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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM ORANGEBURG COUNTY
Honorable Edgar W. Dickson, Circuit Court Judge

Case No.: 2015-CP-38-01234
S.C. Ct. App. Filed August 2, 2023
Appeal Case No.: 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert, Jr., a minor child under the age of eighteen..... Respondent,

v.

The Regional Medical Center, ...Petitioner.

APPENDIX

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

Honorable Edgar W. Dickson, Circuit Court Judge

RECEIVED
SEP 29 2021
SC Court of Appeals

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of 18, Respondent,

v.

Regional Medical Center, Appellant.

AMENDED RECORD ON APPEAL

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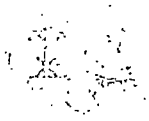
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Orangeburg Common Pleas

Case Caption:	Tekayah Hamilton , plaintiff, et al VS Regional Medical Center , defendant, et al
Case Number:	2015CP3801234
Type:	Order/Other

So Ordered

s/ Edgar W. Dickson #2153

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF ORANGEBURG	)	CIVIL ACTION NO. 2015-CP-38-01234
	)	
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18,	)	ORDER GRANTING DEFENDANT'S MOTION FOR REDUCTION TO STATUTORY CAP AND DENYING DEFENDANT'S MOTION FOR JNOV OR IN THE ALTERNATIVE FOR A NEW TRIAL
Plaintiff,	)	
vs.	)	
Regional Medical Center	)	
Defendant.	)	

This case was tried before a jury in this Court on or about May 9, 2018. The jury returned a verdict finding Defendant was grossly negligent and awarded $1,127,280.00 to the minor plaintiff Robert Lee M. Jr., and $135,477.00 to Plaintiff Tekayah Hamilton. Defendant filed two, separate post-trial motions, one to reduce the award to the statutory cap and a JNOV or in the alternative for a new trial. After review of the motions, memoranda of counsel and supporting documents, I grant in part Defendant's Motion for Reduction to Statutory Cap and deny Defendant's Motion for JNOV or in the Alternative for New Trial.

FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of Defendant's alleged failure to implement policies, procedures, and equipment to allow Defendant to properly monitor an IV with ampicillin administered to RJ on or about October 28, 2014, while a patient at Defendant's facility in Orangeburg, South Carolina. Plaintiff's complaint alleges medical negligence, specifically the following:

> The impression of the treating physician was high fever and admission to the hospital was necessary in order to work up CBC, LP, blood and urine cultures. It was decided to begin Ampicillin and Claforan. Pl.'s Complaint par. 11

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> Defendant Regional, by and through its agents and/or employees, and Defendant Downing[1], owed Plaintiff a duty of care to use that degree of care and skill which ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances. Pl.'s Complaint par.33.
>
> Plaintiff asserts Defendants breached that duty of care and were negligent, grossly negligent, careless, willful, wanton, and reckless in the following particulars:
>
> a) In failing to use reasonable medical care in accordance with the recognized standards of acceptable professional practice in medicine during the care, diagnosis and treatment of Plaintiff;
> b) In failing to act with ordinary and reasonable care in accordance with the recognized standards of acceptable professional practice in medicine;
> c) In failing to follow the Infusion Nurse Society publication on *Policies and Procedures for infusion Nursing of the Pediatric Patient*;
> d) In failing to pursue such appropriate medical modalities and treatments which could have avoided this type of injury and permanent damage;
> e) In failing to act and behave in the same or similar manner that reasonably competent doctors and healthcare facilities and staff would have behaved or acted in the same or similar conditions;
> f) In failing and neglecting to properly inspect the IV site on October 28, 2014, at approximately 4:27 a.m. prior to the administration of antibiotic medication;
> g) In failing and neglecting to properly monitor the IV site after the administration of antibiotic medication;
> h) In failing to adequately train and supervise its medical staff;
> i) In failing to provide the safest care and treatment to Plaintiff; and
> j) For such other acts and omissions that may become more apparent through the discovery of this matter.

Pl.'s Complaint par. 34. Plaintiff attached an affidavit to her complaint by Monica Stobbs, RN, BSN, clarifying and reiterating the breaches in the standard of care by Defendant TRMC, by and through its employees, causing harm to RJ and Tekayah. Specifically, Plaintiff alleged Defendant Regional failed to properly monitor RJ's IV site prior to and after administering medication. Plaintiff did not offer any testimony at trial as to any alleged physician malpractice.

This matter was filed pursuant to South Carolina Tort Claims Act, S.C. Code Ann. §15-78-10, et. Seq. I find that defendant TRMC is a governmental healthcare facility and is afforded the protections of the South Carolina Tort Claims Act, as defined by the Act.

[1] Defendant Downing, a registered nurse, was dismissed as a party after the original Summons and Complaint was filed.

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At trial, Plaintiff offered Monica Stobbs, RN, BSN, as well as Dr. DeVito regarding RJ's future care and Plaintiff herself took the stand. Plaintiff also called nurse Jamie Downing, RN, and published Plaintiff's answers to Defendant's First Set of Requests to Admit to the jury. RJ's medical records and bills were submitted as evidence along with several pictures of his injury and numerous policies and procedures of Defendant Regional.

Defendant called Dr. Davis to dispute RJ's future care. Nurse Jamie Downing, testified along with Cynthia Hurley as to standard of care and expert issues. Defendant also submitted pictures of RJ's injuries, select medical records and select policies and procedures. Defendant moved for a directed verdict at the end of Plaintiff's case and its own. The Court denied both motions for directed verdict.

Defendant TRMC filed two separate post trial motions. The first post trial motion was a reduction of the damage caps to reduce the child's award to $300,000.00 and the second was to reduce the mother's jury award to $20,854.00 pursuant to the Tort Claims Act §15-78-120(a) (1). I find that Defendant TRMC's motion for JNOV/New Trial contained the following grounds: Defendant asserted plaintiff's witness, Monica Stobbs, was not qualified to render pediatric nursing opinions; Defendant TRMC asserted that Plaintiff did not establish gross negligence as required by the Tort Claims Act; Defendant TRMC asserts it was prejudiced by photographs submitted to the jury; Defendant TRMC asserts it was error to not allow its expert to testify to an opinion on gross negligence when Plaintiff's expert was allowed to render such opinion; Defendant TRMC asserts it was an error to publish its answers to Request to Admit to the jury; Defendant TRMC alleges it should be granted a new trial as certain jury charges were not given and finally Defendant's motion stated that the verdict was excessive. In ruling on all of these motions, the court has reviewed the motions submitted by Defendant TRMC, the memoranda of

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both parties and a review of the applicable law. The Court incorporates all of Defendant's arguments raised in Defendant's motions and memoranda herein, as if repeated verbatim.

STANDARD OF REVIEW

A motion for judgment notwithstanding the verdict may only be granted if no reasonable jury could have reached the challenged verdict. RFT Management Co., LLC v. Tinsley & Adams, L.L.P., 399 S.C. 322, 332, 732 S.E.2d 166, 171 (2012). A jury's verdict must be upheld unless no evidence reasonably supports the jury's findings. Curcio v. Caterpillar, Inc., 355 S.C.316, 320, 585 S.E.2d 272, 274 (2003). In ruling on a motion for judgment notwithstanding the verdict, the trial court must view the evidence and all inferences reasonably drawn therefrom in the light most favorable to the opposing party. Law v. S.C. Dep't of Corr., 368 S.C. 424, 434, 629 S.E.2d 642, 648 (2006).

The thirteenth juror doctrine is the method used by the trial court to grant a new trial upon a finding that the evidence presented at trial did not support the jury's verdict. Curtis v. Blake, 392 S.C. 494, 505, 709 S.E.2d 79, 85 (Ct. App. 2011). If the amount of the verdict is grossly inadequate or excessive so as to be the result of passion, impulse, prejudice, or some other influence outside the evidence, the trial court must grant a new trial absolute. Id. at 500, 709 S.E.2d at 82. Compelling reasons must be presented to support the trial judge's invasion of the jury's province, merely highlighting that the verdict is greater than the amount of monetary damages is not enough as such other non-monetary factors must be considered as well. Id. at 501, 709 S.E.2d at 83.

ANALYSIS

First, this Court finds that the statutory cap on damages pursuant to the South Carolina Tort Claims Act (§ 15-78-10, et seq.) is applicable to this case. This action against TRMC is

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subject to the Tort Claims Act, §15-78-10, et. seq. Specifically, the Act provides that no person shall recover a sum exceeding three hundred thousand dollars because of a loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved unless otherwise provided. S.C. Code Ann. § 15-78-120(a)(1).

In this case, the Jury returned a verdict for the minor [redacted] ("RJ"), in the amount of $1,127,280.00 and separately for his mother, Tekayah Hamilton, in the amount of $135,477.00. Defendant believes that the award to RJ should be reduced to the statutory cap of $300,000 and further argues that the award to Tekayah Hamilton should be reduced to $20,854. In response, Plaintiff's posits that since this single occurrence involved the totality of Defendant's conduct, which encompasses the alleged conduct of Defendant's physicians, then the applicable recovery cap of $1,200,000.00 contained in section 15-78-120(a)(3) applies.

Plaintiff's Complaint did not contain any allegations of physician malpractice and I do not find that Plaintiff offered any testimony that a physician breached the standard of care and alleged deviation of same. Plaintiff offered no expert testimony as to this issue at trial.

This Court agrees that the $1,127,280.00 award to RJ should be reduced to $300,000.00 pursuant to section 15-78-120(a)(1). As set forth above, the jury verdict for RJ must be reduced pursuant to the Tort Claims Act. Although a doctor ordered the medication and its administration, the crux of Plaintiff's case and the evidence presented at trial was that a nurse breached the applicable standard of care. I find that Plaintiff offered no evidence showing a physician was involved in any of the allegations in this matter. Furthermore, Defendant is correct that the evidence at trial showed RJ's mother incurred $20,854.00 in past medical expenses. However, the jury was presented evidence that Ms. Hamilton would be required to bear the financial burden to take time off of work and travel for any future expenses. Because she

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will remain his guardian for at least fifteen more years, this court finds the award reasonable. Therefore, this Court finds that the award of $1,127,280.00 to RJ should be reduced to $300,000.00. Further, the award of $135,477.00 to Ms. Hamilton should remain without alteration. The Court denies Defendant's motion to reduce Ms. Hamilton's verdict to $20,854.00 pursuant to the Tort Claims Act.

Next, Defendant asserts that Monica Stobbs was not qualified to give an opinion on the standard of care of pediatric nursing and pediatric IV administration. Nurse Stobbs testified she never managed, maintained or started Pediatric IV's, nor did she review any literature on these issues. She did testify she did these tasks on adult patients. Once qualified, she testified that the assessment, flushing, and other procedures for monitoring and inspecting an IV site prior to the administration of medicine and after the administration of medication are the same regardless of the patient's age. Therefore, this Court sees no reason to depart from its earlier ruling that Monica Stobbs was properly qualified as an expert in nursing, but not as a pediatric nurse. The Court denies the Defendant's motion raised on this ground.

Similarly, Defendant argues that this Court should have directed a verdict in its' favor because Gross Negligence was not established. The determination of gross negligence is a mixed question of law and fact and should be presented to the jury when evidence supports it. Staubes v. City of Folly Beach, 331 S.C. 192, 205, 500 S.E.2d 160, 168 (Ct. App. 1998), aff'd, 339 S.C. 406, 529 S.E.2d 543 (2000). In this case, an inference that Ms. Downing failed to flush the child's IV is an inference that she failed to use slight care. Further, Plaintiff presented evidence that at least 20 minutes passed between RJ's reaction to the ampicillin and the time Defendant's employees responded to Ms. Hamilton's requests for assistance.

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Additionally, witnesses testified that in the medical field, it isn't written down (documented), then it did not happen. Evidence of several failures to document the condition of the IV in question was presented at trial. Because the evidence presented could give rise to intentional conduct and/or a failure to exercise slight care, this Court finds that the evidence presented supported the Jury's finding of Gross Negligence. Defendant's Motion on this ground is denied.

Defendant next argues that the probative value of the photographs of RJ's injuries was substantially outweighed by unfair prejudice. Photographs may be admitted corroborating testimony, however, photographs calculated to arouse the sympathy or prejudice of the jury should be excluded if they are irrelevant or not necessary to substantiate material facts or conditions. State v. Jackson, 364 S.C. 329, 613 S.E.2d 374 (2005). This Court reviewed the photographs prior to their publication.

Although, given the nature of the injury and the child's age, they are hard to look at, there is little doubt the photographs are relevant to corroborate the injury. The photographs were admitted for the purpose of proving the injury and this Court sees no reason to depart from its earlier ruling permitting the pictures because they accurately reflected the facts of the case. Defendant's Motion is denied as to this ground.

Defendant also argues that Defendant's expert, Cynthia Hurley, should have been permitted to testify as to whether or not she believed its' employees were grossly negligent or negligent. Defendant asserts this evidence was proper under Rule 704, SCRE. In general, an expert's testimony on issues of law is inadmissible but not because it simply embraces the ultimate issue. Dawkins v. Fields, 354 S.C. 58 (2003). The Court declines to grant the Defendant's motion on this ground.

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The Defendant raised in its motion for JNOV/New Trial the argument that it has been prejudiced by the publication of Request to Produce pursuant to Rule 36, SCRCP. The Court having considered this motion, declines to order a new trial on this ground.

Defendant moved for a new trial as to certain jury charges set forth in its motion of JNOV/New Trial, which are incorporated herein by reference, were not charged to the jury. The Court declines to grant Defendant's motion on this ground, which is denied.

The Defendant requested a new trial based upon the view that the jury verdict was grossly excessive and contrary to the evidence. Defendant asserts in its memoranda that the verdict was 54 times the amount of the actual damages and was a result of passion, caprice, or prejudice. The Court has considered the argument of the Defendant in its memoranda as set forth above, which is incorporated by reference. The Court denies Defendant's motion for a new trial based upon this ground.

Defendant additionally raised that if the Court denied its JNOV or new trial absolute motions it should grant a new trial nisi remittitur as it asserted the damages for excessive compared to the evidence presented at trial. After considering this argument, the court denies to grant the Motion on this ground.

The Court has considered all the issues raised by the Defendant in its post trial motions and denies the motion for JNOV/New Trial as set forth above and partially grants Defendant's motion to reduce the verdict to the Tort Claims Act liability cap. Accordingly, and for these reasons.

IT IS THERFORE ORDERED, that Defendant's Motion for post-trial relief of 1.) JNOV and 2.) a new trial absolute are DENIED. The Defendant's motion of reduction of damages to the

$300,000.00 statutory cap is GRANTED as to the verdict for the minor child, RJ. 3) Defendants motion to reduce the mothers verdict is denied.

AND IT IS SO ORDERED.

Resident Judge Edgar W. Dickson
The First Judicial Circuit

August ____, 2019
Orangeburg, South Carolina

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***** IMPORTANT NOTICE - READ THIS INFORMATION *****

NOTICE OF ELECTRONIC FILING [NEF]

A filing has been submitted to the court RE: 2015CP3801234

Official File Stamp:	10-25-2019 11:43:21 AM
Court:	CIRCUIT COURT Common Pleas Orangeburg
Case Caption:	Tekayah Hamilton , plaintiff, et al VS Regional Medical Center , defendant, et al
Document(s) Submitted:	Order/Other Order/Other
Filed by or on behalf of:	Edgar Dickson

This notice was automatically generated by the Court's auto-notification system.

The following people were served electronically:

Joseph Reza Shakibanasab for Regional Medical Center
Virginia Watson Williams
Michael C. Tanner for Regional Medical Center
David Reynolds Williams
Jonathan F Krell for Tekayah Hamilton

The following people have not been served electronically by the Court. Therefore, they must be served by traditional means:

Robert Lee M, Jr.

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF ORANGEBURG)

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen,) CIVIL ACTION COVERSHEET

Plaintiff(s))

vs.)

Regional Medical Center and Jamie Downing, RN,)
Defendant(s))

2015-CP - 38- 01334

Submitted By: Jonathan F. Krell
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Telephone #: 843-723-7491
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Other:
E-mail: jonathan@uricchio.com

NOTE: The coversheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filed out completely, signed, and dated. A copy of this coversheet must be served on the defendant(s) along with the Summons and Complaint.

