
THE WITNESS: 0020.
BY MS. MORALES:
Q Okay. And then going back to the 00034, Mr. Schwartz' respiratory rate, that's the first time that it increased was actually at the time that you tried to intubate the patient. Correct?

Page 64

A Was 0034?
Q I'm sorry, I'm looking at --
A Yeah. Okay.
MR. WEAVER: I'm sorry, Jen. I missed the question.
MS. MORALES: I can ask it again, I suppose.
BY MS. MORALES:
Q So we're looking here at 0034. The first time, according to the automate -- automated recording here which is identified on 00034 of Mr. Schwartz's vitals, the first time the respiratory rate was increased was at 0020 which is consistent with the other record that we're looking at which is Exhibit 3, at the time the intubation started, which is -- was attempted at 0020. Correct?
A That is correct.
Q Okay. And so when you testified earlier that his respirations were -- were a little bit elevated, they actually weren't elevated until you attempted to intubate. Correct?
MR. BURTON: Object to form.
THE WITNESS: Per the record.
BY MS. MORALES:
Q And you don't -- you don't have any documentation or anything to suggest otherwise. True?
A I do not.

Page 65

Q So it's fair to say, then, before you attempted intubation that his -- Mr. Schwartz's respiratory rate was stable, as well as his blood pressure. Correct?
MR. BURTON: Object to form.
MS. RIES-BUNTAIN: Join.
THE WITNESS: Per the record.
BY MS. MORALES:
Q And the pulse. Correct?
MR. BURTON: Same objection.
THE WITNESS: That is correct, per the record.
BY MS. MORALES:
Q Okay. So in other words, he had stable vital signs.
MR. BURTON: Object to form.
THE WITNESS: Per the record.
MS. MORALES: Yeah.
BY MS. MORALES:
Q And again, you don't have any evidence or any documentation of other, other than what's in this record. True?
A That is true.
Q Okay. Can you tell me what -- well, strike that.
What equipment did you -- did you get -- did you have in preparation to do this intubation?

Page 66

A A complete airway bag with an assortment of endotracheal tubes, a C-MAC intubation system.
Q Okay. And can you explain to the jury what a C-MAC is?
A It is a computerized fiberoptic computer laryngoscope blade, with a screen.
Q And does that -- does that machine allow for recordings?
A It does.
Q What about photographs?
A I don't know about photographs. Still shots recordings, it does.
Q And had you used a C-MAC machine prior to Mr. Schwartz' intubation?
A I had.
Q Okay. And is it your custom and practice to video, to press a video recording button while you're doing this, intubating?
A It is -- I'm sorry, say that one more time?
Q I'm sorry. Is it your custom and practice to video record while you're attempting to intubate?
A It is policy.
Q Okay. And when you say it's policy, is that policy of Reach Air or are you saying that's standard of care? I'm confused.

Page 67

A It's of Reach Air.
Q Of Reach Air. And do you have an understanding of what happens to that recording?
A It is reviewed.
Q And who is it reviewed by?
A CQI staff at the Santa Rosa level.
Q And what information or knowledge were you provided as far as why such recordings are reviewed?
MR. BURTON: Object as to form.
THE WITNESS: For training purposes.
BY MS. MORALES:
Q Do you also take -- is it also policy to take still photos?
A Not that I recall.
Q And in Mr. Schwartz's case do you recall following that policy in videoing your -- with this machine your attempt to intubate?
A I do not recall that.
Q Do you know if you did one way or the other?
A I don't know that.
Q Is there a reason that you wouldn't have followed the policy on this day to record the intubation?
A No.
Q And it was your custom and practice to do so, correct?

Page 68

A It is our policy.
Q Okay. I'm not asking policy. The question is what's your custom and practice, you, individually, as an EMT or paramedic?
MR. BURTON: Object to form.
THE WITNESS: It would be my custom and practice.
BY MS. MORALES:
Q Did you ever go back and review the video of Mr. Schwartz?
A I don't recall doing that, no.
Q Is it your custom and practice to take still photos?
A It is not.
Q And how -- do you have an understanding is there something that you have to do as a paramedic to download the -- the recording from the machine?
A There is a process involved with that.
Q Okay. Can you explain to us what that process is?
A I can't.
Q And why is that?
A Because I never had to do it.
Q Okay.
A Yeah.
Q What was your understanding when you worked at

Page 69

Reach Air as far as what the process was to get the recordings off of that machine?
A I don't remember.
Q Was there anything that you were required to do to make sure that you preserved it?
A It -- you -- it was in the middle of the tanks, so it was there just like a computer.
Q Okay. And so besides the C-MAC machine you listed some other things that you would have in preparation for the intubation. What are those other -- what other equipment would you have?
A We'd have multiple blades, back-up blades for intubation, multiple tubes, tube sizes, and, of course, suction standing by.
Q Now, knowing that Mr. Schwartz had a meal prior to presenting to the hospital, is there any additional equipment that is needed for a higher risk intubation?
A Just what we -- what we set out, suction.
Q Anything else?
A That is it.
Q What other precautions in your education, training and experience can be made when intubating a patient who has recently had a full meal?
A Tilt the head up a certain de -- a certain angle in the attempt, airway attempt.

Page 70

Q Anything else?
A That is it.
Q Okay. Can you tell me from your recollection what you recall happening when you -- at 20 minutes after when you attempted to intubate Mr. Schwartz?
A I'm sorry, could you kind of rephrase that?
Q Yeah, let me strike that. Let me back up a little bit anyway.
How did it come -- what discussions took place between you and Dr. Garvey pertaining to who was gonna intubate Mr. Schwartz?
A There were no discussions.
Q Okay. How were you assigned that duty?
A The paramedics usually do the intubations, and flight crews. So it was a given that I was gonna do the intubation.
Q Okay. Earlier you testified that that normally doesn't occur in an ER setting. So in this situation how did it come about that you were gonna be the one to intubate Mr. Schwartz?
A It does in an ER setting when there's a flight crew involved, not with the ground paramedic.
Q And so was there any discussion between you and Mr. Schwartz -- I mean you and Dr. Garvey regarding who was gonna do the intubation?

Page 71

A No.
Q Was there any discussion between you and your supervising preceptor, Mr. Lyons, as far as who was gonna do the intubation?
A No.
Q And so you don't recall any discussions. Do nurses do intubations?
A They do.
Q Flight crew nurses?
A They do.
Q And so I guess I'm trying to see how this all kind of went down. If you're in the room, there's no communications as far as who's gonna intubate?
MR. BURTON: Object to form.
THE WITNESS: It's -- it's a given that the paramedics are going to do the intubation.
BY MS. MORALES:
Q How is it a given within your own team who's gonna do it?
A Because most flight nurses are not comfortable with intubations.
Q Okay. And did you have -- you didn't have any discussions even prior to arrival for this patient who was gonna intubate?
A I don't recall that.

Page 72

Q Can you tell me what occurred or what you recall happening at this 20-minute-after mark when you attempted to intubate?
A What happened at the 20 minutes during the intubation?
Q Right.
A He was paralyzed. And I attempted the intubation with a C-MAC, and it was a difficult visualization. It was very anterior.
Q And when you say it was very anterior, to a lay person what does mean?
A That means his airway list was farther up than the normal airway in more of an anterior upward position made it difficult to actually visualize the cords.
Q And did you communicate his anatomy to Dr. Garvey?
A I communicated I was having a difficult time visualizing the glottic opening.
Q Okay. And did you -- who did you say that to? Was it just --
A I just --
Q -- out loud?
A I spoke it out loud.
Q Okay. And did you -- what exactly do you recall saying?

