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, IN AND FOR THE COUNTY OF ELKO; AND THE HONORABLE KRISTON N. HILL, DISTRICT JUDGE,

Respondents,

and

DIANE SCHWARTZ, INDIVIDUALLY AND AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DOUGLAS R. SCHWARTZ,

Real Party in Interest.

No. 83533

APPENDIX OF REAL PARTY IN INTEREST
VOLUME 2, (NOS. 17-261)

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Case No.: CV-C-17-439
Dept. No: 1

AFFIRMATION
Pursuant to NRS 239B.030
This document does not contain
any Social Security Numbers

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD, dba Ruby Crest Emergency Medicine; PHC-ELKO INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

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 MOTION TO STRIKE THE DECLARATION OF SETH WOMACK, M.D., AND ANY JOINDERS THERETO AND PLAINTIFF'S COUNTERMOTION FOR LEAVE TO AMEND THE COMPLAINT

Plaintiffs hereby Oppose: (1) Defendant David Garvey M.D.'s Motion to Strike the Declaration of Shirley Blazich, Esq. and (2) Defendant David Garvey M.D.'s Motion to Strike the Declaration of Seth Womack, M.D. and any Joinders Thereto. Plaintiff also submits her Motion for Leave to Amend the Complaint.

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This Opposition and Countermotion is based upon the pleadings on file herein, the points and authorities attached hereto, and any oral arguments that they may be allowed at the hearing of this Motion.

DATED this 9th day of September 2020.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazich

_____

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DECLARATION SHIRLEY BLAZICH, ESQ., IN SUPPORT OF PLAINTIFF'S 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 MOTION TO STRIKE THE DECLARATION OF SETH WOMACK, M.D., AND ANY JOINDERS THERETO AND PLAINTIFF'S COUNTERMOTION FOR LEAVE TO AMEND THE COMPLAINT

I, Shirley Blazich, Esq., declare under penalty of perjury as follows:

1. I am a partner at Claggett & Sykes Law Firm, counsel of record for Plaintiff Diane Schwartz, in the above-named action. I have personal knowledge of, and am competent to testify to, the facts contained in this Declaration, except on those matters stated upon information and belief, and as to those matters, I believe them to be true. I make this Declaration in support of Plaintiff's Opposition to Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages, and all Joinders thereto.

2. On June 22, 2017, Plaintiff filed her Complaint.

3. On August 21, 2017 the parties agreed to Amend the Complaint to correct the name of two of the Defendants.

4. Plaintiff filed her Amended Complaint on October 7, 2017. Plaintiff erroneously and

inadvertently removed her Punitive Damages claim from the Complaint at that time.

5. Plaintiff later moved to Amend to claim Punitive Damages. The Court denied Plaintiff's Motion with prejudice.

6. On August 18, 2020, Plaintiff filed Plaintiff's Opposition to Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages, and all Joinders Thereto. Within the Opposition, Plaintiff outlined the procedural history within the case as it related to Plaintiff's Motion to Amend to add a claim for punitive damages. Within her Motion, Plaintiff erroneously stated that that the Court denied Plaintiff's Motion "without prejudice," instead of "with prejudice." This was merely a typographical error.

7. On August 26, 2020, Defendant Garvey filed his Motion to Strike the Declaration of Shirley Blazich, Esq. and Motion to Strike the Declaration of Seth Womack, M.D. Within each Motion, Defendant attempts to confuse the issue contained in Plaintiff's Opposition by pointing to the typographical error. But at the end of the day, Plaintiff only mentioned this Court's prior ruling for procedural history. This Court's prior ruling has no applicability to the trauma statute, or Plaintiff's Opposition thereto.

8. Plaintiff opposes Defendants' request to strike the Declaration of Shirley Blazich, Esq. because Defendants' Motion is not based in law or fact. Defendant asks this Court to grant its Motion based on NRCP 56(h). In doing so, Defendant egregiously misrepresents the Nevada Rules of Civil Procedure, and the law.

9. Plaintiff also opposes Defendants' request to strike the Declaration of Seth Womack, M.D. Defendants ask this Court to grant their Motion because, as they believe, Dr. Womack's conclusions are applicable to the punitive damages standard. What Defendants ignore, however, is that the trauma statute requires an analysis of gross negligence or reckless, willful, or wanton conduct. This is not the same as the punitive damages standard. While some of the facts may also apply to punitive damages, Dr. Womack's opinions are based merely on the facts of the case.

10. Finally, Plaintiff seeks leave to amend her Complaint to add a claim for punitive damages against Dr. Garvey and against Northeastern Nevada Regional Hospital. While Plaintiff understands that this Court has previously denied this request with prejudice, Plaintiff asks this Court

to overrule its prior order under NRCP 60. Moreover, pursuant to NRCP 15(a), leave to amend should be freely granted when justice so requires. The evidence here supports an amendment to allow Plaintiff to plead a punitive damages claim.

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

DATED this 9th day of September 2020.

/s/ Shirley Blazich

SHIRLEY BLAZICH, ESQ.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

OPPOSITION TO MOTION TO STRIKE THE DECLARATION OF SHIRLEY BLAZICH, ESQ.

A. INTRODUCTION

Defendant asks this Court to strike the Declaration of Shirley Blazich, Esq. that was incorporated into Plaintiff's Opposition to Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages, and all Joinders thereto filed by co-Defendants. Defendant asks this Court to grant its Motion based on NRCP 56(h). In doing so, Defendant egregiously misrepresents the Nevada Rules of Civil Procedure, and the law. The instant Motion is merely a waste of judicial resources, and an ill fated attempt to distract this Court from the actual facts of this case.

B. LEGAL ARGUMENT

1. Legal Standard

NRCP 56(h) provides:

> **Affidavit or Declaration Submitted in Bad Faith.** If satisfied that an affidavit or declaration under this rule is submitted in bad faith or solely for delay, the court — after notice and a reasonable time to respond — may order the submitting party to pay the other party the reasonable expenses, including attorney fees, it incurred as a result. An offending party or attorney may also be held in contempt or subjected to other appropriate sanctions.

In the present case, Defendant makes outlandish claims that counsel submitted her affidavit in bad faith, yet, Defendant fails to explain how, or why that is. The bottom line: Defendant's Motion and the joinders thereto must be denied.

2. Defendant Misrepresents the Requirements of NRCP 56(d)

NRCP 56(d) provides:

> (d) **When Facts Are Unavailable to the Nonmovant.** If a nonmovant shows by affidavit or declaration that, for specified reasons, it cannot present facts essential to justify its opposition, the court may:
>
> (1) defer considering the motion or deny it;
>
> (2) allow time to obtain affidavits or declarations or to take discovery; or
>
> (3) issue any other appropriate order.

"NRCP 56[d] requires that the party opposing a motion for summary judgment and seeking a denial or continuance of the motion in order to conduct further discovery provide an affidavit giving the reasons why the party cannot present 'facts essential to justify the party's opposition.'"[1]

In the present case, Plaintiff's counsel provided an affidavit which stated why she could not present "essential facts to justify" Plaintiff's opposition--because discovery was still continuing. Even more, counsel provided a list of discovery that was still needed:

- The deposition of Nancy Abrahms of NNRH
- The deposition of Ronnie Lyons of Reach Air (since completed)
- The deposition of the NRCP 30(b)(6) witness for NNRH
- The deposition of the NRCP 30(b)(6) witness for Ruby Crest
- The deposition of Dr. Stefanko of Ruby Crest
- The deposition of Dr. Jones of Ruby Crest
- Initial Expert Disclosures
- Rebuttal Expert Disclosures
- The depositions of all expert witnesses

As such, Plaintiff fully complied with the Nevada Rules of Civil Procedure.

Defendant asks this Court to apply NRCP 56(c) to Plaintiff's counsel's affidavit. In doing so, Defendant blatantly twists the law. NRCP 56 provides:

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[1] Choy v. Ameristar Casinos, Inc., 127 Nev. 870, 872, 265 P.3d 698, 700 (2011).

> (a) **Motion for Summary Judgment or Partial Summary Judgment.** A party may move for summary judgment, identifying each claim or defense — or the part of each claim or defense — on which summary judgment is sought. The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law. The court should state on the record the reasons for granting or denying the motion.
>
> (b) **Time to File a Motion.** Unless a different time is set by local rule or the court orders otherwise, a party may file a motion for summary judgment at any time until 30 days after the close of all discovery.
>
> (c) **Procedures.**
>
> (1) **Supporting Factual Positions.** A party asserting that a fact cannot be or is genuinely disputed must support the assertion by:
>
> (A) citing to particular parts of materials in the record, including depositions, documents, electronically stored information, affidavits or declarations, stipulations (including those made for purposes of the motion only), admissions, interrogatory answers, or other materials; or
>
> (B) showing that the materials cited do not establish the absence or presence of a genuine dispute, or that an adverse party cannot produce admissible evidence to support the fact.
>
> *****
>
> (4) **Affidavits or Declarations.** An affidavit or declaration used to support or oppose a motion must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the affiant or declarant is competent to testify on the matters stated.

A plain reading of the rule provides that when facts are available to the party opposing the motion, either competent evidence must be presented, or an affidavit or declaration may be used if it is based on personal knowledge and if that facts would be admissible in evidence.[2] This clearly does not apply when facts are not available, and instead, NRCP 56(d) applies in those instances.

Defendant asks this Court to require Plaintiff to state what evidence she will obtain from the discovery. This argument is nonsensical. Common sense dictates that Plaintiff does not know exactly what evidence discovery will reveal until the time such discovery is conducted. The law does not require a party to have a crystal ball, and the law certainly does not want a party making up facts it believes it will obtain. Defendant's representations to this Court that the law requires a party to do so is no less than egregious. Defendant misrepresents the Nevada Rules of Civil Procedure and the holding in Choy,[3] in support of its assertion, and as such, Defendant's Motion must be denied.

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[2] Id.

[3] Choy v. Ameristar Casinos, Inc., 127 Nev. 870, 872, 265 P.3d 698, 700 (2011).

II.

OPPOSITION TO MOTION TO STRIKE THE DECLARATION OF SETH WOMACK, M.D.

A. INTRODUCTION

Defendant asks this Court to strike the Declaration of Seth Womack, M.D. contained in Plaintiff's Opposition to Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages, and all Joinders thereto filed by co-Defendants. Defendants ask this Court to grant their Motion because, as they believe, Dr. Womack's conclusions are applicable to the punitive damages standard. What Defendants ignore, however, is that the trauma statute requires an analysis of gross negligence or reckless, willful, or wanton conduct. This is not the same as the punitive damages standard. While some of the facts may also apply to punitive damages, Dr. Womack's conclusions are based merely on the facts of the case. Moreover, Dr. Womack's conclusions are not legal conclusions, and instead, are based on the applicable standard of care. Finally, Defendants ask this Court to strike Dr. Womack's declaration because they believe that Dr. Womack's conclusions regarding Nurse Kevitt are incorrect. Defendant clearly does not understand the evidentiary standard, and ignores that such a disagreement is relevant to the weight of the evidence, and not the admissibility of the evidence. As such, Defendant's Motion and any joinders thereto must be denied.

B. LEGAL ARGUMENT

1. Applying the Trauma Statute Requires an Analysis of Gross Negligence or Reckless, Willful, or Wanton Conduct

The trauma statute provides:

NRS 41.503 Hospital care or assistance necessitated by traumatic injury; presumption regarding follow-up care.

1. Except as otherwise provided in subsection 2 and NRS 41.504, 41.505 and 41.506:
   (a) A hospital which has been designated as a center for the treatment of trauma by the Administrator of the Division of Public and Behavioral Health of the Department of Health and Human Services pursuant to NRS 450B.237 and which is a nonprofit organization;
   (b) A hospital other than a hospital described in paragraph (a);
   (c) An employee of a hospital described in paragraph (a) or (b) who renders care or assistance to patients;
   (d) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS who renders care or assistance in a hospital described in paragraph (a) or (b), whether or not the care or assistance was rendered gratuitously or for a fee; and

(e) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS:
(1) Whose liability is not otherwise limited pursuant to NRS 41.032 to 41.0337, inclusive; and
(2) Who renders care or assistance in a hospital of a governmental entity that has been designated as a center for the treatment of trauma by the Administrator of the Division of Public and Behavioral Health of the Department of Health and Human Services pursuant to NRS 450B.237, whether or not the care or assistance was rendered gratuitously or for a fee,

that in good faith renders care or assistance necessitated by a traumatic injury demanding immediate medical attention, for which the patient enters the 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, to or for the benefit of any claimant arising out of any act or omission in rendering that care or assistance **if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct**.

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4. For the purposes of this section:

(a**) "Reckless, willful or wanton conduct,"** as it applies to a person to whom subsection 1 applies, shall be deemed to be that conduct which the person knew or should have known at the time the person rendered the care or assistance would be likely to result in injury so as to affect the life or health of another person, taking into consideration to the extent applicable:

(1) The extent or serious nature of the prevailing circumstances;
(2) The lack of time or ability to obtain appropriate consultation;
(3) The lack of a prior medical relationship with the patient;
(4) The inability to obtain an appropriate medical history of the patient; and
(5) The time constraints imposed by coexisting emergencies.

In the present case, Defendant seeks to strike Dr. Womack's expert affidavit because Defendant believes that Dr. Womack uses certain "buzz words" which are applicable to punitive damages. As an initial matter, Defendant obviously misunderstands the punitive damage standard. Just because the law requires an analysis of gross negligence, reckless, willful, or wanton conduct, does not necessarily mean that punitive damages come into play. The trauma statute specifically defines what reckless, willful, or wanton conduct means for the purposes of determining if that statute's exceptions are applicable.

Second, Plaintiff is fully aware that punitive damages are not plead in this case at this time. Defendant apparently believes that because this Court denied Plaintiff's Motion to Amend to add punitive damages, that it forecloses any analysis on Defendants' egregious conduct. That is not the case. Dr. Womack's affidavit presents expert opinions about Defendant's conduct that are directly relevant to the applicability of the trauma statute. Just because such opinions may also apply to punitive damages is irrelevant and not any basis for exclusion.

2. Dr. Womack's Opinions are Not Legal Conclusions

Plaintiff generally agrees that an expert should not offer opinions regarding legal conclusions, as it is outside their expertise. Plaintiff also agrees that the imposition of punitive damages or negligence is for the jury to decide. But Defendants fail to realize that Dr. Womack is not offering legal conclusions. Instead, Dr. Womack is offering expert opinions based on the facts of this case.

Defendants will have ample opportunity to conduct discovery, namely with Dr. Womack's deposition, to ascertain what he meant by the terms Defendants take issue with, such as "gross negligence" or "reckless." While Dr. Womack is not permitted to offer legal conclusions, he is certainly qualified to offer opinions regarding the facts of this case. Dr. Womack is entitled to explain what his understanding of those terms are, and how he is applying said terms to the facts at issue here. Defendants are merely attempting to word smith Plaintiff's experts in an attempt to evade liability.

3. Dr. Womack's Opinion Regarding Nurse Kevitt's Documentation goes to Weight, not Admissibility

Defendants also ask this Court to strike Dr. Womack's affidavit because they believe that Dr. Womack's statements regarding Nurse Kevitt's documentation are "incomplete and misleading." Defendant misunderstands the evidentiary standard. It is for the jury to evaluate the adequacy of the evidence. The issue here is the weight of the evidence, not its admissibility. Defendants have the opportunity to cross examine Dr. Womack on these opinions, and offer their own opposing evidence. At the end of the day, it is for the jury to decide how much weight they give to expert opinions.

III.

PLAINTIFF'S COUNTERMOTION TO AMEND

A. INTRODUCTION

Plaintiff seeks leave to amend her Complaint to add punitive damages against: (1) Dr. David Garvey, and (2) Northeastern Nevada Regional Hospital. Plaintiff seeks this amendment based on new evidence that has emerged throughout discovery in this case and which justifies relief. Plaintiff's proposed Third Amended Complaint is attached hereto.[4] Plaintiff understands that this Court has denied Plaintiff's request for leave to add punitive damages with prejudice. Plaintiff, however, asks

[4] See Plaintiff's proposed Third Amended Complaint, attached hereto as **Ex. "1."**

this Court to reconsider its prior ruling under NRCP 60 because of the recent evidence justifies relief and justifies punitive damages. This is consistent with Nevada's strong public policy of hearing cases on their merits. The jury has a right to decide whether punitive damages are appropriate here. In deciding this Motion, this Court need only consider the following:

1. Pursuant to NRCP 15(a)(2) leave to amend a complaint "shall be freely given when justice so requires." The Nevada Supreme Court has repeatedly held that in the absence of any apparent or declared reason such as undue delay, bad faith or dilatory motive on the part of the movant, the leave sought should be freely given.[5] The Nevada Supreme Court has held, "if the original pleadings give fair notice of the fact situation from which the new claim for liability arises, the amendment should relate back for limitation purposes.[6] Here, there is no undue delay, bad faith or dilatory motive on the part of Plaintiff as all of this evidence was recently obtained, and Plaintiff's expert just opined that the facts of this case demonstrated such a gross violation of the standard of care so as to support a claim for punitive damages. Moreover, amendment would not be futile as the facts of this case justify amendment. Whether or not Defendants actions rise to a level to warrant punitive damages is a question for the jury to ultimately decide based on all the evidence presented at trial, and the jury should have the opportunity to decide if punitive damages are warranted here.

2. "Punitive damages are designed to punish and deter a defendant's culpable conduct and act as a means for the community to express outrage and distaste for such conduct."[7] Punitive damages are a "means of punishing the tortfeasor and deterring the tortfeasor and others from engaging in similar conduct."[8] "The allowance of punitive damages also provides a benefit to society by punishing undesirable conduct that is not punishable by the criminal law."[9] The

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[5] Stephens v. Southern Nevada Music Co., Inc. 507 P.2d 138, 139, 89 Nev. 104 (1973).

[6] C.A. Nelson v. City of Las Vegas, 99 Nev. 548, 556, 665 P.2d 1141, 1146 (1983).

[7] Countrywide Home Loans, Inc. v. Thitchener, 124 Nev. 725, 739, 192 P.3d 243 252 (2008); see also Republic Ins. v. Hires, 107 Nev. 317, 320, 810 P.2d 790, 792 (1991) ("Punitive damages provide a benefit to society by punishing undesirable conduct not punishable by the criminal law").

[8] Siggelkow v. Phoenix Ins. Co., 109 Nev. 42, 44-45, 846 P.2d 303, 304-05 (1993).

[9] Id. at 45, 846 P.2d at 305.

Nevada Supreme Court, and other courts, has consistently upheld this standard when applying punitive damages to medical malpractice cases.[10] Other jurisdictions have also upheld this standard when applying punitive damages to medical malpractice.[11] "A plaintiff may recover punitive damages when evidence demonstrates that the defendant has acted with 'malice, express or implied."[12] "'Malice, express or implied,' means conduct which is intended to injure a person **or** despicable conduct which is engaged in with a conscious disregard of the rights or safety of others."'[13] "A defendant has a 'conscious disregard' of a person's rights and safety when he or she knows of 'the probable harmful consequences of a wrongful act and a willful and deliberate failure to act to avoid those consequences.'"[14] "In other words, under NRS 42.001(1), to justify punitive damages, the defendant's conduct must have exceeded 'mere recklessness or gross negligence."[15]

3. Plaintiff believes that NRS 42.005 governs the claim against Dr. Garvey because Dr. Garvey acted with conscious disregard for the rights and safety of Mr. Schwartz. Dr. Garvey made the decision to intubate the decedent, despite stable vital signs and no signs of respiratory distress. Notably, there is evidence in this case that Defendants, including Dr. Garvey, were responsible for a 9 or more intubation attempts unsuccessfully before turning to a surgical airway. This is not only a breach of the standard of care, but is grossly negligent, reckless, willful and wanton in light of the fact that clinical evidence based protocols indicate that no more than 3 intubation attempts should be made before a surgical airway is done. These evidence based protocols

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[10] See Wyeth v. Rowatt, 244 P.3d 765 (Nev. 2010) (Upholding punitive damages against a drug manufacturer that misrepresented the risks of a drug).

[11] See Medvecz v. Choi, 569 F.2d 1221 (3rd Cir. 1977) (Holding that a patient who was paralyzed due to an anesthesiologist could be awarded punitive damages if the anesthesiologist's conduct of abandoning the patient was reckless).

[12] Wyeth v. Rowatt, 126 Nev. Adv. Rep. 44, 244 P.3d 765, 783 (2010) (quoting NRS 42.005(1)).

[13] Id. (quoting NRS 42.001(3) (emphasis added).

[14] Id. (quoting NRS 42.001(1)).

[15] Id. (quoting Countrywide Home Loans, Inc. v. Thitchener, 124 Nev. 725, 742-43, 192 P.3d 243, 254-55 (2008)).

exist because the risk of not following them is death. Something Dr. Garvey should have known at the time of treating Douglas Schwartz.

4. Plaintiff believes that NNRH is liable for punitive damages under both NRS 42.005 and NRS 42.007. NNRH created a culture where it was acceptable to not have inventory compliant with the standard of care. In this case, that is evident through the crash cart. Defendants knew or should have known that failure ensure the crash cart inventory was properly stocked, so that all necessary life saving equipment was available at the patient's bedside during a code blue, could and would result in death. Plaintiff believes NNRH is liable for this conduct under NRS 42.005 as the culture at NNRH allowed for a trauma cart to remain on the premises without being compliant with policies and procedures. This is likely the reason that Defendant has not turned over documentation evidencing the daily crash cart checks. In addition, Plaintiff believes that NNRH and Dr. Garvey are both liable for punitive damages under NRS 439.855 and NNRH's own Patient Safety Plan in effect in June of 2016, for their deliberate failure to notify Douglas Schwartz' family of the fact that he was involved in a sentinel event. Alternatively, NNRH is liable under NRS 42.007 for the conduct of its employees, including Dr. Garvey.

B. FACTUAL BACKGROUND

This case arises from professional negligence that led to the death of Douglas Schwartz. On or around June 22, 2016, Douglas was struck by a car while he was walking.[16] He had just finished eating dinner at a nearby restaurant with the Board of Directors at Elko Federal Credit Union, where he worked as their CEO. Douglas was transported to Northeastern Nevada Regional Hospital by Elko County Ambulance on a "non-emergent" transport, arriving approximately a half an hour later.[17]

Defendant David M. Garvey, M.D., performed a physical examination of Douglas.[18] Dr. Garvey's assessment revealed that Douglas had mild abrasions to the forehead, injury to the right

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[16] Dr. Scissors Affidavit, attached hereto as **Ex. "2."**

[17] Id.

[18] Dr. Scissors Affidavit, attached hereto as **Ex. "2.";** Dr. Womack Report, attached hereto as **Ex. "3."**

lateral posterior chest with moderate pain, and abrasions to the right bicep, elbow and knee.[19] Douglas had a normal heart rate and rhythm, and did not display signs of respiratory distress.[20] Douglas's respirations were normal with clear breath sounds throughout. Douglas's neurological status and abdominal evaluation were normal.[21]

Dr. Garvey elected to have the flight nurse, Barry Bartlett, from Defendant Reach Air, perform the intubation after Rocuronium and Ketamine were administered at 12:18 a.m.[22] Douglas's vital signs were stable up until that point.[23] Mr. Bartlett first attempted intubation at 12:20 a.m., unsuccessfully.[24] A large aspiration of gastric contents occurred after this initial intubation attempt and 13 minutes were spent suctioning his airway and re-oxygenating him with BVM.[25] Mr. Bartlett attempted intubation again at 12:23a.m. and 12:33 a.m. and was again unsuccessful.[26] Apparently, Mr. Bartlett attempted both "tooled and digital intubations" during this time.[27] Dr. Garvey stepped in to attempt to intubate 3 separate times, all unsuccessfully.[28] Intubation attempts continued at 12:40a.m., 12:44a.m., 12:47a.m., 12:52a.m. and 12:53a.m.[29] After another unsuccessful intubation attempt, a cric (surgical airway) was initiated by Dr. Garvey and Mr. Bartlett.[30] Over the course of over 33 minutes, a total of 9 intubation attempts are documented by Defendant Reach Air's flight crew.[31] After multiple aspiration events and failed intubation attempts, Douglas's vital signs and oxygenation indicated

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[19] Id.
[20] Id.
[21] Id.
[22] See Dr. Scissors Aff. At Exhibit **"2."**
[23] Id.
[24] See Dr. Scissors Aff. At Exhibit **"2."**
[25] See Reach Air Records at Exhibit **"4."**
[26] Id.
[27] Id.
[28] Id.
[29] Id.
[30] Id.
[31] Id.

cardiopulmonary arrest so CPR was administered.[32] CPR was unsuccessful and Douglas was pronounced dead at 1:33a.m.[33] From the time the first drug was given for rapid sequence intubation (RSI) until Dr. Garvey pronounced Mr. Schwartz deceased was 1 hour and 15 minutes.[34] During this time, neither Dr. Garvey nor Barry Bartlett were able to establish a definitive airway for Mr. Schwartz.[35]

After Douglas's death NNRH had an Occurrence Report completed by one of its staff following Douglas' many failed intubation attempts which noted that he was "stable and ready for transfer."[36] Contributing factors to this incident occurring were noted to be: "Staff – use of Float Staff"; "Staffing issue"; "Task – training issue"; Work Envmt – Inadequate Equipment Availability."[37] In addition, the Occurrence Report notes that the "trauma cart" was "open" and "not fully stocked – Supplies had to be obtained from 2 other rooms and store room."[38] NNRH has policies and procedures in place to ensure that the crash cart is always fully stocked and ready for use if a patient is experiencing a Code Blue—policies Dr. Garvey was required to follow.[39] This policy requires crash carts to be locked and their inventory checked daily.[40] Despite requests to NNRH to produce documentation of their daily crash cart checks, to date no such documentation has been provided.

In addition, both NRS 439.855, and NNRH's own Patient Safety Plan[41] in effect in June of 2016, require notification to Douglas Schwartz' family of the fact that he was involved in a sentinel event. NRS 439.830 defines a sentinel event as "any death that occurs in a health facility." The NNRH Patient Safety Plan requires the attending physician to provide this required notification. The attending

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[32] Id.

[33] Id.

[34] Dr. Womack Report, attached hereto as **Ex. "3."**

[35] Id.

[36] See Occurrence Report, attached hereto as **Ex. "5."**

[37] Id.

[38] Id.; Dr. Womack Report, attached hereto as **Ex. "3."**

[39] See NNRH's Code Blue Procedure & Crash Cart Maintenance Policy, attached hereto as **Ex, "6."**

[40] Id.

[41] See NNRH's Patient Safety Plan, attached hereto as **Ex. "7."**

physician in this case was Dr. Garvey. It is Plaintiff's belief that this required notification was never given to Douglas Schwartz's family or designee. Dr. Garvey's and NNRH's failure to provide notification to Douglas Schwartz's family that he was involved in a sentinel event pursuant to both NRS 439.855 and NNRH's Patient Safety Plan, constitutes willful and wanton conduct and a conscious disregard for Douglas Schwartz.

Plaintiff retained the services of Dr. Womack to offer expert opinions in this case. After reviewing the facts of this case, Dr. Womack offered the following opinions:

> **Dr. Garvey's omission to perform a cricothyrotomy on Mr. Schwartz in a timely manner was gross negligence.** Dr. Garvey not performing a cricothyrotomy while Mr. Schwartz was suffocating on his own vomit was negligence significantly greater in magnitude than ordinary negligence. It was extraordinary negligence to a high degree. Dr. Garvey failed to exercise even a slight degree of care by omitting to establish emergency oxygenation to Mr. Schwartz with a cricothyrotomy in a timely manner. Mr. Schwartz was in a CICO situation at approximately 12:23 am with a failed second attempt at intubation in the setting of not being able to oxygenate due to airway obstruction from fulminating emesis. The standard of care required that Dr. Garvey perform a cricothyrotomy on Mr. Schwartz immediately after Barry Bartlett's failed attempt at 12:23 am. After 12:23 am, there were no reasonable attempts that met the standard of care to establish emergency oxygenation to Mr. Schwartz. Dr. Garvey was doing nothing within the standard of care to establish emergency oxygenation to Mr. Schwartz. According to the testimony[42] of Barry Bartlett, Dr. Garvey was on the right side of Mr. Schwartz prepping for chest tube insertion until at least 12:33 am – ten minutes after Barry Bartlett's second failed attempt.[43]

Moreover,

> **Dr. Garvey acted with reckless conduct.** It is my understanding that reckless conduct is deemed to be that conduct in which the person knew or should have known at the time the person rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Dr. Garvey made the decision for two separate very serious and meticulous procedures (intubation and chest tube insertion) to be performed upon Mr. Schwartz simultaneously. Dr. Garvey should have known at the time that his conduct would likely result in injury that would affect the life or health of Mr. Schwartz. Dr. Garvey's decision was for Barry Bartlett to intubate Mr. Schwartz, who Dr. Garvey identified as having a high risk difficult airway, while Dr. Garvey cut a hole in Mr. Schwartz's chest for a chest tube to be placed in Mr. Schwartz's chest cavity (chest tube thoracostomy). Dr. Garvey had never talked to Barry Bartlett about Barry's education, training, or experience. Barry Bartlett was still in his internship with REACH. Each of these procedures performed in the proper

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[42] Deposition of Barry Bartlett; Page 78, Line 1 – Page 79, Line 8, attached hereto as **Ex. "8."**

[43] Dr. Womack Report, p. 22-23, attached hereto as **Ex. "3."**

> sequence one at a time have life threatening consequences if something goes wrong. In emergency medicine, first and foremost, a patient's airway comes before most any of the other problems that they could have. It is the ABC's of emergency medicine (A=Airway, B=Breathing, C=Circulation). Airway issues are to be managed before breathing issues; breathing issues are to be managed before circulation issues; and Circulation issues are to be managed before other issues such as disability (neurologic). Once an emergency medicine physician decides to intubate, the airway must be secure and protected before anything else happens including chest tube placement in Mr. Schwartz's situation. Once an ETT is correctly placed, placement is confirmed by direct visualization, end tidal CO2 detection, listening for breath sounds, and performing a chest x-ray. Mr. Schwartz's should not have been intubated. To place the chest tube, rather than sedation and paralysis of a patient with a high risk difficult airway, Dr. Garvey simply needed to numb Mr. Schwartz's chest wall with lidocaine. Instead, Dr. Garvey proceeded with reckless conduct.[44]

Finally:

> **Dr. Garvey acted in bad faith.** Dr. Garvey acted in bad faith by not reasonably explaining the risks of intubation to Mr. and Mrs. Schwartz that could occur by intubating Mr. Schwartz for the flight. Dr. Garvey mainly explained the risks of not intubating. By not reasonably explaining the risks of intubation, Dr. Garvey was unreasonable and unfair. By not reasonably explaining the risks of intubation, Dr. Garvey infringed upon Mr. Schwartz's right to know his risks of the procedure as a patient… Dr. Garvey acted in bad faith by not reasonably explaining the alternative treatments to Mr. and Mrs. Schwartz, regarding intubation. Dr. Garvey did not explain alternative treatments. By not explaining alternative treatments, Dr. Garvey was unreasonable and unfair. By not explaining alternative treatments, Dr. Garvey infringed upon Mr. Schwartz's right to know his alternative treatment options as a patient.[45]

Punitive damages are warranted under the facts of this case.

C. ARGUMENT

1. THIS COURT CAN RECONSIDER ITS PRIOR ORDER PURSUANT TO NRCP 60 BECAUSE OF NEW EVIDENCE IN THIS CASE THAT JUSTIFIES RELIEF

Plaintiff is aware that this Court has denied Plaintiff's previous request to Amend to add punitive damages, with prejudice. However, this Court can reconsider its prior ruling pursuant to NRCP 60:

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[44] Id. at 23-24.

[45] Id. at 24-25.

(b) **Grounds for Relief From a Final Judgment, Order, or Proceeding.** On motion and just terms, the court may relieve a party or its legal representative from a final judgment, order, or proceeding for the following reasons:

(1) mistake, inadvertence, surprise, or excusable neglect;

(2) newly discovered evidence that, with reasonable diligence, could not have been discovered in time to move for a new trial under Rule 59(b);

(3) fraud (whether previously called intrinsic or extrinsic), misrepresentation, or misconduct by an opposing party;

(4) the judgment is void;

(5) the judgment has been satisfied, released, or discharged; it is based on an earlier judgment that has been reversed or vacated; or applying it prospectively is no longer equitable; or

(6) any other reason that justifies relief.[46]

In the present case, new evidence justifies this Court granting Plaintiff relief from its prior order pursuant to NRCP 60(b)(6).[47] Plaintiff last moved to amend in September 2018. Plaintiff sought this amendment based on the medical records and the affidavit of Dr. Scissors. Since that time, Plaintiff has conducted numerous depositions, including the depositions of Dr. Garvey and many of the attending nurses. Plaintiff has also received numerous documents supporting amendment.[48] With this information, Plaintiff retained the services of Dr. Seth Womack. Dr. Womack has taken this information and offered expert opinions that such gross violations of the applicable standard of care rises to reckless, willful, and wanton conduct.

This evidence is new, justified relief, and was not available at the time this Court issued the Order denying punitive damages because the discovery had not yet been conducted. This Motion is also timely because again, the evidence has just been discovered. Expert disclosures are not due until November 5, 2020. Because Plaintiff is now in possession of this information, Plaintiff felt it pertinent to provide this information to the Court and immediately seek leave to amend. As such, Plaintiff requests this Court set aside its prior Order denying punitive damages with prejudice because the new evidence justifies the relief sought.

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[46] NRCP 60(b) and (c).

[47] Order Denying Punitive Damages, attached hereto as **Ex. "9."**

[48] See NNRH's Code Blue Procedure & Crash Cart Maintenance Policy, attached hereto as **Ex, "6."**

2. STANDARDS GOVERNING MOTIONS FOR LEAVE TO AMEND

Pursuant to NRCP 15(a)(2) leave to amend a complaint "shall be freely given when justice so requires." In cases where the statute of limitations has run, the amendment must relate back to the original Complaint:

> (c) **Relation Back of Amendments.** An amendment to a pleading relates back to the date of the original pleading when:
>
> (1) the amendment asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out — or attempted to be set out — in the original pleading.[49]

The decision to grant leave to amend is well within the discretion of this Court and is one that will not be disturbed absent an abuse of that discretion.[50]

The Nevada Supreme Court has repeatedly held that in the absence of any apparent or declared reason such as undue delay, bad faith or dilatory motive on the part of the movant, the leave sought should be freely given.[51] The Nevada Supreme Court has held, "if the original pleadings give fair notice of the fact situation from which the new claim for liability arises, the amendment should relate back for limitation purposes.[52]

The court should only deny a request to amend when the moving party has demonstrated undue delay, bad faith or dilatory motive or where the amendment would unduly prejudice the opposing party.[53] Equally, an amendment will be denied where it is futile.[54] A party generally must seek leave to amend before the deadlines imposed in the discovery scheduling order, unless good cause is shown by the movant for the untimely filing.[55]

Here, both Dr. Garvey and NNRH were initially put on notice of Plaintiff's intent to file punitive damages because Plaintiff's original Complaint had language asserting claims for punitive

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[49] NRCP 15(c).