FILED FOR RECORD
ORANGEBURG, S.C.
2015 DEC 07 P 2:37
CLERK OF COURT

DOCKETING INFORMATION (*Check all that apply*)

**If Action is Judgment/Settlement do not complete*

X JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
X This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (*Check One Box Below*)

Contracts	Torts - Professional Malpractice	Torts - Personal Injury	Real Property
☐ Constructions (100)	☐ Dental Malpractice (200)	☐ Conversion (310)	☐ Claim & Delivery (400)
☐ Debt Collection (110)	☐ Legal Malpractice (210)	☐ Motor Vehicle Accident (320)	☐ Condemnation (410)
☐ General (130)	X Medical Malpractice (220)	☐ Premises Liability (330)	☐ Foreclosure (420)
☐ Breach of Contract (140)	Previous Notice of Intent Case #	☐ Products Liability (340)	☐ Mechanic's Lien (430)
☐ Fraud/Bad Faith (150)	20____-NI-_____	☐ Personal Injury (350)	☐ Partition (440)
☐ Failure to Deliver/ Warranty (160)	☐ Notice/ File Med Mal (230)	☐ Wrongful Death (360)	☐ Possession (450)
☐ Employment Discrim (170)	☐ Other (299)	☐ Assault/Battery (370)	☐ Building Code Violation (460)
☐ Employment (180)		☐ Slander/Libel (380)	☐ Other (499)
☐ Other (199)		☐ Other (399)	

Inmate Petitions	Administrative Law/Relief	Judgments/Settlements	Appeals
☐ PCR (500)	☐ Reinstate Drv License (800)	☐ Death Settlement (700)	☐ Arbitration (900)
☐ Mandamus (520)	☐ Judicial Review (810)	☐ Foreign Judgment (710)	☐ Magistrate-Civil (910)
☐ Habeas Corpus (530)	☐ Relief (820)	☐ Magistrate's Judgment (720)	☐ Magistrate-Criminal (920)
☐ Other (599)	☐ Permanent Injunction (830)	☐ Minor Settlement (730)	☐ Municipal (930)
	☐ Forfeiture-Petition (840)	☐ Transcript Judgment (740)	☐ Probate Court (940)
	☐ Forfeiture-Consent Order (850)	☐ Lis Pendens (750)	☐ SCDOT (950)
	☐ Other (899)	☐ Transfer of Structured Settlement Payment Rights Application (760)	☐ Worker's Comp (960)
			☐ Zoning Board (970)
			☐ Public Service Comm. (990)
			☐ Employment Security Comm (991)

Special/Complex /Other			
☐ Environmental (600)	☐ Pharmaceuticals (630)	☐ Confession of Judgment (770)	☐ Other (999)
☐ Automobile Arb. (610)	☐ Unfair Trade Practices (640)	☐ Petition for Workers Compensation Settlement Approval (780)	
☐ Medical (620)	☐ Out-of State Depositions (650)	☐ Other (799)	
☐ Other (699)	☐ Motion to Quash Subpoena in an Out-of-County Action (660)		
☐ Sexual Predator (510)	☐ Pre-Suit Discovery (670)		

Submitting Party Signature: [signature] Date: 12/2/15

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

FOR MANDATED ADR COUNTIES ONLY

Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chesterfield, Colleton, Darlington, Dorchester, Florence, Georgetown, Greenville, Hampton, Horry, Jasper, Kershaw, Lee, Lexington, Marion, Oconee, Orangeburg, Pickens, Richland, Spartanburg, Sumter, Union, Williamsburg, and York

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.

2. The initial ADR conference must be held within 300 days after the filing of the action.

3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)

4. Cases are exempt from ADR only upon the following grounds:

   a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;

   b. Requests for temporary relief;

   c. Appeals

   d. Post Conviction relief matters;

   e. Contempt of Court proceedings;

   f. Forfeiture proceedings brought by governmental entities;

   g. Mortgage foreclosures; and

   h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.

5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.

6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

Please Note: **You must comply with the Supreme Court Rules regarding ADR. Failure to do so may affect your case or may result in sanctions.**

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF ORANGEBURG) FIRST JUDICIAL CIRCUIT
)
Tekayah Hamilton, individually and as) CASE NO.: 2015-CP-38-01634
parent and guardian ad litem for Robert)
Lee M., Jr., a minor child under the age of)
Eighteen,)
)
Plaintiffs,)
)
vs.) SUMMONS
)
Regional Medical Center and Jamie)
Downing, RN,)
)
Defendants.)

FILED FOR RECORD
ORANGEBURG, S.C.
2015 OCT -7 P 4:29
CLERK OF COURT
ORANGEBURG, S.C.

TO THE DEFENDANT ABOVE-NAMED:

A lawsuit has been filed against you.

Within 30 days after service of this summons on you (not counting the day you received it), you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the South Carolina Rules of Civil Procedure. The answer or motion must be served on the plaintiff's attorneys, at the addresses shown below. If you fail to do so, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

URICCHIO HOWE KRELL JACOBSON
TOPOREK THEOS & KEITH, P.A.

Jonathan F. Krell
PO Box 399
Charleston, SC 29402
Tel.: (843) 723-7491; Fax: (843) 577-4179

Williams & Williams

David R. Williams
1281 Russell Street (29115)
PO Box 1084
Orangeburg, SC 29116
ATTORNEYS FOR PLAINTIFF

CLERK OF COURT
ORANGEBURG, S.C.

September ____, 2015
Charleston, South Carolina

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG Tekoyah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of Eighteen, Plaintiffs, vs. Regional Medical Center and Jamie Downing, RN, Defendants.	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT CASE NO.: 2015-CP-38-01334 COMPLAINT Jury Trial Requested

FILED FOR RECORD
PATRICIA D. CLARK
2015 OCT -7 P 4:29
CLERK OF COURT
ORANGEBURG, SC

Plaintiffs, by and through undersigned counsel, brings this action against Defendants based on the allegations set forth below.

AS A PRELIMINARY MATTER

Plaintiffs attach the affidavit and CV of Monica Stobbs, RN, BSN, to this complaint and incorporate by reference herein.

PARTIES

1. Plaintiffs are citizens and residents of Orangeburg County, South Carolina.

2. Upon information and belief, Defendant Regional Medical Center ("Regional") is an agency, within the meaning of the South Carolina Tort Claims Act (S.C. Code Ann. § 15-78-10, *et seq.*) of the State of South Carolina. Regional operates a hospital and other facilities by staffed physicians, nurses and other health care providers and technicians in Orangeburg County, South Carolina.

3. Upon information and belief, Defendant Jamie Downing, RN, is a citizen and resident of Orangeburg County, South Carolina.

JURISDICTION and VENUE

4. The Court has subject-matter jurisdiction and personal jurisdiction over Defendants and venue is proper in Orangeburg County, South Carolina.

FACTS

5. At all times relevant to the allegations contained in this Complaint, Defendant Regional engaged on its staff as employees, physicians, residents, interns, specialists, nurses and other personnel, and was operated by and through its agents and/or employees, acting within the course and scope of their employment.

6. Defendant Regional, by and through its agents and/or employees, and Defendant Downing, in their treatment of Plaintiff, were required to exercise and use that degree of skill and care ordinarily used under the same or similar circumstances by members similarly situated within the medical profession.

7. Defendant Regional is liable for the acts of its agents and/or employees acting within the course and scope of their employment under the theory of *respondeat superior*.

8. At all times pertinent hereto, Defendant Regional and Defendant Downing were under a duty to provide competent medical treatment, within generally accepted standards of care.

9. On October 25, 2014, Plaintiff, a minor, was admitted to Defendant Regional for treatment of neo-natal fever.

10. At the time of his admission, the minor Plaintiff was one (1) month old. Upon admission, it was discovered that he had a fever of 102.6, but all other symptoms were negative. Additionally, there was no past medical history contributing to the admission.

11. The impression of the treating physician was high fever and admission to the hospital was necessary in order to work up CBC, LP, blood and urine cultures. It was decided to begin Ampicillin and Claforan at this time.

12. The Ampicillin IV began at approximately 11:30 PM on October 25, 2014. The medical record neglects to document the site and condition of the administration.

13. On October 26, 2014 at approximately 7:17 AM, Claforan IV is administered in the site of the administration is not noted.

14. On that same date at 11:22 AM ampicillin is administered and the site and condition of the administration is not noted.

15. Later that day, at approximately 3:52 PM Claforan is administered and the condition of the site is not noted.

16. At 10:55 PM on the same date, ampicillin is administered, but the condition and site of the administration is not noted in the record.

17. One minute later, Claforan is administered and the condition of the site is not noted.

18. On October 27, 2014 at 4:34 AM ampicillin is administered and the condition of the site of the administration is not noted.

19. On October 27, 2014 11:40 AM ampicillin is once again administered and condition of the site is not noted.

20. On October 27, 2014 at 4:08 PM Claforan is administered and the record is devoid of any mention of the site or condition of the IV administration.

21. On October 27, 2014 at 5:48 PM ampicillin is administered and the note fails to document the condition or site of the IV administration.

3

22. On October 27, 2014 at 11 PM, Defendant Downing, RN, initiated an IV antibiotic via peripheral IV and the record is silent on IV location, site appearance and/or if blood return was obtained from the IV prior to administration of the drug.

23. October 27, 2014 at 11:08 AM ampicillin is administered and the record is yet again devoid of any notation of the condition or site of IV.

24. On October 28, 2014 at 4:04 AM a peripheral IV assessment grid fails to document the evaluation of blood return prior to infusion of antibiotic.

25. On October 28, 2014 at 4:27 AM ampicillin was administered and the order was to infuse over 20 minutes. The location of the administration and condition of the site is not mentioned in the record and there is no evaluation of blood return prior to the administration.

26. On October 28, 2014 at 4:49 AM there is a medical note that is silent on the evaluation of the IV site and/or of the IV infiltrate.

27. On October 28, 2014 at 4:50 AM the patient is noted as being "fussy". The IV antibiotics were discontinued, the IV dressing was removed and the minor Plaintiff's hand was puffy with bruising. Additionally there was swelling to the fingers and the peripheral IV was removed. Additionally a warm compress was applied.

28. October 28, 2014 at 5:17 AM, the site condition was noted to have edema and pain. An infiltration score of one was noted. It was noted again that the minor Plaintiff was "fussy".

29. October 28, 2014 at 7:30 AM and assessment of the site was completed and it was noted that the right-hand was swollen with a darkened area to the top of the hand.

30. October 28, 2014 at 7:48 AM on a skin abnormality grid the right-hand was noted to have discoloration and blisters.

31. That as a result of the breach of Defendans duty of professional care, Plaintiffs have, are and will in the future continue to suffer from the following, including but not limited to: pain and suffering; permanent scarring and impairment; loss of enjoyment of life; medical expenses and emotional distress

FOR A FIRST CAUSE OF ACTION
(Medical Negligence)

32. Plaintiff incorporates all allegations of paragraphs above into this cause of action as if set forth verbatim.

33. Defendant Regional, by and through its agents and/or employees, and Defendant Downing, owed Plaintiff a duty of care to use that degree of care and skill which is ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances.

34. Defendants breached that duty of care and were negligent, grossly negligent, careless, willful, wanton and reckless in the following particulars:

a) In failing to use reasonable medical care in accordance with the recognized standards of acceptable professional practice in medicine during the care, diagnosis and treatment of Plaintiff;

b) In failing to act with ordinary and reasonable care in accordance with the recognized standards of acceptable professional practice in medicine;

c) In failing to follow the Infusion Nurse Society publication on *Policies and Procedures for Infusion Nursing of the Pediatric Patient*;

d) In failing to pursue such appropriate medical modalities and treatments which could have avoided this type of injury and permanent damage;

e) In failing to act and behave in the same or similar manner that reasonably competent doctors and healthcare facilities and staff would have behaved or acted in the same or similar conditions;

f) In failing and neglecting to properly inspect the IV site on October 28, 2014 at approximately 4:27 a.m. prior to the administration of antibiotic medication;

g) In failing and neglecting to properly monitor the IV site after the administration of the antibiotic medication.

h) In failing to adequately train and supervise its medical staff;

i) In failing to provide the safest care and treatment to Plaintiff; and,

j) For such other acts and omissions that may become more apparent through the discovery of this matter.

All of which were the direct and proximate cause of Plaintiff's injuries and emotional trauma, all in violation of the statutes and laws of the State of South Carolina, combining and concurring.

35. That as a result of the negligence, carelessness, willfulness, wantonness, and recklessness of Defendants, Plaintiffs have been injured and damaged. Plaintiffs have, are and will in the future continue to suffer from the following, including but not limited to: pain and suffering; permanent scarring and impairment; loss of enjoyment of life; medical expenses and emotional distress - all to their injury and damage in an amount of actual and punitive damages to be determined at the trial of this action.

WHEREFORE, Plaintiffs request that judgment be entered against Defendants on all causes of action and that Plaintiffs be awarded: actual damages; punitive damages; a trial by jury

as to all causes of action properly triable; the costs of this action; and such other and further relief as the Court may deem just and proper.

URICCHIO HOWE KRELL JACOBSON TOPOREK THEOS & KEITH, P.A.

Jonathan F. Krell
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Williams & Williams

David R. Williams
1281 Russell Street (29115)
PO Box 1084
Orangeburg, SC 29116
ATTORNEYS FOR PLAINTIFF

September 30, 2015
Charleston, South Carolina

STATE FO SOUTH CAROLINA
COUNTY OF ORANGEBURG

) IN THE COURT OF COMMON PLEAS
) FIRST JUDICIAL CIRCUIT
) CASE NUMBER: 2015-CP-38-01,334

TEKAYAH HAMILTON, INDIVIVUALLY AND AS PARENT AND GUARDIAN AD LITEM FOR ROBERT LEE M., JR. A MINOR CHILD UNDER THE AGE OF EIGHTEEN,

Plaintiffs,

v.

REGIONAL MEDICAL CENTER AND JAMIE DOWNING, RN,

Defendants.

AFFIDAVIT OF MONICA STOBBS, RN, BSN

FILED FOR RECORD
VIRGINIA B. CLARK
CLERK OF COURT
ORANGEBURG, SC
15 OCT -5 P 4:29

PERSONALLY, appeared before me, the undersigned, who being duly sworn, under the penalties of perjury, says as follows:

1. I am a licensed registered nurse in the state of South Carolina.
2. My education, training and experience are set forth in the attached curriculum vitae (attached hereto as Exhibit 1).
3. My education, training and experience qualify me to render expert opinions regarding the care rendered to Robert Lee M., Jr.
4. I am familiar with the standard of care for what a reasonable, prudent nurse would do or not do in administering IV medication, including but not limited to the intravenous administration of antibiotics including similar situations to that of Robert Lee M., Jr.
5. I reviewed the medical records of Robert Lee M., Jr., which consist, in part, of records from Regional Medical Center located at 3000 St. Matthews Rd., Orangeburg, SC 29118. These are the types of records and documents which I normally consider in rendering an expert medical opinion.

PLAINTIFF'S EXHIBIT 13

6. After review of the afore mentioned medical records, it is my opinion to reasonable degree of medical certainty that Regional Medical Center and the nursing staff while in the course and scope of its employment at Regional Medical Center committed negligent acts or omissions in its care of Robert Lee M., Jr.

7. On October 25, 2014 Robert Lee M., Jr., was admitted to Regional Medical Center for the treatment of neo-natal fever. During the course of treatment at Regional Medical Center, the nursing staff administered intravenous antibiotic medication to Robert Lee M., Jr. Without intending to limit the scope of my opinions, below are some of the breaches of the standard of care for the administration of IV medication to Robert Lee M., Jr.:

   a. Failing and neglecting to properly inspect the IV site on October 28, 2014 at approximately 4:27 a.m. prior to the administration of antibiotic medication.

   b. Failing and neglecting to properly monitor the IV site after the administration of the antibiotic medication.

8. Further, it is my opinion, to a reasonable degree of medical certainty that the actions or inactions of the defendants most probably caused and/or contributed to the injuries and damages suffered by Robert Lee M., Jr.

9. This Affidavit is given in compliance with the South Carolina Code of Laws which do not require me to state all negligent acts or omissions by any defendant. Additionally, I reserve the right to supplement or amend this Affidavit or any testimony by me after receiving additional medical records, documents, depositions and/or information.

Signature Page to Follow

MONICA STOBBS, RN, BSN

SWORN TO AND SUBRSCRIBED BEFORE ME
This 12th day of March 2015

SEAL
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISION EXPIRES: 08/15/2024

Monica Stobbs, RN, BSN
164 Market Street, Suite 295
Charleston, SC 29401
TEL: (857) 334-5310 EMAIL: monicastobbs@gmail.com

PROFESSIONAL BACKGROUND

2012 – Present — MEDICAL UNIVERSITY OF SOUTH CAROLINA, Charleston, SC

Per Diem Nurse at this Level One Trauma Center
- Clinical areas of practice include Adult General Medicine & Surgery

1990 – 2012 — MASSACHUSETTS GENERAL HOSPITAL, Boston, MA

Per Diem Nurse at this Harvard affiliated hospital
- Clinical areas of expertise include Trauma Surgery, Orthopaedics, Neurosurgery, General Surgery, Acute Medical & Cardiac Units
- Interface daily with nationally recognized physicians in collaborative patient care
- Provide advanced in-patient care using state of the art equipment (including ventilator & cardiac monitoring)
- *Certified* IV Therapy Instructor; BCLS; EKG interpretation

1994 - 1996 — MA DEPARTMENT OF PUBLIC HEALTH, Boston, MA
Nurse Consultant

- Monitored seven (7) Long-Term Health Care facilities in MA for Quality Assurance, Regulatory Compliance and Standards of Clinical Practice
- Identified substandard areas of health care delivery
- Assisted facilities in developing plans of correction for substandard areas of practice
- Reported directly to MA's top three (3) Health Care officials
- One (1) of two (2) nurses in the country to perform this role

1986 - 1990 — NEW YORK HOSPITAL-CORNELL MEDICAL CENTER, New York, NY

1989 - 1990 — Acting Head Nurse on an Open Heart Surgery Critical Care Unit
1986 - 1989 — Senior Staff Nurse in this 1,000 Bed Metropolitan Hospital

1988 - 1989 — WASHINGTON UNIVERSITY MEDICAL CENTER, St. Louis, MO

Per Diem Nurse (General Medical/Surgical Units Organ Transplant & Critical Care Units)
- Performed basic & advanced nursing skills in a variety of settings including Critical Care & Organ Transplant Units

1983 - 1985 ST. LOUIS UNIVERSITY HOSPITAL, St. Louis, MO

Charge Nurse/Staff Nurse (Cardiology & Head/Neck Surgical Unit)

- Provided direct patient care including EKG recognition, respiratory & intravenous therapy, advanced physical assessments

EDUCATION: BSN - May 1983, Creighton University School of Nursing
Current License in the State of SC

Presentations:

- Evaluating Spine Injury Claims; NCAJ & APITLA Medical Malpractice Seminar; Raleigh, NC; Nov 2011. CLE credited.
- Evaluating Spine Injury Claims; South Carolina Bar Association; Columbia, SC; October 2012. CLE credited.
- Evaluating Spine Injury Claims; United States Attorney Office, Southern District of Illinois; October 2013. CLE credited.
- Evaluating Spine Injury Claims; United States Attorney Office, Southern District of Florida; February 2014. CLE credited.