Page 73

A I don't recall exactly what I said.
Q Do you recall -- generally what would you say in a situation like that? What would be your custom and practice if you've seen that?
A He's interior.
Q Okay.
A He's interior.
Q And had you intubated a patient who are interior before?
A Many.
Q And have you had difficulty doing so?
A There is difficulty in some.
Q And it's fair to say that that makes it a higher risk intubation, correct?
MR. BURTON: Object to form.
THE WITNESS: It makes it more difficult.
BY MS. MORALES:
Q And at that point did you ask Dr. Garvey to assist you?
MR. WEAVER: Object as to form.
MR. BURTON: Join.
THE WITNESS: I did not.
BY MS. MORALES:
Q Okay. And then what do you recall happening next?

Page 74

A His saturation started to drop very quickly. And we pulled out the -- the blade.
Q And approximately how long did you keep the blade in while you attempted to intubate before you pulled it out?
A Ten to 20 seconds.
Q Okay. And what do you recall happening after that?
A We attempted to ventilate the patient.
Q And how did you attempt to ventilate?
A With a bag valve mask device.
Q And was that ventilation successful?
A It was not.
Q Okay. And then what happened?
A We repositioned the airway.
Q What does that mean?
A It means we repositioned back into a sniffing-type position, or into a good sniffing position and modified the jaw, lifting up with the fingers for a modified jaw thrust.
Q And what does that help do?
A It displaces the tongue out of the hypopharynx.
Q And again, we're -- we're gonna try to explain this to a jury. So displacing the tongue, what is that? How does that help?

Page 75

A It -- what happens in a heavily sedated state your tongue will fall back and will actually block the glottic opening so by pushing up on the mandible, the modified jaw thrust actually pulls it up and opens that airway.
Q Okay. And did that help with the ventilation?
A It did not.
Q Okay. And so then did you try to intubate, try another attempt?
A I did.
Q Okay. And was that at -- in looking at the 60, what time did you -- at what point did you try to re -- try another attempt?
A Very quickly.
Q Okay. And so at what time do you believe that was at?
A I couldn't speculate on that.
Q And when you reviewed the medical records because I know there was some handwritten notes as -- other handwritten notes as well, did you see timing from documented by Reach Air?
A On my chart?
Q Yes. Correct. I thought there was handwritten. Okay. According to this document, we can compare it later to the Reach Air, I believe there was another

Page 76

handwritten on a plain piece of paper.
A ET tube placement was attempted again at 0023.
Q Okay. And what happened during that attempt? So that was, like, three minutes after the first attempt and after you pushed the jaw up. Right?
A That is correct.
Q Okay. So three minutes later what happened? What do you recall of that attempt?
A I got visualization and considered about a 25 percent glottic opening visualization, and emises started to pool into the hypopharnyx.
Q Okay. And what do you recall happening after that?
A Um, I attempted to pass a tube, in the glottic opening.
Q And what tube were you attempted to pass, what size?
A The 7.5, if I recall.
Q Okay. And what happened next?
A I was not able to get it into the -- into the glottic opening. It slipped into the esophagus.
Q Okay.
A And we pulled the tube out and had to start doing very aggressive suctioning of the airway.
Q And was he -- was there emesis already coming up

Page 77

at that point?
A Yes, there was.
MR. WEAVER: I'm sorry, Jen, what was the beginning of the question? Was there emesis coming out of there?
MS. MORALES: Coming up at that point.
THE WITNESS: Yes, there was.
BY MS. MORALES:
Q Okay. And so who started to suction?
A I don't recall whether it was a respiratory therapist or it was Ronnie.
Q Okay. And what were you doing at the time that they were suctioning?
A I was getting another ET tube.
Q What size ET tube are you trying to get?
A 7.5.
Q Is that because that one was -- had been clogged with emesis?
A That is correct.
Q Okay. And what happened after that?
A Um, once we cleared the airway of that initial wave of emesis I attempted a second time.
Q And at what time -- well, this is actually the third time, right? So what time did you attempt again?
A Well, it's the second ET attempt.

Page 78

Q Okay. What time did you do that?
A Well, the record says 0033, but it was -- it was very soon after the -- the first attempt.
Q Okay. And what happened during that attempt?
A Same, had about a 25 percent glottic opening plus the airway, and again, another wave of emesis.
Q Okay. Then what happened?
A I attempted to intubate the trachea.
Q What -- to a lay person what does that mean?
A We tried to get the tube into the glottic opening to secure the airway.
Q And what happened when you tried to do that?
A The tube went into the esophagus.
Q Did it fill up again?
A It did.
Q Okay. And what happened next?
A We pulled the tube and started aggressive suctioning, and I told Dr. Garvey that we were having a major problem here he needs to get involved in this airway now.
Q And what was -- where was Dr. Garvey when you were trying these attempts?
A He was on the right side of the patient prepping for a chest tube insertion.
Q And to your knowledge had he actually inserted

Page 79

the chest tube while you were trying to intubate?
A He did not.
Q So after the 033 attempt, on this sheet it says "0035 CPR in progress". Is that what you recall happening next?
A No.
Q Okay. And what do you recall happening?
A Dr. Garvey came over and prepped for intubation.
Q Okay. And then what happened after that? When did he attempt to intubate?
A I don't know the exact time.
Q What do you recall happening when he came over?
MR. BURTON: Form. Go ahead.
THE WITNESS: Oh. He got his equipment together and got the patient in position. This is after we had logrolled him over to attempt to clear the airway.
BY MS. MORALES:
Q What does logroll mean?
A It means to completely turn the patient face down to allow for passive relief of emesis out of the airway.
Q And when do you believe that you logrolled him? Was of it right before -- right around that 35 time period?
A It was right before Dr. Garvey attempted his intubation.

Page 80

Q And in any of the medical records that you reviewed in preparation for your deposition did you see the timing of when that occurred?
A Of the logroll? Or the intubation attempt by Dr. Garvey?
Q Well, we can start with the logroll since that happened first.
A No. I see nothing in the record.
MS. MORALES: Does everyone have Schwartz 0069 and 70?
MR. WEAVER: I just -- I know I have it, I just -- yes. Thanks.
MR. BURTON: I've got it, too.
MS. MORALES: We may have to get more copies of this. Sorry.
MR. BURTON: We can share it.
MR. WEAVER: We can share it, too, if you want to.
MS. HARMON: What is it we're looking at? Who's handwritten?
THE WITNESS: Do you have a copy for me?
MS. MORALES: Yeah. I'll -- we'll have to go off the record again. Sorry.
VIDEOGRAPHER: We are going off the video record. The time is approximately 11:39 a.m.

Page 81

(Short break.)
(Exhibit 4 is marked.)
VIDEOGRAPHER: We are going back on the video record. The time is approximately 12:19 p.m.
BY MS. MORALES:
Q Okay. So we're back on the record. During the break we got copies of the NNHR -- RH records that Schwartz 00069 and 70. And this appears to be another recording of the attempted intubation of Mr. Schwartz.
Did you have an opportunity before we took a quick break for lunch to review this?
A I did not.
Q Okay. If you want to take a minute to review. And just let me know when you're ready.
A I'm ready.
Q Are you ready? Okay. After your review of this document, the 69, page 69 and 70, Exhibit 4, is there anything in this documentation that is not consistent with your recollection?
A The only thing that red flags for me is this 0033 unsuccessful nine point.
Q Okay.
A I don't know if that's referencing an ET tube? I don't know.
Q Okay. So you don't know what that means?