[50] Adamson v. Bowker, 85 Nev. 115, 450 p.d. 796 (1969).

[51] Stephens v. Southern Nevada Music Co., Inc. 507 P.2d 138, 139, 89 Nev. 104 (1973).

[52] C.A. Nelson v. City of Las Vegas, 99 Nev. 548, 556, 665 P.2d 1141, 1146 (1983).

[53] See Foman v. Davis, 371 U.S. 178 (1962).

[54] Id.

[55] See Nutton v. Sunset Station, Inc. 131 Nev. Adv. Rep. 34 (Nev. Ct. App. June 11, 2015).

damages.[56] Plaintiff sought to amend her Complaint in September 2018 because in a prior amendment punitive damages were erroneously and inadvertently removed.[57] Plaintiff moved to amend the Complaint to re-assert a claim for punitive damages. A request this Court denied. Yet, Defendants were well aware of the nature of their conduct, and well aware the conduct at issue rises to the level of reckless, willful, and wanton conduct, which amounts to a conscious disregard to the rights and safety of Douglas.

Defendants should have further anticipated the instant motion based on the Declaration of Dr. Seth Womack, which was disclosed with Plaintiff's Opposition to Defendant David Garvey M.D.'s Motion for Partial Summary Judgment to Statutorily Limit Damages, and all Joinders Thereto. There is no undue delay, bad faith or dilatory motive on the part of Plaintiff as all of this information was recently discovered, and Plaintiff's expert just opined that the facts of this case demonstrated such a gross violation of the standard of care. Moreover, amendment would not be futile as the facts of this case justify amendment. Whether or not these actions rise to a level to warrant punitive damages is a question for the jury to ultimately decide based on all the evidence presented at trial, and the jury should have the opportunity to decide if punitive damages are warranted here.

3. STANDARDS GOVERNING PUNITIVE DAMAGES

Pursuant to NRS 42.005 Punitive Damages are available and states, in relevant part:

> 1. Except as otherwise provided in NRS 42.007, in an action for the breach of an obligation not arising from contract, where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud or **malice, express or implied**, the plaintiff, in addition to the compensatory damages, may recover damages for the sake of example and by way of punishing the defendant.[58]

NRS 42.005 defines malice, express or implied as:

> "conduct which is intended to injure a person or **despicable conduct which is engaged in with a conscious disregard of the rights or safety of others.** Conscious Disregard is defined as the knowledge of the **probable harmful consequences of a**

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[56] Plaintiff's Original Complaint, attached hereto as **Exhibit "10."**

[57] Plaintiff's Second Amended Complaint, attached hereto as **Exhibit "11."**

[58] NRS 42.005

wrongful act and a willful and deliberate failure to act to avoid those consequences. [59]

Further, NRS 42.007 governs punitive damages against a corporation for the wrongful act of an employee, and states, in relevant part:

> 1. Except as otherwise provided in subsection 2, in an action for the breach of an obligation in which exemplary or punitive damages are sought pursuant to subsection 1 of NRS 42.005 from an employer for the wrongful act of his or her employee, the employer is not liable for the exemplary or punitive damages unless:
>
> **(a)** The employer had advance knowledge that the employee was unfit for the purposes of the employment and employed the employee with a conscious disregard of the rights or safety of others;
>
> **(b)** The employer expressly authorized or ratified the wrongful act of the employee for which the damages are awarded; or
>
> **(c)** The employer is personally guilty of oppression, fraud or malice, express or implied.
>
> If the employer is a corporation, the employer is not liable for exemplary or punitive damages unless the elements of paragraph (a), (b) or (c) are met by an officer, director or managing agent of the corporation who was expressly authorized to direct or ratify the employee's conduct on behalf of the corporation.[60]

"Punitive damages are designed to punish and deter a defendant's culpable conduct and act as a means for the community to express outrage and distaste for such conduct."[61] Punitive damages are a "means of punishing the tortfeasor and deterring the tortfeasor and others from engaging in similar conduct."[62] "The allowance of punitive damages also provides a benefit to society by punishing undesirable conduct that is not punishable by the criminal law."[63] The Nevada Supreme Court, and other courts, has consistently upheld this standard when applying punitive damages to medical malpractice cases.[64] Other jurisdictions have also upheld this standard when applying punitive

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[59] Id.

[60] NRS 42.007.

[61] Countrywide Home Loans, Inc. v. Thitchener, 124 Nev. 725, 739, 192 P.3d 243 252 (2008); see also Republic Ins. v. Hires, 107 Nev. 317, 320, 810 P.2d 790, 792 (1991) ("Punitive damages provide a benefit to society by punishing undesirable conduct not punishable by the criminal law").

[62] Siggelkow v. Phoenix Ins. Co., 109 Nev. 42, 44-45, 846 P.2d 303, 304-05 (1993).

[63] Id. at 45, 846 P.2d at 305.

[64] See Wyeth v. Rowatt, 244 P.3d 765 (Nev. 2010) (Upholding punitive damages against a drug manufacturer that misrepresented the risks of a drug).

damages to medical malpractice.[65]

"A plaintiff may recover punitive damages when evidence demonstrates that the defendant has acted with 'malice, express or implied."[66] '"Malice, express or implied,' means conduct which is intended to injure a person **or** despicable conduct which is engaged in with a conscious disregard of the rights or safety of others."'[67] "A defendant has a 'conscious disregard' of a person's rights and safety when he or she knows of 'the probable harmful consequences of a wrongful act and a willful and deliberate failure to act to avoid those consequences.'"[68] "In other words, under NRS 42.001(1), to justify punitive damages, the defendant's conduct must have exceeded 'mere recklessness or gross negligence."[69]

In Maduike v. Agency Rent-A-Car, the Nevada Supreme Court held that refusal to repair a known dangerous condition, without more, will not support punitive damages.[70] However, the Court retreated from this approach in Thitchener and ruled that the disjunctive "implied malice" prong of the punitive damages statute permits such damages for conscious disregard of unsafe conditions.[71] A conscious disregard is defined as the "knowledge of the probable harmful consequences of a wrongful act and a willful and deliberate failure to act to avoid those consequences."[72]

In Thitchener, the Court allowed punitive damages in a wrongful eviction case, under the implied malice theory, where plaintiffs "presented evidence of multiple ignored warning signs suggesting that Countrywide knew of a potential mix-up, as well as evidence indicating Countrywide continued to proceed with the foreclosure despite knowing of the probable harmful consequences of

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[65] See Medvecz v. Choi, 569 F.2d 1221 (3rd Cir. 1977) (Holding that a patient who was paralyzed due to an anesthesiologist could be awarded punitive damages if the anesthesiologist's conduct of abandoning the patient was reckless).

[66] Wyeth v. Rowatt, 126 Nev. Adv. Rep. 44, 244 P.3d 765, 783 (2010) (quoting NRS 42.005(1)).

[67] Id. (quoting NRS 42.001(3) (emphasis added).

[68] Id. (quoting NRS 42.001(1)).

[69] Id. (quoting Countrywide Home Loans, Inc. v. Thitchener, 124 Nev. 725, 742-43, 192 P.3d 243, 254-55 (2008)).

[70] Maduike, 114 Nev. 1, 953, P.2d 24, 26-27 (1998).

[71] See Thitchener, 124 Nev. at 739-40 & n.51, 192 P.3d at 253-55 & n.51.

[72] NRS 42.001(1).

doing so."[73] The Court has also allowed punitive damages in a simple business transaction where plaintiffs accused defendants of misrepresentation and fraud.[74]

Plaintiff believes that both NRS 42.005 as well as NRS 42.007 govern this case, as demonstrated *infra*.

a. Dr. Garvey

Plaintiff believes that NRS 42.005 governs the claim against Dr. Garvey because Dr. Garvey acted with conscious disregard for the rights and safety of Mr. Schwartz. Dr. Garvey made the decision to intubate the decedent, despite stable vital signs and no signs of respiratory distress. Notably, there is evidence in this case that Defendants, including Dr. Garvey, were responsible for 9 or more intubation attempts unsuccessfully before turning to a surgical airway. This is not only a breach of the standard of care, but is grossly negligent, reckless, willful and wanton in light of the fact that clinical evidence based protocols indicate that no more than 3 intubation attempts should be made before a surgical airway is done. These evidence based protocols exist because the risk of not following them is death. Something Dr. Garvey should have known at the time of treating Douglas Schwartz.

Further evidence of this conduct is outlined by Dr. Womack, who specifically opined:

> **Dr. Garvey's omission to perform a cricothyrotomy on Mr. Schwartz in a timely manner was gross negligence.** Dr. Garvey not performing a cricothyrotomy while Mr. Schwartz was suffocating on his own vomit was negligence significantly greater in magnitude than ordinary negligence. It was extraordinary negligence to a high degree. Dr. Garvey failed to exercise even a slight degree of care by omitting to establish emergency oxygenation to Mr. Schwartz with a cricothyrotomy in a timely manner. Mr. Schwartz was in a CICO situation at approximately 12:23 am with a failed second attempt at intubation in the setting of not being able to oxygenate due to airway obstruction from fulminating emesis. The standard of care required that Dr. Garvey perform a cricothyrotomy on Mr. Schwartz immediately after Barry Bartlett's failed attempt at 12:23 am. After 12:23 am, there were no reasonable attempts that met the standard of care to establish emergency oxygenation to Mr. Schwartz. Dr. Garvey was doing nothing within the standard of care to establish emergency

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[73] Thitchener, 124 Nev. at 744, 192 P.3d at 255.

[74] See Ace Truck v. Kahn, 103 Nev. 503, 511, 746 P.2d 132, 137 (1987), abrogated on other grounds by Bongiovi v. Sullivan, 122 Nev. 556, 582-83, 138 P.3d 433, 451-52 (2006) (noting that this "can probably be said to be toward the lower end of the spectrum of malevolence found in punitive damages case[s]").

> oxygenation to Mr. Schwartz. According to the testimony[75] of Barry Bartlett, Dr. Garvey was on the right side of Mr. Schwartz prepping for chest tube insertion until at least 12:33 am – ten minutes after Barry Bartlett's second failed attempt.[76]

Moreover,

> **Dr. Garvey acted with reckless conduct.** It is my understanding that reckless conduct is deemed to be that conduct in which the person knew or should have known at the time the person rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Dr. Garvey made the decision for two separate very serious and meticulous procedures (intubation and chest tube insertion) to be performed upon Mr. Schwartz simultaneously. Dr. Garvey should have known at the time that his conduct would likely result in injury that would affect the life or health of Mr. Schwartz. Dr. Garvey's decision was for Barry Bartlett to intubate Mr. Schwartz, who Dr. Garvey identified as having a high risk difficult airway, while Dr. Garvey cut a hole in Mr. Schwartz's chest for a chest tube to be placed in Mr. Schwartz's chest cavity (chest tube thoracostomy). Dr. Garvey had never talked to Barry Bartlett about Barry's education, training, or experience. Barry Bartlett was still in his internship with REACH. Each of these procedures performed in the proper sequence one at a time have life threatening consequences if something goes wrong. In emergency medicine, first and foremost, a patient's airway comes before most any of the other problems that they could have. It is the ABC's of emergency medicine (A=Airway, B=Breathing, C=Circulation). Airway issues are to be managed before breathing issues; breathing issues are to be managed before circulation issues; and Circulation issues are to be managed before other issues such as disability (neurologic). Once an emergency medicine physician decides to intubate, the airway must be secure and protected before anything else happens including chest tube placement in Mr. Schwartz's situation. Once an ETT is correctly placed, placement is confirmed by direct visualization, end tidal CO2 detection, listening for breath sounds, and performing a chest x-ray. Mr. Schwartz's should not have been intubated. To place the chest tube, rather than sedation and paralysis of a patient with a high risk difficult airway, Dr. Garvey simply needed to numb Mr. Schwartz's chest wall with lidocaine. Instead, Dr. Garvey proceeded with reckless conduct.[77]

Finally:

> **Dr. Garvey acted in bad faith.** Dr. Garvey acted in bad faith by not reasonably explaining the risks of intubation to Mr. and Mrs. Schwartz that could occur by intubating Mr. Schwartz for the flight. Dr. Garvey mainly explained the risks of not intubating. By not reasonably explaining the risks of intubation, Dr. Garvey was unreasonable and unfair. By not reasonably explaining the risks of intubation, Dr. Garvey infringed upon Mr. Schwartz's right to know his risks of the procedure as a patient… Dr. Garvey acted in bad faith by not reasonably explaining the alternative treatments to Mr. and Mrs. Schwartz, regarding intubation. Dr. Garvey did not explain

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[75] Deposition of Barry Bartlett; Page 78, Line 1 – Page 79, Line 8, attached hereto as **Ex. "8."**

[76] Dr. Womack Report, p. 22-23, attached hereto as **Ex. "3."**

[77] Id. at 23-24.

> alternative treatments. By not explaining alternative treatments, Dr. Garvey was unreasonable and unfair. By not explaining alternative treatments, Dr. Garvey infringed upon Mr. Schwartz's right to know his alternative treatment options as a patient.[78]

Furthermore, Dr. Garvey was not only an Emergency Room physician working at NNRH at the time he rendered care to Douglas. Dr. Garvey was also an employee of Defendant Ruby Crest and a Regional Medical Director of Defendant Reach Air. These facts are undisputed. These facts are also significant because Dr. Garvey's very decision to intubate and transfer Douglas by Defendant Reach Air is in question due to Dr. Garvey's dual role at the time. A dual role that was explicitly prohibited by Dr. Garvey's contract with his employer, Defendant Ruby Crest.[79]

As such, Dr. Garvey's conduct was so egregious he clearly exhibited a conscious disregard for Douglas's safety. Plaintiff now has more than sufficient evidence to support an amendment on a punitive damages claim.

b. Northeastern Nevada Regional Hospital

Plaintiff believes that NNRH is liable for punitive damages under both NRS 42.005 and NRS 42.007. NNRH created a culture where it was acceptable to not have inventory compliant with the standard of care. In this case, that is evident through the crash cart.

Defendants knew or should have known that failure ensure the crash cart inventory was properly stocked, so that all necessary life saving equipment was available at the patient's bedside during a code blue, could and would result in death. The evidence in this case shows that NNRH had an Occurrence Report completed by one of its staff following Douglas' many failed intubation attempts which noted that he was "stable and ready for transfer."[80] Contributing factors to this incident occurring were noted to be: "Staff – use of Float Staff"; "Staffing issue"; "Task – training issue"; Work Envmt – Inadequate Equipment Availability."[81] In addition, the Occurrence Report notes that the "trauma cart" was "open" and "not fully stocked – Supplies had to be obtained from 2 other rooms

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[78] Id. at 24-25.

[79] Dr. Garvey's Contract with Ruby Crest was produced pursuant to a Stipulated Confidentiality Agreement, and therefore a copy is not attached hereto.

[80] See Occurrence Report, attached hereto as **Ex. "5."**

[81] Id.

and store room."[82] NNRH has policies and procedures in place to ensure that the crash cart is always fully stocked and ready for use if a patient is experiencing a Code Blue—policies Defendants were required to follow.[83] This policy requires crash carts to be locked and their inventory checked daily.[84] Despite requests to NNRH to produce documentation of their daily crash cart checks, to date no such documentation has been provided.

Plaintiff believes NNRH is liable for this conduct under NRS 42.005 as the culture at NNRH allowed for a trauma cart to remain on the premises without being complaint with policies and procedures. This is likely the reason that Defendant has not turned over documentation evidencing the daily crash cart checks.

Alternatively, NNRH is liable under NRS 42.007 for the conduct of its employees, including Dr. Garvey. The employees allowed a crash cart to be inadequately stocked. NNRH not only allowed this to happen, but approved and ratified this conduct by not taking the proper procedures to ensure this would never happen again.

Moreover, NNRH employees assisted in the decision to intubate Douglas Schwartz no less than nine (9) times. Defendants "knew or should have known" that deviations from clinical evidence based protocols in performing intubations can and would result in death. To ignore these clinical evidence based protocols, is to ignore the very real risk of death. This is not good faith. This is grossly negligent, reckless, willful and wanton conduct. Defendants knew or should have know of the risks of a failed intubation and the required clinical evidence based protocols.

In addition, Plaintiff believes that NNRH and Dr. Garvey are liable for punitive damages under NRS 439.855 and NNRH's own Patient Safety Plan[85] in effect in June of 2016, for their deliberate failure to notify Douglas Schwartz' family of the fact that he was involved in a sentinel event. NRS 439.830 defines a sentinel event as any "death that occurs in a health facility." As such, Douglas Schwartz' death at NNRH was required to be reported. Furthermore, pursuant to NNRH's Patient

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[82] Id.

[83] See NNRH's Code Blue Procedure & Crash Cart Maintenance Policy, attached hereto as **Ex. "6."**

[84] Id.

[85] See NNRH's Patient Safety Plan, attached hereto as **Ex. "7."**

Safety Plan in effect at that time, the responsibility for notification to Douglas' family fell upon the attending physician, in this case, Dr. Garvey.[86] NNRH's and Dr. Garvey's deliberate and wilful failure to comply with Nevada law and hospital required policies shows a conscious disregard for Douglas Schwartz.

The facts of this case show more than just negligence, they show gross negligence and reckless, willful and wanton conduct and conscious disregard. There are a multitude of facts in this case go beyond mere negligence, and demonstrate that Defendants actions were taken "knowingly, wantonly, willfully, and/or maliciously" and in "conscious disregard."

IV.

CONCLUSION

Based on the foregoing, Plaintiff respectfully requests this Court deny Defendant's Motion to Strike the Declaration of Shirley Blazich Esq. and any joinders thereto, and Defendant's Motion to Strike the Declaration of Dr. Womack and any joinders thereto, in their entirety. Plaintiff also requests this Court Grant Plaintiff's Motion for Leave to Amend as punitive damages are warranted against both Dr. Garvey and NNRH.

DATED this 9th day of September, 2020.

CLAGGETT & SYKES LAW FIRM

/s/ Shirley Blazich

Sean K. Claggett, Esq.
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Attorneys for Plaintiff

[86] Id.

CERTIFICATE OF SERVICE

I hereby certify that on the 9th day of September, 2020, I caused a true and correct copy of the foregoing **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 MOTION TO STRIKE THE DECLARATION OF SETH WOMACK, M.D., AND ANY JOINDERS THERETO AND PLAINTIFF'S COUNTERMOTION FOR LEAVE TO AMEND THE COMPLAINT** on the following person(s) by the following method(s) pursuant to NRCP 5(b):

VIA US MAIL Casey W. Tyler, Esq. James W. Fox, Esq. HALL PRANGE & SCHOOVELD, LLC 1140 N. Town Center Drive, Suite 350 Las Vegas, NV 89144 *Attorneys for Defendant, PHC-Elko, Inc. dba Northeastern Nevada Regional Hospital*	***VIA US MAIL*** Keith A. Weaver, Esq. LEWIS BRISBOIS BISGAARD & SMITH, LLP 6385 S. Rainbow Blvd., Suite 600 Las Vegas, NV 89118 *Attorneys for Defendant, David Garvey, M.D.*
VIA US MAIL Todd L. Moody, Esq. L. Kristopher Rath, Esq. HUTCHISON & STEFFEN, PLLC. 10080 West Alta Drive, Suite 200 Las Vegas, NV 89145 James T. Burton, Esq. KIRTON MCCONKIE 36 S. State Street, Suite 1900 Salt Lake City, UT 84111 *Attorneys for Defendant, Reach Air Medical Services, LLC and for its individually named employees*	***VIA US MAIL*** Robert C. McBride, Esq. Chelsea R. Hueth, Esq. MCBRIDE HALL 8329 W. Sunset Road, Suite 260 Las Vegas, NV 89113 *Attorneys for Defendant, Crum, Stefanko, & Jones, LTD dba Ruby Crest Emergency Medicine*

/s/ Jackie Abrego

An Employee of CLAGGETT & SYKES LAW FIRM

EXHIBIT 1

Case No.: CV-C-17-439
Dept. No: 1

AFFIRMATION
Pursuant to NRS 239B.030
This document does not contain
any Social Security Numbers

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD, dba Ruby Crest Emergency Medicine; PHC-ELKO INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

THIRD AMENDED COMPLAINT (PROPOSED) (Medical Malpractice) and Wrongful Death)

Plaintiff, DIANE SCHWARTZ, individual and as the administrator of the Estate of DOUGLAS SCHWARTZ, by and through her attorneys of record, CLAGGETT & SYKES LAW FIRM, for their causes of action against Defendants, DAVID GARVEY, M.D., individually; CRUM, STEFANKO, & JONES LTD, dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, REACH AIR MEDICAL SERVICES, L.L.C; DOES 1 through X; ROE BUSINESS ENTITIES X1 through XX; and each of them and alleges as follows:

1. At all times relevant herein, Plaintiff, DIANE SCHWARTZ, individually and as the Special Administrator on behalf of the Estate of DOUGLAS R. SCHWARTZ (hereinafter the "Plaintiff" or "Diane"), was and is a resident of Elko County, Nevada.

2. At all times relevant herein, Plaintiff DOUGLAS SCHWARTZ (hereinafter the "Plaintiff" or "Mr. Schwartz"), was a resident of Elko County, Nevada.

3. Upon information and belief, at all times relevant herein, Defendant, David Garvey, M.D. (hereinafter "Dr. Garvey" or "Defendant"), was and is a medical doctor licensed in the State of Nevada, and a resident of Elko County, Nevada.

4. Upon information and belief, at all times relevant herein, Defendant, CRUM, STEFANKO, & JONES LTD, dba RUBY CREST EMERGENCY MEDICINE (hereinafter "Ruby Crest" or "Defendant"), was and is a domestic corporation existing pursuant to the laws of Delaware, authorized to do business in Nevada, and doing business in the State of Nevada.

5. Upon information and belief, at all times relevant herein, Defendant, PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL (hereinafter "NNRH" or "Defendant"), was and is a domestic corporation existing pursuant to the laws of Nevada, authorized to do business in the State of Nevada, and doing business in the State of Nevada.

6. Defendant NNRH was and is at all times relevant operating as a medical care facility in Elko County, Nevada and was and is owned, operated, managed, and controlled as a medical care facility within the County of Elko, State of Nevada, and was held out to the public at large, including the Plaintiff herein, as a properly equipped, fully accredited, completely staffed by qualified and prudent personnel, and operating in compliance with standards of due care maintained by other properly equipped, efficiently operated and administered, accredited medical care facilities in said community, offering full, competent, qualified, and efficient health care services to the general public and to the Plaintiff herein; that Plaintiff herein is informed and believes and thereon alleges, that Defendant, NNRH, administered, governed, controlled, managed, and directed all the necessary functions, activities, and operations of said medical care facility, including its physician care, nursing care, interns, residents and health staff, and other personnel.

7. Upon information and belief, Defendant REACH AIR MEDICAL SERVICES, LLC, (hereinafter "Reach Air" or "Defendant") is a foreign limited liability company existing pursuant to the laws of California, authorized to do business in the State of Nevada, and doing business in the State of Nevada

8. That the true names or capacities, whether corporate, associate, individual or otherwise, of DOES I through X, inclusive, were and now are physicians, surgeons, registered nurses, licensed vocational nurses, practical nurses, registered technicians, aides, attendants, physician's assistants, CRNAs, or paramedical personnel holding themselves out as duly licensed to practice their professions under and by virtue of the laws of the State of Nevada, and were and are now engaged in the practice of their professions in the State of Nevada, and are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Plaintiff is informed and believes, and thereon alleges, that each of the Defendants designated herein as a DOE is legally responsible in some manner for the events and happenings herein referred to and proximately caused injury and damages thereby to Plaintiff as hereinafter alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names and capacities of DOES I through X when the same have been ascertained and to join such Defendants in this action.

9. That the true names or capacities of Defendants, ROE BUSINESS ENTITIES XI through XX, inclusive, are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Defendants designated herein as ROE BUSINESS ENTITIES XI through XX, and each of them, are corporations, firms, partnerships, associations, other medical entities, including but not limited to nursing staffing companies and/or registry nursing companies, emergency physician services group, predecessors-in-interest, successors-in-interest, and/or agencies otherwise in a joint venture with, and/or serving as an alter ego of, any and/or all Defendants named herein; and/or are entities responsible for the treatment, diagnosis, surgery, and/or other provision of medical care to Plaintiff herein, and/or otherwise responsible for the supervision of the individually named Defendants at the time of the events and circumstances alleged herein; and/or are entities employed by and/or otherwise directing the individual Defendants in the scope and course of their responsibilities at the time of the events and circumstances alleged herein; and/or are entities otherwise contributing in any

way to the acts complained of and the damages alleged to have been suffered by the Plaintiff herein. Plaintiff is informed and, on that basis believes and thereon alleges, that each of the Defendants designated as a ROE BUSINESS ENTITY is in some manner negligently, vicariously, and/or statutorily responsible for the events and happenings referred to and caused damages to Plaintiff as herein alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names of such Defendants when the same have been ascertained.

10. Defendants are agents, servants, employees, employers, trade venturers, and/or partners of each other. At the time of the incident described in this Complaint, Defendants were acting within the color, purpose and scope of their relationships, and by reason of their relationships, Defendants may be jointly and severally and/or vicariously responsible and liable for the acts and omissions of their Co-Defendants.

GENERAL ALLEGATIONS

1. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

2. On June 22, 2016, Mr. Schwartz was struck as a pedestrian by a moving vehicle as he was exiting a local restaurant in the 400 block of Commercial Street in Elko, Nevada.

3. Paramedics were called to the scene at 8:17 p.m. and arrived at the scene within a few minutes.

4. Mr. Schwartz was placed in full C-spine precautions. During transport to the hospital, his vitals were within normal limits, 4L of oxygen was started routinely, a heart monitor was placed showing normal sinus rhythm.

5. Mr. Schwartz was transported by Elko County Ambulance to Northeastern Nevada Regional Hospital on a "non-emergent" transport mode arriving at approximately 8:48 p.m.

6. Dr. Garvey performed a physical examination of Mr. Schwartz upon arrival to the emergency department.

7. His assessment revealed that Mr. Schwartz had mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions to the right bicep, elbow and knee.

8. Mr. Schwartz had a normal heart rate and rhythm.

9. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout.

10. Mr. Schwartz's neurological status was normal.

11. Mr. Schwartz's abdominal evaluation was within normal limits.

12. At approximately 9:02 p.m. several diagnostic studies were ordered to further evaluate Mr. Schwartz's injuries including scans of the head, cervical and thoracic spine, chest, abdomen and pelvis.

13. Dr. Garvey contacted Dr. Ray at the University of Utah who accepted the patient for transfer.

14. The air ambulance crew from Reach Air arrived at NNRH to transport Mr. Schwartz to the airport for an air ambulance transport to the University of Utah Hospital.

15. Mr. Schwartz was not informed of the risks of undergoing an intubation. He was not informed of the alternatives to undergoing an intubation procedure.

16. Dr. Garvey elected to have the flight nurse, Barry Bartlett, from Reach Air, perform the intubation after Rocuronium and Ketamine were administered at 12:18 a.m.

17. Mr. Schwartz's vital signs were stable up until this point.

18. Barry Bartlett, first attempted intubation at 12:20 a.m., unsuccessfully, followed quickly by a deterioration of oxygenation and vital signs.

19. Intubation by Barry Bartlett, was again unsuccessful at 12:33 a.m. and a large aspiration of gastric contents was noted.

20. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered.

21. CPR continued and several subsequent intubation attempts were unsuccessful.

22. At 1:20 a.m. Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 1:33 a.m.

23. Barry Bartlett was an employee of Reach Air, and Reach Air has stipulated that Mr. Bartlett was acting in the course and scope of his employment at the time of the Subject Incident.

24. After Mr. Schwartz's death NNRH had an Occurrence Report completed by one of its staff following Douglas' many failed intubation attempts which noted that he was "stable and ready for transfer." Contributing factors to this incident occurring were noted to be: "Staff – use of Float Staff"; "Staffing issue"; "Task – training issue"; Work Envmt – Inadequate Equipment Availability." In addition, the Occurrence Report notes that the "trauma cart" was "open" and "not fully stocked – Supplies had to be obtained from 2 other rooms and store room."

25. NNRH has policies and procedures in place to ensure that the crash cart is always fully stocked and ready for use if a patient is experiencing a Code Blue. This policy requires crash carts to be locked and their inventory checked daily.

26. By not completely stocking the trauma cart, Northeastern Nevada Regional Hospital acted with reckless conduct.[1]

27. In addition, both NRS 439.855, and NNRH's own Patient Safety Plan in effect in June of 2016, require notification to Douglas Schwartz' family of the fact that he was involved in a sentinel event. NRS 439.830 defines a sentinel event as "any death that occurs in a health facility."

28. The NNRH Patient Safety Plan requires the attending physician to provide this required notification. The attending physician in this case was Dr. Garvey. It is Plaintiff's belief that this required notification was never given to Douglas Schwartz's family or designee.

29. Moreover, Dr. Garvey's actions amounted to gross negligence, reckless conduct, and Dr. Garvey acted in bad faith during his treatment of Mr. Schwartz.[2]

FIRST CLAIM FOR RELIEF

(PROFESSIONAL NEGLIGENCE/WRONGFUL DEATH)
DR. DAVID GARVEY, RUBY CREST, REACH AIR, AND NNRH

30. Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

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[1] Dr. Womack Declaration, p. 27-27, attached hereto as **Ex. "1."**
[2] Dr. Womack Declaration, p. 22-23, attached hereto as **Ex. "1."**

31. Defendant Dr. GARVEY owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field.

32. Defendant Dr. GARVEY fell below the standard of care by deciding to intubate Mr. Schwartz without clinical indications for intubation.[3]

33. Defendant Dr. GARVEY fell below the standard of care by failing to request an anesthesiologist to perform the intubation due to the high risk of aspiration.[4]

34. Defendant Dr. GARVEY fell below the standard of care by assigning an RN to perform a high risk, semi-elective intubation in a patient who he knew just ate a large meal.[5]

35. Defendant Dr. GARVEY fell below the standard of care by failing to obtain informed consent for Mr. Schwartz when he failed to advise him of the pros and cons of the procedure as well as other acceptable options (including not doing the procedure at all or having it done by an expert physician).[6]

36. Defendant Dr. GARVEY fell below the standard of care by electing to continue with the same plan of having an RN attempt intubation even after the initial intubation procedure was unsuccessful rather than trying it himself or supporting the patient with a bag-mask technique and/or by calling in an anesthesiologist as the standard of care would require.[7]

37. Defendant Dr. GARVEY further failed to ensure that the "crash cart" was operational and fully stocked.

38. Defendant Dr. GARVEY, further failed to comply with NRS 439.855 and comply with sentinel event reporting.

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[3] See Affidavit of Kenneth N. Scissors, M.D., attached hereto as **"Exhibit 2";** Dr. Womack Declaration, p. 22-23, attached hereto as **Ex. "1."**

[4] Id.

[5] Id.

[6] Id.

[7] Id.

39. Defendant Dr. GARVEY thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[6]

40. Defendant Dr. GARVEY'S actions amounted to gross negligence, reckless conduct, and Dr. Garvey acted in bad faith during his treatment of Mr. Schwartz.[8]

41. Defendant REACH AIR through its employee BARRY BARTLETT, owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field. [9]

42. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by agreeing to attempt an intubation of Mr. Schwartz when he did not have clear indications for intubation and had a high risk of aspiration of gastric contents.[10]

43. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by not deferring to a qualified anesthesiologist.[11]

44. Defendant REACH AIR through its employee BARRY BARTLETT, fell below the standard of care by attempting a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician. [12]

45. Defendant REACH AIR through its employee BARRY BARTLETT, thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[13]

46. Defendant REACH AIR'S employees, agents, and/or servants, including BARRY BARTLETT, was acting in the scope of his employment, under Defendant's control, and in the furtherance of Defendant's interest at the time his actions caused injuries to Mr. Schwartz.

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[8] Dr. Womack Declaraion, p. 22-23, attached hereto as **Ex. "1."**

[9] Id.

[10] Id.

[11] Id.

[12] Id.

[13] Id.

47. Defendant NNRH in the capacity of a medical hospital, providing medical care to the public owed Mr. Schwartz a non-delegable duty to employ medical staff including Dr. GARVEY to have adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.

48. Defendant NNRH further failed to ensure that the "crash cart" was operational and fully stocked. By not completely stocking the trauma cart, Northeastern Nevada Regional Hospital acted with reckless conduct.[14]

49. Defendant NNRH further failed to comply with NRS 439.855 and its Patient Safety Plan and conduct required sentinel event reporting. By failing to comply with NRS 439.855 and its Patient Safety Plan, Defendant NNRH acted in conscious disregard of Douglas Schwartz.

50. At all relevant times mentioned herein, Defendants knew or in the exercise of reasonable care should have known, that the provisions of medical care and treatment was of such a nature that, if it was not properly given, was likely to injure or cause death to the person to whom it was given.

51. Defendants, and each of them, fell below the standard of care for a health care provider who possesses the degree of professional learning, skill, and ability of other similar health care providers in failing to timely and properly treat Mr. Schwartz resulting in significant injuries and death. The allegations against Defendants are supported by the Declarations of Dr. Kenneth N. Scissors and Dr. Seth Womack, which are both attached hereto and incorporated herein by this reference.[15]

52. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

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[14] Dr. Womack Declaration, p. 27-27, attached hereto as **Ex. "1."** See Affidavit of Kenneth N. Scissors, M.D., attached hereto as **"Exhibit 2."**

[15] Id.

53. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff have incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

54. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

55. The actions of Defendant Dr. Garvey and NNRH, as complained of in this claim for relief was undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

56. Defendants Dr. Garvey and NNRH's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendants Dr. Garvey and NNRH with willful and conscious disregard for the safety of Plaintiff.