Publications:

- D.C Trial Lawyers Association (DCTLA) Quarterly Journal; "Evaluating Spine Injury Claims". January 2012
- The Nurse's Note
  - "Spine Arthritis & Back Injury Claims; Jan 2010
  - "Spine Surgery: Complications of Spinal Fusion Surgery"; Feb 2010
  - "Evaluating Breast Cancer Cases"; March 2010
  - "Orthopaedic Emergencies: Acute Compartment Syndrome"; April 2010
  - "Case Report: Plaintiff Wins 1.1 Million in ACS Case"; May 2010
  - "Medical Chronology A Critical Tool for Winning Your Case"; June 2010
  - "Evaluating Brain Injury Cases"; July 2010
  - "Sleep Deprivation"; August 2010
  - "Spinal Disc Replacement Surgery"; Sept 2010
  - "Evaluating Cancer Claims"; Oct 2010
  - "Emergency Room Practice: Imaging Protocols for Abdominal Pain"; Nov 2010.

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG	)	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen, Plaintiffs, -vs- The Regional Medical Center and Jamie Downing, RN, Defendant.	)	2015-CP-38-01234 ANSWER OF THE DEFENDANTS

Defendant, The Regional Medical Center (hereinafter TRMC) and its employee, Jamie Downing, R.N., improperly named, by and through the undersigned, hereby answers the Complaint of plaintiffs as follows:

1. Defendant denies all allegations contained in the Complaint unless specifically admitted, qualified or explained.

2. Defendant lacks sufficient information to admit or deny the allegations contained in paragraph 1 of the Complaint, and therefore denies same.

3. Defendant admits the allegations contained in paragraph 2 of the Complaint insofar as defendant admits that it is a government healthcare facility.

4. Defendant denies the allegations contained in paragraph 3 and 4 of the Complaint.

5. The allegations contained in paragraphs 5, 6, 7, and 8 of the Complaint contain legal conclusions to which no response is required.

6. The defendant would crave reference to plaintiff's medical records as to the allegations

contained in paragraphs 9, 10, and 11 of the Complaint. Defendant denies a deviation from the standard of care by its employees.

7. As to the allegations contained in paragraphs 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30 of the Complaint, defendant would crave reference to the entire EMR and denies a deviation from the standard of care by its employees.

8. Defendant denies the allegations contained in paragraphs 31, 23, 33, 34, and 35 of the Complaint and demands strict proof thereof.

FOR A SECOND DEFENSE

9. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 8 of this Answer as if realleged herein verbatim.

10. Defendants, who are employees of TRMC, assert it is a governmental entity as contemplated by the South Carolina Tort Claims Act, and it hereby asserts all defenses afforded it by the South Carolina Tort Claims Act, §15-78-10, et seq., Code of Laws of South Carolina, whether or not specifically or separately pleaded herein, including §15-78-60 and all subparts.

MT #2

FOR A THIRD DEFENSE

11. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 11 of this Answer as if realleged herein verbatim.

12. Defendant asserts it is entitled to an Order of this Court limiting plaintiffs' recovery, if any, to those actual damages set forth in §15-78-120, Code of Laws of South Carolina, and asserts that it is not liable to plaintiff for punitive damages, exemplary damages, or pre-judgment interest.

FOR A FOURTH DEFENSE

13. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 12 of this Answer as if realleged herein verbatim.

14. Defendant asserts that all times relevant to the Complaint, its physicians, nursing staff, and non-professional employees were in compliance with the applicable standard of care and defendant asserts its employees did not deviate at any time from the standard of care and the treatment of plaintiff. Defendant further asserts that all supervision, staffing, training and medical equipment available to staff fully conformed to and was in full compliance with the applicable standard of care. Therefore, plaintiff is barred from recovery against the defendant TRMC for the allegations contained in the Complaint.

FOR A FIFTH DEFENSE

15. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 14 of this Answer as if realleged herein verbatim.

16. Defendant asserts that plaintiff's alleged injuries were caused solely by a natural disease process, and, therefore, defendant TRMC is not liable to plaintiff in any fashion.

FOR A SIXTH DEFENSE

17. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 16 of this Answer as if realleged herein verbatim.

18. Defendant asserts that any injuries and damages of the plaintiff, which are expressly denied, were not proximately caused by any action or inaction of the defendants.

FOR A SEVENTH DEFENSE

19. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 18 of this Answer as if realleged herein verbatim.

20. Defendant asserts that any injuries and damages of the plaintiff, which are expressly denied, were proximately caused by the acts of a third party.

FOR AN EIGHTH DEFENSE

21. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 20 of this Answer as if realleged herein verbatim.

22. The Defendant asserts, upon information and belief, that the pendant state claims in this action are governed by the South Carolina Tort Claims Act, S.C. Code Ann. § 15-78-10, et. seq., which governs the terms and conditions under which sovereign immunity is abrogated and reserved unto governmental entities and political subdivisions of the state. Pursuant to § 15-78-120 (a) (1), the plaintiff, if entitled to any damages, which Defendant specifically denies, is limited to a maximum of $600,000.00. The Defendant is informed and believes that they are entitled to an Order of this Court striking all reference to damages being construed to be over the amount of $600,000.00. Plaintiff is also not entitled to punitive or exemplary damages pursuant to § 15-78-120 (b).

FOR A NINTH DEFENSE

23. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 22 of this Answer as if realleged herein verbatim.

24. Defendant asserts that to the extent the minor suffered a compensable injury from a course of medical treatment that was in any way negligent, that Plaintiff was at least equally negligent as Defendant TRMC and as such is barred from recovery under the doctrine of comparative negligence.

FOR A TENTH DEFENSE

25. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 25 of this Answer as if realleged herein verbatim.

26. Defendant asserts it is not liable for any conduct constituting the exercise of judgement or discretion, pursuant to §15-78-60(5) Code of Laws of South Carolina.

FOR AN ELEVENTH DEFENSE

27. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 27 of this Answer as if realleged herein verbatim.

28. Plaintiff is barred from recovery for the responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any student, patient, prisoner, inmate, or client of any governmental entity pursuant to S. C. Code Ann. §15-78-60 (25).

FOR A TWELFTH DEFENSE

29. Defendant reiterates and realleges the allegations contained in paragraphs 1 through 28 of this Answer as if realleged herein verbatim.

30. The proper party, pursuant to the S. C. Tort Claims Act, is The Regional Medical Center which should be substituted as the party defendant, Jamie Downing, R.N., pursuant to S. C. Code Ann. §15-78-70.

WHEREFORE, the defendant requests the Court inquire into these matters herein, dismiss plaintiff's complaint with prejudice and with costs, and grant such other and further relief as the Court may deem just and proper.

MICHAEL C. TANNER, L. L.C.

By: _____

Michael C. Tanner
P.O. Box 1061, 392 Second St.
Bamberg, S.C. 29003
(803) 245-9153
Fax: (803) 245-9154
Attorney for TRMC

Bamberg, S.C.
November 24, 2015

STATE OF SOUTH CAROLINA)
)
COUNTY OF BAMBERG)

I, Michael C. Tanner, attorney for defendant, The Regional Medical Center of Orangeburg and Calhoun Couhties, in the case of Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen v. The Regional Medical Center, et al, case number 15-CP-38-1234, hereby certify that I have served the foregoing Answer, by mailing a copy of same, with postage prepaid, by United States mail to the person(s) at the address(es) indicated as follows:

Jonathan F. Krell, Esquire
PO Box 399
Charleston SC 29402

MICHAEL C. TANNER, L.L.C.

By: _____

Michael C. Tanner
P.O. Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for TRMC

Bamberg, S.C.

November 24, 2015

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of Eighteen, Plaintiffs, vs. Regional Medical Center and Jamie Downing, RN, Defendants.	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT CASE NO.: 2015-CP-38-01234 **PLAINTIFF'S RESPONSES TO DEFENDANT'S REQUEST TO ADMIT**

TO: MICHAEL C. TANNER, ESQUIRE, ATTORNEY FOR DEENDANTS ABOVE-NAMED:

The Plaintiff, by and through the undersigned counsel, hereby responds to the Defendant's Request to Admit, as follows:

1. Admit the value of the amount in controversy in this action is less than $100,000.00.

   RESPONSE: Deny.

2. Admit the value and amount in controversy in this action is greater than $100,000.00.

   RESPONSE: Admit.

3. Admit the value of Plaintiff's actual damages exceeds $100,000.00.

   RESPONSE: Admit.

Signature Page to Follow

URICCHIO HOWE KRELL JACOBSON
TOPOREK THEOS & KEITH, P.A

Jonathan F. Krell
PO Box 399
Charleston, SC 29402
Tel.: (843) 723-7491; Fax: (843) 577-4179

December 14, 2015
Charleston, South Carolina

On December 14, 2015, I served Defendants through their attorney, Michael C. Tanner, Esquire, Plaintiff's Responses to Defendant's Request to Admit to the following address:

Michael Tanner, Esquire
P.O. Box 1061
Bamberg, SC 29003

Attorney for Defendants

Debi M. Carrier
Paralegal to Jonathan F. Krell

STATE OF SOUTH CAROLINA)
) COURT OF COMMON PLEAS
COUNTY OF ORANGEBURG)

TAKAYAH HAMILTON, INDIVIDUALLY AND AS PARENT AND GUARDIAN AD LITEM FOR ROBERT LEE M., JR., A MINOR CHILD UNDER THE AGE OF EIGHTEEN,

PLAINTIFF,

VS.

REGIONAL MEDICAL CENTER AND JAMIE DOWNING, RN,

DEFENDANTS.

TRANSCRIPT OF RECORD

2015-CP-38-1234

May 7th, 2018
Orangeburg, South Carolina

B E F O R E:

THE HONORABLE EDGAR W. DICKSON, Judge; and a jury.

A P P E A R A N C E S:

JONATHAN KRELL
ESQ.
Attorney for the Plaintiff

MICHAEL C. TANNER
ESQ.
Attorney for the Defendant

HILDA JORDAN
Circuit Court Reporter

Transcribed by Pamela E. Green, Circuit Court Reporter

PROCEEDINGS

THE COURT: All right. I, I wanted to get some of the motions out of the way, and some bookkeeping stuff out of the way. I don't know if anybody's gonna show up for the roster meeting since this is the only trial, but I just want to make sure.

I was looking over, before we get started on this, I only have eight witnesses in this case.

Is that correct?

I got Ms. Hamilton. I don't -- Mrs. Middleton, Doctor DeVito.

Who -- what does he -- what is his specialty?

MR. KRELL: He's a plastic surgeon, Your Honor---

THE COURT: As is---

MR. KRELL: ---from Charleston.

THE COURT: ---Doctor Davis?

MR. KRELL: Yes, sir.

THE COURT: Okay.

MR. KRELL: DeVito's our expert plastic surgeon, and Doctor Davis is defense experts.

MR. TANNER: He did the IV actually.

THE COURT: Yeah. Yeah.

MR. KRELL: Maybe he's not their expert.

THE COURT: Huh?

MR. KRELL: Maybe I misspoke. He's not their expert. I'm sorry.

THE COURT: Okay. And then Ms. Stobbs is your nursing expert --

MR. KRELL: Yes, sir.

THE COURT: -- that I've got to do a motion with. Ms. Downing is the nurse that put in the---

MR. TANNER: Yes, sir.

THE COURT: And Ms. Hurley is who?

MR. TANNER: She's my expert, Your Honor.

THE COURT: She's---

MR. TANNER: Oh, nursing expert.

THE COURT: Okay. All right. All right. Let me just make sure I'm -- because it's gonna -- and, Mr. Tanner, looking over the record, there isn't no question that the injury occurred due to this inflation issue.

Is that correct?

MR. TANNER: Infiltration, yes, sir.

THE COURT: Infiltration.

MR. TANNER: Yes, sir.

THE COURT: Infiltration.

MR. TANNER: I-N-F-I-L---

THE COURT: Yeah. No, I got it written down.

MR. TANNER: Okay.

THE COURT: I just don't know how to pronounce it.

MR. TANNER: There's another word, extravagation, that actually technically is what happened because of the fluids used, but they're sort of synonymous.

THE COURT: Uh-huh. (Affirmative).

Okay. And you're not claiming that there was any other cause for this other than this infiltration, right?

MR. TANNER: Right. It's an inherent risk of, of the IV.

THE COURT: Right.

MR. TANNER: Yes, sir.

THE COURT: Right.

I, I understand their -- your position is it's an inherent risk. Their position was they were grossly negligent. I just want to make sure---

MR. TANNER: Right.

THE COURT: ---that's what we're talking about, right?

MR. TANNER: Correct.

THE COURT: Okay. All right.

Okay. Okay. I got the -- they're a couple of different motions that y'all wanted me to go over or do.

There were issues about Ms. Downing. Wanted to go into some issues about whether or not she could -- they were gonna be any statements early on about the fact she's never been -- ever had any problems.

MR. TANNER: Yeah, we just wanted to bring up and make

sure that there's -- the fact that she's never been sued before, maybe had a claim brought against her, to show that she's issued the proper care in this case. We just would move any, any evidence like that would be excluded.

THE COURT: Yeah. I mean I, I don't know that, unless you get into -- unless, unless you get into her character, I, I don't know that that's what---

MR. TANNER: Yeah, I know. I, I mean I think it's an improper question---

THE COURT: Okay.

MR. TANNER: ---and I had no intention of getting into that. That was in our---

THE COURT: Okay.

MR. TANNER: ---return. So unless they sort of get into it and open the door, I'm not gonna ask her that.

THE COURT: Right.

Now, the only -- you know, one of the issues is gonna come up. We might talk about it now. Is -- there is that -- Mr., Mr. Krell, you had asked about -- there were still some -- the even record---

MR. KRELL: Yes, sir, that's --.

THE COURT: You wanted that to come in?

MR. KRELL: We haven't even seen it, but---

THE COURT: Well---

MR. KRELL: ---not only -- we provided a privilege log.

THE COURT: Right.

MR. KRELL: They've objected to it. We wanted to argue that we wanted to at least take a look at it to see what, to see what's in there.

THE COURT: Well, I got it.

Okay.

MR. KRELL: Okay.

THE COURT: You don't want it, but you can argue it.

Go ahead and argue it if you want to.

MR. KRELL: Your Honor, I'm -- if you -- I don't believe -- I don't want to see it.

THE COURT: Okay.

MR. KRELL: I'll withdraw that motion.

THE COURT: Okay. All right. And -- but, but let me, let me just tell you, they -- I, I think I -- number one, I think it's protected anyway. So we'll have that to -- understand that.

But, number two, I've looked at it, and I don't think you want to -- their conclusion to come out.

Okay. And, and y'all can talk about it. I'm not trying, I'm not trying to hit y'all too early in the morning, and we can come back to this. I'll let y'all talk about it some other time.

MR. KRELL: A hush has descended over the courtroom.

(Pause.)

MR. KRELL: Let's move on, Judge.

MR. TANNER: We'll, we'll skip it for now.

THE COURT: Okay. All right.

All right. There was -- Mr. Tanner, I think there was or I don't know who. I can't remember. I got them listed here.

One -- I got the doctors being driven out of the practice.

MR. TANNER: Yeah, I mean, again, I -- in my -- I think that's an improper question, and I have no intention to ask it.

THE COURT: I didn't think you did, but I just wanted to make sure.

Okay. The -- let's get to Ms. Stobbs, whether or not she is qualified to be an expert. I have read the deposition.

Mr. Krell, anything you want to tell me about how you want her to be qualified?

MR. KRELL: Well, Your Honor, I think she's got extensive knowledge of nursing. She's got extensive experience in monitoring and administering IVs, and the general administration and the general monitoring is basically the same for a pediatric versus an adult. And if they want to argue that it goes to her credibility, that's fine, but clearly she's qualified as a nurse.

THE COURT: As a, as a nurse?

MR. KRELL: Yes, sir.

THE COURT: Okay. That's right.

MR. KRELL: As a nursing expert in the general field of IV infiltration.

THE COURT: Nursing 101. I believe.

MR. KRELL: That's what they call it. That's, that's---

THE COURT: That's what she called it.

MR. KRELL: It's popped up many times in these depositions.

THE COURT: All right.

MR. TANNER: Negligent -- respectfully, Your Honor, if they were qualifying her as a nurse, that's one thing. But I think what they're actually trying do is qualifying her as a pediatric nurse or a nurse familiar with pediatric IVs. She's never practiced pediatric nursing.

THE COURT: No, I -- I've read it. I've gone through it. She's never done it. She's never done---

MR. TANNER: You know, the, the -- sort of the -- I guess the big case on this is the Batello versus Vicura case where an orthopedist was attempting to give podiatry opinions, and obviously the podiatry -- he's a, he's a physician, but yet he wasn't familiar with the standard of care.

Ms. Stobbs testified numerous times in her deposition that she didn't review any of the literature. She hadn't done it. If the sole purpose of an expert is to educate the jury, respectfully she's lacking in that area because she hasn't -- again, she hasn't started an IV. She hasn't monitored an IV. She's not familiar with the literature.

Categorically, a lot of what she does say is, is just flat out wrong and obviously refuted by the literature and we've cited that in our memorandum. I think we might of been gone before Ms. Hilda was going.

We good?

THE COURT REPORTER: We're good. Go ahead.