Page 82

A I do not know what that means.
Q Okay. On this page as well as the other document that we were looking at, it identifies that CPR was begun at 0035. Is that consistent with your recollection?
A I can't recall the exact time.
Q Okay. Do you recall CPR being started shortly after three attempts at -- two attempts at intubating?
A No.
Q Was it three attempts? How many attempts at intubating before CPR was begun?
A To my recollection, five.
Q And how many of those attempts were by you and how many by Dr. Garvey?
A Two were by me and three by Dr. Garvey.
Q Okay. And which -- in looking at this record, which -- and you can look at either one that helps refresh your recollection. Which -- which timing of the attempted intubations did you do versus Dr. Garvey?
MR. BURTON: Which record do you want him to look at?
MS. MORALES: Whichever one helps refresh his recollection --
MR. BURTON: Okay.
MS. MORALES: -- of this timing.

Page 83

THE WITNESS: It would be 0020 and 0023.
BY MS. MORALES:
Q Okay. Those 0020 and 0023 were your attempts. Correct?
A I believe so.
Q And then Dr. Garvey's was -- first attempt was at 0033?
A I don't know what time his first attempt was.
Q You believe that Dr. Garvey had two attempts before CPR was started; is that correct?
A That would be three attempts.
Q No, by Dr. Garvey.
A By Dr. Garvey.
Q Okay. So you think that there was three attempts by Garvey before CPR began?
A That is correct.
Q And are you able at all to estimate what times that those occurred?
A I can not.
Q Okay. What were you doing when Dr. -- what do you recall -- before we got this hospital record you were talking about how Dr. Garvey stopped the chest tube, getting ready for the chest tube placement, preparation of the chest tube placement, and started to assist in the intubation, what do you -- what do you recall happening

Page 84

during his assist? Or his attempt?
A Just his attempts to do the intubation and just the multiple times that we had to continuously suction the airway.
Q Okay. So let's start with the first time that he attempted. What do you recall of his first attempt? Where were you?
A I was on the right side of him up at the -- up at the head of the patient.
Q And what were you doing during his first attempt?
A I was suctioning.
Q Was there anyone else suctioning or was it just you?
A There were more than just one -- more than me suctioning.
Q Was there one -- more than one machine being used to suction?
A There was.
Q How many machines were being used to suction?
A I remember at one time three.
Q Did you start off using one machine or did you start off using two machines?
A I remember starting off with one.
Q Okay. And at what point looking at this time

Page 85

line do you believe that a second machine was necessary?
A I -- I -- I wouldn't know that.
Q Okay.
A Just by like at the time line.
Q Do you recall if it was during the time that you were attempting to intubate or was it during the time that Garvey was attempting to intubate?
A I -- That I can't recall.
Q What else do you recall during Garvey's first attempt to intubate?
A He was having a difficult time lining up the airway.
Q Was he using that same C-MAC machine that you were using to visualize?
A He was not. He was using what appeared to be a personal blade.
Q Now, is the C-MAC machine, is that Reach Air's?
A That is Reach Air's.
Q And do you know what blade he was using when he first attempted?
A I don't know the name of the blade.
Q Do you know the size of the blade?
A I do not.
Q Okay. So it was his -- it was his blade or the hospital's blade that he was using; is that correct?

Page 86

A That's -- that's correct.
Q It wasn't Reach Air's?
A It was not Reach Air's.
Q What else, if anything, do you recall of his first attempt to intubate?
A He was just having a very difficult time lining up the airway to visualize.
Q Is there anything else that you guys tried to do to make the field easier to visualize?
A We applied Cricoid pressure. It's called a Sellick maneuver and you push down on the trachea to occlude the esophagus.
Q And for a layperson's understanding how does that help?
A What it does is that you -- you're pushing on the trachea so not only -- in -- which, in turn, goes down the esophagus, so it blocks the esophagus and brings the trachea down more in a posterior position for visualization.
Q Okay. And did that seem to help at all?
A It did not.
Q Is that because the emesis was blocking?
A I couldn't --
MR. BURTON: Objection. Form.
THE WITNESS: I couldn't tell. I wasn't doing

Page 87

the intubation.
BY MS. MORALES:
Q Was Dr. Garvey saying anything? Was he explaining what was happening?
A He was not.
Q Now, do you recall anything happening between Garvey's first attempt and second attempt?
A There was tremendous amount of vomiting between the attempts.
Q And at what point did you do the logroll?
A There were so many logrolls I can't tell you exact time sequence in between these attempts.
Q Did the logroll start during your attempt to intubate or during Garvey's attempt to intubate?
A The logroll started during my attempt and I can't remember which one.
Q Okay. And do you see that document anywhere in any of the medical records that you reviewed?
A I do not.
Q Okay. And you wouldn't have done a logroll until he started having emesis. Correct?
A I'm sorry, say that one more time?
Q You wouldn't do the logroll on him until he actually started regurgitating. Correct?
A When I saw the amount of vomitus that is

Page 88

correct.
Q So is it more likely than not that that logroll if it actually occurred during your attempt to intubate happened after your second attempt?
A I believe it was after my second attempt.
Q And explain to me how the logroll works.
A The logroll is a procedure you do when you actually roll the patient over as one unit, and it requires a lot of people to do it, especially a man of his size. And you do it in unison. Everybody gets a point, one on the hips, one on the legs, and one at the shoulder, one at the head, and you do it on the count of three, one, two, three, and up and over.
Q And do you -- is it, like, on their side that you're laying them, or is it on their belly?
A You know, on him it's traditionally on the side, but with him the amount of body we brought him over to the posterior position --
Q I'm sorry, I was coughing. Sorry.
A We did it in the posterior position, face down.
Q And how long do you leave him like that?
A Until the airway is cleared.
Q And in this case can you estimate when that first logroll was done how long it took for his airway to clear, how long you had to keep him on his belly?

Page 89

A I can't -- I couldn't speculate on that.
Q What is -- what's, I guess, the normal amount of time that you would see, a reasonable amount of time that you would see for someone to be able to clear an airway on their belly like that?
A It's just --
MR. BURTON: Objection, form.
THE WITNESS: Sorry. It's just case-by-case.
BY MS. MORALES:
Q If you're explaining to a jury, though, would it be a couple minutes, would it be a few seconds?
MR. BURTON: Objection, form.
THE WITNESS: It wouldn't be a couple of minutes, it would be -- it would be a matter of seconds.
BY MS. MORALES:
Q Like five to ten seconds?
A Again, it's case-by-case.
Q How long would be too long to leave him in that position?
MR. BURTON: Objection, form.
MS. RIES-BUNTAIN: Objection, form.
THE WITNESS: Really is no time limit on that because the airway has to be clear.
BY MS. MORALES:
Q So when that's occurring is someone holding a

Page 90

bucket or something so that the vomit goes in the bucket?
A No. No, it goes all over the floor.
Q Okay. After you rolled him over the first time what do you recall happening next?
A Once the airway was clear we rolled him back into -- onto his back into a sniffing position, the modified jaw thrust.
Q Okay. And what happened after that?
A We attempted bag valve mask ventilation.
Q And did the bag ventilation help at all?
A I can't recall how effective it was at that time.
Q And was the bag ventilation before or after the CPR?
A Well, it was ongoing, before and after CPR.
Q Who was doing the bagging?
A At what time?
Q Did you -- did they change people who were doing it?
A We had -- we had a constant influx of people going back and forth on bag valve mask ventilation.
Q And was that --
A I apologize. I need to go to the bathroom one more time.
Q Yeah.

