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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC File No. 1908703
Appellate Case No. 2022-000067

Kyle R. Bagley, Employee Appellant,

v.

JN Fibers, Inc., d/b/a Sun Fiber, LLC, Employer, and
Great American Insurance Company, Carrier Respondents.

RECORD ON APPEAL – VOLUME III

Bryan N. Sanchez, # 80372
Nicholas J.A. Stark, # 103414
772 Cherry Road (29732)
PO Box 11583
Rock Hill, SC 29731
bryan.sanchez@stacylewislaw.com
nick.stark@stacylewislaw.com

Attorneys For Appellant

C. Barrett Burley, # 77490
M. Brooks Biediger, # 77658
1201 Main Street, Suite 1430
Columbia, SC 29201
bburley@hplplaw.com
bbiediger@hplplaw.com

Attorneys For Respondents

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Transcript of the
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David N. DuPuy, MD

4/29/2020

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Southern Reporting, Inc.

Phone: 803.749.8100

Fax: 803.749.9991

Email: Depos@southernreporting.net

REMOTE APPEARANCES

For the Claimant: Bryan N. Sanchez, Esq.
Lewis Law Firm, LLC
Rock Hill, South Carolina

For the Employer/Carrier: M. Brooks Biediger, Esq.
Holder Padgett Littlejohn & Prickett, LLC
Columbia, South Carolina

The Witness: David N. DuPuy, MD
OrthoCarolina
197 Piedmont Blvd., Suite 111
Rock Hill, South Carolina

The Court Reporter Susan A. Wyant
Home Office
York, South Carolina

Also present: Kyle Bagley
628 Lancaster Hwy #223
Chester, South Carolina

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EXHIBITS

No exhibits were marked during the course of this deposition.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Workers' Compensation Act and all applicable rules.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

David N. DuPuy, MD, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

MR. SANCHEZ: Preliminarily, I just wanted to put on the record that the parties are in agreement that we are going to waive the in-person swearing in of the witness; is that correct, Brooks?

MR. BIEDIGER: Absolutely.

MR. SANCHEZ: Okay.

EXAMINATION

1 BY MR. SANCHEZ:

2 Q All right. Dr. DuPuy, can you hear me good?

3 A Yes, I can.

4 Q All right. Excellent. My name, again --

5 A Yes, sir.

6 Q -- is Bryan -- my name, again, is Bryan Sanchez,
7 and I'm representing Mr. Kyle Bagley in connection
8 with a workers' compensation claim. And the other
9 attorney, Mr. Brooks Biediger -- sorry if I chopped
10 the name --

11 MR. BIEDIGER: BEE-di-ger. That's all right.

12 Q He is representing -- BEE-di-ger, sorry. He is
13 representing the workers' comp carrier and the
14 employer in this matter. You understand you're
15 giving a deposition in connection with this
16 workers' compensation case; is that right?

17 A Yes, sir.

18 Q Okay.

19 A Yes.

20 Q Will you please state your name and your current
21 location or your business address, where you are
22 right now?

23 A I'm Dr. David DuPuy, and our address is 197
24 Piedmont Boulevard, Rock Hill, South Carolina.

25 Q Perfect. And preliminary -- this -- this shouldn't

1 take too long. I appreciate you taking your time,
2 and we're -- we're all busy, and I'm sure you're a
3 lot busier. So, as -- as I said, it shouldn't take
4 too long. But have you ever given a deposition
5 before?

6 A Yes, sir, I have.

7 Q Okay. So you're familiar with it, and I don't
8 really need to go over the ground rules or
9 anything, but if -- if you have any other questions
10 or anything, just let me know. If you need to take
11 a break, that's fine. One thing I just want to
12 mention --

13 A Wait, stop. Back up. What that -- wait one
14 second. I might've missed something because after
15 you asked have I ever done a deposition before, my
16 answer was yes. Then the screen went blank. It
17 started spinning. My picture came up. Went off
18 five images, and then now I see you again. So
19 you'll have to repeat questions after I said, yes,
20 I have done a deposition before.

21 Q Absolutely. And -- and I appreciate it. And if
22 that happens at any other time, just let me know.

23 A I will.

24 Q I -- I will be very brief in my questions. We are
25 all very busy. So I appreciate you taking your

1 time.

2 A Yes, sir.

3 Q Okay. And if you don't understand anything, just
4 let me know. And I -- understand my questions, let
5 me know, and I will rephrase it.

6 Can you please state for the record what your
7 education is and what residencies and licenses you
8 have?

9 A Yes. I attended Emory University in Atlanta,
10 Georgia. Graduated with a bachelor of science in
11 chemistry. I then attended University of Miami
12 School of Medicine, Miami, Florida. Graduated with
13 honors 1970.

14 I then came to Charlotte, North Carolina. And
15 what used to be -- what is now Atrium used to be
16 called "Charlotte Memorial Hospital and Medical
17 Center." I did my internship there in surgery, and
18 I stayed and, for four more years, did my
19 orthopaedic residency program, finishing in 1975,
20 board-eligible orthopedist.

21 I stayed in Charlotte with Mecklenburg
22 Orthopaedic. And after two years, you can take the
23 board examination given by the American Board of
24 Orthopaedic Surgery. I passed that examination and
25 have been board-certified ever since.

1 When I finished medical school, I had licenses
2 -- medical license in the state of Florida and
3 Georgia. Since I had been at Emory, I considered
4 going back to Georgia. When I realized that I was
5 going to stay in North Carolina, I got my North
6 Carolina license and let the Florida and Georgia
7 licenses go.

8 Then when I started working in Rock Hill, I
9 was in Mecklenburg Orthopaedic, and in 1993 we
10 merged to Charlotte Orthopaedic Specialists. In
11 2005, we merged to OrthoCarolina.

12 And so when we opened the office in Rock Hill,
13 I came down and helped set up that office, and
14 that's where I am now. Our office is Piedmont
15 Boulevard, as I said, across the street from the
16 Piedmont hospital. So I've had the South Carolina
17 license now four years.

18 So I'm a practicing orthopaedic surgeon. I
19 have retired from hospital emergency trauma,
20 rounds, and so forth. And I'm just doing office
21 practice now in Rock Hill three days a week. I
22 still do minor surgery.

23 I have one other board certification, which is
24 with the International Academy of Independent
25 Medical Evaluators. It used to be called the

1 "American Academy of Disability Evaluating
2 Physicians." I've been in that since 1993. We
3 have to recertify every three years to keep our
4 board certification, and I have just this past
5 January recertified in that.

6 So I've been in the practice of orthopaedic
7 surgery since 1976. I am what's considered a
8 general orthopaedist, because back then they really
9 didn't subspecialize that much.

10 But my practice is in about equal thirds. I
11 have done thousands of spine operations, neck and
12 back. So about a third of what I do is spine. And
13 then a lot of joint adult reconstruction as people
14 get older and wear out, a lot of total joint
15 replacements, hips, shoulders, ankles, knees. And
16 then the third third of what I do we call "sports
17 medicine," kind of the weekend warrior folks that
18 get hurt and have a knee ACL reconstruction or
19 meniscus tear or shoulder rotator cuff tear.

20 And in my 40-some years of practice, I've done
21 -- seen about 300,000 orthopaedic patients in the
22 office, and about 20,000 operations.

23 Q Wow. Well, Doctor, you -- you certainly are well-
24 credentialed, and -- and I am very envious and --
25 and thank you very much for taking the time.

1 A That -- what's -- one more addition I forgot. When
2 I took my boards in 1977, we were grandfathered and
3 did not have to take boards again. I didn't have
4 to recertify. I was grandfathered. But when I --
5 when we merged to OrthoCarolina, OrthoCarolina --
6 because my -- but my favorite part of orthopaedics
7 is teaching residents, house staff, whomever. And
8 so OrthoCarolina said that if any doctors at
9 OrthoCarolina who are grandfathered want to be
10 involved with teaching, they need to recertify. I
11 agree with that.

12 So in 2011, I recertified. It was a big deal
13 to go through it all so that I could continue my
14 teaching process and programs with OrthoCarolina.

15 Q Excellent, Doctor. Well, thank you very much. And
16 I -- I think you far -- far exceed what an expert
17 is. And I appreciate it once again.

18 So, I'm going to be asking you some questions
19 about your patient, Kyle Bagley. And -- and as I
20 mentioned, I represent him for a workers'
21 compensation claim for injuries that he sustained
22 back on June 14th, 2019. It's my understanding
23 that you have treated Kyle Bagley as a patient; is
24 that right?

25 A Yes. It is. And I'm bringing up the records. I

1 have it on a computer. So I'll be looking to the
2 right some of the time as you have questions,
3 because I've got a screen up with all of my notes,
4 all of the records there.

5 Q Excellent. Yes. And that's my next statement. I
6 was going to say: Feel free to consult with your
7 chart, his records and, you know, all of the other
8 records that you have in his file from other
9 providers.

10 So my records indicate that you initially
11 began treating Mr. Bagley back on September 12th,
12 2019; is that correct?

13 A Yes, sir.

14 Q Okay. And I believe you're still seeing him as a
15 patient; is -- is that right?

16 A Yes. What I have now -- I -- I haven't released
17 him, but I -- when I saw him on February the 20th
18 of this year, knowing that the main issue is with
19 the head injury, in my opinion, that the scans --
20 and we'll get into all this -- but I have left it
21 as a -- what we say "PRN."

22 In other words, from an orthopaedic
23 standpoint, via the tests and all, there doesn't
24 appear to be anything that he needs from an
25 orthopaedic doctor. It appears all to be the

1 treatment from the head injury and, thus, the
2 therapy and braces through therapy, occupational
3 therapy for the hand, physical therapy for the
4 lower extremity. And whether the neurologist, Dr.
5 Rao, seeing him will proceed with that or whether
6 they'll have him come back and see me for the
7 extremity, I've left that open. So I've not made
8 him a definite appointment to return, but certainly
9 have not released him.

10 Q Understood. And I appreciate it and, you know,
11 getting into the main questions that I had for you,
12 you know, I just ask that you give us your
13 responses stated in -- in your, you know, expert
14 opinion to a reasonable degree of medical
15 certainty, you know, being more likely than not,
16 based on your -- your prior knowledge in -- in your
17 career, your training, your research, and your
18 treatment of my client. Is -- is that -- is that a
19 fair statement for you to be giving me your
20 answers?

21 A Yes, sir. Yes, sir. It is.

22 Q Okay. All right. So the first date of service
23 that I have with him and you is September 12, 2019.
24 Could you please state what his history of
25 illnesses, his HPI, about what he says happened in

1 his complaints?

2 A Yes. He states that he was on his job as a welder,
3 and a -- I have down a 700-pound bale, but I think
4 it's been corrected to like 642-pound. But at any
5 rate, that he was struck in the head by this bale,
6 that he continued to work that day, saw the doctor,
7 I believe, but the next day they did a -- through
8 workers' compensation -- a CT scan of the brain;
9 was unremarkable.

10 By the time I saw him -- the injury was in
11 June, so I saw him three months later. He had been
12 getting physical therapy, but it was not effective.
13 He had been sent to an orthotist, and they -- they
14 were going to make some type of a brace, but I
15 wasn't certain exactly what they were going to
16 make.

17 Q Okay.

18 A They -- that's essentially his description of what
19 happened.

20 Q Okay. And -- and did you physically examine him?
21 And, if so, what were the findings that you have
22 for him on that date?

23 A Yes. He had -- he -- his upper extremity, his
24 wrists were in flexion, and which I'll show. The
25 wrists come down into a flexed position such that

1 he's starting to point toward his own body with his
2 hands. And the left hand was much more involved
3 than the right.

4 He had, by then, significant flexion
5 contractures such that his hands, mainly the left,
6 had been held in such tight flexion that I could
7 barely get it extended back to neutral. Neutral
8 being the position that I have now, where your hand
9 would be straight with the forearm, and the fingers
10 extended and the thumb extended, as opposed to
11 flexing down. And so I noted that I could -- his
12 fingers were down into the palm. I could get them
13 back to neutral, but it was extremely tight.