MR. TANNER: So, I don't think she's gonna be able to aid the jury because, frankly, I'm just as qualified, if not more than her, because I've at least read the articles. She's, she's neither started, monitored, nor read the articles. So, so, I don't -- I'm not sure how, under the rules, she's going to assist the jury as an expert because she has no basis on which to testify.

THE COURT: Well, if she's -- and I, and I understand cause I, I -- I've, I've read your cross-examination -- well, your questioning of her knowledge of, of dealing with children. But as far as her qualifications for nursing care, you know, I think she qualifies as a, as a nursing care expert.

Now, you're gonna get to make all the hay you want to---

MR. TANNER: Yes, sir.

THE COURT: ---off that -- other than that. But I, I -- I'll qualify her for nursing care, but that's, that's it. Not neonatal or anything like that.

MR. KRELL: I mean that's fine, Your Honor. I appreciate it.

THE COURT: All right. Let's see.

Oh, had, had y'all got the photographs?

MR. KRELL: I didn't mark anything until we made all these rulings. I've got stickers on everything, but I just kept them all blank until we --

THE COURT: Okay.

MR. KRELL: -- kind of figured all this out through trial.

THE COURT: I, I saw four pictures.

Do y'all -- you've got it?

MR. KRELL: Yes, sir.

THE COURT: Are they marked?

MR. KRELL: I don't have them marked. I've got two photographs, Your Honor.

THE COURT: Aren't there four, four photographs?

MR. KRELL: I may of sent four. I know I've got three. One, one, Your Honor, and I've got smaller ones. Here are

the small ones if you want it. These are the three, Your Honor, that we want---

THE COURT: Well, can you -- let me, let me hold the ones that, that I can hold if you don't mind --

MR. KRELL: Okay.

THE COURT: -- if you don't mind.

Which are the three that you want---

MR. KRELL: I mean I've just got to fill them out, Your Honor.

THE COURT: Yeah. Okay.

MR. KRELL: This was the first one.

THE COURT: Yeah, just get them -- put them down there. I want to get -- at least put an identifying number on them.

MR. KRELL: Okay.

THE COURT: So, on the record, they'll know what I'm talking about.

(Pause.)

THE COURT REPORTER: One, two, three for ID, Judge.

THE COURT: All right. And -- okay. All right. All right. Yes, ma'am, I want you to look at those if you don't mind.

(Pause.)

THE COURT: Okay. And those -- and, and, and just for the record, we've got three photographs that are identified as Plaintiff's 1, 2, and 3 just for purposes of

identification, and you've got those three blown-up?

MR. KRELL: Yes, sir.

THE COURT: Okay.

MR. KRELL: And I'll show them to---

THE COURT: No, no, no.

MR. KRELL: If Michael wants to --.

THE COURT: Okay. All right. Plaintiff's, Plaintiff's marked for Exhibit 1 is a picture of the minor Plaintiff's hand showing the open wound.

Is that correct, Mr. Krell?

MR. KRELL: Yes, sir.

THE COURT: Okay. And you -- you're gonna have somebody who can identify that all three of these are true and accurate reflections?

MR. KRELL: I believe Ms. Hamilton will be able to do that.

THE COURT: Huh?

MR. KRELL: Ms. Hamilton, the---

THE COURT: Okay.

MR. KRELL: ---child's mother.

THE COURT: All right. All right. And, Mr., Mr. Tanner, your objection?

MR. TANNER: Is, is cited in our memo that we sent you last week. Obviously there's -- they're, they're inflammatory. They're sort of graphic. There's no scale on

them. The child's hand is obviously no where near the dimensions that it is on those photos.

I suspect, on the blowup, it's probably gonna look even bigger and greater. We're talking about a 30 day old infant at the time that this event happened. And, and without any reference to scale and reference to depth in, in what all happened, is -- all it's gonna do is just arouse the prejudice of, of the jury.

Certainly, number two, is a photograph after her scar, which sort of looks like the photograph that was done in the independent medical examination. But certainly one in three, again both of those are sort of enlarged to show well beyond what the child's hand would look like at the time. It's impossible -- it's gonna be impossible -- I think it's gonna be impossible for the jury to differentiate that from how small the child's hand was, and truly how small this wound was at the time. And, and there's just no probative value of sort of these open flesh wounds, and, and any probative value I think is -- clearly goes over any sort of -- the prejudice is way, is way greater to the hospital than any probative value that they have.

If the child's gonna testify, it's -- certainly they can identify him. So, it's not like they need the photographs to identify who it is, and, again, it's just not -- without any scale, without anything, it's really not

representative of, of what happened here.

THE COURT: Yeah, just for---

MR. KRELL: Your Honor?

Your Honor, I, I believe that in one of the photographs, if not both, I -- we chose those specifically out of all the ones you saw because there's a adult hand in the picture. I don't know what he's talking about with scale, but one of them has an, an adult hand that it's in the photograph. That's why we---

THE COURT: One, one and two have an adult hand, and, and three has part of an adult hand, and it -- and three is a little bit blurry. I mean---

MR. KRELL: Yeah, it's---

THE COURT: I mean---

MR. KRELL: But, Your Honor, that's what it looked like.

THE COURT: No, I, I---

MR. KRELL: You know, and so he wants to kind of have his cake and eat it too. He, he doesn't -- he says it's prejudicial, but that's what it looked like.

THE COURT: No, and, and I understand, and, and you don't need to really go into any more---

MR. KRELL: Yes, sir.

THE COURT: ---argument. I -- you know, here's the way I look at it is I've got three pictures. I don't think I --

whereas I guess it would be handy having a, a ruler in there, I, I don't think that any of the jurors are not gonna have some idea of, of the size of a child's hand, and I think, I think most of the jurors are gonna be familiar with what -- to me, what you're looking at is just the, the size of the injury in relation to the size of the hand.

And if I've got somebody that says it's a true and accurate copy of it, and we're not doing too many of them, actually I was worried that they may be trying to put in many more pictures of this. But I think this is a representative sample. I think, if somebody testifies it's true and accurate reflection of the child's condition, then I'm, I'm gonna let it in.

I'm gonna note your objection for the record, sir.

MR. TANNER: Thank you, sir.

THE COURT: Okay. All right. And, and so, when we go about putting it in, if you'd just remind me---

MR. TANNER: Yes, sir.

THE COURT: ---of your objection.

All right. The -- there were four or five statements that Ms. Hamilton makes that seem to be reflective of -- I, I don't know who actually spoke them.

Are you intending to get into that area of testimony?

Particularly, Mr. Krell, the way I look at it, and, and you can, you can -- we can argue it as you want to. But Ms.

Hamilton's gonna be able to testify as to what happened to the child. I don't think there's any issue from the Defendant that, that the infiltration is because of this. Nobody else put it in.

There's no testimony that Mrs. Hamilton messed with it, is there?

MR. KRELL: No, sir.

THE COURT: I mean it's just a matter of whether or not the nurse did. So, I'm really -- my general thoughts is, is there's no reason to muddy the record, and here's the gentleman right now.

Is that Mr. Ham --[redacted]

UNIDENTIFIED SPEAKER: Uh-huh. (Affirmative).

MR. KRELL: That's R.J.

THE COURT: All right. Glad to have him here.

Now, he's not gonna -- how, how are y'all gonna handle him being here during---

MR. KRELL: I thought we'd introduce him to the jury, show the jury his scar maybe at the beginning, and then Ms. Hamilton's sister's here to take him back---

THE COURT: How's that---

MR. KRELL: ---to school and then maybe, at the end of the case, we'll get him back.

MR. TANNER: That's fine with me, Judge.

THE COURT: Okay. All right. Okay. Let's -- that,

that way he'll be here and -- but I, I really just didn't think he'd be good to be in here for the whole trial.

MR. KRELL: No, sir.

THE COURT: Okay. Anyway, my, my thought is that just messes the record up. I don't---

MR. KRELL: We'll stay away---

THE COURT: You tell me.

MR. KRELL: We'll stay away from it.

THE COURT: Okay. All right. Thank you, sir.

Is that everything?

Y'all look through there.

(Pause.)

THE COURT: On conformed -- informed consent issue.

Okay. I think -- go ahead. You --.

MR. KRELL: Your Honor, I've, I've been through the records. I haven't seen the documents yet. So, if there's anything in there we just would move to exclude. But -- that there's any --.

THE COURT: Well, I'd, I'd like for you to look at it so we can---

MR. KRELL: Yes, sir.

THE COURT: ---and then we can discuss it before we get into any argument about that.

MR. KRELL: Okay.

THE COURT: Okay. All right.

MR. KRELL: Unless, of course, Mr. Tanner consents to it, it's not coming in---

MR. TANNER: No.

MR. KRELL: It's been -- I don't know.

THE COURT: I mean I, I---

MR. TANNER: I mean it's, it's part -- again, it's part of our defense that's, that's part and parcel of an IV is an infiltration. So, I, I certainly can't consent to it, and there's gonna be replete testimony from the nursing experts. In fact, even Plaintiff's expert concede -- I think she calls it a potential risk of the procedure. But it's, but it's clearly a risk. So, it's an inherent risk in every IV.

So, I can't defend the case without that.

MR. KRELL: I'll take a look, Your Honor.

THE COURT: Okay. All right. Y'all look at that.

Now, I -- let's see. The, the, the voir dire. Oh, the -- oh, voir dire I got in my hand. Terrible place for it to be.

All right. Have y'all looked over each other's voir dire?

MR. KRELL: Yes, sir.

THE COURT: Okay.

MR. KRELL: We looked at it.

THE COURT: Mr. Tanner, have you had an opportunity to look over it?

MR. TANNER: I'm, I'm trying to put my hands on Mr. Krells, Your Honor.

THE COURT: Okay.

MR. TANNER: Your Honor, I think one thing. I do see Ms. Shuler's here. So, we probably need to ask if anybody -- add---

THE COURT: Oh yeah.

MR. TANNER: Add her name to it since she's gonna be sitting here through the trial.

THE COURT: All right. Yeah.

(Pause.)

MR. TANNER: I, I don't have a problem with theirs, Judge. I, I notice Mrs., Mrs. Williams is here, and certainly welcome to have her. But I think I had left her off my voir dire cause I didn't realize she was participating. So, I just want her name on there, and anyone asked if they're clients of hers.

THE COURT: Okay. And, and, Mr. Krell, something that I wasn't doing but I -- when I first started getting on the bench is, just so you'll know, is what I normally do is have you introduce your client, the other attorneys, tell something about your firm and like that. Before I start asking if anybody---

MR. KRELL: Sure.

THE COURT: ---in the jury, you know, has been

represented by, you know, you -- that kind of stuff.

MR. KRELL: Okay. Will do.

THE COURT: But I usually let you do that and let Mr. Tanner---

MR. TANNER: Sure.

THE COURT: ---introduce everybody at his table as well.

MR. KRELL: Okay. I'll go through all the members of our firm.

THE COURT: Huh?

MR. KRELL: I'll go through all the members of our firm. I don't know how---

THE COURT: I, I, I don't know that I'm gonna require you to do, do that.

Mr. Tanner, you have any problem with me not naming everybody in Mr. Krell's firm?

MR. TANNER: No, sir.

THE COURT: Okay. But you, you do need to at least tell them the names.

MR. KRELL: I'll tell them the name. I'll tell them to make sure that I work with my dad.

THE COURT: Okay.

MR. KRELL: He's the only living one on the name met -- on the name letterhead, Your Honor.

THE COURT: Is he really?

MR. KRELL: It's Uricchio Howe and Krell, but Mr. Uricchio and Mr. Howe have been gone for a little while.

THE COURT: Oh, I did not -- you know, I'm sorry. I did not realize that.

(Pause.)

THE COURT: Anything else that y'all believe we need to go over?

Well, let -- going back to the voir dire, let me just mention, Mr. Tanner, Number 10, on yours.

MR. TANNER: Yes, sir, I think that was -- there was some talk, you know, within the last year or so, with the transformation of the hospital, there was some talk in the community that the hospital might be sold, and, and that was sort of geared at that. But if you're uncomfortable with that, I'm---

THE COURT: I am.

MR. TANNER: It's not gonna be the hill I'm gonna die on.

THE COURT: Okay.

MR. TANNER: I'll withdraw that.

THE COURT: All right. Thank you, sir.

All right. Anything else, gentlemen, or lady, that y'all think y'all -- I should go into?

MR. KRELL: I can't -- I think we've agreed on a lot of the things we might want to have---

THE COURT: Yeah. Now, if y'all want to go ahead and let's mark the exhibits now so we can move along. That'd be great. Hilda would appreciate it. I would too.

And, Hilda, here's 1, 2, and 3, and they're gonna be in over, over---

THE COURT REPORTER: Mr. Tanner's objection.

THE COURT: All right.

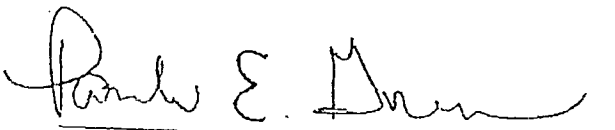
* * *END OF REQUESTED TRANSCRIPT OF RECORD* * *

CERTIFICATE

I, Pamela E. Green, Official Court Reporter for the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for Orangeburg County, South Carolina, on the 7th day of May, 2018.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.

December 22nd, 2020



PAMELA E. GREEN, Court Reporter

2015 CP-38-01234

Tekayah Hamilton, individually and as Parent Guardian Ad Litem for Robert Lee M. Jr., Plaintiff, v. The Regional Medical Center, Defendant.	Transcript of Record

May 7 - 9, 2018
Orangeburg, South Carolina

B E F O R E:

The Honorable Edgar W. Dickson, Judge

A P P E A R A N C E S:

David Williams, Esquire
Jenny Williams, Esquire
Jonathan Krell, Esquire
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Michael Tanner, Esquire
Attorney for the Defendant

Hilda M. Jordan, CVR-M
Circuit Court Reporter

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(Court in session May 7, 2018 at 11:15 a.m.)

THE COURT: All right. Ladies and gentlemen, we're getting ready now to pick a jury in the case of Tekayah Hamilton, individually and as parent and guardian ad litem for [redacted] -- and that's -- it's [redacted] -- right?

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. -- Jr., a minor under the age of eighteen. They are the plaintiffs. The defendant in this case is The Regional Medical Center.

The plaintiffs are represented by Mr. Krell and Mr. Williams. And one of y'all -- I need for y'all to introduce -- yeah, Mr. Krell.

MR. KRELL: Thank you, Your Honor.

THE COURT: Yes, sir.

MR. KRELL: I'm Johnny Krell. I'm from Charleston. I practice law in Charleston with my father, at the Law Firm of Uricchio, Howe & Krell. I have the pleasure of representing Ms. Tekayah Hamilton and her son, [redacted] who I believe most of y'all saw earlier. Sitting beside me is David Williams. You may see his wife, too. Virginia Williams, Jenny Williams, who practice locally at the Law Firm of Williams and Williams. Thank you.

THE COURT: All right. And Ms. Hamilton, could I

MR. KRELL: Yes, I think Your Honor, we've agreed to enter in the photos in? Excuse me, not the photos, the medical chart?

MR. TANNER: Correct.

MR. KRELL: We've agreed to enter the wound care chart?

MR. TANNER: We've agreed policies and procedures -- to the key pieces of evidence and I'll get the photos into evidence.

THE COURT: Okay. All right.

MR. TANNER: And I think we've also talked about earlier about a stipulation. Obviously, they brought this case a personal tort claims act. I think clearly the Court can take judicial notice The Regional Medical Center is a government hospital owned by Orangeburg and Calhoun County, so I ask you to take judicial notice of that fact. I think Mr. Krell's in agreement to that.

THE COURT: Okay.

(Off the record discussion)

MR. KRELL: Your Honor, I know in reviewing Mr. Tanner's charge that the standard -- is gross negligence standard.

MR. TANNER: That's what the law is.

MR. KRELL: And, you know, we have researched Fletcher (sp) verse MUSC. I've got the case, Your Honor, I

can pass up, wherein the standard is just a heightened standard of, breach of a standard of care for a doctor. I think it would transfer to a nurse. There is not a gross negligence standard in this case. It would just be the typical med mal standard that you hold a doctor or a nurse to.

THE COURT: Well, if y'all would give me the case law.

MR. TANNER: And I don't disagree, but if you want, I won't bring that up in my opening if that's what y'all are asking?

MR. KRELL: Yeah. Sure.

MR. TANNER: I don't have a problem with that.

THE COURT: Okay.

MR. WILLIAMS: We just think it's a better thing, Judge to address as we're prepared --

THE COURT: No, no. I'll agree. I'd like to see the case law so I know how we're going to address it at that time, okay?

Okay. Anything else we need to address.

MR. WILLIAMS: Nothing.

MR. TANNER: No, sir.

THE COURT: All right. We'll thank y'all. If y'all will be back here at 1:30, we'll get started.

(Court in recess for lunch break at

12:15 p.m.)

(Plaintiff's Exhibit No. 1, photo, was marked for ID.)

(Plaintiff's Exhibit No. 2, photo, was marked for ID.)

(Plaintiff's Exhibit No. 3, photo, was marked for ID.)

(Plaintiff's Exhibit No. 4, medical records, was marked for ID.)

(Plaintiff's Exhibit No. 5, intravenous therapy manual, was marked for ID.)

(Plaintiff's Exhibit No. 6, office visit records, was marked for ID.)

(Plaintiff's Exhibit No. 7, medical bills, was marked for ID.)

(Plaintiff's Exhibit No. 8, Dr. DeVito office notes, was marked for ID.)

(Defendant's Exhibit No. 1, Davis letter, was marked for ID.)