Page 91

A I drank too much.
VIDEOGRAPHER: We are going off the video record. The time is approximately 12:35 p.m.
(Short break.)
VIDEOGRAPHER: We are going back on the video record. The time is approximately 12:37 p.m.
BY MS. MORALES:
Q You understand you're still under oath. Correct?
A Yes.
Q Okay. So we were talking about the different medical providers take turns bagging. Is that how it works?
A That's how it worked on that particular call.
Q Okay. And do you have any specific recollection of who those providers were that were bagging?
A I do not.
Q And in review of the medical records in this case did you see any documentation of -- strike that.
Okay. And so the second intubation, what do you recall -- by Dr. Garvey, the second attempt at intubating, what do you recall occurring then?
A He was having a hard time visualizing the airway.
Q And was he saying anything aloud during the

Page 92

second attempt?
A Not that I recall.
Q And was he still -- was he using the same blade that he had tried on the first attempt or did he switch out to something else?
A He had the same blade.
Q Okay. Anything else that you remember?
A No.
Q And are you able to identify a timing of his second attempt?
A On the form or my personal?
Q On any of the medical records.
A It looks like it's 0033.
Q You believe that's the second attempt --
A Right.
Q -- or first attempt?
A It appears to be the second attempt.
Q Okay. So if you had two attempts, and the first one being when the -- the first attempt being at 20 minutes after, when was your second attempt then?
MR. BURTON: Objection, form.
BY MS. MORALES:
Q 23?
MR. BURTON: Sorry.
THE WITNESS:. I would say it's at 0023.

Page 93

BY MS. MORALES:
Q Okay. And then after the second attempt do you recall doing the logroll again?
A Whose second attempt, mine?
Q Garvey's. Sorry.
A We did multiple logrolls.
Q Okay. I'm just trying to get, like, an idea of your recollection as far as a timing. So was this the next logroll after the second attempt by Garvey? Or was there another one?
A I can't recall.
Q Okay. Do you recall one way or the other if it was necessary after that second attempt to roll him by Garvey?
A I can't recall that exactly.
Q Okay. Do you recall anything happening between Dr. Garvey's second attempt and what's documented at 0035 for CPR? And "0035 CPR in progress" is on both of these medical records.
A Could you just ask that question one more time?
Q Uh-hum. Do you recall any -- anything else, do you have a recollection of anything else occurring between the 0033 and 0035 time period where CPR is documented on both medical records?
A I do.

Page 94

Q Okay. What do you recall?
A A third intubation attempt by Dr. Garvey.
Q And on that third attempt was he using the same blade?
A He was.
Q Okay. And that blade didn't have any visual field for it? It didn't have a C-MAC machine on it?
A It did not.
Q Is there anything else that you remember of the third attempt?
A He was having a very, very difficult time visualizing.
Q And how did you know that? Was he saying -- was he informing the staff what was going on?
A He was -- you could tell by the intensity of the attempt.
Q And you don't remember him saying anything during that attempt?
A No.
Q Okay. Do you recall one way or another if there was a logroll between the -- that third attempt and the time CPR started at 0035?
A I can't remember that.
Q Okay. What do you recall -- did you actually perform CPR?

Page 95

A I assisted ventilations.
Q And so you were -- when you say ventilations, the bagging?
A That is correct.
Q Who was performing the CPR?
A I can't remember that.
Q And do you recall how long CPR was initiated?
A I do not.
Q Okay. At 0036 it says "King airway." What's a King airway?
A A King airway is a super glottic airway that goes into the esophagus. It has two balloons at each end, distal and proximal, and in between those two balloons you have several port holes that allow oxygenation to go out into the -- into the hypopharynx into the trachea.
Q Okay. Is that something that Reach Air has within its equipment?
A They do not.
Q Is that something that you would expect as an EMT to need for a higher risk intubation?
MR. BURTON: Objection, form.
THE WITNESS: No.
BY MS. MORALES:
Q Why not?
A Because it's not a very effective airway.

Page 96

Q And why do you have that opinion?
A Because they fill up with vomit quickly.
Q And so do you recall where -- strike that. Do you recall Dr. Garvey asking for a King airway?
A I do not.
Q Okay. Do you know where -- where they got the King airway?
A I do.
Q Where?
A From Paul, the transporting paramedic.
Q And what do you remember -- what do you remember about that?
A He offered to put in the King airway.
Q Okay. So it was Paul who actually inserted the King airway, not Dr. Garvey, or are you saying he just went and got the equipment?
A He inserted the airway.
Q So then he was attempting to actually intubate the patient?
A That's not intubation.
Q What is this King airway help do?
A It's sorry, say again.
Q What does it help? How did it help in the intubation process?

Page 97

A It just helps to ventilate the patient when you can't ventilate by other means. It occludes -- in theory it occludes the esophagus, but it does not occlude the esophagus.
Q And did he have to go get this out of his truck or van or did he have it with him?
A I don't recall.
Q Okay. And so he tries to -- Paul tries to insert the King airway. What happens when he does that?
A He does successfully insert the King airway.
Q And did that help in the intubation process at all?
A Not in the intubation process.
Q Did it help in any regard?
A It did.
Q How?
A We restored pulses.
Q How long did Mr. Schwartz lose a pulse before the King airway was placed?
A I -- I can't recall.
Q Okay. And what do you recall happening next?
A Within a very short period of time the King airway became inoperable.
Q Is that because the emesis blocked it?
A That's correct.

Page 98

Q And when you said say a short period of time, how much time would you estimate that was?
A One to two minutes.
Q And during that period of time with a King airway, are -- is intubation continued -- does it continue attempts at intubation or is it just to get some -- the pulse going again?
A It was to restore pulses.
Q Okay. What do you recall happening after that?
A The airway was pulled out.
Q Okay. And was there another attempt to intubate?
A There was, but I don't know what the time line is on that.
Q I'm sorry?
A I don't know what the time line.
Q And who did the attempt after the King airway was removed to intubate?
A Dr. Garvey.
Q Okay. And if you look at -- well, I guess either of the pages. If you look at page 60, which is Exhibit 3.
A Oh, okay.
Q Sorry. It says --- so the King airway is at 0036. And then 0040, heart rate, 120, 02 sat, 82, blood