57. Defendant Dr. Garvey and NNRH's outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of these Defendants, and to deter similar conduct in the future.

58. Pursuant to NRS 42.007, Defendants Ruby Crest and Reach Air are vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

59. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

60. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

61. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

SECOND CLAIM FOR RELIEF

(Vicarious Liability, Corporate Negligence and Ostensible Agency)

Against Defendant NNRH, RUBY CREST, AND REACH AIR

62. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

63. Employers, masters and principals are vicariously liable for the torts committed by their employees, servants and agents if the tort occurs while the employee, servant, or agent was acting in the course and scope of employment.

64. The Defendants were the employers, masters, principals, and/or ostensible agents of each other, the remaining Defendant, and other employees, agents, independent contractors and/or representatives who negligently failed through their credentialing and re-credentialing process to employ and or grant privileges to an emergency room physician with adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.[16]

65. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimately led to his death.

66. Defendant NNRH failed to ensure that the "crash cart" was operational and fully stocked. By not completely stocking the trauma cart, Northeastern Nevada Regional Hospital acted with reckless conduct.[17]

67. Defendant NNRH failed to comply with NRS 439.855 and its Patient Safety Plan and conduct required sentinel event reporting. By failing to comply with NRS 439.855 and its Patient Safety Plan, Defendant NNRH acted in conscious disregard of Douglas Schwartz.

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[16] Id.

[17] Dr. Womack Declaration, p. 27-27, attached hereto as **Ex. "1."** See Affidavit of Kenneth N. Scissors, M.D., attached hereto as **"Exhibit 2."**

68. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries, damages and death in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

69. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

70. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care forherand did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

71. The actions of Defendant NNRH, as complained of in this claim for relief was undertaken knowingly, wantonly, willfully, and/or maliciously.

72. Defendants NNRH's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendant NNRH with willful and conscious disregard for the safety of Plaintiff.

73. Defendant NNRH's outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of the Defendant, and to deter similar conduct in the future.

74. Pursuant to NRS 42.007, Defendants Ruby Crest and Reach Air are vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

75. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

76. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and a loss of earning capacity, in an amount to be proven at trial.

77. Defendants' failure to properly credential and/or re-credential Dr. Garvey or to otherwise assure that an emergency room physician had adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances caused Plaintiff to suffer and ultimately die as a result of his care.

78. The actions of the Defendants have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

THIRD CLAIM FOR RELIEF

(Negligent Hiring, Training, and Supervision)

Against Defendant NNRH, RUBY CREST, AND REACH AIR

79. The Plaintiff repeat and reallege the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

80. The Defendants, and each of them, hired, trained, supervised and/or retained employees to provide treatment to patients, to include Plaintiff, within the appropriate standard of care, which required Defendants to properly assess and recognize when intubation is needed.

81. The Defendants had a duty to hire, properly train, properly supervise, and properly retain competent employees, agents, independent contractors and representatives.

82. Upon information and belief, the Defendants, breached their duty by improperly hiring, improperly training, improperly supervising and improperly retaining incompetent employees regarding the examination , diagnosis, and treatment of patients.

83. Defendant NNRH failed to ensure that the "crash cart" was operational and fully stocked. By not completely stocking the trauma cart, Northeastern Nevada Regional Hospital acted with reckless conduct.[18]

84. Defendant NNRH failed to comply with NRS 439.855 and its Patient Safety Plan and conduct required sentinel event reporting. By failing to comply with NRS 439.855 and its Patient Safety Plan, Defendant NNRH acted in conscious disregard of Douglas Schwartz.

85. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimatley lead to his untimely death.[19]

86. Plaintiff thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries and damages in the sum in excess of Fifteen Thousand Dollars ($15,000.00).

87. The actions of Defendant NNRH, as complained of in this claim for relief was undertaken knowingly, wantonly, willfully, and/or maliciously.

88. Defendant NNRH's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendant NNRH with willful and conscious disregard for the safety of Plaintiff.

89. Defendant NNRH's outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of Defendant NNRH, and to deter similar conduct in the future.

90. Pursuant to NRS 42.007, Defendant NNRH is vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

91. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as

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[18] Dr. Womack Declaration, p. 27-27, attached hereto as **Ex. "1."** See Affidavit of Kenneth N. Scissors, M.D., attached hereto as **"Exhibit 2."**

[19] Id.

a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

92. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff wasrequired to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for Mr. Schwartz and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff allege that she hassuffered special damages in excess of Fifteen Thousand Dollars ($15,000.00).

93. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

94. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wagesand/or loss of earning capacity, in an amount to be proven at trial.

95. The actions of the Defendants have forced the Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

FOURTH CLAIM FOR RELIEF

(Lack of Informed Consent)

Against Defendant DAVID GARVEY, M.D.

96. The Plaintiff repeat and reallege the allegations in the preceding paragraphs herein, and incorporate the same herein by reference.

97. Informed Consent requires the attending physician explain to the patient or guardian(s) including but not limited to alternatives to the treatment or procedure and the reasonable risks of undergoing the procedure.[20]

[20] See Affidavit of Kenneth N. Scissors, M.D. attached hereto as "**Exhbit 2**"

98. Dr. Garvey did not explain to the Plaintiff the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician.

99. Dr. Garvey did not explain to Plaintiff the reasonable risks of the intubation procedure including the risk of aspiration due to a full stomach and that said aspiration, should it occur, could lead to death.

100. Plaintiff would not have opted to have the intubation procedure had they been informed by Dr. Garvey of the less invasive alternative and of the substantial risks involved with intubation.

101. As a result of Dr. Garvey's lack of informed consent, Mr. Schwartz experienced great pain, discomfort and ultimately suffered death.[21]

102. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

103. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

104. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

FIFTH CLAIM FOR RELIEF

(Loss of Consortium)

DIANE SCHWARTZ's Claim Against All Defendants

105. Plaintiff restate and reallege each and every allegation contained in the preceding paragraphs herein, and incorporate the same herein by reference.

106. Plaintiff, Diane Schwartz, is and at all times relevant herein, has been the spouse of Plaintiff Douglas R. Schwartz.

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[21] Id.

107. As a direct and proximate result of Defendants' negligence and carelessness, has lost and will continue to lose a degree of society, comfort and companionship of his spouse, all to her damage in an amount in excess of Fifteen Thousand Dollars ($15,000.00).

108. The actions of Defendants NNRH and Dr. Garvey, as complained of in this claim for relief was undertaken knowingly, recklessly, wantonly, willfully, and/or maliciously.

109. Defendant NRH and Dr. Garvey's conduct was despicable and so contemptible that it would be looked down upon and despised by ordinary decent people, and was carried on by Defendants NNRH and Dr. Garvey with willful and conscious disregard for the safety of Plaintiff.

110. Defendants NNRH and Dr. Garvey's outrageous and unconscionable conduct warrants an award of exemplary and punitive damages pursuant to NRS 42.005, in an amount appropriate to punish and make an example of the Defendant, and to deter similar conduct in the future.

111. Pursuant to NRS 42.007, Defendants herein are vicariously liable for punitive damages arising from the outrageous and unconscionable conduct of its employees, agents, and/or servants, as set forth herein.

112. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

113. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

114. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

WHEREFORE, Plaintiff, DIANE SCHWARTZ, individually and as administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased, expressly reserves her right to amend this Complaint at the time of trial, to include all items of damage not yet ascertained, demand judgment against Defendants, DAVID GARVEY, M.D., an individual; CRUM, STEFANKO, & JONES LTD dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of

Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive and each of the defendants as follows:

1. For general damages, in an amount in excess of Ten Thousand Dollars ($10,000.00), to be set forth and proven at the time of trial;
2. For special damages in an amount in excess of Ten Thousand Dollars ($10,000.00), to be set forth and proven at the time of trial;
3. For punitive damages;
4. For reasonable attorney's fees;
5. For costs and disbursements of this suit; and
6. For such other relief as to the Court deems just and proper.

DATED this __ day of September, 2020.

CLAGGETT & SYKES LAW FIRM

_____

Sean K. Claggett, Esq.
Nevada Bar No. 008407
Jennifer Morales, Esq.
Nevada Bar No. 008829
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Nevada Bar No. 008378
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Las Vegas, Nevada 89107
(702) 655-2346 – Telephone
Attorneys for Plaintiff

Pursuant to FJDCR 19.1.A. DIANE SCHWARTZ, Plaintiff in this matter, is not in debt or bankruptcy.

Pursuant to NRS 239.030, counsel hereby affirms that this document contains no social security numbers.

_____
Jennifer Morales, Esq., Attorney for Plaintiff

Table of Exhibits

Exhibit "1"	Declaration of Dr. Womack	31 pages
Exhibit "2"	Affidavit of Dr. Scissors	5 pages

EXHIBIT 1

Seth P. Womack, MD FAAEM
2115 Dueling Oaks Drive
Tyler, Texas 75703
Womack@erdoctor.com

Claggett & Sykes Law Firm
4101 Meadows Lane, Suite 100
Las Vegas, Nevada 89107

Re: Douglas Schwartz

Introduction and Qualifications

I, Seth P. Womack, MD am a licensed physician. You have asked me to render an opinion concerning the standard of care performed by Dr. David James Garvey regarding the care of Douglas Schwartz on June 22, 2016 in the emergency room of Northeastern Nevada Regional Hospital (NNRH). I am board certified in emergency medicine by the American Board of Emergency Medicine (ABEM). I completed a residency in emergency medicine at the Medical College of Wisconsin in Milwaukee, Wisconsin. During residency I was a flight physician. I have treated patients before, during, and after flight transport from the scene and from hospital to hospital. I have made decisions as to intubate or not intubate patients prior to flight transport. I have worked in emergency rooms and on flights that transferred trauma patients to trauma centers for injuries similar to Mr. Schwartz. I have been working as a full time emergency physician in a level one trauma center for over ten years. I am certified in Advance Trauma Life Support (ATLS), and I am an ATLS instructor. I have intubated hundreds of emergency room patients. I have given presentations on difficult patient airways and airway management. I have completed the Difficult Airway Course specific to the specialty of emergency medicine. I currently work approximately 12 -15 shifts in the emergency department where I work with flight nurses and flight paramedics. When I was a flight physician, I would manage and transport patients with a flight nurse or flight paramedic. I am familiar with the standard of care in this case by virtue of my knowledge, education, experience, training, and skill.

Records Reviewed

I have reviewed the records, case related documents, and definitions regarding the case of Douglas Schwartz that you have provided to me. These consist of the following:

1. Reach Air Medical Records (9pages)
2. Northeastern Nevada Regional Hospital (157 pages)
3. Police Report and Autopsy (30 pages)
4. Elk Count Ambulance Record (18 pages)
5. Elite Investigations Norther Nevada (19 pages)
6. Certificate of Death (1 page)
7. Workman's Compensation (4 pages)
8. Billing Statements from Northeastern Nevada Regional Hospital (7 pages)
9. Posts about Douglas Schwartz (4 pages)
10. 2013-2017 Tax Returns (59 pages)
11. Douglas Schwartz Work Contract (7 pages)
12. Costs for Funeral (3 pages)
13. 2013-2016 Paystubs (89 pages)
14. Plaintiff's First Supplement (8 pages)
15. Elko Police Report (8 pages)
16. Affidavit of Kenneth N. Scissors, M.D. (5 pages)
17. Schwartz Report from Elite Investigations (18 pages)
18. Complaint (Medical Malpractice and Wrongful Death) (24 pages)
19. Errata to Plaintiff's Complaint, Amended Complaint and Second Amended Complaint (12 pages)
20. Second Amended Complaint (Medical Malpractice and Wrongful Death) (22 pages)
21. Amended Complaint (Medical Malpractice and Wrongful Death) (22 pages)
22. Deposition of David James Garvey, M.D. (166 pages)
    i. June 25, 2019
23. Deposition of Carmen Gonzalez (26 pages)

i. March 4, 2019

24. Deposition of Susan Olson, R.N. (78 pages)
    i. March 4, 2019
25. Deposition of Dr. John Patrick Patton (67 pages)
    i. May 31, 2019
26. Deposition of Donna Kevitt, R.N. (111 pages)
    i. March 4, 2019
27. Deposition of Diane Schwartz (163 pages)
    i. January 23, 2019
28. Deposition of Kathleen Jane Dunn (176 pages)
    i. June 8, 2020
29. Deposition of Gary McCalla, MD (194 pages)
    i. June 8, 2020
30. Exhibits 1-4 of the Deposition of Gary McCalla, MD (656 pages)
31. Deposition of Tom Evers, RRT (84 pages)
    i. June 17, 2020
32. Exhibits 1-5 of the Deposition of Tom Evers, RRT (108 pages)
33. Deposition of Barry Bartlett with Exhibits 1-5 (154 pages)
34. Responses to Plaintiff's First Set of Request for Production of Documents (7 pages)
35. Answers to Plaintiff's First Set of Interrogatories (10 pages)
36. Plaintiff's Responses to Defendant David Garvey's First Set of Requests for Production (26 pages)
37. Plaintiff's Answers to Defendant David Garvey's First Set of Interrogatories (19 pages)
38. Plaintiff's Responses to Defendant Reach Air Medical Services' First Set of Interrogatories, Requests for Production and Requests for Admissions (22 pages)
39. Reach and Summit Documents (263 pages)
40. Reach Air Medical Services, LLC's Responses and Objections to First Set of Interrogatories, Requests for Admission, and Requests for Production to Plaintiff (54 pages)

41. Dr. Whimple's Clinic Notes on Douglas Schwartz (20 pages)
42. Dr. Garvey's Partial Motion for Summary Judgement (290 pages)
43. Dr. Garvey's Errata to Motion for Partial Summary Judgement (10 pages)
44. Mr. Schwartz's radiographic imaging studies (June 22, 2016)
    i. CT Brain without contrast
    ii. CT C-Spine without contrast
    iii. CT T-Spine without contrast
    iv. CT Chest with IV contrast
    v. CT Abdomen and Pelvis with IV contrast
45. Northeastern Nevada Regional Hospital Patient Safety Plan
46. Northeastern Nevada Regional Hospital Code Blue Procedure & Crash Cart Maintenance (14 pages)
47. Nevada Trauma Statute (NRS 41.503)
48. Northeastern Nevada Regional Hospital Provision of Care Event for the Unexpected Death of Douglas Schwartz (5 pages) (Evers Exhibit 5)

Facts

Douglas Schwartz was 58 years old on the night of June 22, 2016 when he was stuck by a car while walking out of a restaurant. The Elko County ambulance arrived on the scene at approximately 8:19 pm. Mr. Schwartz complained of right sided body pain. Mr. Schwartz was thrown upon the hood and onto the roof before falling to the ground. Mr. Schwartz had pain to his right ribs. He had diminished lung sounds due to not wanting to take a deep breath. The ambulance crew started an IV, placed Mr. Schwartz in c-spine precautions, and placed oxygen at 4 liters (L) just for precaution. The ambulance crew administered 4 mg of Zofran and 100 mcg of Fentanyl which helped with Mr. Schwartz's pain. At 8:41 pm, the ambulance transported Mr. Schwartz three miles to the emergency room of Northeastern Nevada Regional Hospital without lights and sirens. Mr. Schwartz arrived in the emergency room at 8:51 pm.

Upon arrival to the emergency room, Mr. Schwartz's presenting complaints were right sided rib pain, right knee pain, and right shoulder pain. Mr. Schwartz's pulse ox was 94% on 4 liters of oxygen via nasal cannula[1] (NC).

Donna Kevitt, RN was Mr. Schwartz's nurse. Nurse Kevitt documented that Mr. Schwartz's airway was patent with good air movement, and he was breathing without difficulty. Nurse Kevitt documented that Mr. Schwartz complained of pain in his right supraclavicular area, diaphragm, and right breast. Mr. Schwartz appeared uncomfortable and had diminished breath sounds in his right posterior middle and lower lung lobes. Nurse Kevitt documented that Mr. Schwartz possibly experienced a loss of consciousness. Mr. Schwartz was awake, alert, and oriented to person, place, and time. Nurse Kevitt noted some abrasions to his right scalp, right outer arm, right elbow, and right knee.

Dr. David Garvey was Mr. Schwartz's emergency physician. Dr. Garvey documented[2] that Mr. Schwartz sustained injury to his head, chest, right bicep, right elbow, and right knee. Dr. Garvey noted that Mr. Schwartz had pain with breathing and movement. Dr. Garvey documented that Mr. Schwartz experienced a brief loss of consciousness. Dr. Garvey documented that Mr. Schwartz's symptoms, at their worst, were moderate and unchanged in the emergency department. Mr. Schwartz had a past medical history of hypertension. On Dr. Garvey's review of systems, Mr. Schwartz was positive for chest pain, back pain, and abrasions; he was negative for shortness of breath, nausea, and vomiting. On physical examination, Dr. Garvey documented the following:

1. Appears awake, in obvious pain, uncomfortable
2. Abrasions that are mild to the forehead
3. Moderate chest tenderness to palpation of the right lateral posterior chest
4. Moderate back pain that is moderate of the left scapular and subscapular area

[1] Oxygen tubing with two soft prongs that are inserted into the openings of the patient's nostrils. The oxygen concentration delivered varies from 25 to 40 percent depending on the patient's rate of breathing, volume of air breathed in, and extent of mouth breathing. The flow rates are typically 2-4 L/minute.

[2] A scribe transcribed Dr. Garvey's note. Dr. Garvey reviewed and agreed with the scribe's documentation on Dr. Garvey's behalf.

5. Abrasion to the right knee, elbow, and bicep
6. Normal external neck
7. No cervical midline tenderness, not intoxicated, normal mental status, no focal neurological deficits, and no painful distracting injuries are present
8. Normal heart rate and regular rhythm
9. Does not display signs of respiratory distress; normal respirations, breath sounds are normal and clear throughout
10. Normal appearance of abdomen, normal bowel sounds, abdomen is soft and nontender in all quadrants
11. Normal appearance of skin except for affected areas
12. Normal orientation to person, place, and time; immediate and remote memory is intact; recent memory is impaired
13. Behavior/mood is pleasant and cooperative

Dr. Garvey ordered CT scans on Mr. Schwartz.

At 9:33 pm or 9:40 pm, Mr. Schwartz was moved to CT scan.

At 10:33 pm, Nurse Kevitt administered Dilaudid 1 mg IV and Zofran 4 mg IV to Mr. Schwartz.

At 11:00 pm, Mr. Schwartz was moved back from CT scan to room 12.

At 11:07 pm, the radiologist verified receipt of Mr. Schwartz's CT abdomen and pelvis with Cheryl in the ER for Dr. Garvey.

The radiology report of Mr. Schwartz's CT abdomen and pelvic contained the following:

1. Trace hyperdense fluid just below the right liver lobe as well as next to the left colon. No clear CT evidence for spleen or liver contusion or laceration, however finding should

be considered to reflect trace hemoperitoneum in the setting of significant trauma. Low grade solid organ injury is not excluded.

2. No free air to suggest bowel perforation.

At 11:17 pm, Mr. Schwartz's pulse ox was 91%.

At 11:19 pm, Nurse Kevitt administered Zofran 4 mg IV to Mr. Schwartz.

At 11:27 pm, Mr. Schwartz's pulse ox was 91%.

At 11:30 pm, Mr. Schwartz's pulse ox was 92%.

At 11:36 pm, REACH Air Medical Service's dispatch was notified.

At 11:37 pm, respiratory placed Mr. Schwartz on a Venti (Venturi[3]) mask. Mr. Schwartz's oxygen saturations were 92% and 93%.

At 11:41 pm, REACH Air Medical Service crew was dispatched.

At 11:45 pm, REACH Air Medical Service crew was enroute.

At 11:45 pm, Mr. Schwartz's pulse ox was 91%.

At 11:47 pm, the radiologist verified receipt of Mr. Schwartz's CT chest, CT head, and CT T-spine with Dr. Garvey.

The radiology report of Mr. Schwartz's CT chest contained the following:

[3] Simple mask that fits loosely over the nose and mouth. The mask can provide oxygen concentrations of 35 and 50 percent depending on the rate of breathing, volume of air breathed in, and mask fit. The flow rates are typically 6 – 10 L/minute.

1. Small right anterior pneumothorax (less than 10%).
2. Acute fractures of the 4th through 7th ribs as described. There are acute anterolateral fractures of the right 4th through 7th ribs with the 4th and 6th ribs fractured in 2 places (nondisplaced fractures also noted). Comminution and displacement of the 7th fracture is present.
3. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or sequela of aspiration.

The radiology report of Mr. Schwartz's CT head contained the following:

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

The radiology report of Mr. Schwartz's CT C-spine contained the following:

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

The radiology report of Mr. Schwartz's CT T-spine contained the following:

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.

Dr. Garvey discussed Mr. Schwartz with Dr. Ray at University of Utah who accepted Mr. Schwartz in transfer. Dr. Ray requested that a chest tube be placed and possible intubation[4] prior to air medical transport due to flail segment, pulmonary contusions, low oxygen saturations, and a traumatic right pneumothorax. At 11:57 pm, the REACH team arrived at Mr. Schwartz's bedside to find Mr. Schwartz talking to his family as Dr. Garvey assembled his team

[4] Dr. Garvey testified that he had already planned to intubate, and that Dr. Ray did not tell him to conclusively intubate Mr. Schwartz; leaving that decision up to Dr. Garvey. (Deposition of Dr. Garvey; Page 113, Lines 2-16)

and equipment. Dr. Garvey's plan was place the chest tube while the Reach crew (Barry Bartlett, EMT-Paramedic) performed the intubation. Mr. Schwartz vomited and aspirated a large amount of gastric contents. Suctioning was difficult due to large food particles occluding the suction. Multiple suction machines were used to no avail. Multiple attempts at intubation were made. Intubation was without success. Vomitus in the airway could not be completely cleared. Mr. Schwartz went into cardiac arrest (coded). ER staff tried to suction copious amounts of vomit throughout the code. From the time the first drug was given for rapid sequence intubation (RSI) until Dr. Garvey pronounced Mr. Schwartz deceased was 1 hour and 15 minutes. Mr. Schwartz would regain his pulse at times but would go back into cardiac arrest. During this time, Dr. Garvey nor Barry Bartlett were able to establish a definitive airway for Mr. Schwartz. Once, they were able to increase Mr. Schwartz's pulse ox to 79%-82% with a King airway, but Mr. Schwartz deteriorated again, and his oxygen saturation started dropping[5]. Approximately 46 minutes after the first intubation attempt, Dr. Garvey performed a cricothyrotomy (cric) and placed a trach tube in the correct location (the trachea). The procedure was complicated by vomit. Initially the trach tube was placed but quickly became occluded with gastric contents. The trach tube became dislodged while attempting to clear the vomit. Ultimately, Mr. Schwartz was bagged through his cricothyrotomy via a 5-0 endotracheal tube (ETT) but most of the bagged air expelled from the mouth. Mr. Schwartz's oxygen saturations did not improve, and he went into cardiac arrest, again.

According to the REACH Air Medical Service record, multiple operators attempted to intubate Mr. Schwartz at least 9 times over the time span of approximately 48 minutes. The documentation of the REACH record contained the following:

- 0020 – Once the drugs took effect, Paramedic Bartlett opens the airway and places the C-Mac device resulting in copious amounts of emesis and large food chunks fulminating from the mouth and nose. Intubation is immediately stopped, and the airway is suctioned, which promptly plugs the suction tubing and yankauer tip.

[5] Deposition of Dr. Garvey; Page 153, Lines 5-8

- Over the course of the next 13 minutes, Mr. Schwartz vomits several more times and numerous attempts are made a clearing/maintaining his airway and reoxygenating him with BVM on high flow oxygen.
- 0023 – ETT placement attempt unsuccessful
- 0033 – ETT placement attempt unsuccessful
- In addition to the factors that are making this procedure very difficult (airway contamination, difficulty in keeping the suction devices flowing, difficulty in getting a good facial seal and very stiff bagging effort) his airway is reportedly very inferior/anterior making it a challenge to visualize.
- Paramedic Bartlett attempts several tooled and digital[6] intubations, all of which are unsuccessful.
- 0035 – Mr. Schwartz loses pulses and CPR is initiated for approximately one minute and pulse is restored.
- The airway is again suctioned and a king airway[7] is placed. Bag valve mask (BVM) bagging remains very difficult and shortly afterward the king is removed after becoming plugged by emesis and food particles.
- A 3rd suction unit is placed in play and Mr. Schwartz's oxygen saturation is 47% on high flow oxygen.
- 0040, 0044, and 0047 – Intubation attempts continue with various size ETTs, stylets, bougie introducers, and airway adjuncts. The emesis is almost continuous and proving very difficult to get cleared.
- 0050 – Mr. Schwartz's oxygen saturation is approximately 50%.
- 0052 -- ETT placement attempt unsuccessful; airway suctioned and oxygen is at 55%
- 0053 – ETT placement attempt unsuccessful; several operator changes
- 0054 – Mr. Schwartz's oxygen saturation is 42% with bagging and suctioning at every opportunity. A cricothyrotomy is discussed and the kit prepared.

[6] Attempting intubation with fingers without visualization of the airway
[7] Dr. Garvey testified that he did not have a King airway in the ER. He used the EMS crew's King airway. (page 151; Line 9-14)

- Mr. Schwartz is becoming abdominally distended and a nasal-gastric (NG) tube is attempted in each nostril. The NG tube will not pass, and Mr. Schwartz's nose starts bleeding.
- Facial seal remains a challenge due to vomit and wet face.
- An oral-gastric (OG) tube placement attempt is also unsuccessful and abandoned.
- 0058 – Mr. Schwartz's oxygen saturation is 68% and the third operator is again in place as efforts to reoxygenate are minimally effective and bagging effort is very high.
- Cric airway is kit is being prepared.
- 0102 – Mr. Schwartz's oxygen saturation is 75%.
- Another intubation attempt is unsuccessful.
- 0106 – The cric is initiated by Dr. Garvey and paramedic Bartlett. The tube is very difficult to advance into the trachea. The tube begins to fill up with vomit. The tube is pulled and replaced two additional times with the same results.
- 0117 – Pulses are lost and CPR resumes.
- Emesis continues and additional suction units and methods of airway clearance are discussed.
- 0120 – The monitor is displaying asystole (flat line, no heartbeat). CPR is ongoing.
- 0122 – A pulse of 52 is noted on the monitor.
- CPR continues. Gastric distention is increasing and cannot be evacuated.
- 0125 – CPR ongoing by ER staff
- 0128 – We note an oxygen saturation reading of 64% on the monitor.
- 0129 – Bilateral needle thoracostomy is performed with no results and no air escape.
- 0133 – CPR is stopped, and Mr. Schwartz is pronounced deceased.

Dr. Garvey documented that Mr. Schwartz's cardiac arrest was due to asphyxiation[8].

[8] Act of causing asphyxia: a state of asphyxia: suffocation (Merriam-Webster Unabridged)

Opinion

It is my professional opinion that Dr. David James Garvey breached the applicable standard of care for Mr. Schwartz on June 22, 2016 in the emergency room of Northeastern Nevada Regional Hospital. Dr. Garvey fell below the applicable standard of care by attempting to intubate Mr. Schwartz. Dr. Garvey fell below the applicable standard of care by not performing a cricothyrotomy on Mr. Schwartz sooner. Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him. Mr. Schwartz could protect his own airway. Mr. Schwartz was not in respiratory distress. Mr. Schwartz did not have a flail chest. Dr. Garvey should have removed Mr. Schwartz from the hard backboard as well as the cervical collar. Dr. Garvey should have placed a chest tube after numbing up Mr. Schwartz's chest wall with local lidocaine. Dr. Garvey should have transferred Mr. Schwartz to a higher level of care on oxygen delivered via a simple face mask (Venturi). Instead, Dr. Garvey breached the standard of care by attempting to intubate Mr. Schwartz. Dr. Garvey not only breached the standard of care, Dr. Garvey acted with reckless conduct, in bad faith, and was grossly negligent.

It is my professional opinion that Northeastern Nevada Regional Hospital breached the applicable standard of care by not completely stocking the trauma cart that was used in the care of Mr. Schwartz. By not completely stocking the trauma cart, Northeastern Nevada Regional Hospital acted with reckless conduct.

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Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him. The fact that Mr. Schwartz was stable before Dr. Garvey's attempt to intubate is supported by the following:

1. The ambulance that transported Mr. Schwartz to NNRH did not use lights and sirens.
2. The ambulance that transported Mr. Schwartz to NNRH placed him on oxygen via NC at 4L/min as a precaution.
3. When Mr. Schwartz arrived, he was breathing without difficulty.

4. Nurse Kevitt evaluated Mr. Schwartz on multiple occasions, before and after CT scan, never noting any sign of being unstable.
    i. 9:31 pm: visited this patient and evaluated for pain, information, needs, and comfort
    ii. 11:00 pm: Mr. Schwartz moved back to room 12 from CT
    iii. 11:17 pm: visited this patient and evaluated for pain, information, needs, and comfort
    iv. 11:27 pm: visited this patient and evaluated for pain, information, needs, and comfort
    v. 11:31 pm: visited this patient and evaluated for pain, information, needs, and comfort
5. Mr. Schwartz's pulse (P), respiratory rate (RR), and blood pressure (BP) were stable and within normal limits (WNL). Mr. Schwartz's pulse ox readings were stable and within normal limits of what is expected in a trauma patient with rib fractures and a pneumothorax, especially a patient with inadequate pain control. Patients with these injuries have severe pain when they expand their chest wall on the effected side when they breath. This pain makes them not want to take a deep breath that expands the effected side. This is called splinting. The cornerstone of rib fracture management is pain control. Early and adequate pain relief is essential to avoid complications from splinting and not completely filling a lung with air (atelectasis). Dr. Garvey had only given Mr. Schwartz one dose of pain medicine approximately 1 hour and 45 minutes prior to attempting intubation. Mr. Schwartz's recorded vital signs prior to intubation attempt were as follows:

    i. 11:17 pm: BP 116/75, P 67, RR 16, pulse ox 91%
    ii. 11:27 pm: BP 115/74, P 67, RR 17, pulse ox 91%
    iii. 11:30 pm: BP 120/78, P 67, RR 18, pulse ox 92%
    iv. 11:45 pm: BP 114/73, P 68, RR 18, pulse ox 91%
    v. 12:10 am: P 66, RR 17, pulse ox 97% on nonrebreather mask

vi. 12:15 am: P 73, RR 19, pulse ox 99% on nonrebreather mask

Mr. Schwartz's vital signs did not become unstable until the time of the intubation attempt at 0020.

6. Multiple witnesses gave testimony that describes Mr. Schwartz in stable condition.
   i. Regarding the time around Mr. Schwartz's initial evaluation, Diane Schwartz testified[9] that Mr. Schwartz did not complain of any difficulty breathing.
   ii. Diane Schwartz testified[10] that Mr. Garvey did not have any difficulty breathing while he was in the ER nor did he have on a nasal cannula or oxygen mask.

> Q – Did Doug have any difficulty Breathing while he was in the ER?
>
> A – No
>
> Q – Do you remember him receiving any type of oxygen while he was in the ER?
>
> A – No
>
> Q – Did he have anything up his nose?
>
> A – No
>
> Q – Did he ever have a facemask on?
>
> A – No

   iii. Diane Schwartz testified[11] that when she left Mr. Schwartz; he was fine.
   iv. Diane Schwartz testified[12] that she couldn't understand why they intubated him in the first place that night given the condition he was in and the fact that he was breathing fine and he was okay.
   v. Dr. John Patton (a friend) testified[13] that Mr. Schwartz was stable and doing fine. Dr. Patton was with Mr. Schwartz and Mrs. Schwartz during the CT scan until

[9] Deposition of Diane Schwartz, Page 49; Lines 23-24
[10] Deposition of Diane Garvey; Page 62, Line 19 – Page 63, Line 3
[11] Deposition of Diane Garvey; Page 70, Lines 13-15
[12] Deposition of Diane Garvey; Page 136, Lines 8-12
[13] Deposition of Dr John Patton; Page 13, Line 11 – Page 14

about 45 minutes afterwards. Their conversation with Mr. Schwartz was an interesting conversation as Mr. Schwartz was in a lot of pain.

vi. Dr. John Patton testified[14] that when he and Diane left Mr. Schwartz, Mr. Schwartz was speaking, talking, joking, and laughing. It was uncomfortable for Mr. Schwartz to laugh.

vii. Dr. John Patton testified[15] that he was critical of Dr. Garvey's decision to intubate.

> Q – And is it fair to say that if you don't have an opinion on what happened there, are you – do you have an – are you critical of the decision to intubate?
>
> A – I am critical of that decision, yes.
>
> Q – On what grounds?
>
> A – Because he was stable, laughing, and communicative when we left him.

viii. Dr. John Patton testified[16] that he never noticed Mr. Schwartz gasping for breath and; in general, Mr. Schwartz had conversational breathing.

ix. Carmen Gonzalez (admitting and discharge clerk) testified[17] that Mr. Schwartz seemed normal and that he was laughey and smiley when she went to put his wristband on.

7. According to the Provision of Care Event, Mr. Schwartz was "stable and ready for transfer."

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Mr. Schwartz did not have injuries that were an immediate or imminent[18] threat to life. Mr. Schwartz had rib fractures. Mr. Schwartz's rib fractures were not an immediate or imminent

[14] Deposition of Dr. John Patton; Page 15, Lines 9-12
[15] Deposition of Dr. John Patton; Page 32, Lines 6-12
[16] Deposition of Dr. John Patton; Page 60, Lines 21-25
[17] Deposition of Carmen Gonzalez; Page 9, Lines 23-25
[18] Ready to take place, happening or likely to happen very soon, impending (Merriam-Webster Unabridged)

threat to his life. Mr. Schwartz was stable and maintaining an oxygen saturation greater than 91% with a simple oxygen mask -- even with inadequately treated pain. Radiology could not declare with certainty whether he had lung contusions or areas of the lungs not filling completely with air. CT images of lungs that have pulmonary contusions that are an immediate or imminent threat to life can be declared with certainty. I reviewed Mr. Schwartz's images and did not see any pulmonary contusions that were an immediate or imminent threat to life. Radiology could not declare with certainty whether he had trace subdural brain blood or if he was just dehydrated. A subdural brain bleed that exists and is an immediate and imminent threat to life can be declared with certainty. I reviewed Mr. Schwartz's images and did not see any subdural blood. Mr. Schwartz's CT T-spine contained possible acute injury to his lower thoracic spine that was not an immediate or imminent threat to life. Radiology declared that there was no clear CT evidence for spleen or liver damage and only trace fluid that could be blood was seen in the abdomen. Radiology indicated that if there were abdominal organ injury; it was low grade. Mr. Schwartz's CT C-spine did not show any acute injuries.