(Defendant's Exhibit No. 2, Hand photo, was marked for ID.)

(Court in session after lunch break at 1:30 p.m.)

THE COURT: All right. And Mr. Love was sitting in the right place. Juror No. 106 is our Foreman, okay?

(Court's Exhibit No. 1, note selecting Juror No. 106, John Love as foreperson.)

THE COURT: All right.

Is the plaintiff ready?

MR. KRELL: We are ready and we've got some housekeeping matters that I think we have agreed to.

THE COURT: Oh, okay.

MR. KRELL: And we've agreed to Exhibits 4, 5, and 6, which was -- 4 is the medical chart from The Regional Medical Center; 5, is the policies and procedures; and, 6 is the wound care records that'll come into evidence.

MR. TANNER: That's correct. That is correct.

THE COURT: What was the last thing?

MR. KRELL: No. 6 was the wound care records, from the follow-up care from the initial admission.

THE COURT: Okay. And 4, 5 and 6 are in without objection.

MR. KRELL: Yes, sir.

COURT REPORTER: So that would be 1 through 6 in without objection?

MR. KRELL: If Michael would have agreed to those pictures. I'd appreciate it, but --

THE COURT: I think the pictures are in over his objection.

MR. TANNER: Correct.

COURT REPORTER: All right.

THE COURT: Based on my ruling earlier, okay? Okay.

MR. KRELL: So they're in Your Honor?

THE COURT: Yeah. They're in, assuming someone testifies it's a true and accurate reflection of the way that they looked at the time.

MR. KRELL: Yes, sir.

THE COURT: Yeah, which I anticipate that, but --

MR. KRELL: Yes, sir.

THE COURT: Okay.

(Plaintiff's Exhibit No. 1, photo, was marked and entered)

(Plaintiff's Exhibit No. 2, photo, was marked and entered)

(Plaintiff's Exhibit No. 3, photo, was marked and entered)

(Plaintiff's Exhibit No. 4, medical records from TRMC, was marked and entered)

(Plaintiff's Exhibit No. 5, intravenous therapy manual, was marked and entered)

(Plaintiff's Exhibit No. 6, office visit records, was marked and entered)

(Off the record discussion between the Court and the bailiff)

THE COURT: No, no. You go ahead and put the alternate that's going to sit with the jury is Ms. Guillard, okay?

THE BAILIFF: Okay. Thank you.

THE COURT: Okay. All right.

All right. Y'all ready for me to bring the jury in?

MR. TANNER: Yes, sir.

THE COURT: You ready?

MR. KRELL: Yes, Your Honor.

THE COURT: Yeah, bring the jury on in, please?

THE BAILIFF: Yes, Your Honor.

(Jury in at 1:40 p.m.)

THE COURT: Congratulations.

FOREMAN: We look forward to it.

THE COURT: All'right. Ladies and gentlemen, I hope y'all had a good lunch. We're going to get ready to start the trial now. I always sometime worry about my opening remarks when we start the trial right after lunch because they're not as entertaining as the attorneys remarks are going to be, but y'all need to pay attention to them just as if I was one of the attorneys in this case.

The first thing that's going to happen is that the attorney for the plaintiff, that's the person who brought this lawsuit, will make an opening statement, which will be followed by a similar statement by the attorney for the

defendant. These opening statements are not arguments. The arguments will come at the conclusion of the trial. The purpose of the opening statements is to give the parties

You know -- we haven't sworn them, have we.

THE CLERK: No.

THE COURT: No, we got to do this right. Remember, I told y'all I get a head of myself sometimes? This is one of those times I'm ready to get going. Y'all have got to be sworn in as jurors before we start this case. So I need for y'all to stand, raise your right hand and the clerk's going to swear you in.

(The jury was duly sworn)

THE COURT: Thank y'all. Y'all may sit down. Now, don't forget anything I've said already. I'm going to pick up where I left off, okay?

The arguments will come at the conclusion of the case. The purpose of the opening statements is for each party to outline their claims or defenses and the evidence they intend to present in support of those claims or defenses. Following the opening statements, each side will present its evidence with the plaintiff once again going first. Evidence may take many forms. It may be testimony, documents, models, photographs or the like. Please pay close attention to all of the evidence presented by each party.

You, the jury, are the sole finders of the facts in this case and no one else is permitted to weigh the evidence and render a verdict upon it, except you. After all of the evidence has been presented, the attorneys will make their closing arguments. Unlike these opening statements, these final remarks are truly arguments, that is, each side will emphasize certain portions of the evidence and try to persuade you to agree with their version of the facts. Keep in mind that the opening statements as well as the closing arguments of the attorney are not evidence in this case. Give the attorneys your undivided attention, but keep in mind that what they say is not evidence.

After the arguments are finished, I will explain the law which you are to apply in this case. You will then retire to the jury room to consider the facts and the law. Once you have done so, you'll return a verdict in favor of one side or the other.

During the course of the trial, the plaintiff has the burden of proving her claims and must meet that burden by proving those claims by the greater weight or preponderance of the evidence. What we mean by the greater weight of evidence can be illustrated by imagining a traditional set of scales. And y'all have all seen those. Lady Justice holding the scales, they're evenly balanced. When the case begins, the scales are even. After all of the evidence has

been presented if the scales remain evenly balanced or if they should tip even slightly in favor of the defendant, then the plaintiff will have failed to meet her burden of proof and your verdict would be for the defendant. On the other hand, if the scales should tip even slightly in favor of the plaintiff, then she will have met her burden of proof and your verdict should be for the plaintiff.

As I mentioned earlier, although I am the only person who can tell you what the law is, you are the only ones who can determine the facts. I do not have the right to indicate how I might feel about the evidence presented. Excuse me. I do not have the right to indicate how I might feel about any of the facts.

Throughout the trial, it is my intention to act impartially toward each party. It is also my duty to rule on the admissibility of evidence. There are certain rules that both sides must obey in presenting evidence. These rules have a definite purpose. They ensure that the information you received is the most trustworthy and reliable evidence available. An objection is a procedure that is used for an attorney to call a possible violation of these rules to my attention. For this reason, you should not hold an attorney's objection against him or his client, nor should you conclude from my ruling on the objection, that I favor one side over the other.

I remind you to pay close attention to all of the evidence presented to you. It is you, the jury, who will determine the facts in this case. As a result, you will have to evaluate the credibility, and that simply means the believability, of each witness who testifies. After doing so, you will be prepared to render a just and fair verdict in this case.

All right. Now, Mr. Williams, you're going to give the opening statement?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: All right.

MR. WILLIAMS: May it please the Court?

THE COURT: Yes, sir.

PLAINTIFF'S OPENING STATEMENT

BY MR. WILLIAMS:

Ladies and gentlemen of the jury, Mr. Foreperson, my name is David Williams. I'm an attorney here in Orangeburg. I practice at the law firm of Williams and Williams. There are seven attorneys at our law firm. Our law firm was started by my granddad, the late Marshall Williams and my dad, Charles Williams, and my mother the late Karen Williams. My dad still practices with me, my brother Charlie, who's appearing to be hiding behind the pole, he practices with me. My wife is an attorney, Jenny, who is seated with us here today. And we also have Senator Hutto

I remind you to pay close attention to all of the evidence presented to you. It is you, the jury, who will determine the facts in this case. As a result, you will have to evaluate the credibility, and that simply means the believability, of each witness who testifies. After doing so, you will be prepared to render a just and fair verdict in this case.

All right. Now, Mr. Williams, you're going to give the opening statement?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: All right.

MR. WILLIAMS: May it please the Court?

THE COURT: Yes, sir.

PLAINTIFF'S OPENING STATEMENT

BY MR. WILLIAMS:

Ladies and gentlemen of the jury, Mr. Foreperson, my name is David Williams. I'm an attorney here in Orangeburg. I practice at the law firm of Williams and Williams. There are seven attorneys at our law firm. Our law firm was started by my granddad, the late Marshall Williams and my dad, Charles Williams, and my mother the late Karen Williams. My dad still practices with me, my brother Charlie, who's appearing to be hiding behind the pole, he practices with me. My wife is an attorney, Jenny, who is seated with us here today. And we also have Senator Hutto

and Senator Hutto's son, Skyler. We have Russ Blanchard. It's occasionally our opportunity to work with other attorneys. In this case, I get work with my friend Johnny Krell who you met earlier.

We have the privilege of representing Ms. Hamilton, Tekayah Hamilton and her son, [redacted] who we refer to as R.J. They have a claim that they're here before you and you're our jury. What does it mean to be a jury? I would tell you that jury service is probably second to only one thing, that's service in the armed forces, okay? There is nothing more important to our democracy than having the ability to have a group of our peers, a group of people from our community, make the decision what's right and what's wrong.

You're going to hear a lot of things that are going to be presented. You're going to hear witnesses that are going to present different pieces of evidence. Your job as a jury is to determine what are the facts. You heard the Judge say he's going to tell you about the law, but you can pick -- you can determine what are the facts, and how do I apply these facts to the law that he told me.

What you've got to understand is burden of proof. You know, I think everybody wants to think, by what we've seen on TV, where we hear these criminal cases. This isn't criminal court. We're in civil court and like the Judge

said, it's just Lady Justice with even scales and whoever tips it slightly their way wins. And it's our burden to tip it slightly our way.

I like to reference it like a football, because I know football and I feel like most people understand football. It's like playing football except we're receiving the ball on the fifty yard line. We don't have to score a touchdown. We just have to keep the nose of that football ever so slightly beyond the fifty yard line.

What happened in this case? What brings us before you today? You're going to hear my client, Ms. Hamilton. She's going to present how she had a one-month old at the time of this incident. That one-month old had a one hundred and two degree fever. At a hundred and two degree fever, she did what any mother would do, seek medical care. She came to The Regional Medical Center in hopes that they would help her do two things; one, monitor him; and, two help him reduce that fever. Help her reduce that fever.

Unfortunately, what you're going to hear about is poor R.J. came in with a fever, but left permanently disfigured. You're going to hear how that happened. You're going to hear the rules that apply, and you get to decide whether someone broke the rules. You're going to hear someone tell about the different rules they want to -- exist, that maybe you don't see on paper. It's your job to make that

determination. It's our job to make the allegations, but it's your job to make the determination. And I want you to hear and listen to this lovely woman tell you about what happened. I want you to hear our experts. I want you to listen to what they say. And at the end, I think it's going to be clear to you. I think you're going to understand what happened.

Now, what do we want you to do about this? It's easy -- you've heard -- I guess, somebody asked do you have a problem making a monetary award on a case. We'll we're not in criminal court. Nobody's going to jail. There's no way we can cause anybody any kind of -- anything other than put a dollar figure on it. That's what we're here today to do.

Well, why do you have mother and then the three-year-old today that you saw in the courtroom who you'll see again. Well, mother's got to bring both of their claims. Mother's claims is for one thing, right? The cost associated with her child's care. And that cost is not only the cost that she had due to the initial care, but up until the child's eighteen, up until this child's out of the house. You're going to hear what benefit there is to try to make this disfigurement less and you're going to hear recommendations. The ultimate victim in this case, R.J. R.J.'s the one who's wearing this disfigurement the rest of his life. R.J.'s the one that was in pain. R.J. was the

one that suffered. R.J. is going to be asking, through his mother, through us, for pain and suffering, for loss of enjoyment of life, for value for this permanent disfigurement. I think the hardest thing about our job is trying to explain what that is. And often, you know, it's easy to put medical bills in front of you. It's easy to talk about what experience has happened. It's hard to tell you how to think about the experience going forward. And as I thought about it, you know, it's easy to think about myself. You know, what -- I think everybody's got something they're self-conscious about, something that they notice about themselves. Mine's my front two teeth. My brother over there chased me around -- I was wearing socks as a little boy and I slipped and I chipped out ninety percent of those front two teeth. And you can look at them and you might say they don't look like a big deal to you, but it's been a big deal for me my entire life. I initially -- the feeling of having something foreign in your mouth every day. Then it became -- now, as I get older, I find myself brushing my teeth with baking soda trying to keep the other teeth to match the front two teeth. I do remember in college, I went -- you probably think this is the least of my problems being where I was, but I was at a dance and they had black lights. And I'll never forget my date looked at me, what's wrong with your teeth. Oh, these two glow.

These two fake teeth they don't glow. They looked very odd and I felt that. And I'll use another example. I've got a friend Paul. Paul's got a disfigured hand. It's his right hand. Paul is in his fifties. Still to this day, you see Paul in a picture, his hand is in that pocket. You see him and he's behind somebody else. You don't see Paul expose that hand in those photographs. You don't see Paul eager to come up and shake your hand, how you doing? I'm Paul. He doesn't. If you go and introduce yourself he's going to shake your hand, but you can tell he's self-conscious. I don't know what happened to Paul's hand. I know that it happened when he was too young to remember. But what's different, we know what happened to R.J.'s hand and we know who caused it.

So we're going to be talking a lot about how do you put a dollar figure on that in this case? And I want you to think about that. This case is going to be pretty short. We think we'll be finished with this case today but for one witness tomorrow. That doesn't mean that it's not a serious case. I ask that you listen to us, you listen to all of our evidence. At the end of the day, that football is going to be well past that fifty yard line. Thank y'all for being here. Thank you for your service.

THE COURT: Thank you, Mr. Williams.

Mr. Tanner?

MR. TANNER: May it please the Court?

THE COURT: Yes, sir.

MR. TANNER: We're going to set up the easel, Your Honor.

THE COURT: Okay.

(Mr. Tanner sets up easel)

MR. TANNER: Can y'all see that?

DEFENSE'S OPENING STATEMENT

BY MR. TANNER:

Thank y'all for being here. Again, my name is Michael Tanner, I'm a lawyer from Bamberg. I represent The Regional Medical Center. It's been my privilege to represent the hospital. It's been my privilege for years to represent the hospital. Again, with me is Ms. Glenda Shuler. She's a director at the hospital, Joseph Shakibanasab, a lawyer in my office.

I know that -- I feel certain that there is somewhere else that all thirteen of you now would most rather be, whether that be work, whether that be with your family, but this is the most important time for you to be here with us because you are the finders of fact. You are the jury of the facts in this case, as the Judge has explained to you. This case, again, as Mr. Williams said involves a child, [redacted], and his mother, Ms. Tekayah Hamilton. Ms. Hamilton back, when he was thirty days old,

noticed that he woke up with a fever of a hundred and two point six, an acute onset fever. As Mr. Williams said she did an admirable thing, which most parents would do, she took him to the doctor. She took him to the doctor over at Santee Urgent Care. They realized the severity of his fever, the potential medical issues associated with that fever, and they arranged for what's called a direct admission into the hospital, The Regional Medical Center, which is owned by the citizens of Orangeburg and Calhoun County. It's been the only hospital here for years. And [redacted], again that day was thirty days old. He was admitted under Dr. Megan Bolton. And Dr. Bolton admitted [redacted] for potential sepsis.

In this case you're going to hear a number of medical terms you may or may not know. You may or may not have any foundation, but what sepsis is, is sepsis is a potentially fatal medical condition that starts from an infection, and then when the body responds to fight that infection, it can produce different bacteria and basically the body almost cannibalizes itself. So it is a serious, serious disease. Sepsis has really emerged, you'll hear evidence in the last ten years -- people, physicians, practitioner's have a better understanding of what it is. But it's not something that you want to wait around and confirm a diagnosis.

So what Dr. Bolton did that night on October 25th,

2014, is she recognized the seriousness of this potential sepsis and she ordered treatment. And that treatment plan consisted of IV antibiotic medicine, what the literature called -- and you'll hear witness testify -- empiric antibiotics. And what that is, is that's a broad range of antibiotics that fight multiple diseases. The way that you diagnose ultimately sepsis is by blood tests. And so those tests take time for those cultures to grow out. So rather than wait a couple of days to see does he have sepsis or not, you start treating that condition. Obviously, being [redacted] young age, you treat him with IV antibiotics. He's not old enough to swallow medication. He can't take pills. That is the best and most direct route to treat that infection, and that is what Dr. Bolton did. And this case essentially ranges from October 25th through the night of October 27th. [redacted] has these medicines -- infusion. You'll hear testimony from witnesses about pediatric IV's and the maintenance and monitoring of pediatric IV's. But basically, you can almost fast forward ahead to October 27th, 2014, the night shift, 7:00 p.m. at night to 7:00 a.m. in the morning. And that was when nurse Jamie Downing comes in. And you will hear evidence from the jury, and as you see it here what Nurse Downing did initially was assess the IV. Again, that may be a foreign concept to a number of you, but based on what you do as

she's documented, you'll hear evidence that she assesses that. She noticed that the IV is in the right hand. She checks the condition of the site. There's no complications. It's not draining, infiltration score. You're going to hear the word infiltration a number of times in this case. And the infiltration score at the beginning of her shift is zero. She assess the dressing and the activity. The dressing is dry and intact. It's a transparent bandage. The flow and patency. No complications. Again, patency is an important medical term that you're going to hear about. That is how the IV is flowing. You're going to hear a number of witnesses testify to flushing the IV. That is to make sure that you can get medicine through that IV. You're going to hear that a number of times and it's important to note when this assessment was done, there was no complications. And then you're going to hear about what equipment she used and that's an extension set.