Page 99

pressure 249 over 140. So is that consistent with your recollection of -- of him regaining pulses and vitals?
A That is correct. Blood pressure was very high.
Q Okay. And then it has 0044. On both of these, Exhibit 3 and Exhibit 4, "ET tube attempted by Dr. Garvey, unsuccessful. Started bagging."
So after he was able to get his vitals back there was another attempt by Dr. Garvey; is that correct?
A That is correct.
Q Okay. Anything specific during that period of time that you recall?
A Just that we had ongoing vomitus and suctioning.
Q Okay. And throughout this is there just ongoing suctioning?
A There is, continual suctioning at many points.
Q Okay. And then the next one -- I couldn't read this time. Oh, 47. So on Exhibit 4, which is the other sheet there. Yeah, Exhibit 4 it has 0047, "Unsuccessful". And I guess on both of them because there -- yeah. That was also by Dr. Garvey; is that correct?
A That I do not recall.
Q Okay. What do you see on the other page on Exhibit 3? It's giving the marks there that it's the same as above from 44. Do you have a recollection of anyone else trying to attempt intubation during that time besides

Page 100

Dr. Garvey?
A At 0044?
Q Yeah.
A No.
Q And 0047 you see the little marks there?
A Right.
Q Sorry, I'm right in front of the camera.
A Yeah.
Q So during that period of time those few minutes did anyone else attempt to intubate besides Dr. Garvey?
A No. I attempted a few minutes later.
Q Okay. And then 0050, O2 sat is that 65 percent; is that correct?
A That's per the record.
Q And it says here "Asystole". Correct?
A Per the record, yes.
Q Do you have a recollection that's different than that?
A I don't have a recollection of what the rhythm was.
Q Do you have any evidence that is anything other than what it's documented here?
A I do not.
Q Okay. And do you have a recollection that's inconsistent with this?

Page 101

A I do not.
Q In 0052 "ET insertion attempted" so now you go back in, try again; is that correct?
A That is correct.
Q And how did that switchoff happen? Was there communication there?
A Dr. Garvey wanted me to attempt.
Q Okay. And did you go back to using the C-MAC machine?
A I did.
Q Okay. And was that able to help you at all?
A No, it was not.
Q And were you able to visualize at all during that period of time?
A Probably ten to 20 percent posterior glottic opening had a lot of swelling in the airway at the time.
Q Okay. And do you have an understanding from your education, training, experience why there would be swelling in that area?
A From mostly from airway attempts.
Q 0053, "O2 sat of 50 percent, unsuccessful." Was that you trying to intubate again?
A No, because I never tried to pass a tube.
Q Okay. So did Dr. Garvey take back over?
A I don't recall that.

Page 102

Q Was there anything -- anyone else besides you two who tried to intubate the patient?
A The transporting paramedic, Paul.
Q And at what period of time did he attempt?
A I don't recall.
Q And to your recollection how many times did he attempt?
A I don't -- I don't recall how many.
Q Okay. 0054, heart rate's 147, 42 percent O2 while bagging, blood pressure's 221 over 148. Is that consistent with your recollection?
A Yes, it is.
Q 0057, "NPA placed by Dr. Garvey." What's that mean?
A That means a pharyngeal airway. It's a basic airway that goes into the airways, and opens up the airways.
Q And what -- as a paramedic what's your understanding of how that helps?
A It helps by facilitating oxygen transference from the -- the mask of the bag valve mask down into the hypopharynx, and eventually into the trachea, glottic opening.
Q And did this procedure replacement help Mr. Schwartz?

Page 103

A I don't recall whether it did or not.
Q 0058, "O2 sat 69 percent at NPA, CPR continues Asystole." So do you recall who was performing CPR during that period of time?
A I do not.
Q Do you recall if you were actually giving CPR?
A I did not give compressions.
Q Okay. 0102, 75 percent O2 sat, heart rate 122. I guess that's -- okay, yeah. Is that consistent with your recollection?
A I don't recall.
Q Okay.
A The saturation coming up.
Q 104, 65 percent O2 sat, 207 over 143, 121" heart rate, I guess. Do you recall anything that you guys were doing during that period of time that isn't documented here?
A Attempting BVM assists and continuing to suction the airway as needed.
Q Okay. Okay. And then the 104, we talked about that. 108, the "Crik attempted by Dr. Garvey". Did Dr. Garvey say anything prior to attempting the cric procedure?
A Yes, he was going to set, do central crack thoracotomy, that's correct.
Q Okay. And did you help in any way in performing

Page 104

that procedure?
A I did.
Q And how did you assist?
A I assisted with the set up of the equipment, and also I did a final landmarks for the cut that's needed for the eventual tube insertion.
Q Did you -- I'm sorry, did you actually do the incision? I mean the cut?
A I did not.
Q Okay. And what do you recall occurring when you tried the cric?
A It was somewhat precarious with the fact that it requires such highway -- high airways pressures from the BVM assist the trachea was actually -- was actually moving, so we had to stop BVM assist to stabilize the trachea before the BVM. Before the cut.
Q And how long did you have to stop the BVM?
A I can't recall.
Q Can you estimate? Was it a matter of seconds, minutes?
MR. BURTON: Object to form.
THE WITNESS: Possibly 30 seconds.
BY MS. MORALES:
Q And what happened actual -- after you made that incision?

Page 105

A He inserted the -- the -- we have an instrument that opens up the trachea, tracheal reigns, and you can open it up and continue to place the tube in.
Q Okay. And was that successful?
A Tube went into the trachea.
Q Do you use that C-MAC machine when you're doing that type of procedure?
A No.
Q And what happened after the tube went into the trachea?
A It became compacted with vomit.
Q And then following that you -- the CPR was continued. Correct?
A That's correct.
Q In looking at the last page, page 70, was there any other attempts after the attempt of the cric?
A Attempts at what?
Q Was there any other attempt to do anything as far as intubating or clear out the airway?
A He inserted a second tube, the tracheostomy.
Q And same thing happened?
A That is correct.
Q So there was two attempts at putting in a tube in the cric. Correct?
A That's correct.

Page 106

Q And both of which were unsuccessful. Right?
A The tube was successfully inserted in the trachea, but it was full of vomit.
Q Okay. Anything after going through each line of the medical record that you recall occurring that isn't documented there?
MR. BURTON: Object to the form of the question.
THE WITNESS: No. Not that I can recall.
BY MS. MORALES:
Q Okay. After Mr. Schwartz passed, did you have any discussions with the fam -- any of his family or friends?
A I did not.
Q Did you have any discussions with any of the nurses at the hospital?
A I did not.
Q Did you talk to Dr. Garvey about what happened?
A I did.
Q And when did you talk to Dr. Garvey?
A About 6:00 that morning, I called him.
Q And where were you at when you called him?
A I was at the Reach base, in Elko.
Q And what did you say to him?
A I told him I thought he did an outstanding job, and the entire team did.

Page 107

Q And how did he respond to that?
A He was very thankful that I called him.
Q Anything else discussed during that?
A No.
Q Did you have any discussions with your preceptor at the time, Mr. Lyons?
A Yes, we discussed the call.
Q I'm sorry?
A Yes, we discussed the call.
Q Well, not the call but did you discuss with Dr. Lyons -- I mean -- Dr. Lyons. Did you discuss with Mr. Lyons the whole attempt at intubating and securing an airway for Mr. Schwartz?
A Yes.
Q And what discussions did you have with him?
A We just discussed the overall call, the performance of everybody involved, including our own.
Q And how did he think that -- what did he communicate to you about his -- his perception of what happened?
A He felt that -- that we all did a very -- a very good job under a horrific situation.
Q Did anyone bring up the question of whether or not Mr. Schwartz should have been intubated to begin with?
A No, not that I can recall.