Mr. Schwartz had a pneumothorax that was not an immediate or imminent threat to life. Mr. Schwartz's pneumothorax occupied less than 10% of his right lung cavity. The standard of care required Dr. Garvey to place a right chest tube as a preventative measure because Mr. Schwartz was to go on an air flight. With changes in atmospheric pressure, a pneumothorax can get bigger; and a chest tube prevents such from happening.

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Dr. Garvey fell below the applicable standard of care by attempting to intubate Mr. Schwartz. Dr. Garvey should not have attempted to intubate Mr. Schwartz for the following reasons:

1. Mr. Schwartz had just eaten a full meal which Dr. Garvey knew[19]. It is a known principle of emergency medicine that patients who have stomachs full of food and liquid are at

[19] Deposition of Dr. Garvey; Page 107, Line 25 – Page 108, Line 3

risk of aspiration[20] and airway complications. When a paralytic drug (Rocuronium was administered) is given, the drug paralyzes the muscles that keep stomach contents from coming back up into the esophagus and airway. The drug also takes away the body's ability to protect its own airway and lungs by taking away the gag reflex. Most anything that gets around the opening of the trachea (windpipe) or vocal cords will trigger the gag reflex to prevent aspiration. The fact that Mr. Schwartz had just eaten increased his risk for complications during a rapid sequence intubation (RSI) and made him a difficult airway. Dr. Garvey knew that the attempt at intubation was high risk. Dr. Garvey testified the following[21]:

Q – Did you consider this specific intubation high risk?

A – Oh, yes.

Q – And why is that?

A – Because we have a patient that had just finished a large meal. He was on a backboard in a C collar, and his body habitus all lend to a difficult intubation.

2. Dr. Garvey thought Mr. Schwartz had a flail chest which is one of the reasons Dr. Garvey attempted to intubate him. Mr. Schwartz did not have a flail chest. A flail chest is when at least two or more adjacent (consecutive) ribs are fractured at two points allowing a freely moving segment of chest wall to move in paradoxical motion. Paradoxical motion describes the segment of chest wall that moves inward when the rest of the chest moves outward with a deep breath and vice versa. Mr. Schwartz had a fracture of his fourth rib in two places and sixth rib in two places. The fourth and sixth rib are not adjacent to one another. Mr. Schwartz did not have rib fractures consistent with a flail chest. Dr. Garvey testified that he knew what a flail chest was in the following testimony:

Q – And can you explain for the jury what a flail chest is?

[20] Sucking gastric contents (vomit or emesis) into the trachea and lungs
[21] Deposition of Dr. Garvey; Page 128, Lines 16-23

A – Multiple rib fractures, adjacent ribs fractured in multiple places. So, you've got a segment that is independent of the rest of the chest.

Q – And is it two ribs that are broken in two places or is it three ribs? How many ribs have to be broken to –

A – Two or more.

MR. WEAVER: Just let her get her whole question out before you answer.

Q – So is it two ribs broken in the same area?

A – Two or more ribs broken – broke – two or more adjacent ribs broken in multiple places, yes.

Despite Dr. Garvey knowing what ribs fractures are consistent with a flail chest, he still misdiagnosed Mr. Schwartz with a flail chest and based his decision to intubate Mr. Schwartz from an incorrect diagnosis.

Even if Mr. Schwartz did have a flail chest, it was below the standard of care to immediately intubate him. The authors of Rosen's Emergency Medicine Concepts and Clinical Practice, 8th edition write the following:

> The outcome of flail chest injury is a function of associated injuries. Because many different physiologic mechanisms have been implicated in flail chest, there is no consensus about hospital treatment. The cornerstones of therapy include aggressive pulmonary physiotherapy, effective analgesia[22], selective use of endotracheal intubation and mechanical ventilation, and close observation for respiratory compromise. Respiratory decompensation is the primary indication for endotracheal intubation and mechanical ventilation for patients with flail chest. Obvious problems, such as hemopneumothorax or severe pain, should be corrected before intubation and ventilation are presumed necessary. In fact, in the awake and cooperative patient, noninvasive continuous positive airway

[22] Pain control

pressure (CPAP) by mask may obviate the need for intubation. In general, the most conservative methods for maintaining adequate oxygenation and preventing complications should be used. Adequate analgesia is of paramount importance in patient recovery and may contribute to the return of normal respiratory mechanics. Patients without respiratory compromise generally do well without ventilatory assistance. Several studies have found that patients treated with intercostal nerve blocks or high segmental epidural analgesia, oxygen, intensive chest physiotherapy, careful fluid management, and CPAP, with intubation reserved for patients in whom this therapy fails, have shorter hospital courses, fewer complications, and lower mortality rates. Avoidance of endotracheal intubation, particularly prolonged intubation, is important in preventing pulmonary morbidity because intubation increases the risk of pneumonia.

Mr. Schwartz did not have respiratory decompensation or compromise; he was talking, laughing, and joking. His oxygen saturations were above 90% on a simple oxygen mask and 99% on a nonrebreather.

3. Dr. Garvey should not have intubated Mr. Schwartz based on a risk of aspiration from being on a rigid backboard and wearing a c-collar. Dr. Garvey and staff should have logrolled Mr. Schwartz off of the rigid backboard onto a regular stretcher or ER bed with a soft mattress. Dr. Garvey should have removed Mr. Schwartz's c-collar. Mr. Schwartz could have laid on his side or at 30 degrees head of the bed elevation to protect his own airway if he needed to vomit. More anti-nausea medicines could have been given. Excluding Mr. Schwartz's initial ambulance transport to the emergency room, he had no reason to be on a rigid backboard. Mr. Schwartz's exam was not consistent with any spinal cord injury (SCI). Even in patients with a spinal cord injury, backboards should be removed as soon as possible in the emergency room. In a systemic review of the literature and evidence-based guidelines: Henry Ahn, et al, in the Journal of Neurotrauma (2011) write the following:

What is the optimal type and duration of pre-hospital spinal immobilization in patients with acute SCI?

- Patients should be transferred off the hardboard on admission to a facility as soon as is feasible to minimize time on the hard board. If patients are awaiting transfer to another institution, they should be taken off the hardboard while awaiting transfer.

In addition, Mr. Schwartz did not clinically correlate with an acute spine fracture. He was not tender and did not complain of pain in the area of the irregularity mentioned on his CT T-spine. Mr. Schwartz had pain and tenderness at his scapular and subscapular level. The area mentioned on CT (T10 and T11) are at the level just above the umbilicus (belly button).

After Mr. Schwartz's initial evaluation by Dr. Garvey and Mr. Schwartz's negative CT C-spine, Dr. Garvey should have removed Mr. Schwartz's c-collar. Mr. Schwartz did not complain of any pain in his neck and had a negative physical exam of his neck by Dr. Garvey. Dr. Garvey documented that Mr. Schwartz satisfied all of the Nexus Criteria for not having a c-spine injury. The Nexus Criteria decision instrument stipulates that imaging is not necessary if patients younger than 60 years satisfy all of the following criteria:

i. Absence of posterior midline cervical tenderness
ii. Normal level of alertness
iii. No evidence of intoxication
iv. No abnormal neurologic findings
v. No painful distracting injuries

The sensitivity and negative predictive value of the Nexus Criteria is 99.6% and 99.9%, respectively in patients not receiving imaging such a CT of the c-spine. This is the sensitivity and negative predictive value without a negative CT of the c-spine, as the

Nexus Criteria are mainly used to rule out injury and decide which patients not to image. Adding a negative CT of the c-spine and satisfying all of the nexus criteria even further pushed the chance of Mr. Schwartz not having a c-spine injury towards 100%; more than adequately ruling out any c-spine injury in Mr. Schwartz. Mr. Schwartz had no reason to be in a c-collar.

Dr. Garvey should have performed a cricothyrotomy upon Mr. Schwartz sooner. The situation turned into a failed airway early in the process of trying to intubate. According to the REACH record, Mr. Schwartz began to vomit on the first attempt to intubate by Barry Bartlett at 12:20 am. Copious amounts of emesis and large food chunks began fulminating[23] from the mouth and nose. Intubation was immediately stopped. The airway could not be cleared or suctioned. The vomit clogged both the suction tubing and the yankauer which have inner diameters of only approximately 5 mm and 4 mm, respectively. Over the course of the next 13 minutes, Mr. Schwartz vomited several more times and numerous attempts were made at clearing/maintaining his airway and reoxygenating him with BVM on high flow oxygen. Mr. Schwartz could not be intubated and could not be oxygenated. In emergency medicine, this is called, "can't intubate, can't oxygenate" (CICO). Authors from the Manual of Emergency Airway Management, 3rd Edition write the following:

> The definition of a failed airway is based on one of two criteria being satisfied: (a) a failure of an intubation attempt in a patient for whom oxygenation cannot be adequately maintained with a bag and mask [BVM], or (b) three unsuccessful intubation attempts by an experienced operator and adequate oxygenation. Unlike the difficult airway, where the standard of care dictates the placement of a cuffed endotracheal tube in the trachea providing a definitive, protected airway, the failed airway calls for action to provide emergency oxygenation sufficient to prevent patient morbidity (especially hypoxic brain injury) by whatever means possible until a definitive airway can be secured.

[23] To come on suddenly and intensely (Merriam-Webster Unabridged)

Barry Bartlett attempted to intubate Mr. Schwartz again at 12:23 am, leaving Mr. Schwartz in a CICO situation for 10 minutes before Barry Bartlett's third failed attempt at 12:33. During this time, Dr. Garvey was making not taking any action to provide emergency oxygenation to Mr. Schwartz. The standard of care required Dr. Garvey to perform a cricothyrotomy immediately after Barry Bartlett's failed intubation attempt at 12:23 am. Authors from the Manual of Emergency Airway Management, 3rd Edition write the following:

> If, however, the failed airway is because of a CICO situation, then there is little time left before cerebral hypoxia will result in permanent deficit, and immediate cricothyrotomy is indicated.

As a result of Dr. Garvey not performing a cricothyrotomy in timely manner, Mr. Schwartz remained a failed airway in a CICO situation for over an hour before he was pronounced deceased. At 12:25 am, Mr. Schwartz's pulse ox was 76%. Barry Bartlett had failed a second attempt at intubation at 12:23 am. Mr. Schwartz's airway could not be cleared, and he could not be oxygenated. At least over thirty minutes passed with Mr. Schwartz being a failed airway in a CICO situation before Dr. Garvey initiated a cricothyrotomy at 1:06 am. By this time, countless attempts of using BVM had pushed copious amounts of vomit into Mr. Schwartz's trachea and bronchi (passage that air travels to the lungs). Mr. Schwartz's trachea and bronchi were so clogged with vomit; Dr. Garvey's late cricothyrotomy could not oxygenate Mr. Schwartz's lungs.

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Dr. Garvey's omission to perform a cricothyrotomy on Mr. Schwartz in a timely manner was gross negligence. Dr. Garvey not performing a cricothyrotomy while Mr. Schwartz was suffocating on his own vomit was negligence significantly greater in magnitude than ordinary

negligence. It was extraordinary negligence to a high degree. Dr. Garvey failed to exercise even a slight degree of care by omitting to establish emergency oxygenation to Mr. Schwartz with a cricothyrotomy in a timely manner. Mr. Schwartz was in a CICO situation at approximately 12:23 am with a failed second attempt at intubation in the setting of not being able to oxygenate due to airway obstruction from fulminating emesis. The standard of care required that Dr. Garvey perform a cricothyrotomy on Mr. Schwartz immediately after Barry Bartlett's failed attempt at 12:23 am. After 12:23 am, there were no reasonable attempts that met the standard of care to establish emergency oxygenation to Mr. Schwartz. Dr. Garvey was doing nothing within the standard of care to establish emergency oxygenation to Mr. Schwartz. According to the testimony[24] of Barry Bartlett, Dr. Garvey was on the right side of Mr. Schwartz prepping for chest tube insertion until at least 12:33 am – ten minutes after Barry Bartlett's second failed attempt.

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Dr. Garvey acted with reckless conduct. It is my understanding that reckless conduct is deemed to be that conduct in which the person knew or should have known at the time the person rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Dr. Garvey made the decision for two separate very serious and meticulous procedures (intubation and chest tube insertion) to be performed upon Mr. Schwartz simultaneously. Dr. Garvey should have known at the time that his conduct would likely result in injury that would affect the life or health of Mr. Schwartz. Dr. Garvey's decision was for Barry Bartlett to intubate Mr. Schwartz, who Dr. Garvey identified as having a high risk difficult airway[25], while Dr. Garvey cut a hole in Mr. Schwartz's chest for a chest tube to be placed in Mr. Schwartz's chest cavity (chest tube thoracostomy). Dr. Garvey had never talked to Barry Bartlett about Barry's education, training, or experience[26]. Barry Bartlett was still in his internship with REACH[27]. Each of these procedures performed in the proper sequence one at a

[24] Deposition of Barry Bartlett; Page 78, Line 1 – Page 79, Line 8
[25] Deposition of Dr. Garvey; Page 128, Lines 16-23
[26] Deposition of Dr. Garvey; Page 30, Line 22 – Page 31, Line 1
[27] Deposition of Barry Bartlett; Page 19, Lines 18-20

time have life threatening consequences if something goes wrong. In emergency medicine, first and foremost, a patient's airway comes before most any of the other problems that they could have. It is the ABC's of emergency medicine (A=Airway, B=Breathing, C=Circulation). Airway issues are to be managed before breathing issues; breathing issues are to be managed before circulation issues; and Circulation issues are to be managed before other issues such as disability (neurologic). Once an emergency medicine physician decides to intubate, the airway must be secure and protected before anything else happens including chest tube placement in Mr. Schwartz's situation. Once an ETT is correctly placed, placement is confirmed by direct visualization, end tidal CO2 detection, listening for breath sounds, and performing a chest x-ray. Mr. Schwartz's should not have been intubated. To place the chest tube, rather than sedation and paralysis of a patient with a high risk difficult airway, Dr. Garvey simply needed to numb Mr. Schwartz's chest wall with lidocaine. Instead, Dr. Garvey proceeded with reckless conduct.

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Dr. Garvey acted in bad faith. Dr. Garvey acted in bad faith by not reasonably explaining the risks of intubation to Mr. and Mrs. Schwartz that could occur by intubating Mr. Schwartz for the flight. Dr. Garvey mainly explained the risks of not intubating. By not reasonably explaining the risks of intubation, Dr. Garvey was unreasonable and unfair. By not reasonably explaining the risks of intubation, Dr. Garvey infringed upon Mr. Schwartz's right to know his risks of the procedure as a patient. Dr. Garvey testified[28] the following:

> Q – Okay. So, what risks did you explain to Mr. and Mrs. Schwartz that could occur by intubating him for the flight?
> A – Probably not much. We all – we always assume that the patient has a full stomach, and there's also always the risk of aspiration with an intubation. But the main thing that was – that was explained to them were the risks of not intubating, and the risks of not intubating were much higher than the risks of intubating.

[28] Deposition of Dr. Garvey; Page 119, Line 4 – Page 120, Line 10

Q – Okay. So, I just want to be clear. You did not explain the risks of intubating the patient; correct?

A – No. I probably –

Mr. BURTON: I'm going to object to the extent it mischaracterizes the testimony and it's argumentative.

Mr. WEAVER: Join.

THE WITNESS: I mainly explained the risks of not intubating, which are higher than the risks of intubating.

Q – Okay. So, you explained the risks of not intubating, but you did not explain that by intubating Mr. Schwartz, he could aspirate.

MR. WEAVER: Object as to form.

Q – Correct?

MR. BURTON: And join. Also, mischaracterizes the testimony.

THE WITNESS: Yes. There is always a risk of aspiration, but that risk is low. There's a much greater risk of aspiration if he remained on a backboard in an airplane trying to transport him for two hours to the trauma center.

Dr. Garvey acted in bad faith by not reasonably explaining the alternative treatments to Mr. and Mrs. Schwartz, regarding intubation. Dr. Garvey did not explain alternative treatments. By not explaining alternative treatments, Dr. Garvey was unreasonable and unfair. By not explaining alternative treatments, Dr. Garvey infringed upon Mr. Schwartz's right to know his alternative treatment options as a patient. Dr. Garvey testified[29] the following:

Q – Okay. And I appreciate your answer, but I want to make sure it's clear. You did not explain the risks or alternative treatments to Mr. and Mrs. Schwartz besides intubating for transfer, correct?

MR. WEAVER: Object – sorry. Object as to form. It's been asked and answered.

MS. MORALES: No, he didn't—

[29] Deposition of Dr. Garvey; Page 121, Line 3 – Line 18

MR. BURTON: Several times.

MS. MORALES: -- directly answer

MR. BURTON: Several times. And I join the objection.

THE WITNESS: I said that I -- there were no alternative treatments. So no, I did not explain alternative treatments because there were no alternative treatments. He had to be intubated.

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Northeastern Nevada Regional Hospital's conduct was reckless. It is my understanding that reckless conduct is deemed to be that conduct in which a hospital knew or should have known at the time the hospital rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Northeastern Nevada Regional Hospital's conduct of not completely stocking the trauma cart that was being used in the care of Mr. Schwartz was reckless.

According to the hospital's provision of care event, inadequate equipment availability was a contributing factor[30] to Mr. Schwartz's unexpected death. The brief factual description contains the following:

> Pt was prepared for transfer to University of Utah for a higher level of care. 2 REACH RN's present as well as 2 Elko EMS. EMS student also present. Pt was stable and ready for transfer. Decision was made to intubate and insert chest tube made by U of U and given to Dr. Garvey. All equipment was prepared prior to the start of the procedure. See code sheet for further documentation on code. There were complications with intubation which resulted in patient death. The only staff members present from NNRH were Dr. Garvey, myself, Nancy A, ER tech, Tom E, RT, Cindy F, RN (Travel ICU float), and Sue O, RN, house sup. Trauma cart open, not fully stocked -- Supplies had to be

[30] Other contributing factors reported were (1) staff – use of float staff (2) staffing issue (3) task – training issue

obtained from 2 other rooms and storeroom. Privacy issues with other patients in the ER (Room 11 – verbal witness to trauma).

Northeastern Nevada Regional Hospital should have known that not completely stocking a trauma cart would likely result in injury so as to affect the life or health of another person and is a direct violation of their policy[31].

****

Rebuttal to the Opinion of Dr. Barclay

1. Dr. Barclay opined that Mr. Schwartz sustained a bilateral flail chest injury.
    i. Dr. Barclay's opinion is based on an incorrect interpretation of the definition of a flail chest. Mr. Schwartz did not have a flail chest on his autopsy or his CT scan. There were not two or more adjacent ribs fractured in two or more places. The definition of flail chest is discussed in my opinion.
    ii. Dr. Barclays opinion concerning fractures of Mr. Schwartz's left ribs is based on a failure to consider relevant information. Mr. Schwartz did not have fractures of his left ribs on CT scan. The fractures of Mr. Schwartz's left ribs found on autopsy were likely from the CPR performed on Mr. Schwartz.

2. Dr. Barclay opined that Mr. Schwartz could not be stabilized until conservative management by a trauma surgeon ruled out impending respiratory failure, the need for mechanical respiration, and the need for surgical rib fracture fixation.
    i. Mr. Schwartz was stable and remained stabilized until Dr. Garvey's attempt to intubate him.
    ii. The reasons why Mr. Schwartz was stable are discussed in my opinion.

[31] Assuming the trauma cart and crash cart are the same

3. Dr. Barclay opined that Mr. Schwartz had clinical indications for intubation, including risk of aspiration, low oxygenation, and anticipation of a deteriorating course that leads to respiratory failure.
    i. Dr. Barclay's opinion is based on failure to consider relevant information specific to Mr. Schwartz that is discussed in my opinion. Mr. Schwartz was able to protect his own airway and not aspirate if Dr. Garvey would have removed Mr. Schwartz from the hard backboard. Mr. Schwartz's oxygenation readings were stable and within normal limits of what is expected in a trauma patient with rib fractures and a pneumothorax, especially a patient with inadequate pain control. It was unlikely that Mr. Schwartz was going to have a deteriorating course that lead to respiratory failure.
    ii. The reasons why Mr. Schwartz should not have been intubated are discussed in my opinion.

4. Dr. Barclay opined that it was entirely appropriate to have a highly qualified flight paramedic perform rapid sequence intubation while Dr. Garvey performed the thoracotomy.
    i. Dr. Barclay's opinion is based on an outright mistake. Dr. Garvey was to perform a chest tube thoracostomy. Dr. Garvey was not to perform a thoracotomy, which is an incision into the pleural space of the chest to gain access to thoracic organs.
    ii. Assuming Dr. Barclay meant chest tube thoracostomy, Dr. Barclay's opinion is unreasonable and fails to recognize that Dr. Garvey made the decision for these two separate very serious and meticulous procedures to be performed upon Mr. Schwartz simultaneously. Emergency physicians are the most qualified to perform rapid sequence intubation.
    iii. The reasons why this was inappropriate and reckless are discussed in my opinion.

5. Dr. Barclay opined that since Mr. Schwartz needed a thoracostomy and intubation on an emergent basis, the disclosure Dr. Garvey provided to Mr. Schwartz and his wife, advising them of the serious nature of his injuries and the risk of not intubating is what a reasonable emergency physician would disclose under the circumstances.
    i. Dr. Barclay's opinion is based on the incorrect assumption that Mr. Schwartz needed these procedures emergently, thereby exonerating Dr. Garvey of his duty to explain the risks of these procedures to Mr. Schwartz. Mr. Schwartz did not need a chest tube thoracostomy or an intubation on an emergent basis. Mr. Schwartz needed a chest tube as a preventative measure before flight, and Mr. Schwartz did not need intubation. Further reasoning is discussed in my opinion.

6. Dr. Barclay opined that Dr. Garvey's emergency care and treatment of Mr. Schwartz was within the standard of care.
    i. I respectfully disagree for reasons discussed in my opinion.

7. Dr. Barclay opined that nothing that Dr. Garvey did or failed to do caused or contributed to Mr. Schwartz's injuries.
    i. I respectfully disagree for reasons discussed in my opinions.

8. Dr. Barclay opined that multiple attempts to intubate are within the standard of care.
    i. Dr. Barclay's opinion is based on failure to consider relevant information specific to Mr. Schwartz's situation. Specifically, Mr. Schwartz's was in a "can't intubate, can't oxygenate" situation.
    ii. The reasons that the multiple attempts to intubate Mr. Schwartz are not the standard of care are discussed in my opinions.

Based upon a reasonable degree of medical certainty, it is my opinion that Dr. Garvey did not use such care as reasonably prudent healthcare practitioners practicing in the same field would

have provided under similar circumstances. It is my opinion that the negligence of Dr. Garvey was the direct and proximate cause of Mr. Schwartz's death.

My opinions are based upon my knowledge, education, experience, skills, and training developed as an emergency medicine physician. All opinions are expressed to a reasonable degree of medical certainty. I specifically reserve the right to add to, amend, or subtract from this report as new evidence comes into discovery or as new opinions are formulated. I declare under penalty of perjury, under the Law of the State of Nevada, that the foregoing is true and correct.

Respectfully,

Seth P. Womack, MD FAEEM

Date: August 17, 2020

References

1. Henry Ahn, Jeffrey Singh, Avery Nathens, Russell D. MacDonald, Andrew Travers, John Tallon, Michael G. Fehlings, and Albert Yee. Journal of Neurotrauma. Aug 2011. 1341-1361.

2. Walls, Ron M., and Michael F. Murphy. *Manual of Emergency Airway Management*. third ed., Wolters Kluwer/Lippincott Williams & Wilkins, 2008.

3. Marx, J. A., et al. *Rosen's Emergency Medicine: Concepts and Clinical Practice (2 Volumes)*. Elsevier Saunders, 2014.

EXHIBIT 2

AFFIDAVIT OF KENNETH N. SCISSORS, M.D.

I, Kenneth N. Scissors, MD, being duly sworn, under oath, state that the following assertions are true to the best of my personal knowledge training, experience and belief;

1) I am licensed by the Colorado Board of Medical Examiners to practice medicine in the State of Colorado.

2) My licenses are current with the appropriate State and Federal agencies.

3) My additional qualifications to serve as an expert are set forth in my Curriculum Vitae, attached as Exhibit 1.

4) Based on my training, background, knowledge and experience, I am familiar with the applicable standard of care for the treatment of the signs, symptoms, and condition presented by Mr. Schwartz in the emergency department. I am familiar with the team approach involved in the emergency room to include but not limited to transport teams and nursing care. The areas covered in this report overlap and based on my experience and training I am familiar and qualified in the areas addressed in this report to provide opinions.

5) I am qualified on the basis of my training background, knowledge, experience to offer an expert opinion regarding the accepted standard of medical care of the emergency room physician and the nurse who attempted to intubate Douglas Schwartz, the breaches thereof and the resulting injuries and damages arising therefrom.

Documents Reviewed

1.) Northeaster Nevada Regional Hospital Medical Records
2.) Elko County Ambulance Medical Records
3.) Certificate of Death

4.) Autopsy Protocol
5.) NMS Lab Report
6.) Elko County Sheriff's Office Investigation Report
7.) Radiology Disc from Northeastern Nevada Regional Hospital

Summary of Medical Care at Northern Nevada Regional Hospital Emergency Department on June 22, 2016

On June 22, 2016 Mr. Douglas Schwartz was struck as a pedestrian by a moving vehicle. Paramedics were called at 8:17 p.m. and arrived at the scene within a few minutes. Mr. Schwartz was placed in full C-spine precautions. During his transport to the hospital his vitals were within normal limits, 4L of 02 was started routinely, a monitor was placed showing normal sinus rhythm. Mr. Schwartz was given 4 mg Zofran IVP followed by 100 mcg Fentanyl IVP which helped with his pain. He was transported by Elko County Ambulance to Northern Nevada Regional Hospital on a "non-emergent" transport mode arriving at 8:48 p.m.

Dr. David Garvey performed a physical evaluation of Douglas Schwartz upon arrival to the emergency department. He noted that Douglas Schwartz sustained mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions of the right bicep, elbow, and knee. Mr. Schwartz had a normal heart rate and rhythm. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout. Mr. Schwartz's neurological status was normal. His abdominal evaluation was also within normal limits. Mr. Schwartz's condition was stable.

At approximately 9:02 p.m. several diagnostic studies were ordered to further evaluate Mr. Schwartz's injuries including CT scans of the head, cervical and thoracic spine, chest, abdomen and pelvis.

Dr. Garvey contacted Dr. Ray at University of Utah trauma service who accepted the patient for transfer. According to Dr. Garvey's chart note, Dr. Ray requested that a chest tube be placed and possibly intubation prior to air medical transport.

Dr. Garvey elected to have the flight nurse, Barry, perform the intubation after Rocuronium and Ketamine administration at 0018 hours. The vital signs were stable up until this point. The intubation was first attempted at 0020 unsuccessfully, followed quickly by deterioration of oxygenation and vital signs. Intubation was again unsuccessful at 0033 and a large aspiration of gastric contents was noted. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered. CPR continued and several subsequent intubation attempts were unsuccessful. At 0120 Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 0133

Deviations from the Standard of Care.

Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, Dr. David Garvey who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine are required to properly hire, train, supervise and/or retain employees, including Dr. David Garvey to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Dr. David Garvey breached the standard of care in several ways:

1. Deciding to intubate Mr. Schwartz without clinical indications for intubation. Preventive intubation for air flight is not the standard of care. Intubation has inherent risks, especially in a patient who likely has food in the stomach. Intubation is reserved for patients who are unable to breath adequately on their own, yet Mr. Schwartz was breathing without difficulty and had adequate oxygen levels on simple oxygen supplementation.
2. Even if there was a pressing but non-emergent need to intubate Mr. Schwartz with likely food in the stomach, the standard of care would be to request an anesthesiologist to perform the intubation due to the high

risk of aspiration. It is a deviation from the standard of care for an emergency room physician to assign a RN to perform a high risk semi-elective intubation in a patient with likely gastric contents when highly skilled physicians are available.

3. Since this was a non-emergent and non-essential invasive procedure in an awake, cognitive patient, informed consent was required. That means more than just telling the patient what is to be done. The patient must be told the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician. Dr. Garvey deviated from the standard of care by not giving Mr. Schwartz the opportunity to decline this risky and unnecessary procedure.
4. Once the initial intubation was unsuccessful, Dr. Garvey elected to continue with the same plan of having a RN attempt intubation rather than trying it himself or supporting the patient with a bag-mask technique and calling in an anesthesiologist as the standard of care would require. This led to a large aspiration of gastric contents and a fatal cardiopulmonary arrest.

Reach Air Medical Services through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, identified as "Barry RN" who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Reach Air Medical Services is required to properly hire, train, supervise and/or retain employees, including "Barry RN" to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Nurse Barry violated the standard of care in two instances:

1. Nurse Barry should not have agreed to attempt to intubate Mr. Schwartz given that he did not have clear indications for intubation and had a high risk of aspiration of gastric contents. In this situation, a RN should defer to a qualified physician, preferably an anesthesiologist.

2. Nurse Barry should not have attempted a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but still supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician at this point rather than repeating the same mistake he made initially. The second failed attempt caused a fatal aspiration.

All of the aforementioned breaches of the standard of care caused or contributed to the death of Mr. Schwartz.

All of my opinions expressed herein are to a reasonable degree of medical certainty.

I reserve the right to amend, modify, and add to my opinions upon further review of any additional documents and/or information.

Further Affidant Sayeth Not.

Dated this 21 day of June, 2017

KENNETH N. SCISSORS, M.D.

State of Colorado
County of Mesa
On this 21 day of June, 2017 Kenneth Scissors, MD
personally appeared before me,
X who is personally known to me,
___ whose identity I verified on the basis of CO - DL,
___ whose identity I verified on the oath/affirmation of _____,
a credible witness,
to be the signer of the foregoing document, and he/she acknowledged that he/she signed it.
Therese Luellen
Notary Public
My Commission Expires: 4-5-2021

THERESE LUELLEN
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20014010801
MY COMMISSION EXPIRES 04/05/2021

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Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine are required to properly hire, train, supervise and/or retain employees, including Dr. David Garvey to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Dr. David Garvey breached the standard of care in several ways:

1. Deciding to intubate Mr. Schwartz without clinical indications for intubation. Preventive intubation for air flight is not the standard of care. Intubation has inherent risks, especially in a patient who likely has food in the stomach. Intubation is reserved for patients who are unable to breath adequately on their own, yet Mr. Schwartz was breathing without difficulty and had adequate oxygen levels on simple oxygen supplementation.
2. Even if there was a pressing but non-emergent need to intubate Mr. Schwartz with likely food in the stomach, the standard of care would be to request an anesthesiologist to perform the intubation due to the high

risk of aspiration. It is a deviation from the standard of care for an emergency room physician to assign a RN to perform a high risk semi-elective intubation in a patient with likely gastric contents when highly skilled physicians are available.

3. Since this was a non-emergent and non-essential invasive procedure in an awake, cognitive patient, informed consent was required. That means more than just telling the patient what is to be done. The patient must be told the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician. Dr. Garvey deviated from the standard of care by not giving Mr. Schwartz the opportunity to decline this risky and unnecessary procedure.
4. Once the initial intubation was unsuccessful, Dr. Garvey elected to continue with the same plan of having a RN attempt intubation rather than trying it himself or supporting the patient with a bag-mask technique and calling in an anesthesiologist as the standard of care would require. This led to a large aspiration of gastric contents and a fatal cardiopulmonary arrest.

Reach Air Medical Services through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, identified as "Barry RN" who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Reach Air Medical Services is required to properly hire, train, supervise and/or retain employees, including "Barry RN" to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Nurse Barry violated the standard of care in two instances:

1. Nurse Barry should not have agreed to attempt to intubate Mr. Schwartz given that he did not have clear indications for intubation and had a high risk of aspiration of gastric contents. In this situation, a RN should defer to a qualified physician, preferably an anesthesiologist.

2. Nurse Barry should not have attempted a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but still supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician at this point rather than repeating the same mistake he made initially. The second failed attempt caused a fatal aspiration.

All of the aforementioned breaches of the standard of care caused or contributed to the death of Mr. Schwartz.

All of my opinions expressed herein are to a reasonable degree of medical certainty.

I reserve the right to amend, modify, and add to my opinions upon further review of any additional documents and/or information.

Further Affidant Sayeth Not.

Dated this 21 day of June, 2017

KENNETH N. SCISSORS, M.D.

State of Colorado
County of Mesa
On this 21 day of June, 2017 Kenneth Scissors, MD
personally appeared before me,
X who is personally known to me,
___ whose identity I verified on the basis of CO-DL,
___ whose identity I verified on the oath/affirmation of _____,
a credible witness,
to be the signer of the foregoing document, and he/she acknowledged that he/she signed it.
Therese Luellen
Notary Public
My Commission Expires: 4-5-2021

THERESE LUELLEN
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20014010801
MY COMMISSION EXPIRES 04/05/2021

EXHIBIT 3

Seth P. Womack, MD FAAEM
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Tyler, Texas 75703
Womack@erdoctor.com

Claggett & Sykes Law Firm
4101 Meadows Lane, Suite 100
Las Vegas, Nevada 89107

Re: Douglas Schwartz

Introduction and Qualifications

I, Seth P. Womack, MD am a licensed physician. You have asked me to render an opinion concerning the standard of care performed by Dr. David James Garvey regarding the care of Douglas Schwartz on June 22, 2016 in the emergency room of Northeastern Nevada Regional Hospital (NNRH). I am board certified in emergency medicine by the American Board of Emergency Medicine (ABEM). I completed a residency in emergency medicine at the Medical College of Wisconsin in Milwaukee, Wisconsin. During residency I was a flight physician. I have treated patients before, during, and after flight transport from the scene and from hospital to hospital. I have made decisions as to intubate or not intubate patients prior to flight transport. I have worked in emergency rooms and on flights that transferred trauma patients to trauma centers for injuries similar to Mr. Schwartz. I have been working as a full time emergency physician in a level one trauma center for over ten years. I am certified in Advance Trauma Life Support (ATLS), and I am an ATLS instructor. I have intubated hundreds of emergency room patients. I have given presentations on difficult patient airways and airway management. I have completed the Difficult Airway Course specific to the specialty of emergency medicine. I currently work approximately 12 -15 shifts in the emergency department where I work with flight nurses and flight paramedics. When I was a flight physician, I would manage and transport patients with a flight nurse or flight paramedic. I am familiar with the standard of care in this case by virtue of my knowledge, education, experience, training, and skill.