Obviously, [redacted] Jr. being a very, very small child at that time, had very small hands. Again, you're going to hear witnesses testimony that it was a 24 gauge needle that was put into his hand and then the extension set ran from that hand and the medicine was infused through a syringe pump. You're going to hear witnesses testify that at the hospital -- and not just Orangeburg, most hospitals -- you want to assess your

patient's IV approximately every hour. You're not always going to be an hour. Sometimes, you're going to be a little bit longer. In a perfect world, it would always be an hour, but that's not the world we live in. People have other patients. People have other things going on in the hospital. But basically, what you're going to see is you're going to see that throughout this period of time, these hourly assessments were being done. And they're being done starting, again, at 19:44 and all throughout the evening and into the next morning and at 4:04 in the morning, it was about time for ampicillin to be given. Nurse Downing again -- you're going to hear evidence -- assessed his IV, infiltration score zero. You're going to hear a number of witnesses testify about literature and what the literature said. Basically of nurses, they testify based on their knowledge, their training and their experience, things they learned in school, things they learn in practice and then things that other people, other professionals write about to show what the best practices are. And you're going to hear that an infiltration score of zero, that is the score that you want. Phlebitis score, zero. Phlebitis is another type complication you can have from IV's. You're going to hear when that medicine was administered, shortly thereafter at 4:27, Nurse Downing would reassess the IV, but she didn't document it again. And I'm not going to stand up here and

tell you that she did. Because the reality is you cannot possibly document everything you do. But she assessed it at 4:04. And she could not have given his medication unless she assessed it again at 4:27. It's going to be up for you to evaluate her credibility. She's going to be here tomorrow. She's going to testify and y'all will be able to hear her.

You're going to hear from a number of other witnesses as to what Mr. [redacted] happened when he had an IV infiltration. And one of those witnesses is a lady. Today, Ms. Monica Stobbs, who's present in court. I anticipate she's going to testify here shortly before y'all. And she is going to testify regarding if IV and IV medication administration. Nurse Stobbs, interestingly enough, never practiced pediatric medicine. She's not going to be able to get up there and tell you with her hand on the Bible that she's ever started an IV for a pediatric patient. She's not going to be able to get up there and tell you that she's ever -- has any personal experience monitoring an IV ???. And she's going to tell you -- when I took her deposition what she told me is that she didn't review any of this literature that says these are things that you look for. These are the things to expect. Nurse Stobbs, you're going to hear a lot again about that size of that needle, that 24 gauge needle. And Nurse Stobbs is going to tell you, I

suspect, like she told me numerous times, that you have to get a blood return with that needle. You're going to hear a number of witnesses testify there that's going to tell you that that is simply not true. The literature says you can't always get blood return.

Remember what we were talking about earlier, flow and patency, that is not the accurate method to determine if that IV is flowing properly. And I think the reason why you're going to hear that from Ms. Stobbs is because, again, she hasn't practiced pediatric nursing. You're going to hear from Jamie Downing.

You're going to hear from my expert, who both have done that and who both practice in that. So you're going to be able to, again, evaluate what they tell you. They're going to evaluate what the literature tells you, and then y'all can make an informed decision. Again, [redacted], he did suffer an infiltration. Again, I think if Ms. Stobbs would have read some of those literature, she would know the following things, again, talk about the 24 gauge needle. But she would also know that the data showed that an IV infiltration can occur between twenty-three and seventy-eight percent of the time with an IV, that it is an inherent risk of everyone getting an IV, that you may have an infiltration. The reality is, [redacted] had one. He received treatment in

the hospital for wound center. He was discharged on October 30th. Thankfully, those blood cultures grew out negative. He did not have sepsis. He left the hospital. He left the hospital with his mother. He has had additional wound treatment at TRMC wound center for a short period of time in 2015. And then he saw a plastic surgeon, Dr. DeVito in Charleston. Dr. DeVito saw him twice in 2015, in February of that year and then in March of that year. And, again, R.J. has a scar. You're going to see pictures of that. I'm sure he'll probably get up and show it to you. And Dr. DeVito, you're going to hear him testify that there were steroid injections that R.J. could have had that would have potentially flattened that scar, reduced it a little bit at a time. For whatever reason, he hasn't had those. You're going to hear from another doctor via deposition testimony, Dr. Davis, who the Court appointed as an independent medical examiner. You're going to hear that Dr. Davis conducted his own independent exam of the child in March of this year and issued a report. And that report showed that R.J. has a well-healed scar. He, again, could benefit from steroid injections. You're going to hear him testify under oath that if he'd had those injections, the scar probably today would be not as thick, wouldn't be as flat. Potentially, there is a surgery that he may have, but no one can say whether or not that surgery would ultimately fix the scar.

Most likely, he's probably just going to have the scar. But thankfully what Dr. Davis is going to testify that you'll hear, that he doesn't have any functional limitations. He's a young child. He can write his name. He can draw. He can throw a ball. He can catch a ball. He can play the piano. He can do the things that normal children can do. And it's not anticipated he is going to have any functional limitations in the future. He can make a fist. There's no tendon rod deformities. He can use his fingers as they are, although, again, he has the scar. No one's disputing that he doesn't have a scar. But what we are disputing is that the nursing staff and The Regional Medical Center are the cause of that scar.

And at the end of the case as Mr. Williams said, he's going to stand up here and ask y'all for money. I'm going to stand up here and I'm going to ask you to return a verdict in favor of The Regional Medical Center. I don't have the burden of proof. I don't have to put a single witness up there. The plaintiff has the burden of proof. I ask you to listen to all of the evidence, take your time and render a true verdict, which I feel at the end of the case will be for the hospital. Thank you.

THE COURT: Thank you, Mr. Tanner.

Is plaintiff ready to call it's first witness?

MR. WILLIAMS: Yes, sir, Your Honor, we'd call

Monica Stobbs.

THE COURT: Okay. Ms. Stobbs.

Ms. Stobbs, if you'd come right up there. And I'm going to let you put that heavy thing down first.

THE WITNESS: All right.

THE COURT: All right. And then if you'd put your left hand on the Bible.

THE WITNESS: (Complies)

THE COURT: Raise your right hand.

THE WITNESS: (Complies)

THE COURT: And the clerk's going to swear you in.

(WHEREUPON, Monica Stobbs, was duly sworn)

THE COURT: Okay. Ms. Stobbs, you're going to need to speak louder, more loudly than that. If we need to pull the chair up or -- I'm sure you can talk louder?

THE WITNESS: My name is Monica Stobbs.

THE COURT: Okay. Thank you, ma'am.

All right. Mr. Krell.

MR. KRELL: May it please the Court, Your Honor.

THE COURT: Yes, sir.

MONICA STOBBS - DIRECT EXAMINATION

BY MR. KRELL:

Q Good afternoon. How do you do?

A Good, thank you.

Q Tell us, what you do for a living?

A I've been a nurse for over thirty years for -- until 2015, I practiced actively in a hospital. For twenty-one years I worked at Massachusetts General Hospital in Boston, which is Harvard's Hospital. It's the number one hospital in the country. Prior to that, I worked at Cornell Medical Center in New York City. That's typically rated the number -- in the top ten hospitals in the country. I practice trauma surgery at Massachusetts General Hospital. Primary care, that would be -- one of the components was IV therapy. I was certified in IV therapy at Massachusetts General Hospital as well.

Q Where did you grow up?

A I grew up in southern Illinois. Right outside of St. Louis, Missouri.

Q Where did you go to college?

A I went to Creighton University in Omaha, Nebraska.

Q And did you do a nursing degree at Creighton or --

A Yes. I got a four-year nursing degree at Creighton University, a bachelors of science.

Q And how many IVs do you think you've administered over your career as a nurse?

A Thousands. The primary care for the patients that I have managed has involved IV therapy.

MR. KRELL: At this point, I'm going to introduce

Ms. Stobbs as an expert in nursing.

THE COURT: You said an expert in nursing?

MR. KRELL: Nursing.

THE COURT: Okay.

MR. TANNER: Subject to my prior objection if you'd note that for the record, Your Honor.

THE COURT: All right.

Ladies and gentlemen of the jury she has been qualified as an expert in nursing. And I just tell you a little something. Normally, a person cannot give opinion testimony. Normally, when a person testifies, they must testify as to what they either saw, heard or sensed by smell or something of that nature. However, there is an exception when someone is qualified because of education or experience. They are permitted to give their opinions in certain areas if the Court qualifies them that way. This witness has been qualified in the area of nursing care and may give an opinion in that area. It is evidence for you to use in any way that you see fit.

All right. You may continue.

MR. KRELL: Thank you, Your Honor.

THE COURT: Thank you.

BY MR. KRELL:

Q Have you had a chance to review documents regarding R.J.?

A Yes, I have.

Q All right. Tell the jury what documents you've reviewed in this matter?

A In J.R.'s -- you want me to go through the documents individually?

Q List them for us. Just tell us what you went through.

A I was provided the hospital record for R.J.'s hospitalization where he incurred getting a burn injury from an IV infiltrate. I also have reviewed a subsequent record for evaluation of that hand injury by a plastic surgeon. And I've also reviewed four different literature -- articles that were provided by the defense attorney on IV management. I've reviewed depositions of Nurse Downing and Nurse Craft, which are the two -- which are two -- Nurse Downing was the nurse that administered the IV antibiotic to this baby. And Nurse Craft was the nurse that was on duty just prior Nurse Downing taking over the care of the baby.

Q And were you here to -- Mr. Tanner's opening arguments, did you hear that?

A Yes, I did.

Q And Mr. Tanner spoke about the fact that you never administered an IV to a child; is that correct?

A He did say that. The four articles that he provided to us -- well, first of all, I had never given an IV antibiotic or IV medication to a baby. But the management of the IV,

the rules for management IV are exactly the same if you're a baby or if you're an adult in terms of management of a vein. It's the same safety practices that have to be put into place. And the rules are there just so that an injury to a person, whether it's a baby or an adult, doesn't occur due to improper management of that IV.

Q Thank you. And for our benefits, explain to us how you put an IV in? How do you administer the IV, the actual needle?

A So you basically, you know -- how you're putting an IV in or how you're giving medication?

Q How do you put the IV in?

A So basically, you put a tourniquet on the -- you choose the location. Whether it's an adult or a child, you have to chose the location of where you're going to put the IV. You choose the location. You have to use the antiseptic. You clean the skin. You put a tourniquet on. You clean the skin. You get the IV catheter and you insert the catheter into the vein. And once you have elicited a blood return, you see blood coming from it, you then can flush it with normal saline. And when you're flushing it, you want to watch and make sure that it's not swelling up and that it's actually in the vein and that it's patent.

Q What's a blood return?

A That's a blood return. That's right. The blood return

is what confirms that the IV is actually in the vein and that is an important finding when you place an IV.

Q Is a blood return the only item you look for when checking for patency?

A When you check for patency, it's only one item. The rules basically say that in order to make sure that the IV is patent, to make sure that it's in the vein and that the medication is going to go -- not to the surrounding tissue around where it can cause injury. The rules are that you put into place multiple different things. One is you look at the site. It's just common sense. You're going to look at the IV site and make sure that there's no redness, there's no swelling, that it looks like that there's no abnormal findings. You're going to check for a blood return. If you get a blood return, that's good. Sometimes the smaller gauge catheters do not give a blood return, but you still check for a blood return. It's one additional thing that you can do to make sure that that IV is actually in the vein. And then you flush the IV with normal saline. And while you're flushing with normal saline, you're observing to see if you have any resistance. You're observing to see if there's swelling at the site or if there's any other indication that the IV may not be in the vein.

Q Thank you. And in reviewing the records for R.J., can

you walk us through when he was admitted, and then when this incident occurred. And we can just start with when he was admitted, go through a couple records and then go to when this incident happened.

MR. KRELL: Your Honor, there's' an exhibit that we've admitted and I'd prefer --

THE COURT: You may. Yes. Go ahead.

BY MR. KRELL:

Q And here's what we've marked as Exhibit 4, which is the chart. If you could make sure that corresponds to your records and start with the first page there?

A He was basically admitted to this facility on the 25th of October with a fever. He was five weeks old at the time that he was admitted. They weren't sure of what the cause of the fever was and so he was admitted and started on IV antibiotic therapy in case he had some sort of an infection. He was administered IV antibiotics between the 25th of October when he was admitted until the 28th of October when the IV infiltrated. He had a peripheral IV that was placed in his right hand.

Q What's a peripheral IV?

A It's an IV that was placed into his right hand. It's just a short catheterizing and he was periodically given IV antibiotics.

Q And so we can give medicine through the IV. How do you

do that? Can you explain that to us?

A So, you know, again the rules for administering an IV antibiotic -- you know, a nurse's primary job is to make sure that the patients are safe. That anything that we do to them is not going to harm them. And so these are very, very simple rules that were put into place. And that is, again, before you would administer anything through an IV, you want to look at the site and see if there's any evidence of swelling. And you do this immediately before you give the drug, not twenty minutes before or twenty-three minutes before. At the time that you're administering the drug, prior to administering, at that time, you look at the site, you see if it's swollen or if it has any indication that it might be infiltrated or any indication that it may not be in the vein. Then you basically connect the -- you connect the end of the catheter to the tubing for the IV -- I'm sorry. Then you basically, you connect a syringe on the end that has normal saline in it. And you can withdraw and check for a blood return. And if you get a blood return then that would be evidence that it would be in the vein. And then prior to giving the drug, you would flush it with normal saline. And normal saline is something that if it's not in the vein it's not going to harm the area. It's likely not going to cause a burn type of injury like an antibiotic can if it's not in the vein. So you look at the site, you check

for a blood return and you flush it with normal saline prior to giving the antibiotic, and then you administer the antibiotic.

Q Let me turn your attention to the medical chart and I believe it's maybe number five on the chart in front of you or in the documents you brought, which I believe were the same. Let me turn your attention to that medical record of October the 28th, 2014 at midnight.

A Can you show me number five because that's number four?

Q Yes, ma'am.

MR. KRELL: Is that okay?

THE COURT: Yeah. Yeah.

BY MR. KRELL:

Q Does that corresponded with those documents you have.

A What was the question?

Q I'm going to turn your attention to the midnight on October 28th, 2014. Do you see that record?

A Yes.

Q And what does that record reflect?

A That record reflects that at midnight that a normal saline flush was administered through the IV.

Q And then prior to that, which would bring us back in time to 11:44 p.m. on the 27th, what was administered?

A An antibiotic.

Q Okay. Which one.

A Cefotaxime.
Q Okay. If you keep going back in time to the 11:06 note on the 27th -- do you follow me? It's right at the bottom?
A Yes.
Q What was administered?
A Ampicillin.
Q Okay. And that's actually the medication that we're talking about here today, correct?
A Yes.
Q And if you just keep going back in time, I think it'll be the next page, page six of Exhibit 4. Is the top note 8:00 on the 27th?
A Yes.
Q Okay. What was done then?
A Saline flush.
Q Okay. And then back to 5:48 p.m., what was done?
A Ampicillin.
Q All right. And then at 4:08, what was done?
A Cefotaxime
Q And that's the medication you just spoke about, right?
A Yes.
Q And what's the note right before that, the 16:07 note say?
A It says sodium chloride flush.
Q Okay. So you have a flush at 4:07 p.m.?

A Yes.
Q And then what happens?
A Then the antibiotic is given one minute later.
Q Okay. What's your opinion to a reasonable degree of nursing certainty whether or not at that time at 4:07 the saline flush was administered properly?
A It was administered properly. It was administered one minute prior to the antibiotic.
Q Okay. Now, let's turn back and go forward in time back to page five? Back to our midnight note; we have a saline flush.
A Yes.
Q Okay. And then tell the jury what happened between midnight and 4:27 a.m.?
A I don't see that there's a flush.
Q What's that?
A At midnight, there's a saline flush that's given and then at 4:27 in the morning ampicillin is given.
Q Is there a flush given?
A No.
Q And you can refer to your documents as well. But something does happen at 4:04 a.m., correct?
A At 4:04 there's a note that shows that -- it's just a basic activity check.
Q Is that when Nurse Downing checks the site supposedly?

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A Right.

Q Does she check it at 4:37 a.m. when the medication is administered?

A There's no documentation of that.

Q Do you have an opinion whether or not to a reasonable degree of medical certainty whether or not that should be documented?

A It should be documented. Any medication that's given through an IV should be documented because if it's not documented, it wasn't done.

Q What's that?

A If it's not documented, it wasn't done.

Q Now, tell us a little bit more about the saline flushes. Is that just salt water or what is it?

A Saline flush is a medication basically, but it is salt water. It's comprised of sodium and -- but if you give it through an IV and the IV is infiltrated or the IV isn't in the vein, it's going to cause swelling. You'll see that. But it's not going to cause the skin to break down in a burn-like injury to the skin in the area around the IV.

Q For the purposes of the medical chart, do you have an opinion to a reasonable degree of nursing certainty whether or not the saline flush is considered a medication?

A I consider the saline flush a medication. Anything you give to someone through an IV is a medication. It needs to

to be documented.

Q And is that your opinion to a reasonable degree of medical certainty, it should be documented?

A Yes, that is my opinion to a reasonable degree of medical certainty.

Q Have you reviewed any documents in this case which support that theory as well, or that opinion?

A The literature that was provided by the defense indicates that it should be document. And the policy and procedure for the hospital says that it should be documented.

MR. KRELL: Your Honor, may I approach the witness, please.

THE COURT: You may.

BY MR. KRELL:

Q I show you Plaintiff's Exhibit 5, which I ask you to take a look at.

A This is The Regional Medical Center's policy and procedure for IV therapy.

Q Is it fair to say that's the hospital's rule book?

A Yes.

Q They've got to follow those rules?

A Yes.

Q And why do they have those rules?

A They have these rules so that harm doesn't happen to a patient around IV therapy.

Q What do those rules state about saline flushes?

A The rules state that saline flush should be given and documented.

Q Right. I'm going to let you look at page five of nine, the intravenous therapy peripheral access page.