Page 108

Q Did you have to go back and report this to anyone at Reach Air?
MR. BURTON: And again, you can answer that with a yes or no, but if any questions are asked about discussions you would have had with counsel, don't disclose those informations or any discussions in a peer review setting.
THE WITNESS: Okay. Could you just ask that one more time? I apologize.
BY MS. MORALES:
Q Yeah. Did you have to -- besides Mr. Lyons, did you have to disclose or discuss what occurred in that room with anyone at Reach Air besides your attorneys?
A Yes.
Q And who did you discuss that with?
A Actually, I didn't. I wasn't engaged in the discussion. Mr. Lyon contacted the administrator on call and made him aware of what had transpired.
Q And do you recall who that administrator was that was on call?
A I do not.
Q Did you ever talk to any -- any of the other EMTs that weren't with Reach Air but were in the room at the time, or the medics?
A I don't recall that.

Page 109

Q Besides that one phone call with Dr. Garvey did you ever have any other discussions with him about what occurred in the room that day?
A I did not.
Q Did you ever work with him again after that night?
A I did not.
Q At one point there was an attempt to place an NG tube. Why was that performed?
A He was getting a lot of gastric distention.
Q And can you explain to the jury what that means?
A It's air in the stomach you'll get, you know, BVM assist, bag valve mask assist.
Q And how does NG tube help?
A Decompresses the stomach.
Q And did that help in this case?
A I don't recall.
Q And did Dr. -- who placed the NG tube?
A I don't recall that either.
Q After your two attempts and Garvey's three attempts did you ever make a recommendation that a cric should have been started sooner?
A Did I make the recommendation?
Q Yes.
A Ronnie Lyons did.

Page 110

Q Okay. And who did Lyons say that to?
A To Dr. Garvey and myself.
Q So -- so we're clear because it may have been a poor question, but -- so did -- was Lyons the one that suggested that a cric be done?
A That's correct.
Q Okay. And did he call for that earlier than it was actually performed?
A That is correct.
Q And was there any response like a reason why it wasn't performed sooner?
A No.
Q Did Mr. Lyons ever talk to you and indicate that he believed that the cric should have been started sooner?
A No.
Q Did you have an evaluation that day as an intern for Reach Air?
A Yes.
Q And was there anything negative in that evaluation?
A No.
Q Did you keep a copy of that evaluation for that night?
A I did not.
Q To your knowledge did Dr. -- I'm sorry, Mr.

Page 111

Lyons have any discussions with Dr. Garvey about the need to start the cric procedure sooner?
A No.
Q Did you ever talk to the physician at the receiving hospital?
A I did not.
Q I realize that you were still an intern when this incident occurred in June of 2016. Prior to going out with the flight crew for Reach Air were you provided any policies and procedures pertaining to intubations?
A Yes.
Q Okay. And when you got those policies and procedures did you have to sign off on them that you had read and understood them?
A That is correct.
Q Okay. And do you believe that you followed the policies and procedures of Reach Air during Mr. -- Mr. Schwartz' medical treatment?
A We weren't necessarily operating under Reach's protocols. We were operating under the direction of Dr. Garvey.
Q Okay. And Dr. Garvey, as a director of Reach Air or as -- and/or as an emergency room physician?
MR. BURTON: Object to the form.
THE WITNESS: Dr. Garvey is a sitting physician.

Page 112

BY MS. MORALES:
Q Did anyone ever tell you that you had violated any of the policies and procedures of Reach Air that day?
A No.
Q Did anyone ever tell you that as an intern that you should not have been the one to attempt the intubation of Mr. Schwartz?
A No.
Q Was there any equipment that you believe would have helped in this situation of attempting to intubate Mr. Schwartz?
A No.
Q In this particular case have you reviewed the medical records to determine how long Mr. Schwartz was preoxygenated prior to your attempt at intubation?
A And I'm sorry, I know that was a mouthful, but just one more time.
Q Do you have --
MR. BURTON: Objection to form.
THE WITNESS: I'm sorry.
BY MS. MORALES:
Q Do you know -- do you know how long Mr. Schwartz was preoxygenated prior to your attempt at intubating him?
A I do not know the exact time.
Q Is there any discussions that you've had with

Page 113

anyone besides your attorneys in this case pertaining to the medical care and treatment of Mr. Schwartz that we have not discussed, that you recall?
A None.
Q Do you think that there is anything that you could be shown to help refresh your recollection of any discussions or anything that happened in that room?
MR. BURTON: Object to form.
THE WITNESS: I have it right here (indicating).
BY MS. MORALES:
Q Okay. And do you think that you've told us everything that you recall -- well, strike that.
Is there anything that you recall that we haven't gone over already?
MR. BURTON: Object to form.
THE WITNESS: Not -- not that I can recall.
BY MS. MORALES:
Q Okay. And do you think that there's anything that you could review that would help -- help you recall something that you may not have already?
MR. BURTON: Same objection.
THE WITNESS: No.
BY MS. MORALES:
Q Do you have any plans to move from Reno?
A There is a possibility.

Page 114

Q And where would you be going?
A Possibly overseas.
Q And do you know when that could occur?
A I'm on a 24-hour deployment notice so it could be any time, or eight months down the road.
Q Have you ever reviewed documents from Reach Air pertaining to the training that's provided of the -- to the EMTs, including yourself?
A Yes.
Q And when did you review that?
A During -- during my entire time there. It was a constant review. They have a lot of policies.
Q Okay. And because a lot of these documents I got were hard to understand to read, so if I showed you the format of this -- let's see. Let me show you what we were given, it would be better asked at the 30 (b)(6), but, here's where I see your name listed.
MR. BURTON: Do we have some copies of that one? Or can print off?
MS. MORALES: I can make copies of it, hold on.
BY MS. MORALES:
Q As you sit here today -- maybe this makes it a little easier. As you sit here today were there -- was there additional training that you needed to finish as an intern before you moved to just being an EMT or a medic and

Page 115

not an intern?
MR. BURTON: Before you answer it that's not related to these papers, that's just a general question.
MS. MORALES: Yeah, that's general question is all.
THE WITNESS: No, I just need to serve the amount of time, the amount of shifts.
BY MS. MORALES:
Q And so here -- does everyone one want a copy of this?
MR. BURTON: Yeah, if you're --
MS. MORALES: So let's go off the record again. But I'm almost done so that's good news.
VIDEOGRAPHER: We are going off the video record. The time is approximately 1:17 p.m.
(Short break.)
(Exhibit 5 is marked.)
VIDEOGRAPHER: We are going back on the video record. The time is approximately 1:26 p.m.
BY MS. MORALES:
Q Okay. So I just want you to take a few minutes and look at this. I think your name is found on the last couple pages, which is 339, 340 of Exhibit 5. And I was having a little bit of a hard time trying to match it up here.

Page 116

A Oh, okay. Here we go.
Q So take a minute and then I'll ask you what you know, if anything, about this.
MS. HARMON: What exhibit is this? Is this Exhibit 5?
MS. MORALES: Correct.
MS. HARMON: Thank you.
BY MS. MORALES:
Q Just let me know when you're ready.
A I'm ready.
Q Oh, okay.
A Yeah. Sorry.
Q So you've had an opportunity to review Exhibit 5. Your name's on pages 339 and 340. Are you able to help me decipher what this means?
A I really can't. And I apologize for that. I don't know what this is, yeah.
Q Okay. As you sit here today do you know if you had any outstanding classes that you still had to take before, I guess, advancing to an EMT from an intern for Reach Air?
A I don't recall if I had any more objectives to meet, except taking the final test.
Q And were you told what that final test would consist of?