14 On the lower extremity, he had the inability
15 to pick the toes up. It's called "dorsiflexion,"
16 where you bring your foot so the toes are coming up
17 off the floor, and the right one could do it. On
18 the left, he was barely able to get it up to what
19 you call "neutral" position.

20 So if you're standing straight -- if you're
21 standing up on the floor, that foot is in neutral
22 position. Well, his foot was in a drop-foot
23 position, and I could barely get it to neutral,
24 mainly on the left.

25 And so that presentation, in my opinion, was

1 coming from the brain, as opposed to the spinal
2 cord, either cervical, thoracic, or lumbar. That,
3 to me, was brain-generated.

4 Q Okay. And what -- what was your diagnosis of -- of
5 my client on that initial visit?

6 A The -- my impression is that head injury and the
7 outer lining of the brain --

8 Now I'm looking at the court reporter. Has
9 something changed? Can you still -- everybody
10 hearing me?

11 Q (Indiscernible.)

12 A Is the screen -- okay. Not that I mind looking at
13 the court reporter. Now I'm looking at the defense
14 attorney. Does that matter? I mean, everybody's
15 still getting --

16 Q Yeah.

17 A -- the information?

18 MR. BIEDIGER: (To the deponent) Yeah.

19 You're loud and clear. You're good to go.

20 A The -- the brain has a lining in it called the
21 "cortex." And it's just right under the skull
22 bone. And so, when one has a brain injury, it
23 can either be a cortical brain injury of the
24 lining of the brain, right under the bone of
25 the cortex, or it can be a cerebral, which is

1 down more into the brain tissue. And when you have
2 an injury like this, it's called either
3 "decerebrate" or "decorticate."

4 And when you have -- when it is a decorticate
5 injury, that's when the upper extremities turn and
6 flex like they're pointing toward the body --
7 toward the body itself. If it's decerebrate, the
8 extension of -- the upper extremities extend. And,
9 so, that's why I used the very specific condition
10 of brain injury called "decorticate."

11 And it did not appear that the examination, as
12 abnormal as it was, was in any way involved with
13 actually a nerve injury in the neck, a nerve injury
14 in the low back. It all appeared to me to be
15 coming from the brain. So that was my impression.
16 And mainly in left upper and left lower, so it
17 would be a right-side brain injury.

18 Q Okay.

19 A That was my opinion.

20 Q And is that consistent with the contracture or the
21 -- the inversion that we were discussing earlier?

22 A Yes, sir.

23 Q Okay. And the drop-foot, I think you briefly
24 mentioned it; but it's my understanding that the
25 drop-foot could come from an L5 issue or a -- a

1 brain issue. Is the drop-foot because of the --
2 the corticate issue or what?

3 A Yes. You can have a drop-foot if you damage the
4 lumbar -- Lumbar 5 nerve at the 4-5 space, or if
5 there's something in the brain. When you have a
6 drop-foot and it comes from the Lumbar 5th nerve,
7 it's simply a paralysis. It isn't a flexed,
8 contracted clonus, spastic-type appearance.

9 And his appearance wasn't simply paralysis
10 that one would get if it was an L5 nerve root
11 coming out of the lumbar spine. It presents
12 differently. When it comes out of the brain, the
13 foot is rigid and tight and spasticity. And that
14 was the presentation, as I noted, where he had the
15 five- or six-beat clonus.

16 If you have a Lumbar 5 injury down at the
17 bottom of the lumbar spine, at L4-5, it's weak and
18 paralyzed. If you have it coming from the brain,
19 it is hypertonic, meaning hypertonicity,
20 spasticity, contracture. And that's the way he
21 presented.

22 And that's why I didn't think at all that it
23 had anything to do with the Lumbar 5 nerve root
24 coming out of the lumbar spine. Just as I did not
25 think that any of the upper extremity left-hand

1 flexion and all had anything to do with a cervical
2 spine injury. It was apparent that it was all
3 brain. And the subsequent scans and EMG pretty
4 much supported that opinion.

5 Q Okay. And -- and I'll go over that in -- in one
6 second.

7 So, just so I'm clear, the -- the "five- or
8 six-beat clonus," what was that again?

9 A I'm going to show you on the video in which if I'm
10 testing a reflex on the hand and you tap it,
11 ordinarily a reflex will just jump one time. But
12 in testing his ankle reflex, the foot -- boom,
13 boom, boom, boom -- pounded. It's called a
14 "clonus." And you count the beats and how many
15 times it does it.

16 And he had a four- to six-beat reflex affect
17 called "clonus," indicative of upper motor neuron
18 damage that cannot be brought on by an L5 nerve
19 root damage down at the bottom of the low back,
20 because that's not considered an upper motor
21 lesion. And, so, that has to come from the brain
22 or brainstem or up at that level.

23 Q Okay. And -- and, once again, your findings are
24 consistent, if -- if I'm correct in understanding
25 you, with a decorticate injury; is that right?

1 A Yes. Brain injury.

2 Q Okay. And what is "hyper reflex," for my own
3 edification?

4 A Ordinarily, when I would get the reflex hammer and
5 tap your knee reflex, it would jump. And you have
6 +1 to +4. And, ordinarily, people jump just a
7 little bit, boom, one time and it jumps. Or the
8 biceps reflex or triceps.

9 Some people normally will have maybe a little
10 bit hyper reflexic +3, rarely +4, but his was off
11 the scale of that by +1 to 4. Once you get a six-
12 beat clonus, that is extremely high, well above
13 what one would expect in any normal person.

14 Q Okay. All right. And I -- I believe in that
15 initial office visit of yours, you wrote -- you
16 wrote him out of work indefinitely; is that
17 correct?

18 A Yes. I did. Realizing that "indefinitely" did not
19 mean the rest of his life.

20 Q Okay.

21 A And I wrote it because I knew that he was going to
22 need the braces, he was going to need a lot of
23 therapy when you have that injury. And I saw him
24 three months later. I knew this was going to go on
25 for many, many months before he would be able to

1 walk and drive and stand and weld and use the left
2 hand effectively, if, in fact, he ever gets
3 recovery from that. So that's what I meant by
4 "indefinitely."

5 Q Okay. I appreciate the clarification. And I
6 believe the exact words were "uncertain," but I
7 appreciate it.

8 You also sent Mr. Bagley to physical therapy,
9 which I believe he began with your office on
10 September 12, the same day as your initial
11 appointment; is that your understanding?

12 A Yes.

13 Q Okay. And in looking over his physical therapy
14 notes over there with you all, does his complaints
15 and issues seem to be consistent with your initial
16 evaluation and all the statements we talked about
17 from his initial presentation?

18 A Yes. And the fact that he did not really recover
19 much at all. If you would have a extremity injury
20 of muscle sprain or spasm or even nerve damage,
21 with therapy you're going to be able to stretch the
22 muscles out, and you're going to be able to get
23 effectively extension and all, if it is a
24 peripheral nerve injury.

25 But, if it is a central nerve, like brain,

1 spinal cord -- I mean brain or brainstem, that
2 spasticity overpowers anything that you can do with
3 therapy, and that's what we noted here: that it
4 was something that was really not going to be
5 effectively improved on any quick turnaround time
6 with therapy.

7 Q Okay. And I believe you ordered some -- or you
8 recommended some orthotics for his hand and his
9 feet; is that correct?

10 A Yes, sir.

11 Q Okay. And is that for the contracture or drop-foot
12 issues that we were discussing earlier?

13 A Yes. That's exactly what it is.

14 Q Okay. In -- in your reading of your records and
15 the records from the other providers involved in
16 this, do you have any evidence to suggest that Mr.
17 Bagley has not been consistent with his complaints?

18 A No. No. He's consistent, and I'll even go the --
19 the step further to say that you really almost
20 could not make up the presentation that he
21 presented with. In other words, if you went and
22 said, "Now, I want to try to show Dr. DuPuy how bad
23 I'm hurt if I'm not hurt," he wouldn't be able to
24 do that. You can't fake clonus. The -- the
25 presentation of his hand and -- we can tell when we

1 what your thoughts are on the findings in that?

2 A Now did you say "EEG" or "EMG"?

3 Q Sorry. What did I say? Hold on. Yeah. EEG.

4 A Now, EEG, I did not order. EE -- that's an
5 electroencephalogram just of the brain. I ordered
6 an electromyogram that tells you what the
7 extremities are doing and where the damage is
8 coming from.

9 Q I apologize for that confusion on my behalf. But
10 it's -- it's my understanding that he had an EEG
11 with -- with Dr. Rao at the Neurological Institute.
12 Is -- is that what your records reflect?

13 A Yes. He did. The Dr. Taub, T-a-u-b, did the EMG
14 that I ordered. And Dr. Rao, when he saw him,
15 ordered the EEG, electroencephalogram, and a 96-
16 hour study to determine that. So, as far as the
17 EEG, it showed -- and by the way, I am not at all a
18 specialist of EEG, meaning electroencephalogram. I
19 could read what Dr. Rao said about that, but that's
20 completely his specialty.

21 Q I see.

22 A EMG, electromyogram, is what I do every day.

23 Q Okay. And what are your understandings about his
24 diagnostic scans and the findings in -- in your
25 opinion?

1 A Yes. Now -- so, on my visit of September the 26th,
2 under "Disposition," I told him that I wanted an
3 EMG, nerve conduction study, right upper extremity,
4 and then a neurology consult. And -- and then I
5 had said how the neurology consult should come
6 after he gets the EMG so the neurologist would have
7 that information. And then the neurologist would
8 go with his workup, which is often usually a brain
9 MRI, which he did, and the electroencephalogram,
10 EEG, which he did, and then recommend the four-day
11 continuous monitoring to see really what his brain
12 was doing. Because, by that time, there were not
13 only this spasticity and contractures, but also
14 memory loss and weight loss and so forth.

15 Q Okay. And, earlier you indicated that we'll get
16 into the scans and the findings on that. What --
17 what is your understanding about what those
18 diagnostic scans are showing about his injury?

19 A All right. Well, we'll first go to the EMG. So
20 when Dr. Taub did the EMG, it showed no evidence of
21 -- and it -- it showed no evidence of brain damage.
22 But it's really not set up for that. That's not
23 what the test does. It showed that there was no
24 evidence that the neck nerves were causing the
25 problems to the hand, and it showed no evidence

1 that the lumbar nerves were causing problems to the
2 leg and foot.

3 It did show chronic changes of nerve
4 irregularity and, like, inflammation of Cervical 5
5 and 6, and of Lumbar 5. But it was very mild. It
6 was of a chronic nature.

7 And that -- if you did that in -- let's see,
8 he -- he's 40 years old. If you did the EMG in all
9 40-year-olds, particularly smokers, and he
10 smoked. We talked about that. He said he was
11 going to quit. I don't know that he did quit. But
12 if you did an EMG on normal 40-year-old adults with
13 no symptoms, who are smokers, you're going to see
14 these chronic inflammatory responses that he had.

15 So I did not consider those to be abnormal
16 enough to, in any way, think that they would cause
17 that severe left upper extremity flexion
18 contracture and so forth, or the severe left foot
19 drop-foot.

20 So the EMG, in my opinion, pretty much ruled
21 out the neck and the back as being the reason he's
22 having the condition that he has. So I was
23 satisfied with that. And that was -- my response
24 then was have him see a neurologist for the head
25 injury.

1 Q Okay. And what -- what about the other scans, the
2 MRI, the EEG? Just looking at those, what are your
3 thoughts about what they may say compared to what
4 you saw Mr. Bagley presentation -- what his
5 presentation with you was?

6 A The E -- the MRI of the brain showed a small --
7 we'll call it a "hot spot" of -- of edema and --
8 and activity in the right side parietal. If you
9 put your hand up to your ear, that's the temporal.
10 And then move it slightly forward, and it's to the
11 parietal.

12 So on his right-side brain, it showed a little
13 inflammatory area. You can't be certain that that
14 is exactly the spot in the brain that would be
15 causing the left hand, upper extremity, the left-
16 lower extremity drop-foot. But that was the only
17 abnormality of the brain MRI.