Records Reviewed

I have reviewed the records, case related documents, and definitions regarding the case of Douglas Schwartz that you have provided to me. These consist of the following:

1. Reach Air Medical Records (9pages)
2. Northeastern Nevada Regional Hospital (157 pages)
3. Police Report and Autopsy (30 pages)
4. Elk Count Ambulance Record (18 pages)
5. Elite Investigations Norther Nevada (19 pages)
6. Certificate of Death (1 page)
7. Workman's Compensation (4 pages)
8. Billing Statements from Northeastern Nevada Regional Hospital (7 pages)
9. Posts about Douglas Schwartz (4 pages)
10. 2013-2017 Tax Returns (59 pages)
11. Douglas Schwartz Work Contract (7 pages)
12. Costs for Funeral (3 pages)
13. 2013-2016 Paystubs (89 pages)
14. Plaintiff's First Supplement (8 pages)
15. Elko Police Report (8 pages)
16. Affidavit of Kenneth N. Scissors, M.D. (5 pages)
17. Schwartz Report from Elite Investigations (18 pages)
18. Complaint (Medical Malpractice and Wrongful Death) (24 pages)
19. Errata to Plaintiff's Complaint, Amended Complaint and Second Amended Complaint (12 pages)
20. Second Amended Complaint (Medical Malpractice and Wrongful Death) (22 pages)
21. Amended Complaint (Medical Malpractice and Wrongful Death) (22 pages)
22. Deposition of David James Garvey, M.D. (166 pages)
    i. June 25, 2019
23. Deposition of Carmen Gonzalez (26 pages)

i. March 4, 2019

24. Deposition of Susan Olson, R.N. (78 pages)
    i. March 4, 2019
25. Deposition of Dr. John Patrick Patton (67 pages)
    i. May 31, 2019
26. Deposition of Donna Kevitt, R.N. (111 pages)
    i. March 4, 2019
27. Deposition of Diane Schwartz (163 pages)
    i. January 23, 2019
28. Deposition of Kathleen Jane Dunn (176 pages)
    i. June 8, 2020
29. Deposition of Gary McCalla, MD (194 pages)
    i. June 8, 2020
30. Exhibits 1-4 of the Deposition of Gary McCalla, MD (656 pages)
31. Deposition of Tom Evers, RRT (84 pages)
    i. June 17, 2020
32. Exhibits 1-5 of the Deposition of Tom Evers, RRT (108 pages)
33. Deposition of Barry Bartlett with Exhibits 1-5 (154 pages)
34. Responses to Plaintiff's First Set of Request for Production of Documents (7 pages)
35. Answers to Plaintiff's First Set of Interrogatories (10 pages)
36. Plaintiff's Responses to Defendant David Garvey's First Set of Requests for Production (26 pages)
37. Plaintiff's Answers to Defendant David Garvey's First Set of Interrogatories (19 pages)
38. Plaintiff's Responses to Defendant Reach Air Medical Services' First Set of Interrogatories, Requests for Production and Requests for Admissions (22 pages)
39. Reach and Summit Documents (263 pages)
40. Reach Air Medical Services, LLC's Responses and Objections to First Set of Interrogatories, Requests for Admission, and Requests for Production to Plaintiff (54 pages)

41. Dr. Whimple's Clinic Notes on Douglas Schwartz (20 pages)
42. Dr. Garvey's Partial Motion for Summary Judgement (290 pages)
43. Dr. Garvey's Errata to Motion for Partial Summary Judgement (10 pages)
44. Mr. Schwartz's radiographic imaging studies (June 22, 2016)
    i. CT Brain without contrast
    ii. CT C-Spine without contrast
    iii. CT T-Spine without contrast
    iv. CT Chest with IV contrast
    v. CT Abdomen and Pelvis with IV contrast
45. Northeastern Nevada Regional Hospital Patient Safety Plan
46. Northeastern Nevada Regional Hospital Code Blue Procedure & Crash Cart Maintenance (14 pages)
47. Nevada Trauma Statute (NRS 41.503)
48. Northeastern Nevada Regional Hospital Provision of Care Event for the Unexpected Death of Douglas Schwartz (5 pages) (Evers Exhibit 5)

Facts

Douglas Schwartz was 58 years old on the night of June 22, 2016 when he was stuck by a car while walking out of a restaurant. The Elko County ambulance arrived on the scene at approximately 8:19 pm. Mr. Schwartz complained of right sided body pain. Mr. Schwartz was thrown upon the hood and onto the roof before falling to the ground. Mr. Schwartz had pain to his right ribs. He had diminished lung sounds due to not wanting to take a deep breath. The ambulance crew started an IV, placed Mr. Schwartz in c-spine precautions, and placed oxygen at 4 liters (L) just for precaution. The ambulance crew administered 4 mg of Zofran and 100 mcg of Fentanyl which helped with Mr. Schwartz's pain. At 8:41 pm, the ambulance transported Mr. Schwartz three miles to the emergency room of Northeastern Nevada Regional Hospital without lights and sirens. Mr. Schwartz arrived in the emergency room at 8:51 pm.

Upon arrival to the emergency room, Mr. Schwartz's presenting complaints were right sided rib pain, right knee pain, and right shoulder pain. Mr. Schwartz's pulse ox was 94% on 4 liters of oxygen via nasal cannula[1] (NC).

Donna Kevitt, RN was Mr. Schwartz's nurse. Nurse Kevitt documented that Mr. Schwartz's airway was patent with good air movement, and he was breathing without difficulty. Nurse Kevitt documented that Mr. Schwartz complained of pain in his right supraclavicular area, diaphragm, and right breast. Mr. Schwartz appeared uncomfortable and had diminished breath sounds in his right posterior middle and lower lung lobes. Nurse Kevitt documented that Mr. Schwartz possibly experienced a loss of consciousness. Mr. Schwartz was awake, alert, and oriented to person, place, and time. Nurse Kevitt noted some abrasions to his right scalp, right outer arm, right elbow, and right knee.

Dr. David Garvey was Mr. Schwartz's emergency physician. Dr. Garvey documented[2] that Mr. Schwartz sustained injury to his head, chest, right bicep, right elbow, and right knee. Dr. Garvey noted that Mr. Schwartz had pain with breathing and movement. Dr. Garvey documented that Mr. Schwartz experienced a brief loss of consciousness. Dr. Garvey documented that Mr. Schwartz's symptoms, at their worst, were moderate and unchanged in the emergency department. Mr. Schwartz had a past medical history of hypertension. On Dr. Garvey's review of systems, Mr. Schwartz was positive for chest pain, back pain, and abrasions; he was negative for shortness of breath, nausea, and vomiting. On physical examination, Dr. Garvey documented the following:

1. Appears awake, in obvious pain, uncomfortable
2. Abrasions that are mild to the forehead
3. Moderate chest tenderness to palpation of the right lateral posterior chest
4. Moderate back pain that is moderate of the left scapular and subscapular area

[1] Oxygen tubing with two soft prongs that are inserted into the openings of the patient's nostrils. The oxygen concentration delivered varies from 25 to 40 percent depending on the patient's rate of breathing, volume of air breathed in, and extent of mouth breathing. The flow rates are typically 2-4 L/minute.

[2] A scribe transcribed Dr. Garvey's note. Dr. Garvey reviewed and agreed with the scribe's documentation on Dr. Garvey's behalf.

5. Abrasion to the right knee, elbow, and bicep
6. Normal external neck
7. No cervical midline tenderness, not intoxicated, normal mental status, no focal neurological deficits, and no painful distracting injuries are present
8. Normal heart rate and regular rhythm
9. Does not display signs of respiratory distress; normal respirations, breath sounds are normal and clear throughout
10. Normal appearance of abdomen, normal bowel sounds, abdomen is soft and nontender in all quadrants
11. Normal appearance of skin except for affected areas
12. Normal orientation to person, place, and time; immediate and remote memory is intact; recent memory is impaired
13. Behavior/mood is pleasant and cooperative

Dr. Garvey ordered CT scans on Mr. Schwartz.

At 9:33 pm or 9:40 pm, Mr. Schwartz was moved to CT scan.

At 10:33 pm, Nurse Kevitt administered Dilaudid 1 mg IV and Zofran 4 mg IV to Mr. Schwartz.

At 11:00 pm, Mr. Schwartz was moved back from CT scan to room 12.

At 11:07 pm, the radiologist verified receipt of Mr. Schwartz's CT abdomen and pelvis with Cheryl in the ER for Dr. Garvey.

The radiology report of Mr. Schwartz's CT abdomen and pelvic contained the following:

1. Trace hyperdense fluid just below the right liver lobe as well as next to the left colon. No clear CT evidence for spleen or liver contusion or laceration, however finding should

be considered to reflect trace hemoperitoneum in the setting of significant trauma. Low grade solid organ injury is not excluded.

2. No free air to suggest bowel perforation.

At 11:17 pm, Mr. Schwartz's pulse ox was 91%.

At 11:19 pm, Nurse Kevitt administered Zofran 4 mg IV to Mr. Schwartz.

At 11:27 pm, Mr. Schwartz's pulse ox was 91%.

At 11:30 pm, Mr. Schwartz's pulse ox was 92%.

At 11:36 pm, REACH Air Medical Service's dispatch was notified.

At 11:37 pm, respiratory placed Mr. Schwartz on a Venti (Venturi[3]) mask. Mr. Schwartz's oxygen saturations were 92% and 93%.

At 11:41 pm, REACH Air Medical Service crew was dispatched.

At 11:45 pm, REACH Air Medical Service crew was enroute.

At 11:45 pm, Mr. Schwartz's pulse ox was 91%.

At 11:47 pm, the radiologist verified receipt of Mr. Schwartz's CT chest, CT head, and CT T-spine with Dr. Garvey.

The radiology report of Mr. Schwartz's CT chest contained the following:

[3] Simple mask that fits loosely over the nose and mouth. The mask can provide oxygen concentrations of 35 and 50 percent depending on the rate of breathing, volume of air breathed in, and mask fit. The flow rates are typically 6 – 10 L/minute.

1. Small right anterior pneumothorax (less than 10%).
2. Acute fractures of the 4th through 7th ribs as described. There are acute anterolateral fractures of the right 4th through 7th ribs with the 4th and 6th ribs fractured in 2 places (nondisplaced fractures also noted). Comminution and displacement of the 7th fracture is present.
3. Dependent bibasilar opacities and right perihilar opacity may reflect atelectasis, pulmonary contusion, and/or sequela of aspiration.

The radiology report of Mr. Schwartz's CT head contained the following:

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

The radiology report of Mr. Schwartz's CT C-spine contained the following:

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

The radiology report of Mr. Schwartz's CT T-spine contained the following:

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.

Dr. Garvey discussed Mr. Schwartz with Dr. Ray at University of Utah who accepted Mr. Schwartz in transfer. Dr. Ray requested that a chest tube be placed and possible intubation[4] prior to air medical transport due to flail segment, pulmonary contusions, low oxygen saturations, and a traumatic right pneumothorax. At 11:57 pm, the REACH team arrived at Mr. Schwartz's bedside to find Mr. Schwartz talking to his family as Dr. Garvey assembled his team

[4] Dr. Garvey testified that he had already planned to intubate, and that Dr. Ray did not tell him to conclusively intubate Mr. Schwartz; leaving that decision up to Dr. Garvey. (Deposition of Dr. Garvey; Page 113, Lines 2-16)

and equipment. Dr. Garvey's plan was place the chest tube while the Reach crew (Barry Bartlett, EMT-Paramedic) performed the intubation. Mr. Schwartz vomited and aspirated a large amount of gastric contents. Suctioning was difficult due to large food particles occluding the suction. Multiple suction machines were used to no avail. Multiple attempts at intubation were made. Intubation was without success. Vomitus in the airway could not be completely cleared. Mr. Schwartz went into cardiac arrest (coded). ER staff tried to suction copious amounts of vomit throughout the code. From the time the first drug was given for rapid sequence intubation (RSI) until Dr. Garvey pronounced Mr. Schwartz deceased was 1 hour and 15 minutes. Mr. Schwartz would regain his pulse at times but would go back into cardiac arrest. During this time, Dr. Garvey nor Barry Bartlett were able to establish a definitive airway for Mr. Schwartz. Once, they were able to increase Mr. Schwartz's pulse ox to 79%-82% with a King airway, but Mr. Schwartz deteriorated again, and his oxygen saturation started dropping[5]. Approximately 46 minutes after the first intubation attempt, Dr. Garvey performed a cricothyrotomy (cric) and placed a trach tube in the correct location (the trachea). The procedure was complicated by vomit. Initially the trach tube was placed but quickly became occluded with gastric contents. The trach tube became dislodged while attempting to clear the vomit. Ultimately, Mr. Schwartz was bagged through his cricothyrotomy via a 5-0 endotracheal tube (ETT) but most of the bagged air expelled from the mouth. Mr. Schwartz's oxygen saturations did not improve, and he went into cardiac arrest, again.

According to the REACH Air Medical Service record, multiple operators attempted to intubate Mr. Schwartz at least 9 times over the time span of approximately 48 minutes. The documentation of the REACH record contained the following:

- 0020 – Once the drugs took effect, Paramedic Bartlett opens the airway and places the C-Mac device resulting in copious amounts of emesis and large food chunks fulminating from the mouth and nose. Intubation is immediately stopped, and the airway is suctioned, which promptly plugs the suction tubing and yankauer tip.

[5] Deposition of Dr. Garvey; Page 153, Lines 5-8

- Over the course of the next 13 minutes, Mr. Schwartz vomits several more times and numerous attempts are made a clearing/maintaining his airway and reoxygenating him with BVM on high flow oxygen.
- 0023 – ETT placement attempt unsuccessful
- 0033 – ETT placement attempt unsuccessful
- In addition to the factors that are making this procedure very difficult (airway contamination, difficulty in keeping the suction devices flowing, difficulty in getting a good facial seal and very stiff bagging effort) his airway is reportedly very inferior/anterior making it a challenge to visualize.
- Paramedic Bartlett attempts several tooled and digital[6] intubations, all of which are unsuccessful.
- 0035 – Mr. Schwartz loses pulses and CPR is initiated for approximately one minute and pulse is restored.
- The airway is again suctioned and a king airway[7] is placed. Bag valve mask (BVM) bagging remains very difficult and shortly afterward the king is removed after becoming plugged by emesis and food particles.
- A 3rd suction unit is placed in play and Mr. Schwartz's oxygen saturation is 47% on high flow oxygen.
- 0040, 0044, and 0047 – Intubation attempts continue with various size ETTs, stylets, bougie introducers, and airway adjuncts. The emesis is almost continuous and proving very difficult to get cleared.
- 0050 – Mr. Schwartz's oxygen saturation is approximately 50%.
- 0052 -- ETT placement attempt unsuccessful; airway suctioned and oxygen is at 55%
- 0053 – ETT placement attempt unsuccessful; several operator changes
- 0054 – Mr. Schwartz's oxygen saturation is 42% with bagging and suctioning at every opportunity. A cricothyrotomy is discussed and the kit prepared.

[6] Attempting intubation with fingers without visualization of the airway
[7] Dr. Garvey testified that he did not have a King airway in the ER. He used the EMS crew's King airway. (page 151; Line 9-14)

- Mr. Schwartz is becoming abdominally distended and a nasal-gastric (NG) tube is attempted in each nostril. The NG tube will not pass, and Mr. Schwartz's nose starts bleeding.
- Facial seal remains a challenge due to vomit and wet face.
- An oral-gastric (OG) tube placement attempt is also unsuccessful and abandoned.
- 0058 – Mr. Schwartz's oxygen saturation is 68% and the third operator is again in place as efforts to reoxygenate are minimally effective and bagging effort is very high.
- Cric airway is kit is being prepared.
- 0102 – Mr. Schwartz's oxygen saturation is 75%.
- Another intubation attempt is unsuccessful.
- 0106 – The cric is initiated by Dr. Garvey and paramedic Bartlett. The tube is very difficult to advance into the trachea. The tube begins to fill up with vomit. The tube is pulled and replaced two additional times with the same results.
- 0117 – Pulses are lost and CPR resumes.
- Emesis continues and additional suction units and methods of airway clearance are discussed.
- 0120 – The monitor is displaying asystole (flat line, no heartbeat). CPR is ongoing.
- 0122 – A pulse of 52 is noted on the monitor.
- CPR continues. Gastric distention is increasing and cannot be evacuated.
- 0125 – CPR ongoing by ER staff
- 0128 – We note an oxygen saturation reading of 64% on the monitor.
- 0129 – Bilateral needle thoracostomy is performed with no results and no air escape.
- 0133 – CPR is stopped, and Mr. Schwartz is pronounced deceased.

Dr. Garvey documented that Mr. Schwartz's cardiac arrest was due to asphyxiation[8].

[8] Act of causing asphyxia: a state of asphyxia: suffocation (Merriam-Webster Unabridged)

Opinion

It is my professional opinion that Dr. David James Garvey breached the applicable standard of care for Mr. Schwartz on June 22, 2016 in the emergency room of Northeastern Nevada Regional Hospital. Dr. Garvey fell below the applicable standard of care by attempting to intubate Mr. Schwartz. Dr. Garvey fell below the applicable standard of care by not performing a cricothyrotomy on Mr. Schwartz sooner. Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him. Mr. Schwartz could protect his own airway. Mr. Schwartz was not in respiratory distress. Mr. Schwartz did not have a flail chest. Dr. Garvey should have removed Mr. Schwartz from the hard backboard as well as the cervical collar. Dr. Garvey should have placed a chest tube after numbing up Mr. Schwartz's chest wall with local lidocaine. Dr. Garvey should have transferred Mr. Schwartz to a higher level of care on oxygen delivered via a simple face mask (Venturi). Instead, Dr. Garvey breached the standard of care by attempting to intubate Mr. Schwartz. Dr. Garvey not only breached the standard of care, Dr. Garvey acted with reckless conduct, in bad faith, and was grossly negligent.

It is my professional opinion that Northeastern Nevada Regional Hospital breached the applicable standard of care by not completely stocking the trauma cart that was used in the care of Mr. Schwartz. By not completely stocking the trauma cart, Northeastern Nevada Regional Hospital acted with reckless conduct.

****

Mr. Schwartz was a stable patient before Dr. Garvey attempted to intubate him. The fact that Mr. Schwartz was stable before Dr. Garvey's attempt to intubate is supported by the following:

1. The ambulance that transported Mr. Schwartz to NNRH did not use lights and sirens.
2. The ambulance that transported Mr. Schwartz to NNRH placed him on oxygen via NC at 4L/min as a precaution.
3. When Mr. Schwartz arrived, he was breathing without difficulty.

4. Nurse Kevitt evaluated Mr. Schwartz on multiple occasions, before and after CT scan, never noting any sign of being unstable.
    i. 9:31 pm: visited this patient and evaluated for pain, information, needs, and comfort
    ii. 11:00 pm: Mr. Schwartz moved back to room 12 from CT
    iii. 11:17 pm: visited this patient and evaluated for pain, information, needs, and comfort
    iv. 11:27 pm: visited this patient and evaluated for pain, information, needs, and comfort
    v. 11:31 pm: visited this patient and evaluated for pain, information, needs, and comfort
5. Mr. Schwartz's pulse (P), respiratory rate (RR), and blood pressure (BP) were stable and within normal limits (WNL). Mr. Schwartz's pulse ox readings were stable and within normal limits of what is expected in a trauma patient with rib fractures and a pneumothorax, especially a patient with inadequate pain control. Patients with these injuries have severe pain when they expand their chest wall on the effected side when they breath. This pain makes them not want to take a deep breath that expands the effected side. This is called splinting. The cornerstone of rib fracture management is pain control. Early and adequate pain relief is essential to avoid complications from splinting and not completely filling a lung with air (atelectasis). Dr. Garvey had only given Mr. Schwartz one dose of pain medicine approximately 1 hour and 45 minutes prior to attempting intubation. Mr. Schwartz's recorded vital signs prior to intubation attempt were as follows:

    i. 11:17 pm: BP 116/75, P 67, RR 16, pulse ox 91%
    ii. 11:27 pm: BP 115/74, P 67, RR 17, pulse ox 91%
    iii. 11:30 pm: BP 120/78, P 67, RR 18, pulse ox 92%
    iv. 11:45 pm: BP 114/73, P 68, RR 18, pulse ox 91%
    v. 12:10 am: P 66, RR 17, pulse ox 97% on nonrebreather mask

vi. 12:15 am: P 73, RR 19, pulse ox 99% on nonrebreather mask

Mr. Schwartz's vital signs did not become unstable until the time of the intubation attempt at 0020.

6. Multiple witnesses gave testimony that describes Mr. Schwartz in stable condition.
   i. Regarding the time around Mr. Schwartz's initial evaluation, Diane Schwartz testified[9] that Mr. Schwartz did not complain of any difficulty breathing.
   ii. Diane Schwartz testified[10] that Mr. Garvey did not have any difficulty breathing while he was in the ER nor did he have on a nasal cannula or oxygen mask.

> Q – Did Doug have any difficulty Breathing while he was in the ER?
>
> A – No
>
> Q – Do you remember him receiving any type of oxygen while he was in the ER?
>
> A – No
>
> Q – Did he have anything up his nose?
>
> A – No
>
> Q – Did he ever have a facemask on?
>
> A – No

   iii. Diane Schwartz testified[11] that when she left Mr. Schwartz; he was fine.
   iv. Diane Schwartz testified[12] that she couldn't understand why they intubated him in the first place that night given the condition he was in and the fact that he was breathing fine and he was okay.
   v. Dr. John Patton (a friend) testified[13] that Mr. Schwartz was stable and doing fine. Dr. Patton was with Mr. Schwartz and Mrs. Schwartz during the CT scan until

[9] Deposition of Diane Schwartz, Page 49; Lines 23-24
[10] Deposition of Diane Garvey; Page 62, Line 19 – Page 63, Line 3
[11] Deposition of Diane Garvey; Page 70, Lines 13-15
[12] Deposition of Diane Garvey; Page 136, Lines 8-12
[13] Deposition of Dr John Patton; Page 13, Line 11 – Page 14

about 45 minutes afterwards. Their conversation with Mr. Schwartz was an interesting conversation as Mr. Schwartz was in a lot of pain.

vi. Dr. John Patton testified[14] that when he and Diane left Mr. Schwartz, Mr. Schwartz was speaking, talking, joking, and laughing. It was uncomfortable for Mr. Schwartz to laugh.

vii. Dr. John Patton testified[15] that he was critical of Dr. Garvey's decision to intubate.

> Q – And is it fair to say that if you don't have an opinion on what happened there, are you – do you have an – are you critical of the decision to intubate?
>
> A – I am critical of that decision, yes.
>
> Q – On what grounds?
>
> A – Because he was stable, laughing, and communicative when we left him.

viii. Dr. John Patton testified[16] that he never noticed Mr. Schwartz gasping for breath and; in general, Mr. Schwartz had conversational breathing.

ix. Carmen Gonzalez (admitting and discharge clerk) testified[17] that Mr. Schwartz seemed normal and that he was laughey and smiley when she went to put his wristband on.

7. According to the Provision of Care Event, Mr. Schwartz was "stable and ready for transfer."

****

Mr. Schwartz did not have injuries that were an immediate or imminent[18] threat to life. Mr. Schwartz had rib fractures. Mr. Schwartz's rib fractures were not an immediate or imminent

[14] Deposition of Dr. John Patton; Page 15, Lines 9-12
[15] Deposition of Dr. John Patton; Page 32, Lines 6-12
[16] Deposition of Dr. John Patton; Page 60, Lines 21-25
[17] Deposition of Carmen Gonzalez; Page 9, Lines 23-25
[18] Ready to take place, happening or likely to happen very soon, impending (Merriam-Webster Unabridged)

threat to his life. Mr. Schwartz was stable and maintaining an oxygen saturation greater than 91% with a simple oxygen mask -- even with inadequately treated pain. Radiology could not declare with certainty whether he had lung contusions or areas of the lungs not filling completely with air. CT images of lungs that have pulmonary contusions that are an immediate or imminent threat to life can be declared with certainty. I reviewed Mr. Schwartz's images and did not see any pulmonary contusions that were an immediate or imminent threat to life. Radiology could not declare with certainty whether he had trace subdural brain blood or if he was just dehydrated. A subdural brain bleed that exists and is an immediate and imminent threat to life can be declared with certainty. I reviewed Mr. Schwartz's images and did not see any subdural blood. Mr. Schwartz's CT T-spine contained possible acute injury to his lower thoracic spine that was not an immediate or imminent threat to life. Radiology declared that there was no clear CT evidence for spleen or liver damage and only trace fluid that could be blood was seen in the abdomen. Radiology indicated that if there were abdominal organ injury; it was low grade. Mr. Schwartz's CT C-spine did not show any acute injuries.

Mr. Schwartz had a pneumothorax that was not an immediate or imminent threat to life. Mr. Schwartz's pneumothorax occupied less than 10% of his right lung cavity. The standard of care required Dr. Garvey to place a right chest tube as a preventative measure because Mr. Schwartz was to go on an air flight. With changes in atmospheric pressure, a pneumothorax can get bigger; and a chest tube prevents such from happening.

****

Dr. Garvey fell below the applicable standard of care by attempting to intubate Mr. Schwartz. Dr. Garvey should not have attempted to intubate Mr. Schwartz for the following reasons:

1. Mr. Schwartz had just eaten a full meal which Dr. Garvey knew[19]. It is a known principle of emergency medicine that patients who have stomachs full of food and liquid are at

[19] Deposition of Dr. Garvey; Page 107, Line 25 – Page 108, Line 3

risk of aspiration[20] and airway complications. When a paralytic drug (Rocuronium was administered) is given, the drug paralyzes the muscles that keep stomach contents from coming back up into the esophagus and airway. The drug also takes away the body's ability to protect its own airway and lungs by taking away the gag reflex. Most anything that gets around the opening of the trachea (windpipe) or vocal cords will trigger the gag reflex to prevent aspiration. The fact that Mr. Schwartz had just eaten increased his risk for complications during a rapid sequence intubation (RSI) and made him a difficult airway. Dr. Garvey knew that the attempt at intubation was high risk. Dr. Garvey testified the following[21]:

Q – Did you consider this specific intubation high risk?

A – Oh, yes.

Q – And why is that?

A – Because we have a patient that had just finished a large meal. He was on a backboard in a C collar, and his body habitus all lend to a difficult intubation.

2. Dr. Garvey thought Mr. Schwartz had a flail chest which is one of the reasons Dr. Garvey attempted to intubate him. Mr. Schwartz did not have a flail chest. A flail chest is when at least two or more adjacent (consecutive) ribs are fractured at two points allowing a freely moving segment of chest wall to move in paradoxical motion. Paradoxical motion describes the segment of chest wall that moves inward when the rest of the chest moves outward with a deep breath and vice versa. Mr. Schwartz had a fracture of his fourth rib in two places and sixth rib in two places. The fourth and sixth rib are not adjacent to one another. Mr. Schwartz did not have rib fractures consistent with a flail chest. Dr. Garvey testified that he knew what a flail chest was in the following testimony:

Q – And can you explain for the jury what a flail chest is?

[20] Sucking gastric contents (vomit or emesis) into the trachea and lungs
[21] Deposition of Dr. Garvey; Page 128, Lines 16-23

A – Multiple rib fractures, adjacent ribs fractured in multiple places. So, you've got a segment that is independent of the rest of the chest.
Q – And is it two ribs that are broken in two places or is it three ribs? How many ribs have to be broken to –
A – Two or more.
MR. WEAVER: Just let her get her whole question out before you answer.
Q – So is it two ribs broken in the same area?
A – Two or more ribs broken – broke – two or more adjacent ribs broken in multiple places, yes.

Despite Dr. Garvey knowing what ribs fractures are consistent with a flail chest, he still misdiagnosed Mr. Schwartz with a flail chest and based his decision to intubate Mr. Schwartz from an incorrect diagnosis.

Even if Mr. Schwartz did have a flail chest, it was below the standard of care to immediately intubate him. The authors of Rosen's Emergency Medicine Concepts and Clinical Practice, 8th edition write the following:

> The outcome of flail chest injury is a function of associated injuries. Because many different physiologic mechanisms have been implicated in flail chest, there is no consensus about hospital treatment. The cornerstones of therapy include aggressive pulmonary physiotherapy, effective analgesia[22], selective use of endotracheal intubation and mechanical ventilation, and close observation for respiratory compromise. Respiratory decompensation is the primary indication for endotracheal intubation and mechanical ventilation for patients with flail chest. Obvious problems, such as hemopneumothorax or severe pain, should be corrected before intubation and ventilation are presumed necessary. In fact, in the awake and cooperative patient, noninvasive continuous positive airway

[22] Pain control

pressure (CPAP) by mask may obviate the need for intubation. In general, the most conservative methods for maintaining adequate oxygenation and preventing complications should be used. Adequate analgesia is of paramount importance in patient recovery and may contribute to the return of normal respiratory mechanics. Patients without respiratory compromise generally do well without ventilatory assistance. Several studies have found that patients treated with intercostal nerve blocks or high segmental epidural analgesia, oxygen, intensive chest physiotherapy, careful fluid management, and CPAP, with intubation reserved for patients in whom this therapy fails, have shorter hospital courses, fewer complications, and lower mortality rates. Avoidance of endotracheal intubation, particularly prolonged intubation, is important in preventing pulmonary morbidity because intubation increases the risk of pneumonia.

Mr. Schwartz did not have respiratory decompensation or compromise; he was talking, laughing, and joking. His oxygen saturations were above 90% on a simple oxygen mask and 99% on a nonrebreather.

3. Dr. Garvey should not have intubated Mr. Schwartz based on a risk of aspiration from being on a rigid backboard and wearing a c-collar. Dr. Garvey and staff should have logrolled Mr. Schwartz off of the rigid backboard onto a regular stretcher or ER bed with a soft mattress. Dr. Garvey should have removed Mr. Schwartz's c-collar. Mr. Schwartz could have laid on his side or at 30 degrees head of the bed elevation to protect his own airway if he needed to vomit. More anti-nausea medicines could have been given. Excluding Mr. Schwartz's initial ambulance transport to the emergency room, he had no reason to be on a rigid backboard. Mr. Schwartz's exam was not consistent with any spinal cord injury (SCI). Even in patients with a spinal cord injury, backboards should be removed as soon as possible in the emergency room. In a systemic review of the literature and evidence-based guidelines: Henry Ahn, et al, in the Journal of Neurotrauma (2011) write the following:

What is the optimal type and duration of pre-hospital spinal immobilization in patients with acute SCI?

- Patients should be transferred off the hardboard on admission to a facility as soon as is feasible to minimize time on the hard board. If patients are awaiting transfer to another institution, they should be taken off the hardboard while awaiting transfer.

In addition, Mr. Schwartz did not clinically correlate with an acute spine fracture. He was not tender and did not complain of pain in the area of the irregularity mentioned on his CT T-spine. Mr. Schwartz had pain and tenderness at his scapular and subscapular level. The area mentioned on CT (T10 and T11) are at the level just above the umbilicus (belly button).

After Mr. Schwartz's initial evaluation by Dr. Garvey and Mr. Schwartz's negative CT C-spine, Dr. Garvey should have removed Mr. Schwartz's c-collar. Mr. Schwartz did not complain of any pain in his neck and had a negative physical exam of his neck by Dr. Garvey. Dr. Garvey documented that Mr. Schwartz satisfied all of the Nexus Criteria for not having a c-spine injury. The Nexus Criteria decision instrument stipulates that imaging is not necessary if patients younger than 60 years satisfy all of the following criteria:

i. Absence of posterior midline cervical tenderness
ii. Normal level of alertness
iii. No evidence of intoxication
iv. No abnormal neurologic findings
v. No painful distracting injuries

The sensitivity and negative predictive value of the Nexus Criteria is 99.6% and 99.9%, respectively in patients not receiving imaging such a CT of the c-spine. This is the sensitivity and negative predictive value without a negative CT of the c-spine, as the

Nexus Criteria are mainly used to rule out injury and decide which patients not to image. Adding a negative CT of the c-spine and satisfying all of the nexus criteria even further pushed the chance of Mr. Schwartz not having a c-spine injury towards 100%; more than adequately ruling out any c-spine injury in Mr. Schwartz. Mr. Schwartz had no reason to be in a c-collar.

Dr. Garvey should have performed a cricothyrotomy upon Mr. Schwartz sooner. The situation turned into a failed airway early in the process of trying to intubate. According to the REACH record, Mr. Schwartz began to vomit on the first attempt to intubate by Barry Bartlett at 12:20 am. Copious amounts of emesis and large food chunks began fulminating[23] from the mouth and nose. Intubation was immediately stopped. The airway could not be cleared or suctioned. The vomit clogged both the suction tubing and the yankauer which have inner diameters of only approximately 5 mm and 4 mm, respectively. Over the course of the next 13 minutes, Mr. Schwartz vomited several more times and numerous attempts were made at clearing/maintaining his airway and reoxygenating him with BVM on high flow oxygen. Mr. Schwartz could not be intubated and could not be oxygenated. In emergency medicine, this is called, "can't intubate, can't oxygenate" (CICO). Authors from the Manual of Emergency Airway Management, 3rd Edition write the following:

> The definition of a failed airway is based on one of two criteria being satisfied: (a) a failure of an intubation attempt in a patient for whom oxygenation cannot be adequately maintained with a bag and mask [BVM], or (b) three unsuccessful intubation attempts by an experienced operator and adequate oxygenation. Unlike the difficult airway, where the standard of care dictates the placement of a cuffed endotracheal tube in the trachea providing a definitive, protected airway, the failed airway calls for action to provide emergency oxygenation sufficient to prevent patient morbidity (especially hypoxic brain injury) by whatever means possible until a definitive airway can be secured.