Page 117

A It's just a basic overview of everything that we do and our policy and our protocols.
Q Okay. Do you still have any relationships with anyone at Reach Air?
MR. BURTON: Object to form.
THE WITNESS: I do -- sorry. I do not.
BY MS. MORALES:
Q What about anyone at NNH or RH hospital?
A I do not.
Q I tried. No?
A I do not.
Q Okay. How about any of the people that were in the room, maybe the other paramedics or EMTs that didn't work for Reach Air?
A I do not.
Q Do you know anything about the need or -- well, strike that.
Do you know anything more about Dr. Garvey's decision to intubate Mr. Schwartz other than what we've discussed today?
A No.
MS. MORALES: All right. I have no further questions.
MR. WEAVER: No questions. Thank you.
MS. RIES-BUNTAIN: No questions.

MR. BURTON: No questions.

MR. WEAVER: Thank you. Have a happy holidays. Chelsea has no questions.

MS. MORALES: Chelsea's -- Chelsea's having a lot more fun than we are right now.

MR. BURTON: Okay. Thank you.

VIDEOGRAPHER: This concludes the deposition of Barry Bartlett on December 20th, 2019. Off the video record at approximately 1:30 p.m.

(Deposition concludes at 1:30 p.m.)

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STATE OF NEVADA)
COUNTY OF WASHOE)

I, JULIE ANN KERNAN, a notary public in and for the County of Washoe, State of Nevada, do hereby certify:

That on Friday, the 20th day of December, 2019, at the hour of 9:11 a.m. of said day, at the Offices of Sunshine Litigation Services, 151 Country Circle Estates, Reno, Nevada, personally appeared BARRY AMOS RAY BARTLETT, who was duly sworn by me to testify the truth, the whole truth, and nothing but the truth, and thereupon was deposed in the matter entitled herein;

That said deposition was taken in verbatim stenotype notes by me, a Certified Court Reporter, and thereafter transcribed into typewriting as herein appears;

That the foregoing transcript, consisting of pages numbered 1 through 118, is a full, true and correct transcript of my said stenotype notes of said deposition to the best of my knowledge, skill and ability.

DATED: At Reno, Nevada, this 16th day of January, 2020.

Julie Ann Kernan

JULIE ANN KERNAN, CCR #427

ERRATA SHEET

I declare under penalty of perjury that I have read the foregoing _____ pages of my testimony, taken on _____ (date) at _____(city), _____(state), and that the same is a true record of the testimony given by me at the time and place herein above set forth, with the following exceptions:

Page	Line	Should read:	Reason for Change:
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ERRATA SHEET

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Date: _____ _____
Signature of Witness

_____
Name Typed or Printed

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EXHIBIT 10

Samaritan" provisions. The next addition to S.B. 2 was subsection 5 on page 5 of the bill that would give total immunity to medical doctors, osteopathic physicians, and dentists who, in good faith, provided medical care to a patient free of charge at a nonprofit or governmental health care facility.

Assemblyman Marvel asked if that language was the "Good Samaritan" statute. Ms. Lang confirmed it was contained in the Good Samaritan statute.

Ms. Lang called the committee's attention to Section 2 of S.B. 2, when Chairman Anderson announced that the Ways and Means Committee would be meeting at 2:30 p.m., and that required a recess of his committee at 2:15 p.m. Chairman Anderson called new witnesses to the table and summarized the current discussion centered on S.B. 2. He explained there were committee concerns regarding the language on page 2 and the expansion of emergency room coverage to additional hospitals. Chairman Anderson asked the witnesses to clarify the intent of the language.

Gus Flangas, an attorney representing the Physicians Task Force, introduced his colleagues, Dr. Robert McBeath (to his left) and Dr. Michael Daubs (to his right).

Assemblywoman Parnell voiced concern about the addition of a new population of doctors and the clear standard to be met for the $50,000 liability coverage. If a clear standard was established, her second concern was that the determination would not be made until the matter reached a court of law. She asked for clarification on that process.

Before addressing Assemblywoman Parnell's concerns, Mr. Flangas offered to review the background information that led to insertion of the language. The University Medical Center (UMC) Trauma Center in Las Vegas was extremely vital to Clark County and areas of Arizona and California. The UMC Trauma Center closed its doors in July for 10 days. The impact was devastating to the community and was foretelling of events to come in northern Nevada. Mr. Flangas explained that UMC was a state facility, and it fell under the $50,000 limitation. The employees of UMC also fell under that limitation. The reason for the bill was to help the independent doctors who worked at UMC, but, in fact, were not employees of the UMC Trauma Center. Those doctors were paid $40 per hour to work on a voluntary basis. When they listed the UMC Trauma Center on their malpractice insurance applications, their premiums increased significantly. In Mr. Flangas' judgment, those doctors needed protection.

Mr. Flangas illustrated his point with an example of an independent doctor treating a patient at the UMC Trauma Center. That patient became his patient (i.e., professionally bound to continue with the care and treatment of that patient). The language that was inserted was somewhat designed to add more protection because of that obligation to perform follow-up work on that patient, regardless of location or time. Mr. Flangas explained the previous draft of the bill had no provision for follow-up work, and that caused great concern. It exposed the physician to the loss of the $50,000 coverage as originally drafted. The new language remedied that situation

with the "rebuttable presumption" language. If there was an injury to the patient, it would be presumed to have occurred during the course of treatment for that trauma.

Chairman Anderson interrupted and reminded the witnesses that time was running out for questions from the committee. Mr. Flangas acknowledged the concern and summarized the issue of "rebuttable presumption."

Assemblywoman Parnell interrupted to clarify for the witness that her concern was not that section of the bill. She stated emphatically that there was not one person who would argue the need to protect the trauma doctors in Nevada. Assemblywoman Parnell voiced her concern over language in S.B. 2 that added a new population of doctors who, with special circumstances, would have that same $50,000 liability protection. She voiced additional concern over a clear definition of when the coverage would be applicable and who would make that determination.

Dr. Michael Daubs, an orthopedic surgeon, offered to respond. There existed clear definitions in the *Nevada Administrative Code* that defined a "trauma patient." If a patient qualified under that definition and was treated at a facility that was not a designated trauma center, the doctor would be protected by the proposed legislation.

Assemblywoman Cegavske reiterated an earlier question regarding the terminology "a physician" and asked if that included anesthesiologists in the treatment of trauma patients. Mr. Flangas replied in the affirmative.

Assemblyman Dini asked if coverage included nurse anesthesiologists. Mr. Flangas replied a nurse anesthetist would not be covered under that language. Chairman Anderson requested clarification from the Committee Legal Counsel. Ms. Lang called the committee's attention to subsection 1, page 2, line 17, where it read "an employee of a hospital who renders care." Ms. Lang explained it referred back to the nonprofit hospitals and centers. In regard to a for-profit facility, the same language was provided in subsection 2.

Following Chairman Anderson's clarification, Ms. Lang continued with her testimony and stated it applied to employees of a hospital. It was provided under both subsection 1 and subsection 2. In governmental hospitals, employees were already covered under the sovereign immunity statute. As such, they were not included in that part of the bill, but they did have coverage nonetheless.