18 The electroencephalogram, by what I read with
19 what Dr. Rao did, was fairly nonspecific. And it
20 would be like a cardiologist: You go to the
21 office; he does an EKG. And he says, "Well, I see
22 a little irregularity here or there. I'm going to
23 put you on a Holter monitor. You go home and you
24 wear the thing for a week." And it reads
25 everything that heart does for the whole week.

1 And that was what he wanted to do, Dr. Rao, of
2 the Neurological Institute, for 96 hours, which is
3 a four-day continuous readout to see what his brain
4 really is doing. And I think that's an excellent
5 proposal. I do not have those results. Dr. Rao,
6 in October of 2019, had these records. I don't
7 have any records past that date of November the --
8 November the 19th of 2019 is the last that I have
9 of Dr. Rao.

10 Q All right. And I -- I represent to you that he's
11 been seen by Dr. Rao a couple of times, and -- and
12 he hasn't been able to get back in there due to
13 insurance or, you know, this workers' comp claim,
14 trying to work those out.

15 But we've deposed Dr. Rao, and -- and that's
16 why we're here with you now. Are you familiar with
17 Dr. Rao, who's treating him for his neurological
18 brain issues?

19 A Yes. And I find him very -- just an excellent
20 neurologist.

21 Q Okay. Well, and in looking over his records and
22 your understanding of him in the past, do you have
23 any reason to doubt or question any -- any of Dr.
24 Rao's findings or opinions in this case?

25 A No, sir. As I said, when I referred him to a

1 neurologist, my thought process was that the
2 neurologist would proceed with an MRI, probably
3 EEG, and go from there. Dr. Rao did exactly --
4 certainly not because I recommended it, but did
5 exactly what I think a competent neurologist would
6 and should do. That's exactly what he did. And
7 then on his impressions and his plan were
8 completely in line, in my opinion, of the head
9 injury that Mr. Bagley had.

10 As I said, the answer I just gave you is
11 through the records I have of (audio cuts out) '19,
12 so I don't know what other opinions Dr. Rao may
13 have had, but if they are in line with what he said
14 up to that date, I completely agree with that.

15 Q And, once again, you would defer to Dr. Rao for
16 issues related to the neurological problems and his
17 brain injury in this injury; is that right?

18 A Yes. I do. One hundred percent defer to Dr. Rao
19 for the brain/head injury signs and symptoms --

20 Q Excellent.

21 A -- and treatment, yes. And treatment.

22 Q Excellent. And just by way of, you know, record
23 housekeeping, it indicated that Mr. Bagley was
24 discharged from physical therapy in March. I just
25 want to represent to you that it -- that was a

1 result of him having to switch over health
2 insurances. But you were still wanting him to
3 continue his treatment plan with them, which he has
4 now done with a different provider; is that right?

5 A Yes. And in my training and even in practice, I,
6 of course with orthopaedics, was involved a lot
7 with folks involved with head injuries, where they
8 would have to go to rehab for months because of
9 conditions. And we see this with some of the war
10 heroes that come back from Afghanistan or wherever
11 with head injury, and they all have tight
12 spasticity and they're -- they need ongoing therapy
13 for many, many months, sometimes for years for that
14 condition.

15 Q Okay.

16 A So as I said earlier in this deposition, by no
17 means did I mean to indicate that, "Yeah. A couple
18 months of therapy and that's all he needs." No,
19 no, no. It's just that when we were at an end
20 point where we weren't getting -- effectively
21 getting him much better, and so I was focused on,
22 "Let's get a complete diagnosis to know what we
23 have and then we can continue from there."

24 Q Okay.

25 A And I understood about the problem about the -- or

1 the question of whether or not workers' comp would
2 cover it. They may have denied it. He had to go
3 through another ability to get coverage.

4 Q Okay. And so you do not consider Mr. Bagley
5 currently to be at MMI, or maximum medical
6 improvement?

7 A That is correct. Not even close, in my opinion.
8 That MMI, meaning that maximum medical improvement
9 and/or maximum medical benefits, I think, under the
10 statutes, it means that your effective condition
11 where you are now, is where you're going to be the
12 rest of your life within about three percent of an
13 impairment rating, and we don't have that answer
14 yet.

15 It's -- and -- and one question about it, it's
16 a bit of a surprise that he was able to continue
17 working that day and then that night headache, and
18 then was seen the following day. But we know that
19 one can get what's called "cerebral edema" that
20 comes on later that could account for that. But
21 yet the brain MRI did not show significant brain
22 edema, except for that one trigger point on the
23 right parietal region. But that was months later
24 after the accident in June of '19, and that wasn't
25 for about three months later or four months.

1 So that's why my opinion is we cannot yet say,
2 "This is where he's going to be, and this is what
3 he's going to need," because, by Dr. Rao's note, it
4 appears that he was getting or is getting better,
5 at least through October, a little bit better. And
6 then, when I saw him in February of 2020, he was
7 getting a little better. Certainly still needed
8 the brace of the hands. Certainly still needed the
9 brace on the foot. So by no means able to control
10 his own function, but a little improvement.

11 Q Okay. All right. And so, once again, it's your
12 opinion that -- what -- what is your opinion
13 that -- just to summarize, that Mr. Bagley's
14 injuries are in connection with this workplace
15 incident that we've described?

16 A My opinions are now that we see where, oh, ten
17 months after the accident that if it's determined
18 by Dr. Rao that it is all head injury causing this,
19 that there's probably going to be a permanent
20 condition of impairment. If -- if the condition
21 ends up really not as much brain and more
22 peripheral nerves, the drop-foot may well improve.
23 But even if it is -- when I say "peripheral," that
24 means that the injury would be down at the lumbar
25 spine, which I do not think it is at all -- your

1 improvement would be better.

2 And at about, I would say -- it's nearly been
3 a year, but certainly at about two years, you
4 pretty much know where you're going to be with
5 somebody who has had a closed head injury with
6 these type symptoms. And it would be at that point
7 that I could say more certainly that this is where
8 he's going to end up, this is what he's able to do,
9 as far as a functional capacity evaluation and so
10 forth.

11 Q Okay. And -- and do you believe, in your opinion,
12 that that's all consistent with the head -- the
13 strike to his head from this bale of fiber that we
14 described?

15 A Yes. I do. I have no history or indication that
16 there was any other injury, anything else that
17 occurred, than that, in fact -- than that bale
18 itself.

19 Q Okay. Excellent. And, once again, last question.
20 All of your answers have been stated in your
21 opinion to a reasonable degree of medical
22 certainty?

23 A Yes, sir. They have.

24 Q Okay. Please answer any questions that Brooks may
25 have, please. Thank you, Doctor.

1 A Thank you. I'll be glad to.

2 EXAMINATION

3 BY MR. BIEDIGER:

4 Q Hey, Doctor. My name is Brooks Biediger. I'm an
5 attorney with Holder Padgett Law Firm here in
6 Columbia. And we represent Sun Fiber in Mr.
7 Bagley's case. Can you hear me okay?

8 A Yes. I can.

9 Q Okay. Good. So I'm going to bounce around a
10 little bit. That's kind of what happens when you
11 go second.

12 At any point during his clinical presentation,
13 did Mr. Bagley have a ministroke or anything that
14 looked similar to a ministroke on -- on any of your
15 office visits with him?

16 A Now a ministroke could have occurred and could
17 account for what he has, but are you talking about
18 for the time that I am literally, physically in the
19 room with him?

20 Q Right.

21 A No. And -- and it's -- it's difficult to -- to
22 exactly interpret a ministroke when it is
23 occurring. And it would be as though he's talking
24 to you and then he stops talking and his eyes might
25 flutter or his head might turn or he might get

1 quiet and then would come back and you'd ask him,
2 "What happened?"

3 He said, "Well, I didn't know something
4 happened."

5 So, the answer would be no, and at no point in
6 the -- the -- let's see, the three office visits
7 that I saw him did it appear there was any active
8 brain process destructive activity going on like a
9 ministroke or something like that.

10 And the second thing about a stroke -- well,
11 I'll just say that.

12 Q Okay. That's fine. Yeah. Yeah. I -- so just,
13 briefly, what is a ministroke?

14 A A ministroke can be as mild as what's called a
15 "TIA," transient ischemic episode, where a part of
16 the brain, for whatever reason -- vascular, spasm,
17 clot, whatever -- doesn't get enough oxygen. So
18 that part of the brain stops working for a brief
19 instant. And you might be talking to your mother
20 or grandma or somebody, and they're talking, and
21 all of a sudden, they kind of stop and they sort of
22 flutter or maybe stumble over their words. And
23 then maybe a couple of seconds or a minute later,
24 they'll come back to you. And, so, that would be
25 the least possible mildest mini event.

1 And then, otherwise, a ministroke would be
2 where you actually have loss of function. Your
3 tongue might drool, or your eyelid might drop or
4 your hand goes numb or weak, or you slump, and that
5 might last 30 seconds or three hours. And then,
6 when it comes back, again, that would be called
7 "transient ischemic." But, then, if it's
8 permanent, that's called a ministroke.

9 And you can have a ministroke, depending on
10 what part of the brain -- if it's in the
11 temporoparietal, that's going to affect your mood
12 and affect and anxiety and all of that. If it's in
13 the middle cerebral part, middle cerebral, it may
14 affect your arms' and legs' motor function.

15 Q Now, is ischemia something that's trauma-induced,
16 or does it occur in a -- in a different type of
17 pathological form other than, you know, traumatic
18 injury?

19 A Both. And the ischemia, when it is traumatic,
20 would be -- you've heard the term "aneurysm." The
21 blood vessel can have a little weak spot on it
22 where there's like a weakness of the -- of the wall
23 and like a little bubble in it. And if that
24 ruptures, either just normally or traumatically,
25 that will bleed into that part of the brain. And

1 the brain swells and gets edematous and that -- it
2 can't expand, because your hard -- the hard bone of
3 the head won't let it. So it builds up pressure.
4 And -- or what -- whatever that part of the brain
5 that blood vessel was feeding, if that blood vessel
6 ruptures, the blood doesn't get to the part of the
7 brain that that blood vessel is supposed to feed.

8 So it can be that -- usually the traumatic
9 kind is called the "subdural." In other words, the
10 "dura" is just the lining right up under the brain
11 -- under the -- the skull, and if you get hard
12 enough -- you get hit hard enough and it damages
13 the capillary beds, they bleed. So you get a
14 little blood clot in the subdural. That's when
15 you've got to go in and core through the bone to
16 decompress that. And that's what I'm saying, that
17 there was no evidence at all.

18 Q And -- and, yeah. And -- and as you just said,
19 it's a pretty emergent-type thing if it were to
20 happen, right? I mean, you've got to send them off
21 for emergency treatment, right?

22 A Yes, sir. And that's why they did the CT scan, and
23 that's the next day. He went back in and he said,
24 you know, "My head's really hurting, and I have
25 memory loss," and so forth, weakness to the hand,

1 that's the CT scan. And that would have shown a
2 traumatic subdural hematoma if he'd had one.
3 That's why you do the CT scan. And that's even
4 preferable to the MRI. Because the CT is better to
5 show a subdural hematoma. The MRI shows whether
6 there's tissue damage deeper in the brain. But he
7 didn't have that for a while.

8 So the fact that he had the CT scan the next
9 day that was negative is a very important sign that
10 he did not have a ministroke that bled or a
11 subdural hematoma or a traumatically-induced bleed
12 into the brain.

13 Q Okay. Now, during any of your physical
14 examinations, I guess particularly in September,
15 was there any point where Mr. Bagley had symptoms
16 similar to a ministroke? Like, if his face were to
17 drop? Any -- any symptoms like that?

18 A No. His -- his face, with the -- of course, the
19 facial features are all coming from the brain
20 inside called "cranial nerves," 12 of them. And
21 there was no indication that he had a facial-
22 feature dysfunction, because if you have something
23 in the brain that involves the left side of the
24 arms and legs, it would affect the right side of
25 the head in the face and ears and eyes and nose and

1 so forth.