MR. KRELL: Can y'all see this or is it better --

THE COURT: Mr. Tanner, can you see that?

BY MR. KRELL:

Q Are you at page five of nine?

A I am.

Q And at the bottom of the page, the last bullet point, if you could read what that says?

A It says flushing the INT, which is that -- with saline is to be documented on the MAR medication record.

Q Okay. And the documents that we were looking at before, I believe it was document 5 and 6, are those the MAR's?

A Yes, that's the medication record.

Q Where are the saline flushes prior to administering ampicillin documented?

A They're not documented.

Q And you said earlier if it's not documented, what?

A If it's not documented, it wasn't done.

Q You give the saline flush every time you administer -- before you administer the medication?

A Yes, that's one of the rules is you give a saline flush. That's one of the ways that you can determine whether or not the IV is patent.

Q And do you have an opinion to a reasonable degree of medication certainty whether or not the nurse and TRMC breached the standard of care by not documenting it?

A I believe that the nurse and the hospital breached the standard of care. The nurse did not document whether or not she gave the normal saline flush. There are other assessments that are required, the observation of the site, that also weren't documented. And the facility didn't implement the appropriate guidelines to make sure that the documentation was done as it should be.

Q Well, Mr. Tanner said that you can't document everything. He told that to the jury?

A I mean, it's pretty scary to think that you wouldn't document medication, you wouldn't document something with a five-week-old baby? There just are certain things that you may not document, but certainly medication in a five-week-old baby that you're giving through their vein would be something that you would document. The standard of care requires that. And if it's not documented, it wasn't done.

Q But even -- what does their rule book say about

documenting saline flushes?

A Well, the rule book says that it needs to be documented in the medication record.

Q Let's talk about the articles that you've reviewed and talk about blood return and patency. Can you tell us what article, the first article you're reading?

A I'm going to put this stack down -- the next stack.

COURT REPORTER: You're going to lose that. I'm sorry.

MR. KRELL: Hold on a second. Hold on. Hold on.

THE COURT: Are you going to gather that back together? Are you through asking her about that?

MR. KRELL: I'm going to put it back together, Your Honor.

THE COURT: Okay. All right. Good. Thank you, sir.

A Do you want me to start with the defense articles?

BY MR. KRELL:

Q That would be great.

A And your question was?

Q We can start with the first article.

A So the defense provided us with four different articles. The first article is called Intravenous Extravasation, the Mechanisms Management Prevention. And extravasation just means that the IV came out of the vein

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and now fluid is being administered into the skin in the area around the IV. And the significance of that --

Q What year was it published?

A -- is that it can cause a burn-like injury to the area of the skin. This article is from 1993. It's twenty-five or so years old.

Q What does that article say about blood returns and patency?

A This article says that there are different measures to ensure the patency of the IV to make sure that the IV is actually in the vein. It does say that with small gauge catheters that it may not be reliable to use a blood return for ensuring -- alone, to make sure that the IV is in the vein. But there are other components, and there's one component of checking to make sure that the IV is in the vein.

Q What else in that article did you find instructive in this matter?

A It says that because IV infiltration can be a high risk, that you need to put prevention measures in place. You need make sure that you follow all of the rules in terms of evaluating the IV before giving medication through it. It says that health care providers are often cavalier in managing IV therapy because it's such a common practice.

Q What does that mean? What does cavalier mean there?

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A You know, just give -- without putting all the rules into place give an IV medication. And it says that this inattention to detail can lead to an unfortunate consequence. It can result in permanent disfigurement, loss of function.

Q That's the article they gave us, right?

A Right. It says that the IV site itself should be assessed every hour and it should be assessed more frequently after you begin infusing medication through that IV.

Q How long did -- that's interesting you bring that up. How long did Nurse Downing stay with R.J. after infusing the ampicillin at 4:27 a.m.?

A In her deposition testimony she said that she typically stays with a patient for thirty seconds to one minute after beginning the administration of an IV.

Q Do you have an opinion about that to a reasonable degree of nursing certainty whether or not that is a breach of the standard of care?

A It's a breach of the standard of care. When you start that IV medication on somebody, you should stay with that patient for at least five minutes after it's started. And you need to frequently check on the patient, the IV site, during the administration of the medication.

Q On that same vein, when did Nurse Downing return to the

room after the administration of the 4:27 a.m. ampicillin?

A Well, in her deposition she said that she returned when the pump alarmed, at the end of the infusion of the medication. So she did not indicate that she went back and checked on the patient and the IV site at any point in the interim of twenty minutes that the antibiotic was infusing.

Q All right. Thank you. Anything else from the first article that is authoritative in this matter?

A Another thing that's interesting is it says -- it says here that basically the same antibiotics increase the incidence of extravasation and the potential for severe local reactions and necrosis, which is death -- tissue death. It's like a burn having gone through to the tissue in both adults and infants. So again the management of an IV is the same whether it's an adult or a child or an infant, they have the same risk of complications if the rules for managing the IV are not maintained.

Q Is that it from that article so we move to the next?

A It also says basically that once the pump is started, that the pump may continue to deliver the antibiotic even if it's extravasated outside of the vein. So, you know, that means that the pump is not going to alarm to tell the nurse down the hall somewhere that she needs to go back because the IV is out of the vein. It means that the nurse is responsible for going back periodically while that IV

Q Go ahead to the next article?

A Yes.

Q What's the title of the next article?

A The title of the next one is Assessment of an Infant with a Peripheral Device. That's from 2003.

Q That's only fifteen years old?

A That's only fifteen years old. And this basically just talks about the complication rate of IV's, and that you can incur an infiltration. Which again, as a nurse taking care of a patient, it just signals the red flag that if you're giving a medication you know that there's a potential risk for infiltration. And because of that, you have to protect the patient and you have to make sure that you evaluate the site before you give it, give the medication. You check for a blood return, and you administer a saline flush and you document those findings. So, you know, again, it just suggests that a nurse should be on notice to put those safety measures in place with a patient.

Q And so when you use the term document, what does that mean?

A In the medication record, that you gave the saline flush.

Q You mean you write it down.

A You write it down. If it's not written down, it was not done.

Q Is there anything --

A No, --

Q -- else from that article that's authoritative in this action?

A No.

Q All right. Let's go to the next article?

A This one is called infusion -- Infusion Nurses' Society, Infusion Therapies in the Clinical Practice the 2nd Edition. It's from 2001, so it's only seventeen years old.

Q Tell us what you found out there?

A I mean, this one basically says that again, because of the risk for infiltration of an IV with medication, that before, during and after you have to monitor that site. It basically says that extravasation, if the medication goes outside of the vein that it can result in sloughing of the skin, tissue necrosis. Preventative measures should be put in place to minimize that problem.

Q Do you have an opinion of what type of preventative measures should be put in place?

A Basic, simple nursing 101, whether it's a baby or an adult, the management of a vein, it's the same. And that is, again, I -- you know, I'm going to sound like a broken record, but really it is so easy. You look at the site.

Does it look like it's -- there's any signs of a problem? Does it look like it might be outside of the vein? Check for a blood return and also give a normal saline flush and document that you gave it and what the findings were.

Q Go to the next one.

A This one actually has a table that it shows. And the table basically says the IV site should be checked for patency before, during and after the administration of a vesicant, which would be like an antibiotic, the infusion of saline flush prior to administration. It says that in terms of the policies and procedures for how to monitor that IV site once you've started giving medication through it, it says that the nurse, during the administration -- there can be different ways to do it -- one, the nurse can be in constant attendance during the infusion of the vesicant. Whereas, other options would be that the patient and the site should be monitored at specific intervals during the infusion. So, again, if you're not going to stay with the patient, go back in and at least look at the IV site while it's being administered and make sure that it's not outside of the vein. And then another option would be that two licensed nurses would verify the vein patency before the administration of a vesicant. And, again, a vesicant would be a fluid that could cause a burn or an injury to the tissue if it gets outside of the vein. It also says that

basically vesicants -- that the hand -- and, again, in this baby that's where the IV was. It was in the right hand. It says that the hand should be avoided for vesicant administrations because of the tendons and the nerves could be destroyed if the vesicant extravasates the vein. So, you know, it even says here that the hand was a poor choice for the IV.

Q Is there anything in that article that talks about blood return and patency with blood return? Should it be used to determine patency?

A It say that the blood return in a small-veined IV, it may not be -- may not always be an accurate indicator of whether or not it's in the vein. But it doesn't say you shouldn't do -- check for a blood return. It's just one more measure that you can put into place. It's very simple, very easy to make sure that the IV is actually in the correct location.

Q Is that the article that has a footnote? Is that footnote 49? I don't have the document in front of me?

A I don't know.

Q Well, if you might take a look, is there a footnote on the end of the sentence?

A A picture of a hand?

Q No, that's not it. Let's go on to the next article. What's the title of the next article?

A This is the last article and this one was Intravenous Therapy in Children.

Q What's the date of publication on that?

A I couldn't find a date of publication.

Q Can you tell us what you found in that article?

A This one talks about frequent assessments during the administration of an IV, of a IV medication. On the first page it says that the basic principals of safe administration of IV fluids using medications are the same regardless of the patient's age. So whether a patient is a baby or an adult, this article says that the safety principals are exactly the same.

Q Does that article talk anything about blood return?

A I don't know if this one talks about blood return.

Q We've reviewed those four articles that tell us --

A I just want to say too that this, you know, again talks about, again, what I said, a vein is a vein whether it's an adult or a child. And, again, on page five seventy-nine it begins with the selection of the IV site and the different practices around it are exactly the same whether it's an adult or a child. So -- and it says, you know, that -- to provide the treatment with the maximum amount of safety. It says that a peripheral IV -- the sites for a peripheral IV are discussed for adults, but the same principals apply to a pediatric patient.

Q Does that article address blood returns?
A It may.
Q Do you have any notes that would reflect that? You want to just move on to the next article?
A I don't have it in my notes to reflect that.
Q And there's another article that I provided you?
A Yes.
Q Okay. What's the title of that article?
A The title of this article -- and this would be 2014 and the injury to this child occurred in 2014. So it would be the same relevant time frame, not twenty-five years earlier. But this is 2014. It's Policies and Procedures from Fusion Nursing of the Pediatric Patient. And this is from the Fusion Nurses' Society.
Q That's one of the articles that defense counsel also provided was from the Infusion Nurses' Society, too, correct?
A Yes.
Q And what does this article state on page one hundred about flushing?
A It says slowly aspirate until brisk blood return is obtained. It said flushing is performed prior to each infusion --
Q Uh-huh?
A -- after each infusion. So you give the flush before

and you give the flush after.

Q In this article that is number seven on page one hundred, what does it state?

A It says slowly aspirate until brisk blood return is obtained.

Q Well, what does aspirate mean?

A Pull back. You're withdrawing the syringe to see if there's a blood return.

Q Blood return is just one of the steps ???.

A It's just one of the steps.

Q Do you have an opinion to a reasonable degree of nursing certainty whether or not a saline flush was given to R.J. prior to the ampicillin that was given at 4:27 a.m. on October 28th, 2014?

A There's no documentation --

MR. TANNER: Objection, Your Honor.

THE COURT: Hold on for one second.

MR. TANNER: It's been asked and answered multiple times.

THE WITNESS: That's a --

THE COURT: Wait, just one second. Just one second.

MR. KRELL: Hold on. Hold on.

THE COURT: I'm going to note your objection. I'm going to let her answer it but this will be last time she

answers it, okay?

MR. KRELL: Yes, sir.

THE COURT: Okay. Go ahead.

A There's no documentation that a flush was given before the ampicillin was administered.

BY MR. KRELL:

Q Ms. Stobbs, what's the effect of an infiltration of a medication like ampicillin?

A What happened to this child. It can cause a burn-like injury to the skin in the area. So in this case the IV infiltrated in the baby's right hand and within a short period of time the skin on the back of the hand was like a burn. It basically came off, left him with a scar.

Q Thank you. Please answer any questions defense counsel has.

THE COURT: Mr. Tanner.

MR. TANNER: Thank you, Judge Dickson.

THE COURT: Yes, sir.

MR. TANNER: May it please the Court?

THE COURT: Yes, sir.

MONICA STOBBS - CROSS-EXAMINATION

BY MR. TANNER:

Q Ms. Stobbs, again, I think you've been a registered nurse since 1983; is that right?

A Yes.

Q That's more than twenty-five years ago, right?
A It'd be closer to over thirty.
Q So all of these articles were available to you to read early-on in your nursing career, correct?
A Correct.
Q But you weren't familiar with any of these articles until we provided them to you, correct?
A Correct.
Q I think you started out at St. Louis University Hospital; is that right?
A Yes.
Q And that's in Missouri?
A Yes.
Q Were you ever pediatric advanced life certified as a nurse?
A I was adult certified as adult ACLS.
Q ACLS. But that's different that PALS, Correct? P-A-L-S?
A Correct.
Q And you were never certified in that, were you?
A No.
Q And, again, when you were at St. Louis University Hospital did you ever take care of a pediatric patient?
A No.
Q And you never administered an IV to pediatric patient

there, did you?
A No.
Q And you never monitored and assessed a pediatric IV did you?
A No.
Q In fact, you have no experience at St. Louis University Hospital regarding any pediatric nursing, correct?
A Correct.
Q All right. But yet you're going to sit here and you're going to tell the jury that a vein is a vein; correct?
A Well, articles you've provided me with say that.
Q They say other things don't they?
A Well, you've asked me do they say a vein is a vein; essentially they do. They said that the safety practices around it are the same, whether it's an adult or the child.
Q All right, Ms. Stobbs. Thank you. Let's turn to Intravenous Therapy in Children, that you point out to the jury was provided by my office. Tell me when you have that?
A Which one?
Q Intravenous Therapy in Children. And I believe it's page five sixty-two.
A Yes, I have it.
Q Would you look at five sixty-two?
A Yeah. I'm on five sixty-two.
Q You see the heading that says vessel size, in bold?

A Yes.
Q Read that for the jury, please?
A It says the size of venous and arterial vessels in the infant and child are smaller than those in the adult. Although the vessels are anatomically positioned in the same location throughout life, there's sometimes thread-like characteristics and tendency to hide, making difficult to locate in a young patient.
Q Let me stop you there. I think you forgot a word. You see where it says the size of vessels and arterial vessels in the infant and child are obviously smaller?
A Oh, yes. It does. Obviously smaller than those in the adult.
Q So that says that a vein is not a vein, correct?
A It says that a vein is a vein. It's not saying that children don't have veins or babies don't have veins. It's saying that they're smaller in size.
Q So even though this article that's twenty-something years old says that they're obviously smaller and pediatric veins are sometimes thread-like in characteristics, you're going to sit here and tell the jury that a vein is a vein is a vein?
A Absolutely.
Q Okay.
A And this same article also talks about that the same

[illegible] from what, and the only [illegible] of pain around IV therapy.

Q And you're getting paid to come testify on behalf of Ms. Hamilton, correct?

A Yes, I am.

Q And I think you hold yourself out as an expert witness, correct?

A I sorry. I don't understand that question.

Q Do you advertise your services?

A I don't advertise my services as a nurse expert, no.

Q Do you have a website?

A I have a website, yes.

Q Does your website talk about how to win.

A I do general medical consulting.

Q Yes, ma'am. If you could answer my question --

A My question is I do not advertise myself specifically as a nurse expert.

Q You have a website?

A I have a website for general consulting, general medical consulting that I do with attorneys.

Q And your website talks about how you help them win, doesn't it? Doesn't it Ms. Stobbs? Either it does or it doesn't?

A Well, it does. Whether it's defense or the plaintiff's side. It doesn't matter because the medical records speak

for themselves: The facts in the medical records are what determine whether right or wrong was done. It is not which side gets -- which side I'm working for, because I may review a case and say I don't think there's a case.

MR. TANNER: Your Honor, I'd move to strike that soliloquy she gave as non-response to my question. My question was just whether her website asked if she wins.

THE COURT: Ms. Stobbs, if you would just respond to the questions. If it's a yes or no question and you believe you need to further explain it, I'll allow you to do that, but you just need to say yes or no and then respond, okay?

THE WITNESS: Okay. Yes.

BY MR. TANNER:

Q And after that you went to Washington University Medical Center, correct?

A (Witness pauses)

Q In your nursing practice? We're talking about your nursing practice?

A No, I went to Cornell University in New York City.

Q Well, you were at St. Louis University Hospital in 1983?

A Yes.

Q And 1985, right?

A Correct.

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Q And then you're at Washington University Medical Center from 1988 to 1989, correct?

A Sir, do you see when I started New York Cornell Medical Center?

Q Well, you have 1990. Were you working at two places at once?

A I went from St. Louis University to Cornell University Medical Center. When I was at Cornell University Medical Center, I did a short interim where I still maintained my position at Cornell in New York City and went to Washington University, which is in St. Louis, because they had the -- at that time the only physician that was doing successful heart and lung transplants on patients, so I wanted to have the opportunity to work with those kinds of patients.

Q Okay. And the medical issues in this case have nothing to do with heart and lung surgery, correct?

A Correct.

Q Okay. And again, according to your CV, you were at Washington University Medical Center as a per diem nurse in 1988 and 1989, correct?

A Correct.

Q All right. And didn't provide any pediatric experience there, did you?

A No.

Q All right. And never started a pediatric IV at the

A No.

Q And never assessed and monitored pediatric [illegible]; correct?

A No.

Q All right. And I just think you just the jury that you were at Cornell. And I heard you say earlier how you were there and their reputation. Again, at Cornell, did you ever practice pediatric nursing?

A No.

Q Did you ever start a pediatric IV at Cornell?

A No.

Q Did you ever maintain a pediatric IV?

A No.