Assemblyman Brown, addressing Assemblyman Dini's concern of nurse anesthetists, stated he believed that group had to carry their own professional insurance and were not necessarily classified as employees of hospitals.

In way of clarification, Dr. Michael Daubs stated it was his understanding nurse anesthetists were employed by hospitals.

Assemblyman Dini reiterated his comparison between lines 32-39 on page 2 (i.e.,

"serious medical condition requiring immediate medical attention") versus the language on line 2 of page 3 where it stated "acute life-threatening medical conditions." He observed there was a difference in standards between the two cited areas of S.B. 2.

Gus Flangas offered to respond and stated there was no clear answer to that concern. He suspected it happened in the drafting of the bill, and he was unsure if there was any actual distinction in the language. Chairman Anderson predicted that upcoming testimony from the hospital administrators and their attorney would resolve that issue.

Assemblyman Marvel asked when the $50,000 protective cap expired for a patient judged to be stabilized and who made that determination. Dr. Daubs offered to respond, and he acknowledged the issue of stabilization was a difficult one in the medical community. The language was added because the doctor's initial contact with a patient was usually the first of several appointments. From his standpoint, a patient was stabilized if he was discharged from the clinic; the condition had been treated and he did not have to return to the clinic.

Assemblyman Marvel summarized by saying the $50,000 cap might be in place for a period of time. Dr. Daubs replied in the affirmative and, for many injuries, stated it could be 6-12 weeks.

Dr. Robert McBeath clarified that attempting to place a definite time limit on the $50,000 was not recommended. The intent was tied to the actual relationship between the doctor and patient as well as the nature of the injury. That relationship commenced when the doctor first treated the patient at the trauma center. The doctor's judgment that the patient could be discharged from his care was the essential point.

Assemblyman Marvel asked if, as a matter of formality, the physician waived his liability at the point the patient was stabilized. Was the doctor required to sign-off; Mr. Flangas replied that would not be feasible under the law to have the doctor waive his rights for personal injury, especially in a trauma situation. As far as the issue of time limit expiration, Mr. Flangas stated that if a charge of malpractice was raised during treatment, it would be essential to prove that the malpractice actually occurred during that treatment. That was the essence of the bill. If it could be demonstrated that the malpractice occurred in the follow-up treatment, the presumption no longer was in place. It would become a malpractice action based on events during follow-up actions.

Chairman Anderson illustrated the issue with an example of a patient who showed signs of cardiac arrest and went to the emergency room of a rural hospital. After the patient was stabilized, he was sent home with the expectation that his treatment would continue with his personal physician. Chairman Anderson asked if there was a point in time when the $50,000 coverage no longer applied in that case. He added that previous testimony indicated the question would become an arguable point in court proceedings.

Mr. Flangas replied that theoretically the $50,000 cap would continue as a presumption. In the hypothetical case posed by Chairman Anderson, Mr. Flangas took the example a step further. Several months passed uneventfully and then the patient had symptoms that caused him to see his doctor. The patient was erroneously told he had indigestion and not a heart attack. That case would be considered malpractice due to subsequent events outside of the trauma center, and the $50,000 cap no longer applied.

Chairman Anderson modified his hypothetical case and stated the patient showed up at the emergency room convinced he was having a heart attack. The attending physician diagnosed the condition as indigestion and sent the patient home. The patient died of a massive coronary attack in the hospital parking lot. Chairman Anderson asked if the $50,000 cap covered the physician and could be recovered by the patient's family.

Mr. Flangas requested clarification if the hypothetical patient had presented to the emergency room at the UMC Trauma Center. Chairman Anderson replied the patient was in Carson City. Dr. Daubs stated a heart attack was not considered a trauma and therefore would not be covered.

Dr. McBeath acknowledged there was some confusion in the language. The testimony in the Senate had centered on the example of the trauma victim being seen at another facility, not necessarily at UMC. During the Senate hearing, Dr. McBride illustrated the point with a case of a gunshot wound being handled at a community hospital.

Chairman Anderson voiced confusion and was still attempting to fully understand his hypothetical case. Because Nevada only had three designated trauma centers (i.e., Las Vegas, Reno, and Fallon), the likelihood of being seen in an emergency room of a hospital was very high for many Nevada citizens.

Dr. Daubs requested clarification if the hypothetical scenario was the example of a patient who was judged to be a trauma patient, but was not seen at a designated trauma center. Chairman Anderson read from lines 35-37 on page 2 of the bill "enters a hospital through its emergency room or trauma center may not be held liable for more than $50,000 in civil damages exclusive of interest computed from the date of judgment." Dr. Daubs responded the heart attack would not fall under the trauma criteria.

Risa Lang, Committee Legal Counsel, asked if the witness was referring to the way they defined the situation, for example, going into a designated trauma center. She voiced confusion over why a heart attack would not be judged as a serious medical situation for a person in an emergency room or a trauma center. She called attention to subsection 2 that did not refer to designated trauma centers, but specifically addressed hospitals. In the example given, it would be an acute life-threatening medical condition, and she was unsure why a heart attack did not fall into that category.

Dr. Dan McBride, a member of the Physicians Task Force and President of the American College of Surgeons, approached the witness table and offered to clarify the issue. In testimony before the Senate, the discussion centered on limiting the coverage to patients with traumatic injuries. It was never the intent to extend blanket coverage to all emergency room patients, such as heart attacks. It was designed to extend the same liability coverage of physicians in the trauma center to physicians treating trauma cases in other facilities and hospitals.

Chairman Anderson emphasized the need for language that was sufficiently narrow for interpretation purposes.

Gus Flangas asked Dr. Daubs to address the issue. Dr. Daubs echoed the testimony of Dr. McBride and stated it was never the intent to include all medical cases, such as heart attacks. Dr. McBeath declared the core of the issue was in the definition of a trauma patient, and there were statutory definitions in place. He advised the statutory definitions would provide guidance for the bill language.

Chairman Anderson thanked the witnesses for their testimony and called representatives of the hospital association to the witness table. Robert Barengo, representing Sunrise Hospital, commenced testimony and explained the bill had been sponsored by the physicians. The heart of the issue was the treatment of trauma cases in all medical facilities. All hospitals received trauma patients. Physicians had a major concern that by treating a trauma patient in an emergency room, their liability might differ from what they would have had at a designated trauma center. Mr. Barengo described the bill as an attempt to have the designation of "trauma" follow the patient to whatever facility he entered for treatment.

Mr. Barengo described Section 1 as addressing the trauma centers, whereas Section 2 attempted to bring in all hospitals that treated trauma. Line 2 of page 3 included the language "acute life-threatening," and he viewed that as an attempt to define "trauma." A more refined definition of trauma was located in NRS 450B.105. Mr. Barengo suggested the addition of that definition to solve the problem. A physician treating any patient in any facility who met the definition of traumatic condition would be under the cap.

Assemblyman Oceguera voiced his opinion that because the language was so overly broad, it would invite unintended interpretations. He agreed there were established definitions of "trauma" in the NRS 450B.105 that would solve the issue.

In response to Assemblyman Oceguera, Mr. Barengo reminded the committee the use of that definition of trauma would bring into play the *Nevada Administrative Codes* (i.e., NAC 450B.798 and 450B.770) that dealt with the trauma issue.

Chairman Anderson called a committee recess with a request to reconvene at 4:30 p.m.