2 And so there was no indication he had any
3 dysfunction, paralysis, numbness, weakness,
4 slurring his words, drooling saliva, squinting his
5 eyes, smiling. Those are the -- for any -- those
6 are the things you test. And he was normal for his
7 cranial nerve exam.

8 Q Did you tell Mr. Bagley that his injury would put
9 his body through a safe zone, which is kind of like
10 having a ministroke? Did you ever tell him that?

11 A No. I never mentioned the word "ministroke." I
12 never mentioned that word because that's really not
13 what you think of with head injury, in my opinion.
14 And, of course, again, I'm not the brain
15 subspecialist, but, no, I did not mention the word
16 "ministroke."

17 In fact, when you asked me the question today,
18 that really is not an accurate diagnosis, in my
19 opinion. Now, if Dr. Rao used it, okay. But, no,
20 that's -- that's not a word in my vocabulary I use
21 anyway. So, if he -- and his wife was always with
22 him, and she was very attentive. And I think they
23 paid attention and all. But, no, I never mentioned
24 that word, "ministroke."

25 Q And -- and I'm not sure if Dr. Rao mentioned it or

1 not, but I know Mr. Bagley did in his deposition.

2 I'm -- I'm going to try to use this feature, if I

3 can. There's a "share screen" feature, somehow.

4 Let's see if I can --

5 A Well, you can read it to me. I mean, either way.

6 Q Yeah.

7 A I -- yeah.

8 Q Here you go. Can you see what I'm showing you?

9 A Yeah. I see it. I can see it --

10 Q Okay.

11 A -- when I get closer.

12 Q And so this is from Mr. Bagley's deposition. It

13 would've been September 30 of 2019. This is

14 Page -- Page 96 --

15 A Yeah.

16 Q -- Lines 12 through 15.

17 A Right.

18 Q And Mr. Bagley says, "The first thing he -- he did"

19 -- he's talking about your physical exam -- "was

20 grab my head and squish over my ears. When he

21 squished over my right ear, I guess he seen

22 everything in my face drop, and he stepped back."

23 Do you -- you recall that happening?

24 A Not specifically, no. But, now, what I'm reading

25 is his answer: "So I explained to him what Dr.

1 Brown had said and told him I was going through
2 therapy. I actually told him Dr. Jarrell said they
3 determined -- the first thing he did" . . . So it
4 says -- I'm thinking that that answer says Dr.
5 Brown, because he did see --

6 Q Oh, I'm sorry. I'm sorry. I meant -- I meant to
7 show you the question. If you go to Line 6, it
8 says, "So why don't you tell me about the
9 conversation you had with Dr. DuPuy regarding your
10 diagnosis?"

11 A Okay. Oh, okay. Then he talks about Dr. Brown.
12 No.

13 Q Okay. And so, if we go down a little bit, it's
14 kind of on the -- the turn of the of Page 96, 97,
15 "and he is thinking that the impact to the head --
16 your body and your mind has a memory, and the
17 memory knows where to go in safe mode. And so he's
18 saying that to his best understanding that because
19 I got hit closer to the right side of the -- the
20 cortex and the nerves got smacked, it put my body
21 through a safe zone, which is kind of like having a
22 ministroke."

23 So is -- is that an accurate . . .

24 A I can say -- and even in his defense, I can say I
25 absolutely did not say that. I would never have

1 said such a statement. When I read it there, it is
2 so inaccurate that "the memory talks about a safe
3 zone," absolutely not.

4 Q So -- so, yeah, does the -- does the -- what -- do
5 you have any idea of what he's talking about?

6 A I have no idea what he's talking about. And I --
7 even as I'm reading it today, I never said --
8 because I don't believe that anyway.

9 Q Yeah.

10 A I think it's inaccurate, and the memory, it -- when
11 you talk about memory things, there are things that
12 the memory will forget because they're trying to
13 keep you -- it's called "regression" and
14 "sublimation" and all those things. That's --
15 that's entirely different here. That -- that --
16 no. I said none of what I've read on Pages 96 and
17 -- no.

18 Q Okay. So what about smoking? Is smoking the type
19 of thing that -- that could induce some sort of
20 ministroke or TIA, something like that?

21 A Absolutely. Smoking is just so disastrous for the
22 cardiovascular system. And I talked to him about
23 it. And especially when you have nerve damage.
24 And I was upfront; I put it in my records. I said,
25 now -- and -- and I might've used the word

1 "disastrous" to him. There was no question about
2 it. It isn't, "Well, you should cut down."
3 Absolutely not. Because, not only is it so
4 damaging in just general to the brain and heart and
5 the whole body, but once you have nerve damage,
6 it's the nicotine -- is isn't even the smoke; I
7 explained it to them, how that blocks the healing
8 effect.

9 And that's why bones don't heal when you
10 smoke. And when we do bone grafts, we won't even
11 do it electively on people that smoke, because it's
12 not going to heal.

13 So I was very specific. In fact, he made the
14 comment, "Yep," I think -- I think his wife also
15 smokes and that they both needed to quit. But
16 then, unfortunately, I saw on record that as he was
17 seen a few months later, I -- I think I had him at
18 a pack a day. I think he was down to maybe half a
19 pack. So it appears that he may still be smoking.

20 But the answer is that: Absolutely,
21 unquestionably just disastrous for somebody that's
22 had nerve injury, ether from brain or from
23 peripheral.

24 Q And would that have the tendency to, I guess,
25 extend his recovery time or extend his disability

1 in any way --

2 A Yes, sir.

3 Q -- if he continued smoking?

4 A Yes, sir. There's no question about that.

5 Q Okay. So if we could just briefly review Mr.

6 Bagley's subjective symptoms when he saw you first

7 and then I believe that's when you were talking

8 about the -- the decorticate position of the left

9 hand, right?

10 A Yes.

11 Q And you explained that the decorticate position is

12 that sort of flexed position caused by the -- the

13 damage to the cortical area of the brain, right?

14 A Yes. And Dr. Rao -- again, I'm going to defer to

15 him for all that, but I don't know that he

16 mentioned that in his thing. It's just that we see

17 on an acute somebody -- if you're at a boxing match

18 or an MMA or something and you see somebody knocked

19 out, sometimes they're postured. They will

20 immediately bring those arms up like this and flex

21 and kind of grimace. That's a cortex injury,

22 decorticate. Sometimes --

23 Q The -- the fencing maneuver. Is -- is that -- that

24 the fencing maneuver? Is that kind of like that?

25 A The what maneuver?

1 Q I think they call it the "fencing," where they --
2 the arms go out. Is that --

3 A Yes.

4 Q -- what you're talking about?

5 A That idea. And then decerebrate is -- is a little
6 bit different, but yes, sir. That's what it is.

7 Q Okay. And so --

8 A And I don't mean --

9 Q Sir, go ahead.

10 A Excuse me. I don't mean to -- I don't want to go
11 on record as saying, "Oh. No. I know this is the
12 -- the cortex part of the brain versus the
13 cerebral, versus the parietal." No, no, no. I'm
14 not that at all. His presentation was, to me, the
15 -- the decorticate part of the injury. But I defer
16 to Dr. Rao for the very specifics of the anatomic
17 part of where the damage is.

18 Q Yeah. From an orthopaedic standpoint, is there
19 anything structurally or mechanically wrong with
20 Mr. Bagley's head or brain, from what you can tell?

21 A No. That's a surprise to me that those scans are
22 essentially normal. The -- but it doesn't mean
23 that an injury can't have occurred at the cellular,
24 microscopic level. But he didn't have a -- a
25 subdural hematoma, and he doesn't have an area in

1 the brain by MRI where it's just dark, where the
2 brain tissue has died and the body has carried --
3 kind of cleaned it up. He doesn't have that.

4 And so that, to me -- this is an -- an
5 irregular presentation and, of course, that's why I
6 defer it to Dr. Rao and the -- the neurology
7 subspecialist.

8 But from an orthopaedic standpoint, I do not
9 think that there is an injury to the cervical
10 nerves from the neck, shoulder, arm, out to the
11 hand.

12 The EMG nerve conduction showed that he had
13 some ulnar nerve -- little bit of entrapment at the
14 elbow. That wasn't caused by the injury. That's
15 just what he has. The EMG nerve conduction of the
16 lower extremities shows that there's a little bit
17 of nerve irritation, chronic, at the Cervical 5-6
18 region at lower lumbar, as well. But I don't think
19 that that is related to the accident.

20 Q And it -- and it -- I'm sorry. Go ahead.

21 A And if you -- like I said, you get a 40-year-old
22 heavy smoker, or any adult, and they're going to
23 have those changes on EMG nerve conduction fairly
24 frequently.

25 Q Right.

1 A But, without any question, my impression is that
2 this contracted hand, closed injury to the hand and
3 to the foot, is from the accident and it involves
4 the brain.

5 Q Now, would you classify the -- the contracted hand
6 symptoms as an -- an objective standard, or would
7 that be a subjective standard?

8 A That is objective.

9 Q Okay.

10 A But that's --

11 Q And so --

12 A (Indiscernible.)

13 Q Go ahead.

14 A (No response.)

15 Q And so I -- I guess, in -- in terms of -- if I were
16 a -- if I were a doctor trying to recreate your
17 findings, what specific evidence would I -- would I
18 look at to -- to show the -- the objective side of
19 this as far as the -- the decorticate position
20 having to do with the work injury itself?

21 A All right. What you do is you look at the position
22 his hand is in, and it was flexed, the wrist
23 flexed, I'm going to reproduce maybe 45 degrees,
24 and the fingers down in the palm.

25 So what you do it you slowly bring that thumb

1 and force it back up to extension and take each
2 finger and force it back up to extension. Now, if
3 you are voluntarily trying to fool me and say, "I'm
4 going to have this position, but as Dr. DuPuy
5 slowly stretches it, I'm going to let him stretch
6 it" . . .

7 Are we still on here?

8 Q Yeah. Yeah. Luckily, yeah. Go ahead.

9 A Something came on about a message.

10 Q That wasn't me, I don't think.

11 A So if -- if you -- if you're -- and I'm slowly able
12 to get -- it's called "give-way weakness," because
13 you're not able to say, "Well, I'm going to let him
14 move it 3 millimeters and now another quarter of an
15 inch, and another quarter of an inch," and you
16 ratchet it back up. And it is so obvious to me,
17 and to a physician, when they're doing it
18 voluntarily.

19 But if you have an -- an flexed contracture
20 because of this, as we talked, hypertonic
21 contraction, it's like when somebody has had a
22 stroke and their hand is all shrunk down on one
23 side, which is what you see. And so you take and
24 you slowly can stretch it. That's very objective.
25 And it is very easily determined when they're

1 sandbagging you, when they're making it up, called
2 "symptom magnification," "exaggerated,"
3 "malingering," whatever you want. I saw no
4 indication of that in the physical exam.

5 And the same thing with the foot. So when you
6 have a fixed contracted muscle and tendon and you
7 slowly extend it, it is a slow, very smooth, low,
8 like stretching a tight rubber band. It doesn't
9 ratchet, it doesn't clunk. He wasn't flinching and
10 jerking and huffing and puffing and all that. None
11 of that that you would see with somebody making it
12 up.

13 Q What about the -- I guess the -- of all the
14 objective diagnostic testing you've seen, is there
15 any indication of acute injury?

16 A No. That's the surprise to me. And then --

17 Q Right. Go ahead. I'm sorry.

18 A And -- and that's where I'm leaving it to Dr. Rao,
19 because there's nothing from a peripheral nerve
20 down in the arms and legs to account for that
21 degree of spasticity and flexion and position.

22 And if you voluntarily want to hold your hand
23 in that position with no damage, your muscles tire
24 out. You can't hold it that long. It'd just be
25 like I'm pointing to you on the screen. And if I

1 say, "Well, I'm just going to hold this for an hour
2 or a month or a week," you can't. You just finally
3 give up. And that's why I am willing to go on
4 record, greater likelihood than not that I think
5 that these injuries to a foot, arm, leg, and, of
6 course, I don't know about memory in the brain, are
7 real and objective and accurate and related to the
8 head injury that I think he had.