[23] To come on suddenly and intensely (Merriam-Webster Unabridged)

Barry Bartlett attempted to intubate Mr. Schwartz again at 12:23 am, leaving Mr. Schwartz in a CICO situation for 10 minutes before Barry Bartlett's third failed attempt at 12:33. During this time, Dr. Garvey was making not taking any action to provide emergency oxygenation to Mr. Schwartz. The standard of care required Dr. Garvey to perform a cricothyrotomy immediately after Barry Bartlett's failed intubation attempt at 12:23 am. Authors from the Manual of Emergency Airway Management, 3rd Edition write the following:

> If, however, the failed airway is because of a CICO situation, then there is little time left before cerebral hypoxia will result in permanent deficit, and immediate cricothyrotomy is indicated.

As a result of Dr. Garvey not performing a cricothyrotomy in timely manner, Mr. Schwartz remained a failed airway in a CICO situation for over an hour before he was pronounced deceased. At 12:25 am, Mr. Schwartz's pulse ox was 76%. Barry Bartlett had failed a second attempt at intubation at 12:23 am. Mr. Schwartz's airway could not be cleared, and he could not be oxygenated. At least over thirty minutes passed with Mr. Schwartz being a failed airway in a CICO situation before Dr. Garvey initiated a cricothyrotomy at 1:06 am. By this time, countless attempts of using BVM had pushed copious amounts of vomit into Mr. Schwartz's trachea and bronchi (passage that air travels to the lungs). Mr. Schwartz's trachea and bronchi were so clogged with vomit; Dr. Garvey's late cricothyrotomy could not oxygenate Mr. Schwartz's lungs.

****

Dr. Garvey's omission to perform a cricothyrotomy on Mr. Schwartz in a timely manner was gross negligence. Dr. Garvey not performing a cricothyrotomy while Mr. Schwartz was suffocating on his own vomit was negligence significantly greater in magnitude than ordinary

negligence. It was extraordinary negligence to a high degree. Dr. Garvey failed to exercise even a slight degree of care by omitting to establish emergency oxygenation to Mr. Schwartz with a cricothyrotomy in a timely manner. Mr. Schwartz was in a CICO situation at approximately 12:23 am with a failed second attempt at intubation in the setting of not being able to oxygenate due to airway obstruction from fulminating emesis. The standard of care required that Dr. Garvey perform a cricothyrotomy on Mr. Schwartz immediately after Barry Bartlett's failed attempt at 12:23 am. After 12:23 am, there were no reasonable attempts that met the standard of care to establish emergency oxygenation to Mr. Schwartz. Dr. Garvey was doing nothing within the standard of care to establish emergency oxygenation to Mr. Schwartz. According to the testimony[24] of Barry Bartlett, Dr. Garvey was on the right side of Mr. Schwartz prepping for chest tube insertion until at least 12:33 am – ten minutes after Barry Bartlett's second failed attempt.

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Dr. Garvey acted with reckless conduct. It is my understanding that reckless conduct is deemed to be that conduct in which the person knew or should have known at the time the person rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Dr. Garvey made the decision for two separate very serious and meticulous procedures (intubation and chest tube insertion) to be performed upon Mr. Schwartz simultaneously. Dr. Garvey should have known at the time that his conduct would likely result in injury that would affect the life or health of Mr. Schwartz. Dr. Garvey's decision was for Barry Bartlett to intubate Mr. Schwartz, who Dr. Garvey identified as having a high risk difficult airway[25], while Dr. Garvey cut a hole in Mr. Schwartz's chest for a chest tube to be placed in Mr. Schwartz's chest cavity (chest tube thoracostomy). Dr. Garvey had never talked to Barry Bartlett about Barry's education, training, or experience[26]. Barry Bartlett was still in his internship with REACH[27]. Each of these procedures performed in the proper sequence one at a

[24] Deposition of Barry Bartlett; Page 78, Line 1 – Page 79, Line 8
[25] Deposition of Dr. Garvey; Page 128, Lines 16-23
[26] Deposition of Dr. Garvey; Page 30, Line 22 – Page 31, Line 1
[27] Deposition of Barry Bartlett; Page 19, Lines 18-20

time have life threatening consequences if something goes wrong. In emergency medicine, first and foremost, a patient's airway comes before most any of the other problems that they could have. It is the ABC's of emergency medicine (A=Airway, B=Breathing, C=Circulation). Airway issues are to be managed before breathing issues; breathing issues are to be managed before circulation issues; and Circulation issues are to be managed before other issues such as disability (neurologic). Once an emergency medicine physician decides to intubate, the airway must be secure and protected before anything else happens including chest tube placement in Mr. Schwartz's situation. Once an ETT is correctly placed, placement is confirmed by direct visualization, end tidal CO2 detection, listening for breath sounds, and performing a chest x-ray. Mr. Schwartz's should not have been intubated. To place the chest tube, rather than sedation and paralysis of a patient with a high risk difficult airway, Dr. Garvey simply needed to numb Mr. Schwartz's chest wall with lidocaine. Instead, Dr. Garvey proceeded with reckless conduct.

****

Dr. Garvey acted in bad faith. Dr. Garvey acted in bad faith by not reasonably explaining the risks of intubation to Mr. and Mrs. Schwartz that could occur by intubating Mr. Schwartz for the flight. Dr. Garvey mainly explained the risks of not intubating. By not reasonably explaining the risks of intubation, Dr. Garvey was unreasonable and unfair. By not reasonably explaining the risks of intubation, Dr. Garvey infringed upon Mr. Schwartz's right to know his risks of the procedure as a patient. Dr. Garvey testified[28] the following:

> Q – Okay. So, what risks did you explain to Mr. and Mrs. Schwartz that could occur by intubating him for the flight?
> A – Probably not much. We all – we always assume that the patient has a full stomach, and there's also always the risk of aspiration with an intubation. But the main thing that was – that was explained to them were the risks of not intubating, and the risks of not intubating were much higher than the risks of intubating.

[28] Deposition of Dr. Garvey; Page 119, Line 4 – Page 120, Line 10

Q – Okay. So, I just want to be clear. You did not explain the risks of intubating the patient; correct?

A – No. I probably –

Mr. BURTON: I'm going to object to the extent it mischaracterizes the testimony and it's argumentative.

Mr. WEAVER: Join.

THE WITNESS: I mainly explained the risks of not intubating, which are higher than the risks of intubating.

Q – Okay. So, you explained the risks of not intubating, but you did not explain that by intubating Mr. Schwartz, he could aspirate.

MR. WEAVER: Object as to form.

Q – Correct?

MR. BURTON: And join. Also, mischaracterizes the testimony.

THE WITNESS: Yes. There is always a risk of aspiration, but that risk is low. There's a much greater risk of aspiration if he remained on a backboard in an airplane trying to transport him for two hours to the trauma center.

Dr. Garvey acted in bad faith by not reasonably explaining the alternative treatments to Mr. and Mrs. Schwartz, regarding intubation. Dr. Garvey did not explain alternative treatments. By not explaining alternative treatments, Dr. Garvey was unreasonable and unfair. By not explaining alternative treatments, Dr. Garvey infringed upon Mr. Schwartz's right to know his alternative treatment options as a patient. Dr. Garvey testified[29] the following:

Q – Okay. And I appreciate your answer, but I want to make sure it's clear. You did not explain the risks or alternative treatments to Mr. and Mrs. Schwartz besides intubating for transfer, correct?

MR. WEAVER: Object – sorry. Object as to form. It's been asked and answered.

MS. MORALES: No, he didn't—

[29] Deposition of Dr. Garvey; Page 121, Line 3 – Line 18

MR. BURTON: Several times.

MS. MORALES: -- directly answer

MR. BURTON: Several times. And I join the objection.

THE WITNESS: I said that I -- there were no alternative treatments. So no, I did not explain alternative treatments because there were no alternative treatments. He had to be intubated.

****

Northeastern Nevada Regional Hospital's conduct was reckless. It is my understanding that reckless conduct is deemed to be that conduct in which a hospital knew or should have known at the time the hospital rendered care or assistance would be likely to result in injury so as to affect the life or health of another person. Northeastern Nevada Regional Hospital's conduct of not completely stocking the trauma cart that was being used in the care of Mr. Schwartz was reckless.

According to the hospital's provision of care event, inadequate equipment availability was a contributing factor[30] to Mr. Schwartz's unexpected death. The brief factual description contains the following:

> Pt was prepared for transfer to University of Utah for a higher level of care. 2 REACH RN's present as well as 2 Elko EMS. EMS student also present. Pt was stable and ready for transfer. Decision was made to intubate and insert chest tube made by U of U and given to Dr. Garvey. All equipment was prepared prior to the start of the procedure. See code sheet for further documentation on code. There were complications with intubation which resulted in patient death. The only staff members present from NNRH were Dr. Garvey, myself, Nancy A, ER tech, Tom E, RT, Cindy F, RN (Travel ICU float), and Sue O, RN, house sup. Trauma cart open, not fully stocked -- Supplies had to be

[30] Other contributing factors reported were (1) staff – use of float staff (2) staffing issue (3) task – training issue

obtained from 2 other rooms and storeroom. Privacy issues with other patients in the ER (Room 11 – verbal witness to trauma).

Northeastern Nevada Regional Hospital should have known that not completely stocking a trauma cart would likely result in injury so as to affect the life or health of another person and is a direct violation of their policy[31].

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Rebuttal to the Opinion of Dr. Barclay

1. Dr. Barclay opined that Mr. Schwartz sustained a bilateral flail chest injury.
    i. Dr. Barclay's opinion is based on an incorrect interpretation of the definition of a flail chest. Mr. Schwartz did not have a flail chest on his autopsy or his CT scan. There were not two or more adjacent ribs fractured in two or more places. The definition of flail chest is discussed in my opinion.
    ii. Dr. Barclays opinion concerning fractures of Mr. Schwartz's left ribs is based on a failure to consider relevant information. Mr. Schwartz did not have fractures of his left ribs on CT scan. The fractures of Mr. Schwartz's left ribs found on autopsy were likely from the CPR performed on Mr. Schwartz.

2. Dr. Barclay opined that Mr. Schwartz could not be stabilized until conservative management by a trauma surgeon ruled out impending respiratory failure, the need for mechanical respiration, and the need for surgical rib fracture fixation.
    i. Mr. Schwartz was stable and remained stabilized until Dr. Garvey's attempt to intubate him.
    ii. The reasons why Mr. Schwartz was stable are discussed in my opinion.

[31] Assuming the trauma cart and crash cart are the same

3. Dr. Barclay opined that Mr. Schwartz had clinical indications for intubation, including risk of aspiration, low oxygenation, and anticipation of a deteriorating course that leads to respiratory failure.
    i. Dr. Barclay's opinion is based on failure to consider relevant information specific to Mr. Schwartz that is discussed in my opinion. Mr. Schwartz was able to protect his own airway and not aspirate if Dr. Garvey would have removed Mr. Schwartz from the hard backboard. Mr. Schwartz's oxygenation readings were stable and within normal limits of what is expected in a trauma patient with rib fractures and a pneumothorax, especially a patient with inadequate pain control. It was unlikely that Mr. Schwartz was going to have a deteriorating course that lead to respiratory failure.
    ii. The reasons why Mr. Schwartz should not have been intubated are discussed in my opinion.

4. Dr. Barclay opined that it was entirely appropriate to have a highly qualified flight paramedic perform rapid sequence intubation while Dr. Garvey performed the thoracotomy.
    i. Dr. Barclay's opinion is based on an outright mistake. Dr. Garvey was to perform a chest tube thoracostomy. Dr. Garvey was not to perform a thoracotomy, which is an incision into the pleural space of the chest to gain access to thoracic organs.
    ii. Assuming Dr. Barclay meant chest tube thoracostomy, Dr. Barclay's opinion is unreasonable and fails to recognize that Dr. Garvey made the decision for these two separate very serious and meticulous procedures to be performed upon Mr. Schwartz simultaneously. Emergency physicians are the most qualified to perform rapid sequence intubation.
    iii. The reasons why this was inappropriate and reckless are discussed in my opinion.

5. Dr. Barclay opined that since Mr. Schwartz needed a thoracostomy and intubation on an emergent basis, the disclosure Dr. Garvey provided to Mr. Schwartz and his wife, advising them of the serious nature of his injuries and the risk of not intubating is what a reasonable emergency physician would disclose under the circumstances.
    i. Dr. Barclay's opinion is based on the incorrect assumption that Mr. Schwartz needed these procedures emergently, thereby exonerating Dr. Garvey of his duty to explain the risks of these procedures to Mr. Schwartz. Mr. Schwartz did not need a chest tube thoracostomy or an intubation on an emergent basis. Mr. Schwartz needed a chest tube as a preventative measure before flight, and Mr. Schwartz did not need intubation. Further reasoning is discussed in my opinion.

6. Dr. Barclay opined that Dr. Garvey's emergency care and treatment of Mr. Schwartz was within the standard of care.
    i. I respectfully disagree for reasons discussed in my opinion.

7. Dr. Barclay opined that nothing that Dr. Garvey did or failed to do caused or contributed to Mr. Schwartz's injuries.
    i. I respectfully disagree for reasons discussed in my opinions.

8. Dr. Barclay opined that multiple attempts to intubate are within the standard of care.
    i. Dr. Barclay's opinion is based on failure to consider relevant information specific to Mr. Schwartz's situation. Specifically, Mr. Schwartz's was in a "can't intubate, can't oxygenate" situation.
    ii. The reasons that the multiple attempts to intubate Mr. Schwartz are not the standard of care are discussed in my opinions.

Based upon a reasonable degree of medical certainty, it is my opinion that Dr. Garvey did not use such care as reasonably prudent healthcare practitioners practicing in the same field would

have provided under similar circumstances. It is my opinion that the negligence of Dr. Garvey was the direct and proximate cause of Mr. Schwartz's death.

My opinions are based upon my knowledge, education, experience, skills, and training developed as an emergency medicine physician. All opinions are expressed to a reasonable degree of medical certainty. I specifically reserve the right to add to, amend, or subtract from this report as new evidence comes into discovery or as new opinions are formulated. I declare under penalty of perjury, under the Law of the State of Nevada, that the foregoing is true and correct.

Respectfully,

Seth P. Womack, MD FAEEM

Date: August 17, 2020

References

1. Henry Ahn, Jeffrey Singh, Avery Nathens, Russell D. MacDonald, Andrew Travers, John Tallon, Michael G. Fehlings, and Albert Yee. Journal of Neurotrauma. Aug 2011. 1341-1361.

2. Walls, Ron M., and Michael F. Murphy. *Manual of Emergency Airway Management*. third ed., Wolters Kluwer/Lippincott Williams & Wilkins, 2008.

3. Marx, J. A., et al. *Rosen's Emergency Medicine: Concepts and Clinical Practice (2 Volumes)*. Elsevier Saunders, 2014.

EXHIBIT 4

REACH | CAL-ORE Life Flight

Inc. Date: 06/23/2016
Run #: IFT
PCR #: 16-14083

REACH Air
Santa Rosa, CA 95403
DISPATCH
800-332-1292 ADMIN

Prehospital Care Report - Critical Care

Medical Record #: 000330967

Patient Information

Name: SCHWARTZ, DOUGLAS
Address: [redacted]
Country:
Age: 58 Years
Gender: Male
Weight: 90.718 KG / 200.00 LB
Phone: [redacted]
Pediatric Color: Not Applicable
D.O.B: [redacted] (mm/dd/yyyy)
SSN [redacted]
Race:
Ethnicity:
Study: Not Applicable

Billing Information

Payment Method:
Work Related? No

Call Type and Location	Call Disposition	Response Times
Call Type: Interfacility Transfer (Unscheduled)	**Disposition:** Treated, Transported	**Run #:** IFT
Vehicle Dispatch Location:	**Resp. Mode:** No Lights or Sirens	**Call Sign:** REACH58
Dispatch Reason: Auto vs. Pedestrian	**Destination:** University of Utah Healthcare, 50 Medical Drive, Salt Lake City, UT 84132	**Vehicle #:** N271SM
Resp. Mode: No Lights and Sirens		**1st Resp. Arr.:**
Service Level: Critical Care Transport	**Dest. Determ.:** Specialty Resource Center	**PSAP:**
Unit Role: Non-Transport	**Diverted From:**	**Disp. Notified:** 23:36
Urgency: Immediate	**Dispatch Delay:**	**Unit Disp.:** 23:41
Response: Interfacility Transfer (Unscheduled)	**Turn Around Delays:**	**Standby Date/Time:**
Location: Health Care Facility (clinic, hospital, nursing home)		**Enroute:** 23:45
Facility: Northeastern Nevada Regional Hospital		**At Scene:** 23:55
Address: 2001 Errecart Boulevard Elko, Elko, NV 89801		**At Patient:** 23:57
		Depart: 01:39
		Arrive Dest: 01:40
		In Service: 01:41

Unit Personnel

Crew Member	Level of Certification	Role
Lyons, Ronnie (RL)		
Bartlett, Barry (BB)	EMT-Paramedic	

EMS Scene Information

Number of Patients: Single
Mass Casualty Incident: No
Level of Service Provided: Critical Care Transport
Referring EMS Agency:
Other EMS or Public Safety Agencies on Scene:

History of Present Illness

AUTO vs PEDESTRIAN ACCIDENT: At app. 2200 hours this date Mr. Schwartz and his family were enjoying an evening out and had finished dinner at a local restaurant. As they departed he was struck by an automobile and the driver fled the scene of the accident. Mr. Schwartz arrived at NNRH where he was evaluated by Dr. Garvey and REACH 58 was summoned at 2345 for transfer to the University of Utah hospital for trauma services.

REACH team arrives at 2357 to find Dr. Garvey speaking with the receiving physician by phone. Dr. Garvey reports Mr. Schwartz has an approximate 10% pneumothorax on the right side of his chest with a flail segment but is tolerating it well at this time. The receiving physician has recommended Mr. Schwartz be intubated with chest tube placement pre-flight. We arrive bedside to find Mr. Schwartz talking with his family as Dr. Garvey assembles his team and equipment. The procedure is explained to the pt. and family and the family is escorted from the room. Dr. Garvey has invited the REACH team to assist along with his staff in this process. The team includes a respiratory therapist, app. six ER nurses, one paramedic as well as both REACH attendants.

A procedural time out is completed, Dr. Garvey is sterile and ready for chest tube placement and Paramedic Bartlett is at the head of the bed for the initial attempt. The BVM, C-Mac, intubation gear and suction are at the ready and 180 mg's Ketamine and 90 mg's Rocuronium are both drawn up from REACH stock and verified by another nurse at the foot of the bed. The transport monitor is placed and 90% oxygen saturation will be the cut-off reading to stop and reoxygenate. Mr. Schwartz is pre-oxygenated to 99% and with staff in place around the bed the sedative and paralytic are pushed at 0018 hours with a 60 second pause for effect. Once the drugs take effect Paramedic Bartlett opens the airway at 0020 and places the C-Mac device resulting in copious amounts of emesis and large food chunks fulminating from the mouth and nose.

Intubation is immediately stopped and the airway suctioned, which promptly plugs the suction tubing and yankauer tip. Over the course of the next 13 minutes Mr. Schwartz vomits several more times and numerous attempts are made at clearing / maintaining the airway and reoxygenating him with the BVM on high flow oxygen. ET tube placement is attempted again at 0023 and 0033, both unsuccessfully. In addition to the factors that are making this procedure very difficult (airway contamination, difficulty in keeping the suction devices flowing, difficulty in getting a good facial seal and very stiff bagging effort) his airway is reportedly very inferior / anterior making it a challenge to visualize. Cric pressure and POCPOM are provided several times with little to no benefit. Paramedic Bartlett attempts several tooled and digital intubations, all of which are unsuccessful.

Dr. Garvey steps in to attempt intubation three separate times and he too is unsuccessful due to the factors at hand. Mr. Schwarts loses pulses at 0035 and CPR is initiated for app. one minute and pulse is restored. The airway is again suctioned and a king airway placed from ER stock. BVM bagging remains very difficult and shortly afterward the king is removed after becoming plugged by emesis and food particles. A third suction unit is placed in play and vital signs at this time are 225/136, 119 and 47% on high flow oxygen. Intubation attempts continue with various size ET tubes, styletts and bougie introducers and airway adjuncts at 0040, 0044 and 0047 hours. The emesis is almost continuous and proving very difficult to keep cleared. At 0050 hours his oxygen saturation is ~50%. 0052 unsuccessful attempt, airway suctioned and oxygen sat is 55%. 0053 unsuccessful attempt and the airway suctioned, several operator changes. 0054 vital signs 221/148, 122, 42% with bagging and suctioning at every opportunity. A cricothyrotomy is discussed and the kit prepared.

Mr. Schwartz is becoming abdominally distended and a 16 french NG tube is attempted, once in each nare, and will not pass resulting in epistaxis. Facial seal remains a challenge due to the emesis and wet face. An oral OG placement attempt is also unsuccessful and abandoned. Staff in the room are watching his vital signs on the monitor and keeping the crew up to date on changes. At 0058 hours his oxygen saturation is 68% and the third operator is again in place as efforts to reoxygenate are minimally effective and bagging effort is very high. Cric airway is being prepared, however, the bagging pressure results in his trachea moving with each bag effort and will necessitate the need to stop bagging in order to make the attempt. 0102 vital signs are heart rate of 122 and oxygen saturation of 75%. After another unsuccessful intubation attempt the cric is initiated by Dr. Garvey and Paramedic Bartlett at 0106. The guidewire and dilators are placed however the ET tube is very difficult to advance into the trachea. As advancement is attempted it begins filling up with emesis, is pulled and replaced two additional times with the same results. Pulses are lost at 0117 and CPR resumes. Emesis continues and additional suction units and methods of airway clearance are discussed.

0120 the monitor is displaying asystole, CPR is ongoing with ER staff and at 0122 a pulse of 52 is noted on the monitor. CPR continues, gastric distension is increasing and cannot be evacuated. 0125 CPR ongoing by ER staff and at 0128 we note a oxygen saturation reading of 64% on the monitor. 0129 pleural decompression needles are placed in both the right and left upper chest cavities with no results and no air escape. 0133 hours CPR is stopped and Mr. Schwartz is pronounced deceased. The AOC on call for REACH, Mr. Jeff Cress, is updated on our outcome and the crew is released from the ER after assisting the ER crew in clean up duties.

Medication Administered

Time	Crew	Medication	Route	Site	Dose/Rate	Con.	Response	Progress Notes	PTA
00:18	RL	Ketamine	Intravenous		*180MG*			180 mg's Ketamine SIVP for sedation. Dose verified by ER nurse.	*No*

Crew Signature

Crew Member

I acknowledge that I have provided the above assessments/treatments for this patient.

I Agree I Disagree Not Applicable

Ambulance Crew Member Statement

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives were available or willing to sign on the patient's behalf.

I Agree I Disagree Not Applicable

Signature

Printed Name Ronnie Lyons Date

Reason Pt. Unable to Sign

Crew Signature

Crew Member

I acknowledge that I have provided the above assessments/treatments for this patient.

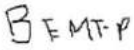
I Agree I Disagree Not Applicable

Ambulance Crew Member Statement

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives were available or willing to sign on the patient's behalf.

I Agree I Disagree Not Applicable

Signature



Printed Name Barry Bartlett Date

Reason Pt. Unable to Sign

EXHIBIT 5

Original Summary

Provision of Care Event (93061) - 06-24-2016

SIM
Safety Incident Management

Provision of Care

This form is often used as the catch-all for events that have no other place. This form can be thought of as the miscellaneous form.

GENERAL INFORMATION ABOUT THE PROVISION OF CARE EVENT

General Event Type	Provision of Care
Specific Event Type	Patient Death (Unexpected)
Type of Person Affected	In-Patient
Severity Level (Reported)	E. Death
Injury Incurred?	Yes
Equipment Involved/Malfunctioned?	No
Brief Factual Description	Pt was prepared for transfer to University of Utah for a higher level of care. 2 REACH RN's present as well as 2 Elko EMS. EMS student also present. Pt was stable and ready for transfer. Decision was made to intubate and insert chest tube made by U of U and given to Dr. Garvey. . All equipment was prepared prior to start of procedure. See code sheet for further documentation on code. There were complications with intubation which resulted in patient death. The only staff members present from NNRH were Dr. Garvey, myself, Nancy A, ER tech, Tom E, RT, Cindy F, RN (Travel ICU float), and Sue O, RN, house sup. Trauma cart open, not fully stocked - Supplies had to be obtained from 2 other rooms and store room. Privacy issues with other patients in the ER (Room 11-verbal witness to trauma).
Contributing Factors (Reported)	• Staff - Use of Float Staff • Staffing Issue • Task - Training Issue • Work Envmnt - Inadequate Equipment Availability
Immediate Actions (Reported)	

When and Where Event Occurred

WHEN AND WHERE THE EVENT OCCURRED

Event Date	06-23-2016
Time (00:00) use military	01:33
Site	Northeastern Nevada Regional Hospital
Department	Emergency
Unit	Main Department
Specific Location	Patient Room
Patient room number/location	Bed 12

Person Affected Details

DETAILS OF THE PERSON AFFECTED BY THE EVENT

Person Affected MRN	330967
Encounter/Account #	6139781
Person Affected First Name	DOUGLAS
Person Affected Middle Name	
Person Affected Last Name	SCHWARTZ
Suffix	
Person Affected Date of Birth	06-02-1958
Person Affected Admission Date	06-22-2016
Discharge Date	
Person Affected Gender	Male
Person Affected Race	White
Person Affected Preferred Language	
Person Affected Street 1	
Person Affected Street 2	
Person Affected City	
Person Affected State	
Country	United States
Person Affected ZIP	
Person Affected Phone #	
Person Affected Alternate #	
Attending Physician	
Attending Physician Service	

Injury Details

PLEASE PROVIDE INFORMATION ABOUT THE INJURY

Nature of Injury	• Other
Location of Injury on Body	Traumatic, unsuccessful intubation resulting in patient death.
Treatment Provided	Yes

Parties Involved / Notified / Witnesses

CLICK ADD TO ENTER PARTIES INVOLVED / NOTIFIED / WITNESSES IN THE EVENT

Party Involved / Notified / Witnesses

ITEM 1

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Physician
Physician Service	
Party Involved Name	Dr Garvey
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 2

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Registered Nurse
Party Involved Name	Sue Olson, RN
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 3

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Registered Nurse
Party Involved Name	Donna Kevitt
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 4

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Registered Nurse
Party Involved Name	Cindy Fus
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 5

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Other (please specify)
Other Classification of Party	ER Tech
Party Involved Name	Nancy Abrahams
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

ITEM 6

PERSON INVOLVED / NOTIFIED / WITNESSES

Role in Event	Involved Party
Classification of Party	Respiratory Therapist
Party Involved Name	Tom Evers
Dept	
Party Involved Employee ID	
Phone #	
Date	
Time	
Party Involved Notes	

Privacy Statement

PRIVACY STATEMENT

This is a confidential and privileged quality assurance and patient safety work product document. It is protected from disclosure by the provisions of the Patient Safety and Quality Improvement Act (42 CFR Part 3) and other state and federal laws. Unauthorized disclosure or duplication is prohibited.

End of Form

EXHIBIT 6

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 7

Current Status: *Active* **PolicyStat ID:** *2203308*

Effective:	*06/2002*
Approved:	*02/2016*
Last Revised:	*02/2016*
Next Review:	*02/2017*
Owner:	*Becky Sharp: Regulatory Coordinator*
Policy Area:	*Leadership*
References:	*439.800, 439.855, 439.860, 439.865, 439.870, 439.875, 439.877, 439.890, CMS CFR §482.21(e)(1), LD.03.01.01, NRS 439.835, TJC LD.04.04.05*
Applicability:	*Northeastern Nevada Regional Hospital*

Patient Safety Plan

SCOPE:

House Wide

PURPOSE:

To build a system for providing safe patient care and for preventing adverse patient outcomes.

DEFINITIONS:

Adverse Event: Harm to a patient as a result of medical care or harm that occurs in a healthcare setting. Although an adverse event often indicates that the care resulted in an undesirable clinical outcome and may involve medical errors, adverse events do not always involve errors, negligence, or poor quality of care and may not always be preventable.

Error: An unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

Facility-acquired Infection: A localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

1. Surgical site infections;
2. Ventilator-associated pneumonia;
3. Central line-related bloodstream infections;
4. Urinary tract infections; and
5. Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

Hazardous Condition: Any set of circumstances (exclusive of the disease or condition for which the patient is being treated), which significantly increases the likelihood of a serious adverse outcome.

Failure Mode and Effects Analysis (FMEA): A systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change.

Medical Error: Any event (unanticipated outcome) within the control of a provider that results in harm and requires a new or modified practitioner order for management of the patient's medical care.

"Near Miss": Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. Near misses fall within the scope of the definition of a sentinel event, but outside the scope of those sentinel events that are subject to review by The Joint Commission under its Sentinel Event Policy.

"Never Events": Episodes of care that should never happen in any facility, at any time. Examples include patient abduction, wrong site procedure, and procedure on wrong patient.

Root Cause Analysis: A credible process for identifying the basic or causal factors that underlie variation in performance, including the risk of possible occurrence of a sentinel event.

Hospital Acquired Conditions: Conditions that result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis and could reasonably have been prevented through the application of evidence based guidelines. These include, but are not limited to:

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage 2 or 3 pressure ulcers not present on admission
5. Falls and trauma
6. Catheter-associated urinary tract infections
7. Central line-associated blood stream infection
8. Hospital acquired infections
9. Surgical site infections

Patient Safety Officer (PSO): The person who is designated as such by a medical facility pursuant to NRS 439.870. Northeastern Nevada Regional Hospital (NNRH) shall designate an officer or employee of the facility to serve as the PSO. The PSO will:

- Supervise reporting of sentinel events
- Serve on the patient safety committee
- Take such actions as he/she determines necessary to insure safety of patient as a result of sentinel event activity
- Report any action taken to Patient Safety Committee
- Work under the direction of the Director of Quality, Risk & Safety

POLICY:

The Safety Plan at NNRH is implemented to provide a collaboratively planned, systematic, organization-wide approach to process design and performance measurement, assessment and improvement of patient safety. With a goal of delivering the safest and highest quality health care to the residents of the community, the plan

is designed and organized to support the mission, vision and values of the hospital and LifePoint Healthcare Inc.

In formulating the plan, it is recognized that the implementation of an effective patient safety plan is dependent on a participative management approach, including all organization leaders, the Governing Board, senior management, the Patient Safety Committee, departmental management, and medical staff. We believe our plan provides our organization with the mechanisms to achieve patient safety that is expected by our customers and the community we serve.

Senior management is fully committed to the belief that improving patient safety is the most important challenge that we face in the healthcare industry and in our hospital. The purpose of the plan is to develop mechanisms to integrate and coordinate the activities of all of our healthcare staff so that patient safety is the foremost concern at every stage of every process that we conduct. Patient safety is to be the number one priority in the design of new processes, in the evaluation of existing processes and in the re-design of existing processes. The hospital-wide goal is to be proactive in preventing errors and complications.

To accomplish this goal, we are committed to comparing ourselves to national databases, searching for "best practices", studying designs of systems, and always searching for methods of strengthening our existing system designs by adding risk reduction strategies. Senior leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes based on such evaluations. All individuals who work in the hospital are able to participate in safety and quality initiatives, either on an individual basis or a team approach. Staff, including the medical staff, is encouraged to discuss any areas of concern that impact patient safety and quality. Relevant literature concerning patient and staff safety is distributed throughout the hospital in the form of flyers, posters, newsletters and through staff meetings. Patients and their family members are encouraged to speak with the hospital staff concerning any safety and quality issues.

PROCEDURE:

INFECTION CONTROL

The patient safety plan is inclusive of the infection prevention and control plan which is based on a yearly risk assessment carried out by the infection control nurse under the direction of the Infection Control, Quality Council and Patient Safety committees. This plan will be developed by a nationally recognized infection control organization as approved by the State Board of Health which may include without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., The Centers for Disease Control and Prevention (CDC) of the United States Department of Health and Human Services, The World Health Organization, etc.

This facility-specific infection control plan must be developed and reviewed under the supervision of a certified infection preventionist, pursuant to NRS 439.865.

The infection control nurse will be responsible for the implementation of this plan under the approval of the Infection Control, Quality Council and Patient Safety committees. The infection control nurse will be a member of these committees and report on his/her activities at least quarterly.

In the absence of the infection control nurse, the house supervisor or director on call will be responsible for the control of infections at all times.

REPORTING OF PATIENT SAFETY EVENTS

All employees have an affirmative duty to report any occurrence which is not consistent with the routine operation of the hospital and its staff, or the routine care of a particular patient or visitor, or any situation which

has potential to cause harm to patients, visitors, or employees. This duty also applies to 'near miss' situations. *Willful failure to report such occurrences may subject the employee to corrective action up to and including termination.*

Patient related occurrences and other abnormal situations will be reported and tracked using an online electronic reporting database developed by **RL Solutions** according to the NNRH Occurrence Report Policy.

NNRH will follow all statutory, regulatory and licensing agency reporting guidelines and NNRH policies.

A. NRS 439.855 mandates that

   a. Within 24 hours after becoming aware of a sentinel event, an employee of NNRH will notify the PSO of the event.

   b. Within 13 days after receiving notification, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division using their occurrence reporting form.

   c. If the PSO personally discovers or becomes aware of a sentinel event in the absence of notification by another employee, the PSO shall report the date, time, and a brief description of the sentinel event to the Health Division within 14 days after becoming aware of the sentinel event using their occurrence form.

Once opportunities for improvement are identified, strategies for change can be developed using evidence based practice. Measures are used to determine the effectiveness of the improvement and ongoing feedback is provided to staff, the Patient Safety Committee and Quality Council.

DISCLOSURE OF EVENT TO PATIENT AND/OR FAMILY

When a sentinel event, hospital acquired condition, or an outcome that differs significantly from the anticipated outcome occurs, the patient, and when appropriate, the patient's family or the patient's designee shall be informed as soon as reasonably possible but within 7 days (NRS 439.855). The disclosure of facts of an event should occur after determination of the surrounding facts and after consultation with the Chief Executive Officer (CEO) or designee or Risk Management.

In most instances, disclosure should be handled by the attending physician who has responsibility for the overall care of the patient. The physician or his/her designee should communicate:

- Acknowledgement of the event
- Data known to date
- That a full analysis will take place
- What is currently taking place as a result of the event
- Additional data on an ongoing basis
- Measures taken to prevent recurrence
- Apologize that an event occurred

PATIENT SAFETY COMMITTEE

The Patient Safety Committee is the interdisciplinary committee designated to manage the organization-wide patient safety program and shall be organized with strict adherence to NRS 439.875.