9 Again, having said what you -- answered what
10 you said, the physical findings or evidence that
11 there's no nerve damage coming out of the neck,
12 arm, shoulder to the hand or out of the lumbar
13 spine, hip, lower leg to the foot. I think that's
14 all coming from the brain.

15 Q Well, so you -- but you would defer to Dr. Rao in
16 terms of the actual brain side of the injury,
17 right?

18 A Yes, sir.

19 Q Okay.

20 A Completely. And if he says there's no brain damage
21 to account for that, then I accept that because he
22 is the specialist. A neurologist is a specialist
23 for brain function, not myself.

24 Q Yeah. That -- that -- that was fixing to be my
25 next question. You -- you caught it ahead.

1 So if -- if -- if -- if Dr. -- Dr. Rao or some
2 other neurologist were to examine Mr. Bagley in
3 order to say that they don't find any evidence of
4 any sort of acute injury to explain the symptoms,
5 it -- it -- would -- would that impact your opinion
6 as you just stated it?

7 A Yes. Because I would say I have nothing from an
8 orthopaedic standpoint to say this has anything to
9 do with a neck injury or an arm injury or a back
10 injury or a leg and foot injury. And if they say
11 it's not coming from the brain, then I do not know
12 why he is in that fixed position.

13 And as I said, the fact that he was able to
14 continue working and then presented to the workers'
15 comp the next day, the CT scan was normal, that
16 part doesn't make sense with this syndrome either.
17 But, of course --

18 Q Would you -- I'm sorry. Go ahead.

19 A But, I mean, that's what I'm saying: It is what it
20 is.

21 Q Yeah. Yeah. What would you expect to see if -- if
22 -- given what you know about the accident and given
23 what you know about his condition now, what would
24 you have expected to see on the CT scan the next
25 day?

1 A Subdural hematoma or something. And then -- and
2 then, also, by the MRI of the brain even a couple
3 of months later, see a significant brain injury to
4 cause this. And it would have been very specific
5 along the cerebral line.

6 That term Dr. Rao may have mentioned, it's
7 call the "homunculus." And it's the entire right
8 side about a little bit ahead, in front of the ear,
9 where it's the whole side of the brain in the
10 cerebrum. And it -- it outlines what part
11 determines the thumb and the tongue and the chin
12 and the lower extremities. And there's actually a
13 picture of it like an image of a human and what
14 nerves are involved where. That I would have
15 expected damage there. But it looks like there was
16 none seen.

17 Q Okay. And so, at least from -- from an orthopaedic
18 standpoint, you can't say what's causing -- what
19 underlying pathology is causing Mr. Bagley's
20 symptoms; is that fair to say?

21 A That is exactly what I say. Yes.

22 Q And then, of course, your -- your -- the scope of
23 your evaluation is limited to the orthopaedic side
24 of things?

25 A Yes. It is. My expertise is limited to the

1 orthopaedic arms and legs part, not inside the
2 brain.

3 Q Okay. And -- and I've got to ask you if you had --
4 how did you get involved in this case?

5 A Well, I don't know. Let's see. I mean, I -- at
6 our practice, OrthoCarolina, and I'm in at the
7 same, about 17 -- 15 to 17 percent of our work is
8 workers' comp --

9 Q Okay.

10 A -- throughout all OrthoCarolina, and I'm going to
11 look down to see under -- there are a lot of legal
12 requests. Let's see.

13 Q You know, I tell you what. Maybe -- maybe I could
14 shortcut this. Have you ever spoken with Mr.
15 Sanchez or anybody from his office at any point
16 about this case?

17 A No, sir. Today's the first time I've spoken --

18 Q Okay.

19 A -- to anybody.

20 Q That's it. That's all I need to know, Doctor.

21 MR. BIEDIGER: Thank you so much for taking
22 your time. I really appreciate it. And I --
23 I appreciate joining us via Zoom with all the
24 technical issues that it has, but I could hear
25 you loud and clear. I appreciate it. Thank

1 you.

2 THE DEPONENT: Yes. Certainly. I appreciate
3 that.

4 MR. SANCHEZ: Thank you very much, Doctor
5 DuPuy. I hope you and your family are -- are
6 safe and healthy. Have a great day.

7 Last little housekeeping measure, you
8 have the right to read over your deposition or
9 waive it. Do you want to read it over? Or do
10 you want to waive it?

11 THE DEPONENT: No. I'll waive that. The only
12 thing would be is if -- if it comes to a trial
13 deposition again -- I don't know if this is
14 discovery or what, but if it comes to a trial
15 deposition, I would want to read it just to
16 remember everything I said here today. But,
17 no, I'll waive that.

18 MR. SANCHEZ: Yeah. And we're taking your
19 deposition so we don't have to bring you to
20 trial for the workers' comp case. So this
21 is --

22 MR. BIEDIGER: That's right.

23 MR. SANCHEZ: -- going to be instead of that.

24 THE DEPONENT: That -- I'm fine with that.
25 I'll waive it.

1 (Off the record at 11:19 a.m.)

2 FURTHER DEPONENT SAITH NOT.

3 (Whereupon, there being no further

4 questions, the deposition was

5 concluded at 11:19 a.m.)

6 (*This transcript may contain quoted material.

7 Such material is reproduced as read or quoted

8 by the speaker.)

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BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 1908703

Kyle R. Bagley,)	
Employee,)	
vs.)	DEPOSITION OF
Sun Fiber, LLC,)	BRETT GUNTER, M.D.
Employer,)	SEPTEMBER 8, 2020
and)	
Strategic Comp,)	
Carrier/Defendant.)	
_____)	

Deposition on oral examination of BRETT GUNTER, M.D., reported by Patricia G. Bachand, Court Reporter and Notary Public in and for the State of South Carolina; pursuant to Rule 30 of the South Carolina Rules of Civil Procedure; said deposition was taken on Tuesday, the 8th day of September 2020, scheduled for three o'clock p.m. and commencing at the hour of 2:97 p.m.

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APPEARANCES:

REPRESENTING THE EMPLOYEE:

BRYAN N. SANCHEZ, ESQ.
Lewis Law Firm
772 Cherry Road
Rock Hill, South Carolina 29732
(info@stacylewislaw.com)

REPRESENTING THE CARRIER/DEFENDANT:

M. BROOKS BIEDIGER, ESQ.
Holder, Padett, LittleJohn & Prickett, LLC
1201 Main Street, Suite 1430
Columbia, South Carolina 29201
(bbiediger@hplplaw.com)

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* * * * *

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1 Court Reporter's Legend:

2

3 dashes [--] Intentional or purposeful interruption

4 ... Indicates trailing off

5 [ph] Denotes phonetically written

6 [sic] Written as said

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1 This deposition is taken in accordance with the
2 South Carolina Rules of Civil Procedure.

3 It is agreed and stipulated by the deponent and
4 respective counsel that the reading and signing of the
5 deposition by the deponent is expressly waived.

6 WHEREUPON:

7 BRETT GUNTER, M.D., being duly sworn and
8 cautioned to speak the truth, the whole truth and nothing
9 but the truth, testifies as follows:

10 DIRECT EXAMINATION BY MR. BIEDIGER:

11 **Q. Good afternoon, Dr. Gunter. And thank you for**
12 **taking the time to sit for this deposition today. My name**
13 **is Brooks Biediger. We just met. I represent Sun Fiber in**
14 **a workers' compensation claim brought by Kyle Bagley. And**
15 **I see you got your notes in front of you. Have you had a**
16 **chance to look over your notes? Do you want some time?**

17 A. I've had a chance to look over them. Thank you.

18 **Q. Okay. And is it fair to say that your opinions**
19 **today will be to a reasonable degree of medical certainty?**

20 A. Yes.

21 **Q. If you would just briefly give us the benefit of**
22 **your education, training, experience and so forth.**

23 A. In 1987 I graduated from the University of
24 Alabama with a bachelor of science degree in chemical
25 engineering. In 1991 I graduated from the University

1 Alabama School of Medicine with a Doctorate in Medicine.
2 In 1998 I completed a neurosurgical residency at the
3 University of Tennessee College of Health Sciences. In
4 2000 I was -- achieved certification by the American Board
5 of Neurological Surgery. In 2010 I achieved
6 recertification by the same board. And I currently
7 participate in their Maintenance of Certification Program.

8 **Q. Okay. And where do you currently practice?**

9 A. Currently, I practice at Lexington Brain and
10 Spine Institute.

11 **Q. Okay. And this is something that I'm sure you**
12 **get frequently, but if you would briefly just tell us the**
13 **difference between a neurosurgeon and a neurologist.**

14 A. So just like cardiologist and cardiac surgeons,
15 neurologists manage the non-surgical disorders of the
16 neurologic system. And neurosurgeons manage the surgical
17 disorders of the neurologic system, including surgical
18 disorders of the brain, spine, and peripheral nerves.

19 **Q. Okay. So both are specialists in brain and nerve**
20 **function, right?**

21 A. Yes.

22 **Q. And I guess they use the same diagnostic testing**
23 **and -- but the key difference being the treatment**
24 **modalities that y'all employ, right?**

25 A. Right. So there's two key differences. One is

1 the treatment modalities and the subject matter, because a
2 neurologist might manage something like a neurodegenerative
3 condition like Multiple Sclerosis, let's say. And then the
4 other one is -- neurosurgeons manage the structural
5 disorders of the spine itself. Like, you know, spinal
6 fractures, degenerative conditions of that boney spine,
7 which would be outside the neurologist's purview.

8 **Q. Okay. And so I guess from a patient's**
9 **standpoint, if a patient comes in with a closed head**
10 **injury, is there any difference in how a neurologist versus**
11 **a neurosurgeon might evaluate them, or diagnose them,**
12 **perhaps?**

13 A. Well, probably not too much difference.
14 Neurosurgeons are frequently seeing head traumas and head
15 injuries, and so we might have more concern about injuries
16 to take skill and associated structures. But I would say
17 that the evaluation would probably be very similar.

18 **Q. Okay. And let's just step right into your**
19 **treatment with Mr. Bagley. And are you aware that he**
20 **alleges a work injury on June 14, 2019?**

21 A. Yes.

22 **Q. And what is your understanding of his injury?**

23 A. (As read) "He was on his way to fix a broken ramp
24 on the floor. He was in the process of welding supports on
25 the sides. He had one knee down on the floor and one knee

1 was in a crouched position. He was abruptly, quote,
2 knocked backwards and landed on his back by a 650-pound
3 bale of fiber that had come off the roller and knocked him
4 backwards."

5 Q. Okay. And according to the records we have, you
6 met with Mr. Bagley on two occasions. That would be March
7 10, 2012 [sic] and July 8, 2020. Does that sound right?

8 A. Yes.

9 Q. Any other visits outside of those two?

10 A. Not that I'm aware of.

11 Q. And if you would just briefly summarize your care
12 for Mr. Bagley.

13 A. So the visit in March of 2020 was a visit that
14 was directed at his lumbar spine at his back -- at his
15 lower back. And the assessment from that was that at this
16 point:

17 I reviewed his MRI and I'm unable to identify an
18 acute injury. Now, I had also seen him in person, taking
19 his history and done a physical examination on him at that
20 time. The findings on this MRI are degenerative in nature
21 and I would -- that would take years to develop.

22 Unfortunately, I do not have his nerve conduction
23 velocity tests. The only diagnosis that I can apply here
24 is the lumbar myofascial syndrome. The most important
25 ingredients in that treatment of lumbar myofascial syndrome

1 are the passage of time and physical therapy. I do not
2 identify any additional treatments that will likely improve
3 his back syndrome. I do not identify a mechanical
4 restriction to his return to work.

5 **Q. And as to the July visit?**

6 A. The July visit was focused on his cervical spine.
7 At that time, two pieces of imaging were reviewed: an MRI
8 of the brain and an MRI of the cervical spine. And my
9 assessment -- and, of course, he had a history and physical
10 exam at that time as well.

11 The assessment was: At present I am unable to
12 identify either significant cervical spinal disease or
13 intracranial disease to explain his current condition. I
14 had read a report indicating that, quote, an adjustment
15 disorder may be present. There are not indications for
16 neurosurgical intervention. He will need continued
17 rehabilitation for the contractures of his left upper and
18 left lower -- excuse me -- left upper and lower extremity.
19 And I said that there was no indication for neurosurgical
20 intervention at that time.

21 **Q. Okay. And so I'll try to get through these as**
22 **quickly as possible. I'm going to hand you mergings of**
23 **diagnostic imaging reports that we have, and I've grouped**
24 **them by body part, essentially. And the first one is going**
25 **to be a CT scan of the head dated August 29, 2019 -- August**

1 29, 2019. And as you'll see from the Impression section,
2 is a negative unenhanced head CT with no mass lesion,
3 hemorrhage, or infarction. Do you see that, Doctor?

4 A. Yes.

5 Q. Did you have a chance to review this CT before
6 you reached your diagnosis?

7 A. Yes.

8 Q. Okay. And is there any evidence of
9 traumatically-induced brain injury on the CT?

10 A. No.

11 Q. And then the next diagnostic we have is going to
12 be an MRI of the brain on September 24, 2019. And the same
13 question: Is there any evidence of acute injury on this
14 MRI?

15 A. No.

16 Q. And then lastly, the MRI, which I believe you
17 referred Mr. Bagley for, is a second MRI of the brain dated
18 June 9, 2019. Is there any evidence of acute injury on
19 this MRI?

20 A. The exam date was June 9, 2020.

21 Q. I'm sorry. June 9, 2020. Yes.

22 A. That was a normal MRI of the brain as well.

23 Q. Okay. Thanks, Doctor.

24 MR. BIEDIGER: And if we could mark that as
25 Exhibit 1.

1 (DEFENDANT'S EXHIBIT NO. 1 MARKED FOR
2 IDENTIFICATION PURPOSES (4 PAGES) - DIAGNOSTIC
3 IMAGING REPORTS)

4 Q. All right. Doctor, the next pack I'm going to
5 hand you is for that cervical spine.

6 MR. BIEDIGER: And we'll go ahead and mark
7 that as Exhibit 2, if we can.

8 (DEFENDANT'S EXHIBIT NO. 2 MARKED FOR
9 IDENTIFICATION PURPOSES (6 PAGES) - RADIOLOGY
10 RESULTS)

11 Q. And the same scenario, the first page is going to
12 be a CT scan from June 17, 2019. So that would have been
13 three days after the accident. Is there evidence of acute
14 injury on that CT?

15 A. No.

16 Q. And then go a couple of pages, we've got an MRI
17 of the cervical spine dated July 13 -- or July 3rd, 2019.
18 Do you see evidence of acute injury on this MRI?

19 A. No.

20 Q. And then a couple of pages after that, the second
21 CT scan from June 9, 2020, at your referral. Is there any
22 evidence of acute injury on this MRI?

23 A. This is that second MRI. And your question --
24 you indicated it was a CT scan.

25 Q. I'm sorry. Is there any evidence of acute injury

1 on the second MRI?

2 A. No.

3 Q. And if you look at the CT scan, the next page,
4 also June 9, 2020, is there any evidence of acute injury on
5 the second CT?

6 A. No.

7 Q. And the next packet is going to be Exhibit 3 for
8 that lumbar spine.

9 (DEFENDANT'S EXHIBIT NO. 3 MARKED FOR
10 IDENTIFICATION PURPOSES (6 PAGES) - RADIOLOGY
11 RESULTS)

12 Q. And, again, it's the CT dated June 17, 2019 of
13 that lumbar spine. Is there any evidence of acute injury
14 on that CT?

15 A. No.

16 Q. And if you'll go a couple pages back, did a MRI
17 of the lumbar spine on July 3rd, 2019. Is there any
18 evidence of an acute injury on this MRI?

19 A. No.

20 Q. And then for the last MRI, which is going to be
21 February 27th, 2020, do you see any evidence of acute
22 injury on this MRI?

23 A. No.

24 Q. And then, Doctor, you have an EMG nerve
25 conduction study. Have you had a chance to review this?

1 A. I don't know.

2 MR. BIEDIGER: If we can just mark that a an
3 exhibit.

4 (DEFENDANT'S EXHIBIT NO. 4 MARKED FOR
5 IDENTIFICATION PURPOSES (5 PAGES) - METROLINA
6 NEUROLOGICAL ASSOCIATES MEDICAL RECORDS DATED
7 10/22/2019)

8 MR. BIEDIGER: Can we go off the record for
9 just a second?

10 (Off the record.)

11 EXAMINATION RESUMED BY MR. BIEDIGER:

12 Q. All right. Doctor, have you had a chance to
13 review the EMG nerve study?

14 A. Yes.

15 Q. And do you see any evidence of acute injury on
16 the EMG nerve study?

17 A. No.

18 Q. Doctor, are there any other diagnostic testing
19 that you'd like to see -- I mean, I know we've got multiple
20 MRIs, multiple CT scans and so forth. Is there any other
21 sort of diagnostic imaging you'd like to see on Mr. Bagley?

22 A. None that I can think of.

23 Q. And is there any objective evidence of an acute
24 injury to Mr. Bagley's brain, neck, or back?

25 A. No.

1 Q. Okay. And then, briefly, what were Mr. Bagley's
2 symptoms when he -- when you evaluated him?

3 A. His present syndrome is as follows from that July
4 note, which was targeted at his neck. At that time from
5 that standpoint of his neck he had a syndrome that was
6 headaches, neck pain, and left shoulder and arm pain. At
7 the time of his visit in March, his headache was -- excuse
8 me -- his syndromes were 50 percent low back pain and 50
9 percent left hip and leg pain.

10 Q. Now, for a closed head injury, is it fair to say
11 you'd expect a majority of the symptoms to present early on
12 and then heal and get better over time? Is that kind of
13 the standard course for you to see?

14 A. Yes.

15 Q. And so if Mr. Bagley had weakness in his
16 extremities caused by a closed head injury, is it fair to
17 say that would -- you would expect to see that present
18 within the first month or so after the injury, and get
19 better over time?

20 A. Yes.

21 Q. Now, I believe your report noted that you
22 reviewed Dr. Brown's evaluation from Midlands Orthopaedics;
23 is that right?

24 A. Yes.

25 MR. BIEDIGER: And I've got a copy for you,

1 if you want to refer to it, whatever exhibit number we are.

2 (DEFENDANT'S EXHIBIT NO. 5 MARKED FOR
3 IDENTIFICATION PURPOSES (12 PAGES) - MIDLANDS
4 ORTHOPAEDIC MEDICAL RECORDS)

5 Q. And, Doctor, briefly, if I could draw your
6 attention to the second page on the physical exam section.
7 About halfway through the paragraph there it says, "The
8 patient has 5 out of 5 bilateral upper and bilateral lower
9 extremity strength. Of note, the patient has good full
10 strength in both the flexors as well as all extensors of
11 his upper extremity and does not have poor oppositional
12 tone." Do you see that?

13 A. Yes.

14 Q. What is your -- what does that mean?

15 A. His motor exam is normal.

16 Q. And when you evaluated Mr. Bagley on July 8,
17 2020, a year after this evaluation, what was his motor
18 examination then? What was your record?

19 A. His motor examination was abnormal. At that time
20 he had a reduction in strength on the left and his wrist
21 extensors, the wrist flexors and hand grip such, so that he
22 had limited hand grip function. Only enough grip to create
23 -- to move against gravity.

24 In other words, he couldn't generate a
25 significant amount of force with his left hand grip. At

1 that time his upper extremities demonstrated a reduction in
2 touch to the left palm and overall five digits, and a
3 reduced sensation to light touch over the left lower
4 extremity.

5 And then his lower extremity was examined in
6 March, prior to that July visit, where he had a reduction
7 in strength in the hip flexors, hip quadriceps on the left.
8 The anterior tibialis, which is the muscle in your lower
9 leg, was also reduced. Okay.

10 Q. And so based on Mr. Bagley's mechanism of injury,
11 would you consider it unusual for him to have five out of
12 five strength a month after the accident, but then a year
13 later to have reduced strength?

14 A. Yes.

15 Q. And why is that?

16 A. Well, an acute injury should produce an acute
17 change in neurologic exam, and so you would expect to see
18 the signs and symptoms of a neurologic injury immediate and
19 proximate to the injury.

20 Q. And, Doctor, just briefly, if we could go to your
21 assessment section, the July 8th, 2020 report, where you
22 say that you're unable to identify other significant
23 cervical spine disease or intracranial spinal disease, etc.
24 Is there any neurological explanation for what's causing
25 Mr. Bagley's symptoms?

1 A. I could not identify a neurologic explanation for
2 his symptoms. I would like to correct something in this
3 note. It says "intracranial spinal disease." It's just
4 meant to be intracranial disease. No spinal.

5 **Q. Right.**

6 A. That's just a clerical error. So it should read,
7 "At present I am unable to identify either significant
8 cervical spine disease or intracranial disease to explain
9 his current condition."

10 **Q. And is it your opinion, to a reasonable degree of**
11 **medical certainty, that -- does Mr. Bagley have a**
12 **permanent, severe brain injury?**

13 A. No.

14 **Q. Now, you mentioned the adjustment disorder. What**
15 **did you mean by that?**

16 A. It's just -- I just noted that someone else had
17 made that diagnosis. That's not a diagnosis that I make.

18 **Q. And because that would be sort of a psychological**
19 **emotional behavioral-type diagnosis, right?**

20 A. Yes.

21 **Q. Do you suspect any sort of psychological overlay**
22 **to Mr. Bagley's symptoms?**

23 A. I simply am unable to explain his current
24 condition based on physical medicine. And so since I can't
25 explain it based on physical medicine, then that leaves

1 behavioral or psychological medicine as a possible
2 explanation. But those are not areas of my speciality.

3 Q. Right. And so from a neurological standpoint,
4 can you say Mr. Bagley's current issues were caused by a
5 work accident on June 14, 2019?

6 A. I cannot.

7 Q. And just briefly, if we talked about the rest of
8 the assessment section where you said there's no indication
9 for neurosurgical intervention, but he will need continued
10 rehabilitation for contractures of his left upper and lower
11 extremity, what sort of rehabilitation do you believe it
12 will take?

13 A. Well, it's going to take physical therapy. And
14 exactly how they go about treating a contracture that
15 exists -- the key with contracture is to prevent them from
16 occurring.

17 MR. SANCHEZ: What was that? I apologize.

18 A. To prevent them from occurring. So it would be
19 better if you would prevent them from occurring. But --
20 and I -- certainly, this is a good question for a physical
21 who specializes in rehabilitation medicine. But the
22 general answer is he will need some form of physical
23 therapy, potentially with sequential splinting and things
24 like that.

25 Q. Would you put any sort of temporary or permanent

1 **work restrictions on Mr. Bagley?**

2 A. Based on his contractures, sure, he has
3 limitations. But I can't identify any work restrictions
4 based on his cervical spine, intracranial condition, or his
5 lumbar spine.

6 **Q. From a -- the intracranial -- I guess from a**
7 **neurological neurosurgical standpoint, is Mr. Bagley at**
8 **maximum medical improvement?**

9 A. Yes.

10 **Q. And what would the date of MMI be?**

11 A. Well, the date of his -- on the day that I saw
12 him, I would have said for each of his conditions that he
13 was at maximum medical improvement. So for the lumbar
14 spine, I would say March the 10th, 2020. And for his
15 intracranial condition and cervical spine, I would have
16 said July the 8th, 2020. 'Cause those are the days I saw
17 him. And on those dates, I was unable to identify a cause
18 related to those anatomic locations for his complaints.