The Governing Board is responsible for the oversight of the Patient Safety Plan. The Patient Safety Committee functions under the guidance and with the oversight of the CEO and Quality Council, with the PSO, or designee, serving as Chairperson. The meetings, records, data gathered, and reports generated by the Patient

Safety Committee are protected by the peer review privilege set forth by the Health Care Quality Improvement Act of 1986 (Title IV of Public Law 99-660, as amended, and other applicable Nevada Statutes).

The committee shall be composed of the following members and others as the committee may from time to time add to accomplish specific goals and objectives within the authorized scope of activities outlined herein:

A. PSO, Chairman
B. Chief Nursing Officer and/or Member representing the Governing Board
C. Director, Quality, Risk & Safety
D. Medical Staff member
E. Nursing Staff member
F. Member representing Pharmacy services
G. Infection Prevention and Control Practitioner
H. Facility Safety office or designated representative

At each monthly meeting, a representative from each of the medical, nursing and pharmaceutical staff, executive team or Governing Board, and the PSO or designee, must be in attendance.

Members of the Patient Safety Committee can be called ad-hoc to assist the PSO in analyzing possible sentinel events or adverse outcomes or assist with any other urgent patient safety matter.

The committee shall operate within the following scope of activities (NRS 439.870):

- Receive reports from the PSO
- Evaluate actions of the PSO in connection with all reports of sentinel events alleged to have occurred in the hospital
- Review and evaluate the quality of measures carried out by the hospital to improve the safety of patients who receive treatment at the hospital
- Make recommendations to the Governing Board to reduce the number and severity of sentinel events that occur at the hospital
- Adopt patient safety checklists and patient safety policies according to NRS 439.877 for use by:
  - All providers of health care who provide treatment to patients at the medical facility
  - Other personnel of the medical facility who provide treatment or assistance to patients
  - Employees of the medical facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility
  - Persons with who the medical facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients at the facility
  - Patient safety checklists must follow best practice protocols to improve the health outcome of patients at NNRH according to NRS 439.877 and must include without limitation:
    - Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care
    - Checklist to ensure employees and contractors follow protocols to ensure that the room and environment of the patient is sanitary

- Checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received discharge instructions regarding medication management
- Instructions concerning aftercare and any other instructions concerning patient's care after discharge
- Checklists adopted by NNRH include:
  - Central Line Insertion (with prompt for practitioner order)
  - Universal Protocol and Surgical Site Fire Risk Assessment/Time Out
  - Safe Surgery Checklist
  - Discharge Instructions (prescription medication instructions, aftercare instructions, any other instructions related to discharge such as follow-up appointments)
  - Daily Room Cleaning (room and environment sanitation)
  - CDC Environmental Checklist for Monitoring Terminal Cleaning
  - Pre-Oxytocin Checklist (with prompt for practitioner order)

- In addition, the Patient Safety Committee will adopt and monitor compliance with our policy for the use of two patient identifiers, hand hygiene and any other patient safety checklist and policy adopted pursuant to this section. This may include active surveillance, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
- The Patient Safety Committee shall monitor and document the effectiveness of the patient identification policy and at least annually, review the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklist and patient safety policies that may be appropriate for adoption at NNRH.
- On or before July 1st of each year, the committee submits a report to the Director of the Legislative Council Bureau for transmittal to the Legislative Committee on Health Care. The report is to include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph above outlining checklist review (NRS 439.800).
- At least once each calendar quarter, report to the Governing Board regarding:
  - The number of sentinel events that occurred at the hospital during the preceding calendar quarter; and
  - Any recommendations to reduce the number and severity of sentinel events that occur at the hospital.

REFERENCES:

TJC Standard LD.04.04.05 (2013): Patient Safety Program Components and Governing Body Report

TJC Standard LD.03.01.01 (2013): Patient Safety Culture Regular Evaluation (survey)

CMS CFR §482.21(e)(1): Patient Safety as a component of Performance Improvement Program

Nevada Revised Statutes §439.800 and any implementing Health Division and/or State Board of Health rules and regulations: Patient Safety Plan, Program, Officer and Committee; event reporting, investigation and action plan implementation; and an annual summary of events.

Nevada Revised Statutes §439.860 and any implementing agency rules and regulations pertaining to inadmissibility of report, document or other information compiled or disseminated pursuant to the provisions of §439.800 through §439.890, inclusive, in administrative or legal proceedings.

Attachments:

No Attachments

---**The Patient Safety Plan approval page(page 7) has been removed based on NRS439.845.**

EXHIBIT 8

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?

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,

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?

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

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.

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

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.

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?

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?

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?

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 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?

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

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.

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

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:

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.

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.

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?

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?

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

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.

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?

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?

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

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?

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.

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.

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?

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.

(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.

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

-- 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:

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.

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?

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, 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?

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.

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?

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

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

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

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

-- 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?

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?

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.

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.

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

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?

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?

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

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

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.

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?

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

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 --

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,

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:

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?

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.

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?

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.

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?

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

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.

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?

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.

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?

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?

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?

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

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

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.

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

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.

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.

(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?

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.

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

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

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?

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

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

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?

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

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.

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

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.

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.

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?

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.

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?

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.

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

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

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?

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.

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?

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

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?

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.

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.

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.

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.

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.

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.

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.

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

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.

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

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.

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?

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.)

---o0o---

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

HEALTH INFORMATION PRIVACY & SECURITY: CAUTIONARY NOTICE

Litigation Services is committed to compliance with applicable federal and state laws and regulations ("Privacy Laws") governing the protection and security of patient health information. Notice is hereby given to all parties that transcripts of depositions and legal proceedings, and transcript exhibits, may contain patient health information that is protected from unauthorized access, use and disclosure by Privacy Laws. Litigation Services requires that access, maintenance, use, and disclosure (including but not limited to electronic database maintenance and access, storage, distribution/ dissemination and communication) of transcripts/exhibits containing patient information be performed in compliance with Privacy Laws. No transcript or exhibit containing protected patient health information may be further disclosed except as permitted by Privacy Laws. Litigation Services expects that all parties, parties' attorneys, and their HIPAA Business Associates and Subcontractors will make every reasonable effort to protect and secure patient health information, and to comply with applicable Privacy Law mandates, including but not limited to restrictions on access, storage, use, and disclosure (sharing) of transcripts and transcript exhibits, and applying "minimum necessary" standards where appropriate. It is recommended that your office review its policies regarding sharing of transcripts and exhibits - including access, storage, use, and disclosure - for compliance with Privacy Laws.

EXHIBIT 9

CASE NO. CV-C-17-439

DEPT. NO. 1

FILED

2018 OCT 16 P 2:22

ELKO CO. [illegible]
CLERK [illegible]

IN THE FOURTH JUDICIAL DISTRICT COURT

OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

DIANE SCHWARTZ, individually and as administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased;

Plaintiff,

V.

DAVID GARVEY, M.D., an individual; TEAM HEALTH HOLDINGS, INC., dba RUBY CREST EMERGENCY MEDICINE, PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH MEDICAL SERVICES, L.L.C., DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

ORDER DENYING PLAINTIFF'S MOTION TO DISMISS

This matter came before the Court on Plaintiff's Motion to Amend Complaint filed September 4, 2018. The proposed Third Amended Complaint is attached to the motion. On September 20, 2018, Defendant Garvey filed Defendant David Garvey M.D.'s Opposition to Plaintiff's Motion for Leave to Amend Complaint. On September 24, 2018, Defendant PHC filed Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Opposition to Plaintiff's Motion for Leave to Amend Complaint and Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Joinder to Defendant David Garvey, M.D.'s

Plaintiff seeks leave of the Court to file her Third Amended Complaint. All Defendants have opposed the amendment for several reasons. In Adamson v. Bowker, 85 Nev. 115, 121, 450 P.2d 796, ___ (1969), the Nevada Supreme Court quoted with approval Foman v. Davis, 371 U.S. 178, 182, 83 S. Ct. 227, 230, 9 L. Ed. 2d, 222, 226 (1962), wherein it was stated:

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason—such as undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendment previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment, etc.—the leave sought should, as the rules require, be "freely given."

In the case at hand, the Complaint was filed June 22, 2017. The original Complaint included a claim for punitive damages in the Fifth Claim for Relief (Loss of Consortium). On July 20, 2017, Defendant PHC filed its Motion for Partial Dismissal of Plaintiff's Complaint. PHC sought dismissal of the first claim for relief and the punitive damages portion of the Fifth Claim for Relief. On August 3, 2017, Defendant Garvey filed a Motion to Dismiss Plaintiff's prayer for punitive damages. On August 28, 2017, Defendant REACH Air filed its Answer to Complaint as well as its Joinder in David Garvey, M.D.'s Motion to Dismiss Plaintiff's Request for Punitive Damages. On September 1, 2017, Defendant Garvey filed his Request for Submission of his Motion to Dismiss.

According to Defendant REACH Air, in its opposition to the motion to amend, on October 17, 2017, Plaintiff amended her complaint, omitting any claim for punitive damages. The court docket does not show an Amended Complaint filed on October 17, 2017. An Amended Complaint is loose in the court file with a notation, written in red ink, "REC'D 10/20/17." It does not have a certificate of service attached. The Amended Complaint was actually filed on February 5, 2018, but it, also, does not include a certificate of service, so the Court cannot tell when, or if, it was served on the parties. The Amended Complaint does not contain any claim for punitive damages and does not request punitive damages in the prayer.

Moreover, at page 13 of the Amended Complaint, under the Fifth Claim for Relief, the heading states, "Plaintiff Eli Colburn's Claim Against All Defendants." Eli Colburn is not a party to this action.

In any event, on October 12, 2017, Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Answer to Amended Complaint was filed. On November 13, 2017, REACH Air filed its Answer to Amended Complaint. On February 2, 2018, a Stipulation and Order to Amend the Amended Complaint was filed. On February 12, 2018, Plaintiff filed her Second Amended Complaint. It does not include a claim or prayer for punitive damages or a certificate of service. However, on April 23, 2018, Defendant David Garvey M.D.'s Answer to Plaintiff's Second Amended Complaint was filed. On May 25, 2018, an Order Setting Hearing on Pending Motions was filed. A hearing was scheduled for one-half day on September 6, 2018, on Defendant PHC's motion for partial dismissal; Defendant Garvey's motion to dismiss the request for punitive damages; and Defendant REACH Air's motion to dismiss the request for punitive damages. On June 21, 2018, Defendant, Crum, Stefanko, & Jones Ltd dba Ruby Crest Emergency Medicine's Answer to Plaintiff's Second Amended Complaint was filed.

On June 28, 2018, the Joint Case Conference Report was filed. All parties participated except Defendants Crum, et.al. The report was signed by the attorneys for the participating parties. The only mention of punitive damages is included in a recitation of Defendant REACH Air's Affirmative Defenses Twenty-Ninth through Thirty-Sixth.

The hearing on the various motions to dismiss went forward on September 6, 2018, with counsel appearing for all parties except Defendants Crum, et.al. At that hearing, counsel informed the Court that they would not be arguing the motions to dismiss the punitive damages request because punitive damages had been omitted from the Amended Complaint and Second Amended Complaint. Additionally, Plaintiff had filed her Motion to Amend Complaint two days before the hearing. Plaintiff's counsel told the Court that punitive damages had been unintentionally omitted by her office from the Amended Complaint and Second Amended

Opposition to Plaintiff's Motion for Leave to Amend Complaint. On that same date, Defendant REACH Air filed REACH Air Medical Services, LLC's Memorandum in Opposition to Plaintiff's Motion for Leave to Amend Complaint. On September 28, 2018, Defendants Crum, Stefanko, & Jones Ltd filed Defendant, Crum, Stefanko, & Jones Ltd, d/b/a Ruby Crest Emergency Medicine's Joinder to Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Opposition to Plaintiff's Motion for Leave to Amend Complaint. On October 1, 2018, Defendant Garvey filed Defendant David Garvey, M.D.'s Joinder to Defendant REACH Air Medical Services, LLC's Memorandum in Opposition to Plaintiff's Motion for Leave to Amend Complaint. On October 2, 2018, Plaintiff filed Plaintiff's Reply to David Garvey, M.D.'s Opposition to Plaintiff's Motion for Leave to Amend Complaint; Plaintiff's Reply to Defendant PHC-ELKO Inc.. dba Northeastern Nevada Regional Hospital's Opposition to Plaintiff's Motion for Leave to Amend Complaint; and, Plaintiff's Reply to REACH Air Medical Services, LLC's Opposition to Plaintiff's Motion for Leave to Amend Complaint.

On October 4, 2018, Plaintiff filed a Request for Review. On October 5, 2018, Defendant PHC filed a Request for Submission of Defendant PHC-ELKO, Inc. dba Northeastern Nevada Regional Hospital's Joinder to Defendant David Garvey, M.D.'s Opposition to Plaintiff's Motion for Leave to Amend Complaint.

A hearing on this matter was held on June 5, 2019. None of the parties was present. Plaintiff was represented by Jennifer Morales, Esq. Defendant Garvey was represented by Alissa Bestick, Esq. Defendant PHC was represented by Zachary Thompson, Esq. Defendant REACH Air was represented by Austin Westergard, Esq. Defendants Crum, et.al. were represented by Gerald Tan, Esq. The Court, having considered the documents filed by the parties and the oral arguments, finds and orders as follows.

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Complaint.

On September 10, 2018, Plaintiff filed her Errata to Plaintiff's Complaint, Amended Complaint and Second Amended Complaint. Exhibit 1 to the Errata is the *curriculum vitae* of Kenneth Scissors, M.D., the doctor who had authored the affidavit attached to the three complaints. At the September 6 hearing, the Court had informed Plaintiff's counsel that, although Dr. Scissors had referenced the *curriculum vitae* as an exhibit to his affidavit, it was not in fact attached. The Court, therefore, was unable to discern, on the basis of the affidavit, whether Dr. Scissors practiced in a field "substantially similar" to that involved in this case.

Concerning the motion presently before the Court, Plaintiff's proposed Third Amended Complaint contains the punitive damages request in the Fifth Claim for Relief that was in the original Complaint but omitted from the next two complaints. It also contains, for the first time, punitive damages allegations in the first four claims for relief.

In Defendant Garvey's opposition to the motion to amend, his counsel asserts that he sent an email to Plaintiff's counsel on April 10, 2018, five months before Plaintiff filed her Motion to Amend Complaint, stating that Defendant Garvey would be filing an answer to Plaintiff's Amended Complaint, given that the Amended Complaint no longer sought punitive damages. An email is attached to the opposition supporting this allegation. Plaintiff's counsel did not dispute this. In its opposition, PHC-ELKO states that Plaintiff delayed seeking leave to amend for seven months. At the September 6 hearing, Plaintiff's counsel had no explanation for the delay. She blamed her paralegal for removing the punitive damages language. The delay is too great, whether it was five months or seven months. Additionally, Plaintiff filed two amended complaints, both times omitting any allegations or prayer for punitive damages. In the meantime, several defendants filed answers, triggering the early case conference which occurred on May 9, 2018, and was attended by counsel for all parties except Defendants Crum et.al. The Joint Case Conference Report was filed on June 28, 2018, signed by counsel for all parties except Defendants Crum, et.al. Discovery then began. At the September 6, 2018, hearing, the three

appearing defendants did not argue their motions to dismiss because Plaintiff had filed her Motion to Amend Complaint two days before the hearing.

Although several defendants have alleged that they have been prejudiced by the delay, it is not necessary that this Court find any prejudice. The existence of prejudice is but one example cited by the Foman and Adamson courts of reasons for which a trial court may deny a motion to amend. Two of the other examples in those cases are "undue delay," and "repeated failure to cure deficiencies by amendment previously allowed . . . ." Id. Plaintiff delayed seeking leave to amend, after which she was or should have been aware of the problem, for at least five months, and for possibly as many as seven months. Plaintiff amended two times after her original complaint, both times excluding the issue of punitive damages. The amendment now sought by Plaintiff not only includes punitive damages as sought in the original complaint, it now adds the issue of punitive damages, where none existed before, to four claims for relief. Finally, the proposed Third Amended Complaint does not even contain a prayer for punitive damages. This is simply too much. The allegations made by Plaintiff are of the utmost seriousness. She alleges that the actions of these defendants led to the death of her husband. Surely, Plaintiff's counsel could have paid more attention to this case than she apparently has.

Plaintiff asks that any denial of her Motion to Amend be without prejudice so that she can seek to amend at a later date. A denial without prejudice will not cure the problems caused by Plaintiff's undue delay and previous failures to correct the deficiencies.

Therefore, IT IS HEREBY ORDERED that Plaintiff's Motion to Amend Complaint is **DENIED** with prejudice.

SO ORDERED this 15 day of October, 2019.

NANCY PORTER
DISTRICT JUDGE - DEPARTMENT 1

CERTIFICATE OF MAILING

Pursuant to NRCP 5(b), I hereby certify that I am an employee of the Fourth Judicial District Court, Department 1, and that on this 16th day of October, 2019, I deposited for mailing in the U.S. mail at Elko, Nevada, postage prepaid, a true file-stamped copy of the foregoing **ORDER DENYING PLAINTIFF'S MOTION TO AMEND COMPLAINT** addressed to:

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Jennifer Morales, Esq.
CLAGGETT & SYKES LAW FIRM
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Chelsea R. Hueth, Esq.
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EXHIBIT 10

Case No.: CV-17-439
Dept. No: 1

FILED
2017 JUN 22 PM 1:02
ELKO CO DISTRICT COURT
CLERK ____ DEPUTY LP

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; TEAM HEALTH HOLDINGS, INC., dba RUBY CREST EMERGENCY MEDICINE, PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C., DOE BARRY, R.N., DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

COMPLAINT
(Medical Malpractice)
and Wrongful Death)

COMES NOW, Plaintiff, DIANE SCHWARTZ, individual and as the administrator of the Estate of DOUGLAS SCHWARTZ, by and through her attorneys of record, CLAGGETT & SYKES LAW FIRM, for their causes of action against Defendants, DAVID GARVEY, M.D., individually, TEAM HEALTH HOLDINGS, INC., dba RUBY CREST EMERGENCY MEDICINE, PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, REACH AIR

MEDICAL SERVICES, L.L.C. DOES 1 through X; ROE BUSINESS ENTITIES X1 through XX; and each of them and alleges as follows:

1. At all times relevant herein, Plaintiff, DIANE SCHWARTZ, individually and as the Special Administrator on behalf of the Estate of DOUGLAS R. SCHWARTZ (hereinafter the "Plaintiff" or "Diane"), was and is a resident of Elko County, Nevada.

2. At all times relevant herein, Plaintiff DOUGLAS SCHWARTZ (hereinafter the "Plaintiff" or "Mr. Schwartz"), was a resident of Elko County, Nevada.

3. Upon information and belief, at all times relevant herein, Defendant, David Garvey, M.D (hereinafter "Dr. Garvey" or "Defendant"), was and is a medical doctor licensed in the State of Nevada, and a resident of Elko County, Nevada.

4. Upon information and belief, at all times relevant herein, Defendant, TEAM HEALTH HOLDINGS. INC., dba RUBY CREST EMERGENCY MEDICINE (hereinafter "Ruby Crest" or "Defendant"), was and is a domestic corporation existing pursuant to the laws of Delaware, authorized to do business in Nevada, and doing business in the State of Nevada.

5. Upon information and belief, at all times relevant herein, Defendant, PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL (hereinafter "NNRH" or "Defendant"), was and is a domestic corporation existing pursuant to the laws of Nevada, authorized to do business in the State of Nevada, and doing business in the State of Nevada.

6. Defendant NNRH was and is at all times relevant operating as a medical care facility in Elko County, Nevada and was and is owned, operated, managed, and controlled as a medical care facility within the County of Elko, State of Nevada, and was held out to the public at large, including the Plaintiff herein, as a properly equipped, fully accredited, completely staffed by qualified and prudent personnel, and operating in compliance with standards of due care maintained by other properly equipped, efficiently operated and administered, accredited medical care facilities in said community, offering full, competent, qualified, and efficient health care services to the general public and to the Plaintiff herein; that Plaintiff herein is informed and believes and thereon alleges, that Defendant, NNRH, administered, governed, controlled, managed, and directed all the necessary

functions, activities, and operations of said medical care facility, including its physician care, nursing care, interns, residents and health staff, and other personnel.

7. Upon information and belief, Defendant REACH AIR MEDICAL SERVICES, LLC, (hereinafter "Reach Air" or "Defendant") is a foreign limited liability company existing pursuant to the laws of California, authorized to do business in the State of Nevada, and doing business in the State of Nevada

8. Plaintiff is informed and believes and thereon alleges that at all times relevant herein, Defendant, Doe Barry, R.N. was and is a resident of Elko, Nevada.

9. That the true names or capacities, whether corporate, associate, individual or otherwise, of Defendants, DOE BARRY, R.N., and DOES I through X, inclusive, were and now are physicians, surgeons, registered nurses, licensed vocational nurses, practical nurses, registered technicians, aides, attendants, physician's assistants, CRNAs, or paramedical personnel holding themselves out as duly licensed to practice their professions under and by virtue of the laws of the State of Nevada, and were and are now engaged in the practice of their professions in the State of Nevada, and are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Plaintiff is informed and believes, and thereon alleges, that each of the Defendants designated herein as a DOE Barry R.N. and DOE is legally responsible in some manner for the events and happenings herein referred to and proximately caused injury and damages thereby to Plaintiff as hereinafter alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names and capacities of DOE BARRY R.N. or DOES I through X when the same have been ascertained and to join such Defendants in this action.

10. That the true names or capacities of Defendants, ROE BUSINESS ENTITIES XI through XX, inclusive, are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Defendants designated herein as ROE BUSINESS ENTITIES XI through XX, and each of them, are corporations, firms, partnerships, associations, other medical entities, including but not limited to nursing staffing companies and/or registry nursing companies, emergency physician services group, predecessors-in-interest, successors-in-interest, and/or agencies otherwise in a joint venture with, and/or serving as an alter ego of, any and/or all Defendants named herein; and/or are

entities responsible for the treatment, diagnosis, surgery, and/or other provision of medical care to Plaintiff herein, and/or otherwise responsible for the supervision of the individually named Defendants at the time of the events and circumstances alleged herein; and/or are entities employed by and/or otherwise directing the individual Defendants in the scope and course of their responsibilities at the time of the events and circumstances alleged herein; and/or are entities otherwise contributing in any way to the acts complained of and the damages alleged to have been suffered by the Plaintiff herein. Plaintiff is informed and, on that basis believes and thereon alleges, that each of the Defendants designated as a ROE BUSINESS ENTITY is in some manner negligently, vicariously, and/or statutorily responsible for the events and happenings referred to and caused damages to Plaintiff as herein alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names of such Defendants when the same have been ascertained.

11. Defendants are agents, servants, employees, employers, trade venturers, and/or partners of each other. At the time of the incident described in this Complaint, Defendants were acting within the color, purpose and scope of their relationships, and by reason of their relationships, Defendants may be jointly and severally and/or vicariously responsible and liable for the acts and omissions of their Co-Defendants.

GENERAL ALLEGATIONS

1. The Plaintiff repeat and reallege the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

2. On June 22, 2016, Mr. Schwartz was struck as a pedestrian by a moving vehicle as he was exiting a local restaurant in the 400 block of Commercial Street in Elko, Nevada.

3. Paramedics were called to the scene at 8:17 p.m. and arrived at the scene within a few minutes.

4. Mr. Schwartz was placed in full C-spine precautions. During transport to the hospital, his vitals were within normal limits, 4L of oxygen was started routinely, a heart monitor was placed showing normal sinus rhythm.

5. Mr. Schwartz was transported by Elko County Ambulance to Northeastern Nevada Regional Hospital on a "non-emergent" transport mode arriving at approximately 8:48 p.m.

6. Dr. Garvey performed a physical examination of Mr. Schwartz upon arrival to the emergency department.

7. His assessment revealed that Mr. Schwartz had mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions to the right bicep, elbow and knee.

8. Mr. Schwartz had a normal heart rate and rhythm.

9. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout.

10. Mr. Schwartz's neurological status was normal.

11. Mr. Schwartz's abdominal evaluation was within normal limits.

12. At approximately 9:02 p.m. several diagnostic studies were ordered to further evaluate Mr. Schwartz's injuries including scans of the head, cervical and thoracic spine, chest, abdomen and pelvis.

13. Dr. Garvey contacted Dr. Ray at the University of Utah who accepted the patient for transfer.

14. The air ambulance crew from Reach Air arrived at NNRH to transport Mr. Schwartz to the airport for an air ambulance transport to the University of Utah Hospital.

15. Mr. Schwartz was not informed of the risks of undergoing an intubation. He was not informed of the alternatives to undergoing an intubation procedure.

16. Dr. Garvey elected to have the flight nurse, Doe Barry, R.N. from Reach Air, perform the intubation after Rocuronium and Ketamine were administered at 12:18 a.m.

17. Mr. Schwartz's vital signs were stable up until this point.

18. Doe Barry, R.N. first attempted intubation at 12:20 a.m., unsuccessfully, followed quickly by a deterioration of oxygenation and vital signs.

19. Intubation by Doe Barry, R.N. was again unsuccessful at 12:33 a.m. and a large aspiration of gastric contents was noted.

20. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered.

21. CPR continued and several subsequent intubation attempts were unsuccessful.

22. At 1:20 a.m. Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 1:33 a.m.

FIRST CLAIM FOR RELIEF

(PROFESSIONAL NEGLIGENCE/WRONGFUL DEATH)

DR. DAVID GARVEY, DOE BARRY, R.N., RUBY CREST, REACH AIR AND NNRH

23. The Plaintiff repeat and reallege the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

24. Defendant Dr. GARVEY owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field.

25. Defendant Dr. GARVEY fell below the standard of care by deciding to intubate Mr. Schwartz without clinical indications for intubation.[1]

26. Defendant Dr. GARVEY fell below the standard of care by failing to request an anesthesiologist to perform the intubation due to the high risk of aspiration.[2]

27. Defendant Dr. GARVEY fell below the standard of care by assigning an RN to perform a high risk, semi-elective intubation in a patient who he knew just ate a large meal.[3]

28. Defendant Dr. GARVEY fell below the standard of care by failing to obtain informed consent for Mr. Schwartz when he failed to advise him of the pros and cons of the procedure as well as other acceptable options (including not doing the procedure at all or having it done by an expert physician).[4]

29. Defendant Dr. GARVEY fell below the standard of care by electing to continue with the same plan of having an RN attempt intubation even after the initial intubation procedure was

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[1] See Affidavit of Kenneth N. Scissors, M.D., attached hereto as "Exhibit 1".
[2] Id.
[3] Id.
[4] Id.

unsuccessful rather than trying it himself or supporting the patient with a bag-mask technique and/or by calling in an anesthesiologist as the standard of care would require.[5]

30. Defendant Dr. GARVEY thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[6]

31. Defendant DOE BARRY, R.N. owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field. [6]

32. Defendant DOE BARRY, R.N. fell below the standard of care by agreeing to attempt an intubation of Mr. Schwartz when he did not have clear indications for intubation and had a high risk of aspiration of gastric contents.[7]

33. Defendant DOE BARRY, R.N. fell below the standard of care by not deferring to a qualified anesthesiologist.[8]

34. Defendant DOE BARRY, R.N. fell below the standard of care by attempting a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician. [9]

35. Defendant DOE BARRY, R.N. thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[10]

36. Defendant NNRH employees, agents, and/or servants, including DOE BARRY, R.N. was acting in the scope of his employment, under Defendant's control, and in the furtherance of Defendant's interest at the time his actions caused injuries to Mr. Schwartz.

37. Defendant NNRH in the capacity of a medical hospital, providing medical care to the public owed Mr. Schwartz a non-delegable duty to employ medical staff including Dr. GARVEY to have adequate training in the care and treatment of patients consistent with the degree of skill and

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[5] Id.
[6] Id.
[7] Id.
[8] Id.
[9] Id.
[10] Id.

learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.

38. At all relevant times mentioned herein, Defendants knew or in the exercise of reasonable care should have known, that the provisions of medical care and treatment was of such a nature that, if it was not properly given, was likely to injure or cause death to the person to whom it was given.

39. Defendants, and each of them, fell below the standard of care for a health care provider who possesses the degree of professional learning, skill, and ability of other similar health care providers in failing to timely and properly treat Mr. Schwartz resulting in significant injuries and death. The allegations against Defendants are supported by the Report of Dr. Kenneth N. Scissors.[11]

40. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Ten Thousand Dollars ($10,000.00).

41. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff have incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

42. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Ten Thousand Dollars ($10,000.00).

43. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

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[11] Id.

6. Id.

44. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

45. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

SECOND CLAIM FOR RELIEF

(Vicarious Liability, Corporate Negligence and Ostensible Agency)

Against Defendant NNRH, RUBY CREST AND REACH AIR

46. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

47. Employers, masters and principals are vicariously liable for the torts committed by their employees, servants and agents if the tort occurs while the employee, servant, or agent was acting in the course and scope of employment.

48. The Defendants were the employers, masters, principals, and/or ostensible agents of each other, the remaining Defendant, and other employees, agents, independent contractors and/or representatives who negligently failed through their credentialing and re-credentialing process to employ and or grant privileges to an emergency room physician with adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.[12]

49. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimately led to his death.

50. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries, damages and death in the sum in excess of Ten Thousand Dollars ($10,000.00).

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[12] Id.

51. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

52. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care forherand did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Ten Thousand Dollars ($10,000.00).

53. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

54. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and a loss of earning capacity, in an amount to be proven at trial.

55. Defendants' failure to properly credential and/or re-credential Dr. Garvey or to otherwise assure that an emergency room physician had adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances caused Plaintiff to suffer and ultimately die as a result of his care.

56. The actions of the Defendants have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

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THIRD CLAIM FOR RELIEF

(Negligent Hiring, Training, and Supervision)

Against Defendant NNRH, RUBY CREST AND REACH AIR

57. The Plaintiff repeat and reallege the allegations as contained in the preceding paragraphs hercin, and incorporates the same herein by reference.

58. The Defendants, and each of them, hired, trained, supervised and/or retained employees to provide treatment to patients, to include Plaintiff, within the appropriate standard of care, which required Defendants to properly assess and recognize when intubation is needed.

59. The Defendants had a duty to hire, properly train, properly supervise, and properly retain competent employees, agents, independent contractors and representatives.

60. Upon information and belief, the Defendants, breached their duty by improperly hiring, improperly training, improperly supervising and improperly retaining incompetent employees regarding the examination, diagnosis, and treatment of patients.

61. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimatley lead to his untimely death.[13]

62. Plaintiff thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries and damages in the sum in excess of Ten Thousand Dollars ($10,000.00).

63. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

64. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for Mr. Schwartz and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff allege that she has suffered special damages in excess of Ten Thousand Dollars ($10,000.00).

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[13] Id

65. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

66. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

67. The actions of the Defendants have forced the Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

FOURTH CLAIM FOR RELIEF

(Lack of Informed Consent)

Against Defendant DAVID GARVEY, M.D.

68. The Plaintiff repeat and reallege the allegations in the preceding paragraphs herein, and incoporate the same herein by reference.

69. Informed Consent requires the attending physician explain to the patient or guardian(s) including but not limited to alternatives to the treatment or procedure and the reasonable risks of undergoing the procedure.[14]

70. Dr. Garvey did not explain to the Plaintiff the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician.

71. Dr. Garvey did not explain to Plaintiff the reasonable risks of the intubation procedure including the risk of aspiration due to a full stomach and that said aspiration, should it occur, could lead to death.

72. Plaintiff would not have opted to have the intubation procedure had they been informed by Dr. Garvey of the less invasive alternative and of the substantial risks involved with intubation.

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[14] See Affidavit of Kenneth N. Scissors, M.D. attached hereto as "Exhibit 1"

73. As a result of Dr. Garvey's lack of informed consent, Mr. Schwartz experienced great pain, discomfort and ultimately suffered death.[15]

74. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

75. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

76. As a direct and proximate result of the negligence and carelessnesss of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

FIFTH CLAIM FOR RELIEF

(Loss of Consortium)

77. Plaintiffs restate and reallege each and every allegation in the preceding paragraphs herein, and incorporate the same herein by reference.

78. Plaintiff, Diane Schwartz, is and at all times relevant herein, has been the spouse of Plaintiff Douglas R. Schwartz.

79. As a direct and proximate result of Defendants' negligence and carelessness, has lost and will continue to lose a degree of society, comfort and companionship of her spouse, all to her damage in an amount in excess of Ten Thousand Dollars ($10,000.00).

80. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

81. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

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[15] Id.

82. As a direct and proximate result of the negligence and carelessnesss of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

83. Defendant's conduct complained of herein was despicable and so contemptible that it would be looked down upon and despised by ordinary, decent people, and was carried on by Defendant with willful and conscious disregard for the safety of Mr. Schwartz, and others in the State of Nevada, entitling Plaintiff to exemplary and punitive damages.

84. The outrageous and unconscionable conduct of Defendant warrants an award of exemplary and punitive damages in an amount appropriate to punish Defendant and make an example of it, and to deter similar conduct in the future.

85. The acts of Defendant complained of herein were willful, malicious, fraudulent, oppressive and done in conscious disregard of Plaintiff's rights and safety, and the rights and safety of others in the State of Nevada, and Plaintiff is entitled to exemplary and punitive damages pursuant to NRS Chapter 42 and common law, for a sum in excess of Ten Thousand Dollars ($10,000.00), to be proven at the time of trial, together with prejudgment interest at the rate allowed

WHEREFORE, Plaintiff, DIANE SCHWARTZ, individually and as administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased, expressly reserves her right to amend this Complaint at the time of trial, to include all items of damage not yet ascertained, demand judgment against Defendants, DAVID GARVEY, M.D., an individual; TEAM HEALTH HOLDINGS, INC., dba RUBY CREST EMERGENCY MEDICINE, PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada;; REACH AIR MEDICAL SERVICES, L.L.C.; DOE BARRY, R.N., DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive and each of the defendants as follows:

For general damages, in an amount in excess of Ten Thousand Dollars ($10,000.00), to be set forth and proven at the time of trial;

86. For general damages, in an amount in excess of Ten Thousand Dollars ($10,000), to be set forth and proven at the time of trial.