19 **Q. And do you have an opinion as to whether he's**
20 **suffering any sort of permanent physical impairment as a**
21 **result of his injury?**

22 A. No. He is not.

23 MR. BIEDIGER: All right. Thank you so much
24 for taking your time, Doctor. I don't have any other
25 questions.

1 CROSS-EXAMINATION BY MR. SANCHEZ:

2 Q. All right. Doctor, a few questions. Were you
3 aware of Mr. Bagley receiving treatment from a neurologist,
4 Dr. Brown of the Neurologic Institute?

5 A. Yes.

6 Q. Did you have a chance to read his medical
7 records?

8 A. Some of them.

9 Q. And in your examination with Mr. Bagley recently,
10 I believe his mom and him were here with you, there was --
11 did he indicate to you that Dr. Brown did not physically
12 examine him in his -- in his evaluations or treatments with
13 him?

14 A. I don't recall that. But it certainly -- he may
15 certainly have said that.

16 Q. So my client will testify that he did not get
17 physically examined, and that's a little point of
18 contention with the whole, you know, motor exam versus
19 abnormal motor exam. But I would like to draw your
20 attention to Exhibit 5, page 3, if you could, please.

21 On the top right it says appointment date July
22 5th, 2019. Page 3, I believe. Right here, July 5th, 2019.

23 MR. BIEDIGER: That's page 4 on mine.

24 Q. My bad. Right. Page 4. Sorry. On to top it
25 indicates that his chief complaint is for diffuse left-

1 **sided and upper and lower extremity sensory abnormalities.**

2 **What does that mean?**

3 A. Diffuse left-sided upper and lower sensory
4 abnormalities would be a general term, as I would interpret
5 it, to mean that he has -- the left upper extremity and
6 left lower extremity, being the left arm and the left leg.
7 And diffuse would mean that it would be along the whole
8 left arm and the whole left leg.

9 Usually, we say "diffuse" to exclude like
10 radicular. So there's a map called a dermatome, that
11 highlights where that nerve roots go. And so if something
12 is radicular then it -- you know, it would follow, say, a
13 nerve root. Like in the arm it might be the sixth cervical
14 nerve root. If it's diffuse it doesn't follow any
15 particular nerve root; it might involve several nerve root
16 territories.

17 So the way I would interpret this is diffuse
18 meaning it doesn't follow any specific nerve root
19 territory. Left-sided means it's the left side, obviously.
20 Upper and lower extremity means arm and leg. Sensory
21 abnormality is a -- is vague, but it could mean loss of
22 scent -- loss of light touch, also pain and temperature,
23 loss of vibration or loss of some other sensory function.

24 And so it's not -- it's not a terribly precise
25 comment, but it's about right for a chief complaint. I

1 mean, it's a fair chief complaint.

2 **Q. So would that be something that the doctors would**
3 **assess, his abnormalities as a --**

4 A. Yes.

5 **Q. So if Dr. Brown assessed that here in this July**
6 **5th, could you point to where that motor exam is here?**

7 A. Well, that would be a sensory exam, so --

8 **Q. I'm sorry. Sensory exam.**

9 A. -- we need to look for the sensory examination.
10 So he did examine him, manually, according to this report.
11 He says, "The patient has diffuse tenderness to palpation
12 overlying his bilateral trapezius muscles, right greater
13 than left, occipital nerves as well as overlying his
14 shoulders and other soft tissues. Sensation is intact to
15 light touch to the bilateral upper and bilateral lower
16 extremities."

17 So that comment on the next page of his physical
18 exam indicates that he examined him for light touch and it
19 was normal.

20 **Q. So how would it be rectified with the fact that**
21 **he was having sensory abnormalities, as we just discussed?**

22 A. Well, the patient -- the chief complaint is
23 something the patient tells you about. So the chief
24 complaint the patient -- like, "Why did you come to the
25 doctor?"

1 "I came to the doctor because I have a cold."
2 Well, so you walk in the exam room and the patient's
3 sneezing. And you say, "Well, you know, do you have
4 allergies?"

5 "Well, yes, I have allergies." Well, maybe it's
6 not a cold. Maybe he has allergic rhinitus. Which sounds
7 like a cold, but it ain't a cold. And so there's two
8 different sources for each of these things. One is a
9 physical examination which indicates he has normal
10 sensation to light touch. And the other one is that
11 patient says -- and, obviously, it was interpreted by a
12 medical worker, but the patient says diffuse left upper and
13 lower extremity sensory abnormalities.

14 So in the chief complaint, you'll have to wonder
15 are they constant or do they come and go. Perhaps they're
16 intermittent and when the doctor examined him, it was in a
17 time when he wasn't symptomatic. In other words, he didn't
18 have it.

19 And then there's another issue with regard to
20 numbness and sensory abnormalities. For instance, a lot of
21 patients will come in and see me, and say, "I'm numb." But
22 when I examine them, they have intact sensory function. In
23 other words, they feel, they sense numbness, but they don't
24 actually have numbness that I can detect on physical exam.

25 So a sense of numbness, a complaint of numbness,

1 and a physical exam finding of numbness may not be the same
2 thing. So all those are rational and reasonable
3 explanations. I have no idea if any of those are true.
4 I'm just giving you some plausible explanations for this
5 observation.

6 Q. So then is it fair to say that you're not able to
7 tell us if it's true whether or not there was a normal
8 motor exam that you were talking about earlier from Dr.
9 Brown's records that you read over?

10 A. I cannot say that his exam was normal when Dr.
11 Brown examined him, despite the fact that they said it was
12 normal.

13 Q. I just want to be sure we're clear on that.
14 Because as I mentioned earlier, my client mentioned that he
15 didn't examine him and he was a little frustrated by that
16 provider.

17 So with that being said, you know, what kind of
18 issues would you normally expect to see in treating a
19 patient who was hit on the -- you know, the top cortex are
20 of his brain, by a 650-pound bale? In other words, what
21 would you see as being a normal issue or symptomatology that
22 one would present to your office with?

23 A. What would be common?

24 Q. Correct.

25 A. Of course, nothing would be normal under that --

1 if a 650-pound bale is not a normal thing. But what are
2 common symptoms? Well, of course, it depends. You know,
3 this kind of trauma could lead from anywhere from no
4 symptoms at all to death. And so you'd have to expect any
5 of that spectrum.

6 So in this case he did not get knocked out. Now,
7 it's not consistently always true, but most of the severe
8 closed injuries are associated with a loss of
9 consciousness. And so the lack of a loss of consciousness
10 is -- the absence of that loss of consciousness is
11 associated less often with severe head injury than the
12 presence of loss of consciousness. In other words, the
13 likelihood of a severe had injury goes up when you get
14 knocked out.

15 He says he did not get knocked out. And so you
16 would not anticipate a severe closed head injury if that
17 patient failed to have loss of consciousness. Now, that
18 doesn't mean you can't get post-concussive symptoms, which
19 are different. You can get post-concussive symptoms either
20 with or without loss of consciousness.

21 But severe closed head injury symptoms, like
22 neurologic decline, neurologic, dysfunction as a result of
23 the head injuries, you would expect to have loss of
24 consciousness.

25 **Q. Okay. And explain to me how an impact to the**

1 **head could cause contracture of your left upper**
2 **extremities.**

3 A. Well, it would need to produce damage to the
4 prefrontal cortex -- to the motor cortex of that
5 prefrontal. But it would need to produce damage to the
6 motor cortex, so the precentral gyrus.

7 So you would expect to see that kind of damage on
8 an MRI. So it would have to produce an injury to the motor
9 cortex, which should be shown at -- at the very least his -
10 - in the presence of a non-penetrating wound to the brain,
11 so now we're talking about purely closed head injuries,
12 which everybody agrees with at the most is we have here,
13 'cause nothing penetrated his head.

14 So with a closed head injury you would need to
15 produce an injury to the motor cortex. And it should be
16 visible immediately. And it should be should be seen at
17 least as a bruise or a contusion on the early CAT scan that
18 he had, which he did not. And it should be seen as an
19 alteration in the anatomy of the motor cortex on the
20 subsequent MRIs, but it did not, as those MRIs, were read
21 as normal.

22 And so you would expect at closed head injury
23 that produced contracture of an upper and lower extremity
24 would do that by damaging the upper motor neuron that goes
25 to those areas of your body. And so the leg cortex is

1 actually interhemispheric, it's actually in-between the two
2 halves of the brain, which is uncommonly injured because
3 it's fairly well protected in the interhemispheric sulcus.

4 And then the arm, which is out more on the
5 surface of that cortex -- excuse me of that brain, in the
6 motor strip, could be affected. But it's right next to the
7 face, and to get the hand and the arm but not the face
8 would be unusual, because they're geographically,
9 immediately adjacent.

10 So you would expect to see injury in two specific
11 areas of the motor cortex. One would be out here over the
12 hemisphere, but the other one would be interhemispheric.
13 So you would have to have two distinct lesions if you were
14 to prove it there.

15 Now, literally, anywhere along the corticospinal
16 tract you would produce something that might produce a
17 delayed contracture, like in the brainstem or in the pons.
18 But if you had those injuries, you'd expect a decline in
19 level of consciousness for sure. Because especially in the
20 pons, those areas are associated with your wakeful state.

21 So the one place that you could get it, where you
22 wouldn't have to have a disorder of the wakeful state, at
23 least not long-term disorder of that wakeful state, and
24 produce a contracture, and produce a relatively sparing of
25 the sensory function would have to be the motor cortex.

1 But he doesn't have that, because he had an MRI
2 that was normal.

3 Q. Now, isn't it true that MRIs and CTs don't always
4 pick up certain things like that.

5 A. But they would pick this up. This would be big.

6 Q. What about been EEG?

7 A. Well, an EEG wouldn't be helpful to me, unless
8 you thought he was having persistent seizure disorder. And
9 relating a seizure disorder to this trauma would be
10 impossible.

11 Q. Well, I guess -- I'm trying to understand what
12 exactly is going on with him. Because, you know, there was
13 -- you know, the MRI that we glossed over earlier
14 mentioning some white matter -- I mean, some single -- you
15 know, a bright spot in the right parietal subcortical area
16 --

17 A. Can I interrupt you --

18 Q. Yeah.

19 A. -- for a moment? I did not gloss over that test.

20 Q. No, I mean that we just briefly mentioned it. I
21 apologize.

22 A. Please carry on.

23 Q. I apologize. I didn't mean to --

24 A. That's quite all right.

25 Q. I didn't mean to short --

1 A. I just wanted to make that --

2 Q. -- shrift that. I guess, you know that was some
3 indication, there was some right frontal slowing indicated
4 on the EEG. And I struggling to understand how my client
5 was a functioning individual, working, able to lift, push,
6 pull, everything. No problem until this bale hit him on
7 the head. Now, obviously, we understand the workers'
8 compensation system and bouncing around from doctors and
9 all of that, and I understand that. But what I'm trying to
10 figure out here is -- is what exactly is going on.

11 I mean, the diagnosis on your page 5 of this, you
12 know, evaluation of yours on July 8th, 2020, indicates
13 headaches due to old head injury, work-related injury. Are
14 we contending that, that's what he has going on here as
15 your visit diagnosis is?

16 The one I received from your office has five
17 pages, page 5 of 5. And this is on page 5 of 5.

18 A. Ask me your question. I'm sorry, I got lost --

19 Q. Yeah, I guess what is your diagnosis of Mr.
20 Bagley in connection with your evaluation of him, July 8th
21 of 2020?

22 A. The only diagnosis that you can give Mr. Bagley
23 is a description of his symptoms. So he has contractures
24 of that left and upper and lower extremity without physical
25 explanation. The contractures exist. We found them on

1 physical exam. But they're without -- without clear
2 neurologic explanation.

3 That diagnosis that you showed me, headaches
4 related to a head injury or something, that's a diagnosis
5 assigned by somebody in this office. But not by me. So
6 the cause of his current syndrome is unknown to me. And I
7 share your concern and your curiosity about what's wrong
8 with him. 'Cause clearly he has abnormalities. I mean, on
9 physical exam he has contractures.

10 But neurosurgery from a surgical perspective is
11 pretty easy. Well, how can that be? Well, because
12 problems that we take care of leave evidence. They leave
13 tracks. And so while I'm not telling you the diagnosis
14 that fit him, I can only tell you the ones that he doesn't
15 have.