87. For special damages in an amount in excess of Ten Thousand Dollars ($10,000.00), to be set forth and proven at the time of trial;

88. For reasonable attorney's fees;

89. For costs and disbursements of this suit; and

90. For such other relief as to the Court seems just and proper.

DATED this 22nd day of June, 2017.

CLAGGETT & SYKES LAW FIRM

Sean K. Claggett, Esq.
Nevada Bar No. 008407
Jennifer Morales, Esq.
Nevada Bar No. 008829
Matthew S. Granda, Esq.
Nevada Bar No. 012753
4101 Meadows Lane, Suite 100
Las Vegas, Nevada 89107
(702) 655-2346 – Telephone
Attorneys for Plaintiff

Pursuant to FJDCR 19.1.A. DIANE SCHWARTZ, Plaintiff in this matter, is not in debt or bankruptcy.

Pursuant to NRS 239.030, counsel hereby affirms that this document contains no social security numbers.

Jennifer Morales, Esq., Attorney for Plaintiff

Table of Exhibits

Exhibit "1"	Affidavit of Kenneth Scissors, M.D.	5 pages

Exhibit "1"

AFFIDAVIT OF KENNETH N. SCISSORS, M.D.

I, Kenneth N. Scissors, MD, being duly sworn, under oath, state that the following assertions are true to the best of my personal knowledge training, experience and belief;

1) I am licensed by the Colorado Board of Medical Examiners to practice medicine in the State of Colorado.

2) My licenses are current with the appropriate State and Federal agencies.

3) My additional qualifications to serve as an expert are set forth in my Curriculum Vitae, attached as Exhibit 1.

4) Based on my training, background, knowledge and experience, I am familiar with the applicable standard of care for the treatment of the signs, symptoms, and condition presented by Mr. Schwartz in the emergency department. I am familiar with the team approach involved in the emergency room to include but not limited to transport teams and nursing care. The areas covered in this report overlap and based on my experience and training I am familiar and qualified in the areas addressed in this report to provide opinions.

5) I am qualified on the basis of my training background, knowledge, experience to offer an expert opinion regarding the accepted standard of medical care of the emergency room physician and the nurse who attempted to intubate Douglas Schwartz, the breaches thereof and the resulting injuries and damages arising therefrom.

Documents Reviewed

1.) Northeaster Nevada Regional Hospital Medical Records
2.) Elko County Ambulance Medical Records
3.) Certificate of Death

4.) Autopsy Protocol
5.) NMS Lab Report
6.) Elko County Sheriff's Office Investigation Report
7.) Radiology Disc from Northeastern Nevada Regional Hospital

Summary of Medical Care at Northern Nevada Regional Hospital Emergency Department on June 22, 2016

On June 22, 2016 Mr. Douglas Schwartz was struck as a pedestrian by a moving vehicle. Paramedics were called at 8:17 p.m. and arrived at the scene within a few minutes. Mr. Schwartz was placed in full C-spine precautions. During his transport to the hospital his vitals were within normal limits, 4L of 02 was started routinely, a monitor was placed showing normal sinus rhythm. Mr. Schwartz was given 4 mg Zofran IVP followed by 100 mcg Fentanyl IVP which helped with his pain. He was transported by Elko County Ambulance to Northern Nevada Regional Hospital on a "non-emergent" transport mode arriving at 8:48 p.m.

Dr. David Garvey performed a physical evaluation of Douglas Schwartz upon arrival to the emergency department. He noted that Douglas Schwartz sustained mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions of the right bicep, elbow, and knee. Mr. Schwartz had a normal heart rate and rhythm. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout. Mr. Schwartz's neurological status was normal. His abdominal evaluation was also within normal limits. Mr. Schwartz's condition was stable.

At approximately 9:02 p.m. several diagnostic studies were ordered to further evaluate Mr. Schwartz's injuries including CT scans of the head, cervical and thoracic spine, chest, abdomen and pelvis.

Dr. Garvey contacted Dr. Ray at University of Utah trauma service who accepted the patient for transfer. According to Dr. Garvey's chart note, Dr. Ray requested that a chest tube be placed and possibly intubation prior to air medical transport.

Dr. Garvey elected to have the flight nurse, Barry, perform the intubation after Rocuronium and Ketamine administration at 0018 hours. The vital signs were stable up until this point. The intubation was first attempted at 0020 unsuccessfully, followed quickly by deterioration of oxygenation and vital signs. Intubation was again unsuccessful at 0033 and a large aspiration of gastric contents was noted. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered. CPR continued and several subsequent intubation attempts were unsuccessful. At 0120 Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 0133

Deviations from the Standard of Care.

Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, Dr. David Garvey who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine are required to properly hire, train, supervise and/or retain employees, including Dr. David Garvey to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Dr. David Garvey breached the standard of care in several ways:

1. Deciding to intubate Mr. Schwartz without clinical indications for intubation. Preventive intubation for air flight is not the standard of care. Intubation has inherent risks, especially in a patient who likely has food in the stomach. Intubation is reserved for patients who are unable to breath adequately on their own, yet Mr. Schwartz was breathing without difficulty and had adequate oxygen levels on simple oxygen supplementation.
2. Even if there was a pressing but non-emergent need to intubate Mr. Schwartz with likely food in the stomach, the standard of care would be to request an anesthesiologist to perform the intubation due to the high

risk of aspiration. It is a deviation from the standard of care for an emergency room physician to assign a RN to perform a high risk semi-elective intubation in a patient with likely gastric contents when highly skilled physicians are available.

3. Since this was a non-emergent and non-essential invasive procedure in an awake, cognitive patient, informed consent was required. That means more than just telling the patient what is to be done. The patient must be told the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician. Dr. Garvey deviated from the standard of care by not giving Mr. Schwartz the opportunity to decline this risky and unnecessary procedure.
4. Once the initial intubation was unsuccessful, Dr. Garvey elected to continue with the same plan of having a RN attempt intubation rather than trying it himself or supporting the patient with a bag-mask technique and calling in an anesthesiologist as the standard of care would require. This led to a large aspiration of gastric contents and a fatal cardiopulmonary arrest.

Reach Air Medical Services through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, identified as "Barry RN" who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Reach Air Medical Services is required to properly hire, train, supervise and/or retain employees, including "Barry RN" to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Nurse Barry violated the standard of care in two instances:

1. Nurse Barry should not have agreed to attempt to intubate Mr. Schwartz given that he did not have clear indications for intubation and had a high risk of aspiration of gastric contents. In this situation, a RN should defer to a qualified physician, preferably an anesthesiologist.

2. Nurse Barry should not have attempted a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but still supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician at this point rather than repeating the same mistake he made initially. The second failed attempt caused a fatal aspiration.

All of the aforementioned breaches of the standard of care caused or contributed to the death of Mr. Schwartz.

All of my opinions expressed herein are to a reasonable degree of medical certainty.

I reserve the right to amend, modify, and add to my opinions upon further review of any additional documents and/or information.

Further Affidant Sayeth Not.

Dated this 21 day of June, 2017

KENNETH N. SCISSORS, M.D.

State of Colorado
County of Mesa
On this 21 day of June, 2017 Kenneth Scissors, MD
personally appeared before me,
X who is personally known to me,
whose identity I verified on the basis of CO - DL,
whose identity I verified on the oath/affirmation of
a credible witness,
to be the signer of the foregoing document, and he/she acknowledged that he/she signed it.
Therese Luellen
Notary Public
My Commission Expires: 4-5-2021

THERESE LUELLEN
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20014010801
MY COMMISSION EXPIRES 04/05/2021

EXHIBIT 11

Case No.: CV-C-17-439
Dept. No: 1

AFFIRMATION
Pursuant to NRS 239B.030
This document does not contain
any Social Security Numbers

IN THE FOURTH JUDICIAL DISTRICT COURT OF THE

STATE OF NEVADA, IN AND FOR THE COUNTY OF ELKO

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

Plaintiff,

vs.

DAVID GARVEY, M.D., an individual; BARRY BARTLETT, an individual (Formerly Identified as BARRY RN); CRUM, STEFANKO, & **JONES LTD**, dba Ruby Crest Emergency Medicine; PHC-ELKO INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive,

Defendants.

SECOND AMENDED COMPLAINT
(Medical Malpractice)
and Wrongful Death)

COMES NOW, Plaintiff, DIANE SCHWARTZ, individual and as the administrator of the Estate of DOUGLAS SCHWARTZ, by and through her attorneys of record, CLAGGETT & SYKES LAW FIRM, for their causes of action against Defendants, DAVID GARVEY, M.D., individually; BARRY BARTLETT, individually; CRUM, STEFANKO, & **JONES LTD**, dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL

HOSPITAL, REACH AIR MEDICAL SERVICES, L.L.C; DOES 1 through X; ROE BUSINESS ENTITIES X1 through XX; and each of them and alleges as follows:

1. At all times relevant herein, Plaintiff, DIANE SCHWARTZ, individually and as the Special Administrator on behalf of the Estate of DOUGLAS R. SCHWARTZ (hereinafter the "Plaintiff" or "Diane"), was and is a resident of Elko County, Nevada.

2. At all times relevant herein, Plaintiff DOUGLAS SCHWARTZ (hereinafter the "Plaintiff" or "Mr. Schwartz"), was a resident of Elko County, Nevada.

3. Upon information and belief, at all times relevant herein, Defendant, David Garvey, M.D. (hereinafter "Dr. Garvey" or "Defendant"), was and is a medical doctor licensed in the State of Nevada, and a resident of Elko County, Nevada.

4. Plaintiff is informed and believes and thereon alleges that at all times relevant herein, Defendant, BARRY BARTLETT, (hereinafter "Bartlett" or "Defendant") was and is a resident of Elko, Nevada.

5. Upon information and belief, at all times relevant herein, Defendant, CRUM, STEFANKO, & **JONES LTD**, dba RUBY CREST EMERGENCY MEDICINE (hereinafter "Ruby Crest" or "Defendant"), was and is a domestic corporation existing pursuant to the laws of Delaware, authorized to do business in Nevada, and doing business in the State of Nevada.

6. Upon information and belief, at all times relevant herein, Defendant, PHC-ELKO, INC. dba NORTHEASTERN NEVADA REGIONAL HOSPITAL (hereinafter "NNRH" or "Defendant"), was and is a domestic corporation existing pursuant to the laws of Nevada, authorized to do business in the State of Nevada, and doing business in the State of Nevada.

7. Defendant NNRH was and is at all times relevant operating as a medical care facility in Elko County, Nevada and was and is owned, operated, managed, and controlled as a medical care facility within the County of Elko, State of Nevada, and was held out to the public at large, including the Plaintiff herein, as a properly equipped, fully accredited, completely staffed by qualified and prudent personnel, and operating in compliance with standards of due care maintained by other properly equipped, efficiently operated and administered, accredited medical care facilities in said community, offering full, competent, qualified, and efficient health care services to the general public

and to the Plaintiff herein; that Plaintiff herein is informed and believes and thereon alleges, that Defendant, NNRH, administered, governed, controlled, managed, and directed all the necessary functions, activities, and operations of said medical care facility, including its physician care, nursing care, interns, residents and health staff, and other personnel.

8. Upon information and belief, Defendant REACH AIR MEDICAL SERVICES, LLC, (hereinafter "Reach Air" or "Defendant") is a foreign limited liability company existing pursuant to the laws of California, authorized to do business in the State of Nevada, and doing business in the State of Nevada

9. That the true names or capacities, whether corporate, associate, individual or otherwise, of DOES I through X, inclusive, were and now are physicians, surgeons, registered nurses, licensed vocational nurses, practical nurses, registered technicians, aides, attendants, physician's assistants, CRNAs, or paramedical personnel holding themselves out as duly licensed to practice their professions under and by virtue of the laws of the State of Nevada, and were and are now engaged in the practice of their professions in the State of Nevada, and are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Plaintiff is informed and believes, and thereon alleges, that each of the Defendants designated herein as a DOE Barry R.N. and DOE is legally responsible in some manner for the events and happenings herein referred to and proximately caused injury and damages thereby to Plaintiff as hereinafter alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names and capacities of DOE BARRY R.N. or DOES I through X when the same have been ascertained and to join such Defendants in this action.

10. That the true names or capacities of Defendants, ROE BUSINESS ENTITIES XI through XX, inclusive, are unknown to Plaintiff who, therefore, sues said Defendants by such fictitious names. Defendants designated herein as ROE BUSINESS ENTITIES XI through XX, and each of them, are corporations, firms, partnerships, associations, other medical entities, including but not limited to nursing staffing companies and/or registry nursing companies, emergency physician services group, predecessors-in-interest, successors-in-interest, and/or agencies otherwise in a joint venture with, and/or serving as an alter ego of, any and/or all Defendants named herein; and/or are entities responsible for the treatment, diagnosis, surgery, and/or other provision of medical care to

Plaintiff herein, and/or otherwise responsible for the supervision of the individually named Defendants at the time of the events and circumstances alleged herein; and/or are entities employed by and/or otherwise directing the individual Defendants in the scope and course of their responsibilities at the time of the events and circumstances alleged herein; and/or are entities otherwise contributing in any way to the acts complained of and the damages alleged to have been suffered by the Plaintiff herein. Plaintiff is informed and, on that basis believes and thereon alleges, that each of the Defendants designated as a ROE BUSINESS ENTITY is in some manner negligently, vicariously, and/or statutorily responsible for the events and happenings referred to and caused damages to Plaintiff as herein alleged. Plaintiff will seek leave of the Court to amend this Complaint to insert the true names of such Defendants when the same have been ascertained.

11. Defendants are agents, servants, employees, employers, trade venturers, and/or partners of each other. At the time of the incident described in this Complaint, Defendants were acting within the color, purpose and scope of their relationships, and by reason of their relationships, Defendants may be jointly and severally and/or vicariously responsible and liable for the acts and omissions of their Co-Defendants.

GENERAL ALLEGATIONS

1. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

2. On June 22, 2016, Mr. Schwartz was struck as a pedestrian by a moving vehicle as he was exiting a local restaurant in the 400 block of Commercial Street in Elko, Nevada.

3. Paramedics were called to the scene at 8:17 p.m. and arrived at the scene within a few minutes.

4. Mr. Schwartz was placed in full C-spine precautions. During transport to the hospital, his vitals were within normal limits, 4L of oxygen was started routinely, a heart monitor was placed showing normal sinus rhythm.

5. Mr. Schwartz was transported by Elko County Ambulance to Northeastern Nevada Regional Hospital on a "non-emergent" transport mode arriving at approximately 8:48 p.m.

6. Dr. Garvey performed a physical examination of Mr. Schwartz upon arrival to the emergency department.

7. His assessment revealed that Mr. Schwartz had mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions to the right bicep, elbow and knee.

8. Mr. Schwartz had a normal heart rate and rhythm.

9. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout.

10. Mr. Schwartz's neurological status was normal.

11. Mr. Schwartz's abdominal evaluation was within normal limits.

12. At approximately 9:02 p.m. several diagnostic studies were ordered to further evaluate Mr. Schwartz's injuries including scans of the head, cervical and thoracic spine, chest, abdomen and pelvis.

13. Dr. Garvey contacted Dr. Ray at the University of Utah who accepted the patient for transfer.

14. The air ambulance crew from Reach Air arrived at NNRH to transport Mr. Schwartz to the airport for an air ambulance transport to the University of Utah Hospital.

15. Mr. Schwartz was not informed of the risks of undergoing an intubation. He was not informed of the alternatives to undergoing an intubation procedure.

16. Dr. Garvey elected to have the flight nurse, Barry Bartlett, from Reach Air, perform the intubation after Rocuronium and Ketamine were administered at 12:18 a.m.

17. Mr. Schwartz's vital signs were stable up until this point.

18. Barry Bartlett, first attempted intubation at 12:20 a.m., unsuccessfully, followed quickly by a deterioration of oxygenation and vital signs.

19. Intubation by Barry Bartlett, was again unsuccessful at 12:33 a.m. and a large aspiration of gastric contents was noted.

20. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered.

21. CPR continued and several subsequent intubation attempts were unsuccessful.

22. At 1:20 a.m. Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 1:33 a.m.

FIRST CLAIM FOR RELIEF

(PROFESSIONAL NEGLIGENCE/WRONGFUL DEATH)

DR. DAVID GARVEY, BARRY BARTLETT,

RUBY CREST, REACH AIR, AND NNRH

23. The Plaintiff repeat and reallege the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

24. Defendant Dr. GARVEY owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field.

25. Defendant Dr. GARVEY fell below the standard of care by deciding to intubate Mr. Schwartz without clinical indications for intubation.[1]

26. Defendant Dr. GARVEY fell below the standard of care by failing to request an anesthesiologist to perform the intubation due to the high risk of aspiration.[2]

27. Defendant Dr. GARVEY fell below the standard of care by assigning an RN to perform a high risk, semi-elective intubation in a patient who he knew just ate a large meal.[3]

28. Defendant Dr. GARVEY fell below the standard of care by failing to obtain informed consent for Mr. Schwartz when he failed to advise him of the pros and cons of the procedure as well as other acceptable options (including not doing the procedure at all or having it done by an expert physician).[4]

29. Defendant Dr. GARVEY fell below the standard of care by electing to continue with the same plan of having an RN attempt intubation even after the initial intubation procedure was

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[1] See Affidavit of Kenneth N. Scissors, M.D., attached hereto as **"Exhibit 1"**.

[2] Id.

[3] Id.

[4] Id.

unsuccessful rather than trying it himself or supporting the patient with a bag-mask technique and/or by calling in an anesthesiologist as the standard of care would require.[5]

30. Defendant Dr. GARVEY thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[6]

31. Defendant BARRY BARTLETT, owed a duty of care to Mr. Schwartz to render medical care and treatment in a professional manner consistent with the standard of care prescribed in his medical field. [6]

32. Defendant BARRY BARTLETT, fell below the standard of care by agreeing to attempt an intubation of Mr. Schwartz when he did not have clear indications for intubation and had a high risk of aspiration of gastric contents.[7]

33. Defendant BARRY BARTLETT, fell below the standard of care by not deferring to a qualified anesthesiologist.[8]

34. Defendant BARRY BARTLETT, fell below the standard of care by attempting a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician. [9]

35. Defendant BARRY BARTLETT, thereby caused Mr. Schwartz to suffer severe complications including a large aspiration of gastric contents and a fatal cardiopulmonary arrest.[10]

36. Defendant NNRH employees, agents, and/or servants, including BARRY BARTLETT, was acting in the scope of his employment, under Defendant's control, and in the furtherance of Defendant's interest at the time his actions caused injuries to Mr. Schwartz.

37. Defendant NNRH in the capacity of a medical hospital, providing medical care to the public owed Mr. Schwartz a non-delegable duty to employ medical staff including Dr. GARVEY to have adequate training in the care and treatment of patients consistent with the degree of skill and

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[5] Id.
[6] Id.
[7] Id.
[8] Id.
[9] Id.
[10] Id.

learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.

38. At all relevant times mentioned herein, Defendants knew or in the exercise of reasonable care should have known, that the provisions of medical care and treatment was of such a nature that, if it was not properly given, was likely to injure or cause death to the person to whom it was given.

39. Defendants, and each of them, fell below the standard of care for a health care provider who possesses the degree of professional learning, skill, and ability of other similar health care providers in failing to timely and properly treat Mr. Schwartz resulting in significant injuries and death. The allegations against Defendants are supported by the Report of Dr. Kenneth N. Scissors.[11]

40. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, with said injuries ultimatley leading to death and damages in the sum in excess of Ten Thousand Dollars ($10,000.00).

41. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff have incurred damages, both general and special, including medical expenses as a result of the treatment of Mr. Schwartz's injuries and funeral expenses.

42. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for her and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Ten Thousand Dollars ($10,000.00).

43. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

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[11] Id.

44. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and/or loss of earning capacity, in an amount to be proven at trial.

45. The actions of the Defendant have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

SECOND CLAIM FOR RELIEF

(Vicarious Liability, Corporate Negligence and Ostensible Agency)

Against Defendant NNRH, RUBY CREST, AND REACH AIR

46. The Plaintiff repeats and realleges the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

47. Employers, masters and principals are vicariously liable for the torts committed by their employees, servants and agents if the tort occurs while the employee, servant, or agent was acting in the course and scope of employment.

48. The Defendants were the employers, masters, principals, and/or ostensible agents of each other, the remaining Defendant, and other employees, agents, independent contractors and/or representatives who negligently failed through their credentialing and re-credentialing process to employ and or grant privileges to an emergency room physician with adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances.[12]

49. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimately led to his death.

50. Mr. Schwartz thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries, damages and death in the sum in excess of Ten Thousand Dollars ($10,000.00).

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[12] Id.

51. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

52. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff was required to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care forherand did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff alleges that she has suffered special damages in excess of Ten Thousand Dollars ($10,000.00).

53. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

54. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wages and a loss of earning capacity, in an amount to be proven at trial.

55. Defendants' failure to properly credential and/or re-credential Dr. Garvey or to otherwise assure that an emergency room physician had adequate training in the care and treatment of patients consistent with the degree of skill and learning possessed by competent medical personnel practicing in the United States of America under the same or similar circumstances caused Plaintiff to suffer and ultimately die as a result of his care.

56. The actions of the Defendants have forced Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

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THIRD CLAIM FOR RELIEF

(Negligent Hiring, Training, and Supervision)

Against Defendant NNRH, RUBY CREST, AND REACH AIR

57. The Plaintiff repeat and reallege the allegations as contained in the preceding paragraphs herein, and incorporates the same herein by reference.

58. The Defendants, and each of them, hired, trained, supervised and/or retained employees to provide treatment to patients, to include Plaintiff, within the appropriate standard of care, which required Defendants to properly assess and recognize when intubation is needed.

59. The Defendants had a duty to hire, properly train, properly supervise, and properly retain competent employees, agents, independent contractors and representatives.

60. Upon information and belief, the Defendants, breached their duty by improperly hiring, improperly training, improperly supervising and improperly retaining incompetent employees regarding the examination , diagnosis, and treatment of patients.

61. Defendants' breach of the applicable standard of care directly resulted in Plaintiff sustaining significant injuries that ultimatley lead to his untimely death.[13]

62. Plaintiff thereby experienced great pain, suffering, and anxiety to his body and mind, sustaining injuries and damages in the sum in excess of Ten Thousand Dollars ($10,000.00).

63. As a further direct and proximate result of the aforesaid negligence and carelessness of Defendants, Plaintiff has incurred damages, both general and special, including medical expenses as a result of the necessary treatment of her injuries, and will continue to incur damages for future medical treatment necessitated by incident-related injuries she has suffered.

64. As a further proximate result of the aforementioned negligence and carelessness of Defendants, the Plaintiff wasrequired to, and did, employ physicians, surgeons, and other health care providers to examine, treat, and care for Mr. Schwartz and did incur medical and incidental expenses thereby. The exact amount of such expenses is unknown at this present time, but Plaintiff allege that she hassuffered special damages in excess of Ten Thousand Dollars ($10,000.00).

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[13] Id.

65. As a further direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

66. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will continue to suffer lost wagesand/or loss of earning capacity, in an amount to be proven at trial.

67. The actions of the Defendants have forced the Plaintiff to retain counsel to represent her in the prosecution of this action, and she is therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

FOURTH CLAIM FOR RELIEF

(Lack of Informed Consent)

Against Defendant DAVID GARVEY, M.D.

68. The Plaintiff repeat and reallege the allegations in the preceding paragraphs herein, and incorporate the same herein by reference.

69. Informed Consent requires the attending physician explain to the patient or guardian(s) including but not limited to alternatives to the treatment or procedure and the reasonable risks of undergoing the procedure.[14]

70. Dr. Garvey did not explain to the Plaintiff the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician.

71. Dr. Garvey did not explain to Plaintiff the reasonable risks of the intubation procedure including the risk of aspiration due to a full stomach and that said aspiration, should it occur, could lead to death.

72. Plaintiff would not have opted to have the intubation procedure had they been informed by Dr. Garvey of the less invasive alternative and of the substantial risks involved with intubation.

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[14] See Affidavit of Kenneth N. Scissors, M.D. attached hereto as "Exhibit 1"

73. As a result of Dr. Garvey's lack of informed consent, Mr. Schwartz experienced great pain, discomfort and ultimately suffered death.[15]

74. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

75. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

76. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

FIFTH CLAIM FOR RELIEF

(Loss of Consortium)

DIANE SCHWARTZ's Claim Against All Defendants

77. Plaintiff restate and reallege each and every allegation contained in the preceding paragraphs herein, and incorporate the same herein by reference.

78. Plaintiff, Diane Schwartz, is and at all times relevant herein, has been the spouse of Plaintiff Douglas R. Schwartz.

79. As a direct and proximate result of Defendants' negligence and carelessness, has lost and will continue to lose a degree of society, comfort and companionship of his spouse, all to her damage in an amount in excess of Ten Thousand Dollars ($10,000.00).

80. The actions of the Defendants have forced the Plaintiff to retain counsel to represent them in the prosecution of this action, and they are therefore entitled to an award of a reasonable amount as attorney fees and costs of suit.

81. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff has suffered, and will continue to suffer, pain, suffering, and loss of enjoyment of life in an amount to be proven at trial.

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[15] Id.

82. As a direct and proximate result of the negligence and carelessness of Defendants, Plaintiff suffered and will suffer lost wages, in an amount to be proven at trial.

WHEREFORE, Plaintiff, DIANE SCHWARTZ, individually and as administrator of the Estate of DOUGLAS R. SCHWARTZ, deceased, expressly reserves her right to amend this Complaint at the time of trial, to include all items of damage not yet ascertained, demand judgment against Defendants, DAVID GARVEY, M.D., an individual; BARRY BARTLETT, an individual; CRUM, STEFANKO, & **JONES LTD** dba RUBY CREST EMERGENCY MEDICINE; PHC-ELKO, INC., dba NORTHEASTERN NEVADA REGIONAL HOSPITAL, a domestic corporation duly authorized to conduct business in the State of Nevada; REACH AIR MEDICAL SERVICES, L.L.C.; DOES I through X; ROE BUSINESS ENTITIES XI through XX, inclusive and each of the defendants as follows:

1. For general damages, in an amount in excess of Ten Thousand Dollars ($10,000.00), to be set forth and proven at the time of trial;
2. For special damages in an amount in excess of Ten Thousand Dollars ($10,000.00), to be set forth and proven at the time of trial;
3. For reasonable attorney's fees;
4. For costs and disbursements of this suit; and
5. For such other relief as to the Court seems just and proper.

DATED this 12th day of February, 2018.

CLAGGETT & SYKES LAW FIRM

Sean K. Claggett, Esq.
Nevada Bar No. 008407
Jennifer Morales, Esq.
Nevada Bar No. 008829
Matthew S. Granda, Esq.
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Las Vegas, Nevada 89107
(702) 655-2346 – Telephone
Attorneys for Plaintiff

Pursuant to FJDCR 19.1.A. DIANE SCHWARTZ, Plaintiff in this matter, is not in debt or bankruptcy.

Pursuant to NRS 239.030, counsel hereby affirms that this document contains no social security numbers.

Jennifer Morales, Esq., Attorney for Plaintiff

Table of Exhibits

Exhibit "1"	Affidavit of Kenneth Scissors, M.D. –	5 pages

Exhibit "1"

AFFIDAVIT OF KENNETH N. SCISSORS, M.D.

I, Kenneth N. Scissors, MD, being duly sworn, under oath, state that the following assertions are true to the best of my personal knowledge training, experience and belief;

1) I am licensed by the Colorado Board of Medical Examiners to practice medicine in the State of Colorado.

2) My licenses are current with the appropriate State and Federal agencies.

3) My additional qualifications to serve as an expert are set forth in my Curriculum Vitae, attached as Exhibit 1.

4) Based on my training, background, knowledge and experience, I am familiar with the applicable standard of care for the treatment of the signs, symptoms, and condition presented by Mr. Schwartz in the emergency department. I am familiar with the team approach involved in the emergency room to include but not limited to transport teams and nursing care. The areas covered in this report overlap and based on my experience and training I am familiar and qualified in the areas addressed in this report to provide opinions.

5) I am qualified on the basis of my training background, knowledge, experience to offer an expert opinion regarding the accepted standard of medical care of the emergency room physician and the nurse who attempted to intubate Douglas Schwartz, the breaches thereof and the resulting injuries and damages arising therefrom.

Documents Reviewed

1.) Northeaster Nevada Regional Hospital Medical Records
2.) Elko County Ambulance Medical Records
3.) Certificate of Death

4.) Autopsy Protocol
5.) NMS Lab Report
6.) Elko County Sheriff's Office Investigation Report
7.) Radiology Disc from Northeastern Nevada Regional Hospital

Summary of Medical Care at Northern Nevada Regional Hospital Emergency Department on June 22, 2016

On June 22, 2016 Mr. Douglas Schwartz was struck as a pedestrian by a moving vehicle. Paramedics were called at 8:17 p.m. and arrived at the scene within a few minutes. Mr. Schwartz was placed in full C-spine precautions. During his transport to the hospital his vitals were within normal limits, 4L of 02 was started routinely, a monitor was placed showing normal sinus rhythm. Mr. Schwartz was given 4 mg Zofran IVP followed by 100 mcg Fentanyl IVP which helped with his pain. He was transported by Elko County Ambulance to Northern Nevada Regional Hospital on a "non-emergent" transport mode arriving at 8:48 p.m.

Dr. David Garvey performed a physical evaluation of Douglas Schwartz upon arrival to the emergency department. He noted that Douglas Schwartz sustained mild abrasions to the forehead, injury to the right lateral posterior chest with moderate pain, and abrasions of the right bicep, elbow, and knee. Mr. Schwartz had a normal heart rate and rhythm. Mr. Schwartz did not display signs of respiratory distress; his respirations were normal with clear breath sounds throughout. Mr. Schwartz's neurological status was normal. His abdominal evaluation was also within normal limits. Mr. Schwartz's condition was stable.

At approximately 9:02 p.m. several diagnostic studies were ordered to further evaluate Mr. Schwartz's injuries including CT scans of the head, cervical and thoracic spine, chest, abdomen and pelvis.

Dr. Garvey contacted Dr. Ray at University of Utah trauma service who accepted the patient for transfer. According to Dr. Garvey's chart note, Dr. Ray requested that a chest tube be placed and possibly intubation prior to air medical transport.

Dr. Garvey elected to have the flight nurse, Barry, perform the intubation after Rocuronium and Ketamine administration at 0018 hours. The vital signs were stable up until this point. The intubation was first attempted at 0020 unsuccessfully, followed quickly by deterioration of oxygenation and vital signs. Intubation was again unsuccessful at 0033 and a large aspiration of gastric contents was noted. After the aspiration, the vital signs and oxygenation indicated cardiopulmonary arrest and CPR was administered. CPR continued and several subsequent intubation attempts were unsuccessful. At 0120 Mr. Schwartz had asystole (complete lack of heart beat) and he was pronounced dead at 0133

Deviations from the Standard of Care.

Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, Dr. David Garvey who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Northern Nevada Regional Hospital and Ruby Crest Emergency Medicine are required to properly hire, train, supervise and/or retain employees, including Dr. David Garvey to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Dr. David Garvey breached the standard of care in several ways:

1. Deciding to intubate Mr. Schwartz without clinical indications for intubation. Preventive intubation for air flight is not the standard of care. Intubation has inherent risks, especially in a patient who likely has food in the stomach. Intubation is reserved for patients who are unable to breath adequately on their own, yet Mr. Schwartz was breathing without difficulty and had adequate oxygen levels on simple oxygen supplementation.
2. Even if there was a pressing but non-emergent need to intubate Mr. Schwartz with likely food in the stomach, the standard of care would be to request an anesthesiologist to perform the intubation due to the high

risk of aspiration. It is a deviation from the standard of care for an emergency room physician to assign a RN to perform a high risk semi-elective intubation in a patient with likely gastric contents when highly skilled physicians are available.

3. Since this was a non-emergent and non-essential invasive procedure in an awake, cognitive patient, informed consent was required. That means more than just telling the patient what is to be done. The patient must be told the pros and cons of the procedure and that there are acceptable options, including not doing the procedure at all or having it done by an expert physician. Dr. Garvey deviated from the standard of care by not giving Mr. Schwartz the opportunity to decline this risky and unnecessary procedure.
4. Once the initial intubation was unsuccessful, Dr. Garvey elected to continue with the same plan of having a RN attempt intubation rather than trying it himself or supporting the patient with a bag-mask technique and calling in an anesthesiologist as the standard of care would require. This led to a large aspiration of gastric contents and a fatal cardiopulmonary arrest.

Reach Air Medical Services through its owners, officers, employees, agents and/or contractors, deviated from the applicable standard of care, through the actions of its employee, agent or contractor, identified as "Barry RN" who provided medical care and treatment to Mr. Schwartz in the emergency room on June 22, 2016.

Reach Air Medical Services is required to properly hire, train, supervise and/or retain employees, including "Barry RN" to provide treatment within the appropriate standard of care to patients such as Douglas Schwartz in the emergency room on June 22, 2016.

Nurse Barry violated the standard of care in two instances:

1. Nurse Barry should not have agreed to attempt to intubate Mr. Schwartz given that he did not have clear indications for intubation and had a high risk of aspiration of gastric contents. In this situation, a RN should defer to a qualified physician, preferably an anesthesiologist.

2. Nurse Barry should not have attempted a second intubation after the failed first attempt. At that point Mr. Schwartz was struggling, but still supportable with a bag-mask technique. Nurse Barry should have deferred to a qualified physician at this point rather than repeating the same mistake he made initially. The second failed attempt caused a fatal aspiration.

All of the aforementioned breaches of the standard of care caused or contributed to the death of Mr. Schwartz.

All of my opinions expressed herein are to a reasonable degree of medical certainty.

I reserve the right to amend, modify, and add to my opinions upon further review of any additional documents and/or information.

Further Affidant Sayeth Not.

Dated this 21 day of June, 2017

KENNETH N. SCISSORS, M.D.

State of Colorado
County of Mesa
On this 21 day of June, 2017 Kenneth Scissors, MD
personally appeared before me,
X who is personally known to me,
___ whose identity I verified on the basis of CO - DL,
___ whose identity I verified on the oath/affirmation of _____,
a credible witness,
to be the signer of the foregoing document, and he/she acknowledged that he/she signed it.
Therese Luellen
Notary Public
My Commission Expires: 4-5-2021

THERESE LUELLEN
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20014010801
MY COMMISSION EXPIRES 04/05/2021