16 He doesn't have an acute injury of his cervical
17 spine or his spinal cord or his nerve roots, because
18 there's no evidence of that. And he doesn't have an injury
19 to his brain, at least based on the evidence. And he
20 doesn't have an injury to his lumbar spine, based on
21 evidence.

22 Now, I'm not disputing the fact that he has
23 contractures and those other things. I simply am unable to
24 identify the link between those findings and injury to
25 either his brain, cervical spine, or lumbar spine.

1 **Q. Okay. Is there certain tests or evaluations or**
2 **treatments that could be rendered to help a judge or**
3 **doctors ascertain that?**

4 A. I think we've already done everything that could
5 be done. In fact, we repeated most of these tests.
6 Because we were so concerned that the findings exist, that
7 we repeated tests which had already been done, to ensure
8 that we hadn't missed something.

9 The advantage there is you might get a better
10 quality study, you might get a different radiologist to
11 read it, you get another set of eyes to look at it.
12 Because like you on a diagnosis and like he wants a
13 diagnosis, he wants to understand what's wrong too. All I
14 can tell him right now is what's not wrong.

15 **Q. So then going forward, in connection with his**
16 **injury, what are your recommendations to get him treatment**
17 **for? Therapy for the contractures, is that my**
18 **understanding?**

19 A. Yes.

20 **Q. And post concussion syndrome, what kind of**
21 **sequella would you expect from that?**

22 A. So post -- so first of all, a concussion is
23 literally any strike to the head, okay? Now, there are
24 different types of concussions, right? So there are
25 concussions that are associated with anatomic injury to the

1 brain that can be identified on a radiographic study.

2 For instance, contussions, subtraumatic,
3 subarachnoid hemorrhage, intracerebral hemorrhages. Even
4 vascular injuries as a result of that. He has none of
5 those things. Because all the tests that look for those
6 things, we couldn't find anything.

7 So now we have a concussion where something
8 struck his head. And so, literally, a concussion can be as
9 simple as if I walk over to this wall and I bump my head
10 into the wall. I mean, the broadest description of
11 concussion.

12 And today's society is struggling to define
13 concussion. If you don't believe it, look it up on Google
14 and see how much they struggle to define that word. But
15 literally, concussion means to strike. It means (witness
16 indicates) that.

17 So concussion is a poorly-defined event. So post
18 concussive syndrome means what happens to somebody, what
19 are the complaints that the patient can make after having
20 been struck in the head.

21 If you look at -- like the last time I looked
22 that up in a trauma textbook that's -- the textbook's about
23 yay-thick. And there's two volumes of it. And then inside
24 that textbook there's twelve pages occupied by everything
25 that can happen with post concussive syndrome. They

1 literally list them like everything that people really
2 complain of. So I'm not going to make an attempt at
3 listing all of that. Her fingers will get tired before I
4 get done with that.

5 But the most common things are headache,
6 difficulty concentrating, irritability, altered sleep
7 patterns, tiredness, a sense of malaise, intermittent
8 alterations in vision like a loss of visual acuity that
9 intermittent, or vision that comes and goes, altered
10 sensorium to taste. There's a lot of things that, that can
11 happen.

12 Now, you wouldn't expect a contracture or an
13 alteration in tone -- muscle tone to produce -- that could
14 produce a contracture to occur in a patient who has a
15 concussion, but without any radiographic evidence of
16 injury, okay?

17 So you need -- in order to produce a contracture
18 due to injury to the motor strip, you need to have an
19 injury that you can see. You need to have a bruise in
20 there, or a more intracerebral hemorrhage in there, that
21 actually produces cortico damage to permanently reduce the
22 motor function in the affected extremity.

23 And the first thing that you should see,
24 physiologically, is paresis -- paralysis of that upper
25 extremity. So if this had done it, you would expect him to

1 be paralyzed, first, and then slowly get an alteration in
2 tone which produces this (witness indicates).

3 And then you have to treat that by trying to
4 prevent this from happening, because it's the interposed
5 action of muscles in the affected extremity. So none of
6 this time course, clinical presentation fits the way you
7 would expect it to fit if the contractures were produced by
8 an injury.

9 For instance, he never had loss of consciousness.
10 He never had an injury -- a definable injury to his brain
11 in the correct areas. It would need to be in the motor
12 strip, below the face -- there's something called a
13 Homunculus, which is what all the little -- somebody drew
14 on the motor strip what it affects, which is good for
15 medical students and doctors like me, because you can look
16 at the motor strip and understand what part of the strip is
17 related to certain functions.

18 So his leg is in the interhemispheric fissure and
19 the hand and arm is past the fascial part. And so it would
20 have to affect that part of the inter -- I mean, that part
21 of the motor strip and the interhemispheric portion of to
22 motor strip, but spare the stuff on either side of it.

23 Yeah, that stuff works. So he needed to have
24 that, or an injury along the corticospinal tract, which I
25 told you is unlikely, 'cause that would have to go in to

1 brainstem or some other deep structure in the brain, which
2 would be associated with a decline of consciousness, which
3 he never had like some -- like, those are the kind of bad
4 injuries where the patient's in a coma, and you come in and
5 you see them and they're in a coma, and then they wake up
6 and they can't move their right arm.

7 All right. So none of the time course fits.
8 Finally, if he had those injuries, which he didn't because
9 they never showed up, then you would expect the first thing
10 that he would have would be paralysis followed by the
11 development of spasticity which is an abnormal tone in the
12 extremities, followed by contractures, which he didn't do.

13 So none of this fits with that normal time
14 course. So it just doesn't -- it doesn't fit clinically
15 with what you would expect. So largely, the explanation
16 for his current syndrome is not something that I can give
17 you an answer to. I can simply tell you that it's not
18 related to an injury to his cervical spine, because it
19 doesn't exist, or his lumbar spine, because it doesn't
20 exist, or his brain, because you don't see it.

21 **Q. So then I guess how else could somebody develop**
22 **these contractures that we were just talking about if they**
23 **don't have that evidence on MRIs, that you just mentioned?**

24 A. Well, the -- one of the doctors mentioned an
25 adjustment disorder, which means that something has

1 happened through behavioral or psychological means that
2 causes the patient to do this. But I am not prepared to
3 answer questions about that, because that is not my
4 speciality. And I don't diagnose or treat those
5 conditions.

6 I can simply say that the physical part of this,
7 I am prepared to discuss, it is in my specialty, I do see
8 it all the time, and it just doesn't -- I do not see that
9 here.

10 **Q. From a physical standpoint.**

11 A. From a physical standpoint.

12 **Q. So what other possible standpoints are there to**
13 **shed some light on this --**

14 A. Psychological, slash, behavioral.

15 **Q. Okay. Of which --**

16 A. I can't comment on.

17 **Q. Of course. But with that being said, in your**
18 **experience have you noticed that people have aggravated**
19 **psychological issues as a result of an injury, and**
20 **frustration with treatment recoveries.**

21 A. I presume so. But again, I'm not prepared to
22 really answer that question.

23 **Q. All right. I mean, so from a -- from a**
24 **neurosurgical, and that means surgery, there's no treatment**
25 **options for this man and his injury that we're talking**

1 about, correct?

2 A. Yes.

3 Q. Okay. Now, from a physical therapy standpoint,
4 there is some therapies that, you know, you mentioned
5 earlier, that he could possibly obtain to get him better.
6 Is that's my understanding?

7 A. Yes.

8 Q. Okay. And are you relating that -- that
9 statement of what he may need from a physical therapy
10 standpoint to his injuries that he's received?

11 A. I'm relating to the -- of contractures. The
12 problem I have is I can't relate his injuries to his
13 contractures directly. And I've said that a bunch of
14 different ways, that I am unable to relate the two. So
15 that's something that you-guys will have to do. You'll
16 have to be much smarter than me to do that.

17 Q. Well, unfortunately, we -- we got a good report
18 and have a judge determine and -- you know, Dr. DuPuy, his
19 orthopaedic, he's been deposed and he indicated that this
20 was related to that. And so did Dr. Rowe, the neurologist.
21 I guess that's why we're here, today, asking you what your
22 thoughts are.

23 A. So I cannot relate the development of
24 contractures to the injury in any way other than temporal,
25 which means they occurred around the same time.

1 Q. So would you defer to his other providers who
2 have addressed that issue?

3 A. They're certainly entitled to their opinion. But
4 in my opinion, there is no relationship between his
5 injuries and the development of those contractures,
6 physically.

7 Q. Okay. And then I guess what work restrictions do
8 you think would be applicable for someone -- 'cause you
9 mentioned earlier that based on the contractures he would
10 have some limitations.

11 A. So you're asking me to base his work restrictions
12 on his contractures?

13 Q. Well, earlier you mentioned that there was --
14 based on contractures, yes, he had some limitations. I'm
15 just asking you to explain that a little.

16 A. Okay. So based on his -- based on the evidence
17 of cervical, lumbar, or intracranial injury from this
18 event, there are no restrictions to his return to work.
19 However, based on his contractures, I would say he's
20 unemployable.

21 Q. Okay. All right. Then I guess the last question
22 I have for you, 'cause I know I got to get you out of here,
23 is that who -- you indicated that the primary diagnosis on
24 page 1 of your report, which was also page 5 of 5,
25 headaches due to old head injury, who would have written

1 that in there if that's not you who indicated that
2 diagnosis?

3 A. Probably one of that coders, trying to find a
4 code for headaches.

5 MR. SANCHEZ: All right. No more questions.

6 MR. BIEDIGER: No more questions, Doctor.

7 Thank you so much.

8 Further deponent sayeth not.

9 (There being no further questions, the deposition
10 concluded at 3:47 p.m.)

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CERTIFICATE OF REPORTER

I, PATRICIA G. BACHAND, COURT REPORTER AND NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA AT LARGE, HEREBY CERTIFY THAT I REPORTED THE DEPOSITION OF BRETT GUNTER, M.D., ON TUESDAY, THE 8TH DAY OF SEPTEMBER 2020, THAT THE WITNESS WAS FIRST DULY SWORN BY ME, AND THAT THE FOREGOING ## PAGES CONSTITUTE A TRUE AND CORRECT TRANSCRIPTION OF SAID DEPOSITION.

I FURTHER CERTIFY THAT I AM NEITHER ATTORNEY NOR COUNSEL FOR, NOR RELATED TO OR EMPLOYED BY ANY OF THE PARTIES CONNECTED WITH THIS ACTION, NOR AM I FINANCIALLY INTERESTED IN SAID CAUSE.

I FURTHER CERTIFY THAT THE ORIGINAL OF SAID TRANSCRIPT WAS THEREAFTER SEALED BY ME AND DELIVERED TO M. BROOKS BIEDIGER, ESQ., HOLDER, PADGETT, LITTLEJOHN & PRICKETT, LLC, 1201 MAIN STREET, SUITE 1430, COLUMBIA, SOUTH CAROLINA, WHO WILL RETAIN THIS SEALED ORIGINAL TRANSCRIPT AND SHALL BE RESPONSIBLE FOR FILING SAME WITH THE COURT PRIOR TO TRIAL OR ANY HEARING WHICH MIGHT RESULT IN A FINAL ORDER ON ANY ISSUE.

IN WITNESS WHEREOF, I HAVE SET MY HAND AND SEAL THIS 16TH DAY OF SEPTEMBER 2020.



PATRICIA G. BACHAND, COURT REPORTER
MY COMMISSION EXPIRES MARCH 8, 2027

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Jan 17 2023

SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC File No. 1908703
Appellate Case No. 2022-000067

Kyle R. Bagley, Employee Appellant,

v.

JN Fibers, Inc., d/b/a Sun Fiber, LLC, Employer, and
Great American Insurance Company, Carrier Respondents.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

Respectfully Submitted,



Bryan N. Sanchez, # 80372
772 Cherry Road (29732)
PO Box 11583
Rock Hill, SC 29731
bryan.sanchez@stacylewislaw.com

December 6, 2022

Attorney For Appellant