Q And after that, is that when you moved to Boston?

A Yes.

Q Okay. And you were at Massachusetts General Hospital, right?

A Yes.

Q And you worked in trauma surgery and orthopaedics?

A Yes.

Q Again, no peds experience?

A No.

Q Never would have started a pediatric IV up in Boston?

A No.

Q Never would have assessed a pediatric patient for an IV?

A No.

Q And then you moved to South Carolina in 2012; is that right?

A Yes.

Q All right. And you worked at the Medical University for a short period of time?

A Yes.

Q All right. And, again, at MUSC you didn't work in peds, did you?

A No.

Q Never started a pediatric IV?

A No.

Q You never monitored or maintained a pediatric IV, did you?

A No.

Q And as you sit here today, you have never one time in your thirty-something year career monitored or started a pediatric IV, correct?

A Correct.

Q You talk a lot about a 24 gauge needle and blood return. You remember that in your deposition?

A Yes.

Q Okay. And you recall you were deposed in March of this

year?
A Yes.
Q And how much are you getting paid an hour to come testify here?
A Two hundred dollars an hour.
Q And up to this point in time, have you billed over, in excess of five thousand dollars?
A It's possible.
Q Have you billed over seventy-five hundred dollars?
A I don't know.
Q You don't know as you sit here today how many hours you have devoted to this case?
A I don't know the exact number.
Q Okay. And, again, in your -- all your time in this case, you didn't research any literature at all, did you Nurse Stobbs?
A No.
Q All right. But despite all your years of clinical practice at all these prestigious facilities, you didn't do any research on pediatric IV, either initiating or maintaining, correct?
A Management of an IV is the same whether it's in a baby or an adult in terms of the safety practices.
Q That's your story and you're sticking to it?
A It's not my story. It's the standard of care and it's

the truth.

Q Would you agreed that inherent risks of every IV is an infiltration?

A It is potential risk, a potential risk, which is why we have to put into place the appropriate safety measures to make sure that that doesn't -- you can minimize that event.

Q Are you telling the jury that there's a difference between a risk and a potential risk?

A I'm saying that when -- it's a potential risk. If you have an IV put in, then there's a potential risk of IV infiltration.

Q I'm sorry. I guess I just don't understand your answer. Are you telling the jury that there's a difference between a risk and a potential risk?

A Potential risk to me is the exact same thing. It is a potential risk that may occur in an IV infiltrate if you have an IV and getting medication through it.

Q So is it the same thing? I'm just having a hard time. Is it the same thing as a risk?

A Potential risk is one and the same. A potential risk is one and the same thing.

Q So a potential risk and a risk are one and the same thing?

A That's correct.

Q All right. You saw where Nurse Downing came on, on the

evening of October 27th, 2014?
A (Witness pauses)
Q You saw that from reviewing the chart?
A Yes.
Q You saw where she assessed the child?
A Yes.
Q Okay. And part of that assessment is to assess the IV site of the child?
A Correct.
Q And she documented that, correct?
A Yes.
Q She documented that a IV was in the right hand, correct?
A Yes.
Q She documented that it was an over the needle catheter, right?
A Yes.
Q And the catheter is that straw-like part of the catheter where the needle -- the needle starts the catheter, right?
A Yes.
Q And the catheter is actually a straw-like part that the IV tubing hooks up and that's how the medication is administered?
A Yes.

Q And she documented that in the record is right?
A Yes.
Q She documented the site condition, correct?
A Yes.
Q And she documented that there was no complications with that site condition, correct?
A Four hours prior to the administration of the ampicillin; that's correct.
Q Okay. Well, we're still talking about 19:44, okay? Let's talk about 19:44. That's what my questions were, okay?
A Uh-huh. (Affirmative response)
Q And that's a yes?
A Yes.
Q She documented that the site condition, there was no complications at 19:44, correct?
A Correct.
Q And she documented the infiltration score was zero, correct?
A Correct.
Q And that's in the infusion society materials that we provided, correct?
A Yes.
Q And that's also in the infusion materials that plaintiff provided, correct?

A Yes.
Q And that is an optimal score, is it not?
A Yes.
Q That is no signs or symptoms of infiltration, correct?
A Correct.
Q And also she documented a phlebitis score of zero, correct?
A Correct.
Q And that is also optimal score, is it not?
A Yes.
Q And that is no sign and symptoms of phlebitis on that IV, correct?
A Correct.
Q She documented the dressing, did she not?
A Yes.
Q She documented that it was dry and in tact with a clear bandage, correct?
A Yes.
Q That bandage is so she can see through and you can see that catheter, correct?
A Yes.
Q She documented the flow of the patency, that there was no complications, correct?
A Yes.
Q She documented the extension set that was used, did she

not?
A Yes.
Q And so before she's administered any medication, she has assessed that IV, has she not?
A Yes.
Q And she has documented that in the chart, has she not?
A She's -- this is not around the time of medication. At the time of 4:27 when the medication was given, those documented findings don't exist. What you asked me, yes, that's correct, prior to the time of the administration.
Q And Ms. Stobbs, I certainly appreciate your answer. I was asking you again that 19:44, that's 7:44. We're not talking about 4:27. That wasn't my question. My question was she's documented at 19:44 all of that in the chart, correct?
A At 7:44 p.m. the night before the administration of ampicillin, that is correct.
Q And then she assess the IV again at 20:54, correct?
A At 8:54 p.m. the night before, she does document those findings.
Q And it's also documented an infiltration score of zero, correct?
A Yes.
Q It's documented a phlebitis score of zero, correct?
A Yes.

Q At either 7:44 or 20:54, she doesn't document any signs of redness, does she?
A No.
Q She doesn't document any signs of swelling, does she?
A No.
Q And all of that again is in the chart, correct?
A Yes.
Q Okay. And, again, that's before the medicine is administered, correct?
A Yes.
Q All right. She does another IV assessment at 22:05, correct?
A Correct.
Q And if you see that the policy here, it talks about protocols for flushing and assessing. You want to assess that IV or flush that IV rather, a minimum of every four hours or after the administration of the medication, correct?
A Correct.
Q Or as needed, correct?
A Correct.
Q That's what PRN means? That's Latin for as needed?
A Yes.
Q So, again, at 20:54 Nurse Downing hasn't administered any medication yet, has she?

A Correct.

Q That's what the literature says, correct?

A Yes.

Q All right. And she's done it, has she not?

A Yes.

Q And she's documented that, correct?

A Up to this point.

Q Her next assessment, I believe, is timed at 22:05. Have you reviewed that?

A Yes.

Q Okay. Any documentation of infiltration score being anything other than zero?

A No.

Q Phlebitis score documented at zero, correct?

A Correct.

Q And she again didn't document any signs of redness on the IV, correct?

A Correct.

Q She didn't document any signs of swelling on the IV, correct?

A Correct.

Q Now, to do all of this, she actually had to be in the

room looking at [redacted], correct?

A Yes.

Q The IV that's in his right hand? She just can't just chart this from the desk, can she?

A I guess she could, but I would hope she would document what she saw.

Q Okay. And is there anything in the record that shows she didn't document other than what she saw?

A No.

Q She assesses the IV again at 23:23, correct?

A Yes.

Q Infiltration score again of zero?

A Yes.

Q Your optimal score. Phlebitis score is zero?

A Yes.

Q No documentation of any signs of redness, correct?

A Correct.

Q No documentation of any swelling in the IV?

A Correct.

Q Do you have an opinion on whether that documentation complied with the standard of care to a reasonable degree of nursing certainty?

A Up to that point, it complied with the standard of care.

Q All right. She comes back and assess the IV again at

12:37, correct?
A Correct.
Q Infiltration score is documented at zero?
A Yes.
Q Phlebitis score is documented at zero?
A Yes.
Q Any redness documented?
A No.
Q Any swelling documented?
A No.
Q What time is her next assessment?
A Her next assessment is at 4:04 in the morning.
Q Okay. Do you have there in front of you TRMC --
MR. TANNER: I beg the Court's indulgence.
BY MR. TANNER:
Q All right. Nurse Stobbs, we were talking about the 00:37 IV assessment, right?
A I'm sorry, what?
Q What was the last -- did we talk about 00 -- 12:37, correct?
A Yes.
Q And the next assessment, I think you said was at 4:00?
A I see 4:04, but, no, there was one at 2:44 activities and daily living.
Q There was also one at 1:00, wasn't there Nurse Stobbs?

A [illegible] I see 1:41.

Q All right. [illegible] Do you see that, Mr. [illegible] right there?

A Okay.

A Okay. So 11:23 --

Q You see right there where it says performed on 10/28, 1:00 eastern time, Jamie Lee Downing?

A On one seventy-nine?

Q Yes, ma'am.

A Are we on the same page?

Q I believe so. Let me show you. On 10/28, 1:00, Jamie Downing?

A No, mine is a different --

Q Well, where's Plaintiff's Exhibit 1?

THE COURT: I believe it's --

MR. KRELL: It's on the Exhibit table.

BY MR. TANNER:

Q I thought you had that.

THE COURT: I think it's over there. I think -- isn't it 4?

MR. KRELL: Yes, sir.

MR. TANNER: I'm sorry.

BY MR. TANNER:

Q Plaintiff's 4. Go to page one seventy? Here it is.

A Okay.

Q All right. Do you see that IV assessment at 1:00 a.m.?

BY MR. TANNER:

Q Performed on 10/28, 1:00 a.m., Jamie Downing?

A Okay. There's another time above it of 2:49?

Q Yes, ma'am. But it says performed on 10/28, 1:00 a.m., correct?

A Yes.

Q All right. IV assessment, infiltration score zero -- and this goes on to one eighty, so if you want to flip to that page?

A Yes.

Q Infiltration score zero, phlebitis zero, correct?

A Correct.

Q And then there's another assessment at 2:42, correct?

A Yes.

Q IV activity assess, infiltration score zero, phlebitis score zero, correct?

A Yes.

Q And then the next one is at 4:04, right?

A Yes.

Q So there was actually two in between 12:37 and 4:04, right?

A So their policies and procedures says every sixty minutes. So 1:00 a.m. until 2:42 would be almost two hours

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in between.

Q I'd be an hour and forty-two minutes, right?

A Correct, not sixty minutes.

Q I'm not -

A And then the next one is 4:04, which would be again, close to one hour and fifteen minutes, not what the policy and procedure of the hospital is, every sixty minutes.

Q Yes, ma'am. And you're not going to sit here under oath and tell the jury that you do everything, if it says one hour, that you've always for thirty-three years done exactly the one hour, are you?

A When it comes to safety management of an IV, absolutely. The rule is every sixty minutes and that needs to be followed.

Q You were talking earlier about the four-hour flushes, correct?

A (Witness pauses)

Q When Mr. Krell was asking you questions?

A Yes, that in addition to the flush that's given, that should be given prior to an antibiotic.

Q Those flushes that you talk about, those are the four-hour flushes from this policy, correct?

A (Witness pauses)

Q From this policy that says it's to have IMT flush with one milliliter saline on insertion, after administration or

a minimum of every four hours, correct?

A Correct.

Q And those are the flushes that populate in the medical record, correct?

A Those flushes populate. But in addition the flushes around an antibiotic will populate as well, which is why there's a flush at 4:45 in the morning after the ampicillin is started, but it probably, more likely than not, was intended to be the flush given prior that medication.

Q You've never used the Cerner System, correct?

A No.

Q And that's the system of record keeping at The Regional Medical Center, correct?

A There are a variety of types of electronic records. Essentially, they work in general in the same way.

Q And Ms. Stobbs, again, you can explain whatever you want to the jury, but if you could just answer my question first?

A I have not worked with that particular electronic system, no.

Q You read Nurse Downing's deposition, did you not?

A I did read Nurse Downing's deposition.

Q And you read in her deposition that it's her custom, habit and practice to inspect the IV site prior to administering a medication, correct?

A [illegible] Downing way a nurse for one month, so what best practice and procedure was, I don't find credible.

Q And, again, Ms. Stubbs, if you could just answer my question?

A That is what she said.

Q And you read that, right?

A I read that.

Q All right. And she was under oath just like you were, right?

A Correct.

Q She's under oath like you are today?

A Yes.

Q To tell the truth, right?

A (No response)

Q And what she's documented in the assessment records is what she had done prior to that time, correct?

A Yes.

Q And that's what she documented, right?

A Yes.

Q And you truly believe that the management of a vein is a vein whether it's an adult or a pediatric patient?

A That's what the articles that -- I do believe that. And the articles that you provided me with say that.

Q And we talked about a few of them. I think Mr. Krell provided -- I think he was asking you some questions about

the policies and procedures for infusing nursing in a pediatric patient, do you recall that?

A Yes.

Q Do you have those hand?

A Which one? The on you provided or the one Mr. Krell

Q The one Mr. Krell provided?

A May I have his article?

Q Okay? Do you have a Preface?

A Yes.

Q You want to turn to that, please?

A Okay.

Q Would you read the first sentence in the second paragraph on that page?

A It says children are not just little adults and are physiologically different.

Q It's pretty clear that the Infusing Nursing Society shows that there's a difference between adults and children, correct, Nurse Stobbs?

A Not in their veins or in the management of an IV. It says that physiologically, meaning their body size may be different. Physiologically does not mean that their vein would be different. The location is the same place. The practice principles around management of IV therapy, this does not talk about that. This basically is just saying that physiologically, meaning size-wise, maybe, you know,

different rate of growth, those kinds of things may be different.

Q Are you going to tell the jury that physiologically as stated by the Infusion Nurses Society deals with everything else different between an infant, a child, and an adult, but not the size of the veins? Is that what you're telling these people?

A That is what I'm saying. Things that would be different would be doses of medication, obviously based on size. The vein is going to be in the same place of a baby as it's going to be in an adult. And the management for IV therapy in terms of safety practices and what the rules are, it's exactly the same.

Q Well, we just talked earlier when I started asking you questions that they're not in the same place, correct? And that we talked about on five sixty-two?

A (Witness pauses)

Q It says vessel size, there are sometimes thread-like characteristics and tendency to hide them making them difficult to locate in the young patient, Anatomic and Physiologic Differences in Children. I didn't write the book.

A That same article references in other places that the management of an IV is the same in an adult as it is in the child. And I can show you those places if you'd like me to.

Q Children present a wide variety of physical characteristics differing from those in adults, correct?

A Correct.

Q That's what all through this text wrote, correct?

A Correct.

Q But you've testified as authoritative in the field of nursing, correct?

A Correct. It also says if the site's a peripheral IV --

MR. TANNER: Your Honor, again, she's not responsive --

THE WITNESS: Okay.

THE COURT: I guarantee you Mr. Krell is going to ask you that question, okay?

THE WITNESS: Okay.

THE COURT: Okay.

BY MR. TANNER:

Q Nurse Stobbs, again, if you turn back to policies and procedures for infusing nursing in patient? And I'm on page one twenty-five this time.

A All right.

Q Let me know when you're there, please, ma'am?

A I'm on page one twenty-five.

Q You see at the top of the page infiltration and extravasation?

A Yes.

Q Do you agree that these terms can be used synonymously?

A Yes.

Q And extravasation depends on the type of fluid; is that correct? A vesicant versus a non-vesicant?

A No. It refers to fluid not going into the vein. It refers to fluid coming out of the vein, regardless of whether it's a vesicant or whether it's plain old normal saline or whatever it is.

Q So you're going to tell the jury that the difference between vesicant and non-vesicant doesn't have to do with IV medication?

A There are different types of fluids that you can administer IV. You can administer a vesicant, which if it goes outside of the vein can cause a burn-like injury to the tissue in that area. You have non-vesicants like normal saline for instance, the normal saline flush, which if those go outside of your vein may not cause that type of an injury.

Q You see that box up there that says considerations for the pediatric patient?

A Yes.

Q And that says vein fragility and the high acuity levels of young patients can increase the likelihood of infiltration and extravasation, resulting in significant morbidity, correct?

A Yes.

Q And, again, [redacted], was admitted for a work up of sepsis, correct?

A Yes.

Q You would agree with me that sepsis could be fatal if untreated, correct?

A It could be.

Q And it's a serious medical condition?

A It is.

Q Larger amounts of subcutaneous fat in children can make the identification of an early infiltration difficult. You see that?

A Yes.

Q And you disagree with that statement, don't you?

A I do disagree with that. There are other articles that show that an IV infiltrate can be noticed immediately. When you have fluid that's leaking out of the vein into the area around it, you will see swelling particularly, the back of the hand doesn't have fat on it that would hide it as an IV would be if it was, for instance, placed in the arms and in different locations.

Q Nurse Stobbs, how many texts have you written on infusing nursing for pediatric patients?

A None.

Q You would agree with me the Infusion Nurses' Society is

far more credible than you, correct?

A Yes.

Q And despite the fact that they say larger amounts of subcutaneous fat in children can make the identification of an early infiltration difficult, you're saying -- you're telling this jury in Orangeburg County that they're somehow wrong?

A I'm saying that's what this article says, but there would be other articles that may say something different.

Q Well, do you have those other articles?

A No.

Q So you don't have them here to share with the jury in Orangeburg County?

A I know that from thirty years of practice, over thirty years of practice with an IV infiltrate on the back of the hand, which is an area that doesn't have any fat, you will notice swelling in that area if it's -- fluid is being delivered outside of the vein.

Q But the article that we do have to share with the jury in Orangeburg County says that it's difficult to recognize, correct?

A That is what this article says.

Q And that is what -- this was materials provided by the plaintiff, correct?

A Correct.

Q You see under precautions -- [illegible]

A Yes.

Q You use the smallest gauge and length catheter to accommodate the prescribed therapy?

A Yes.

Q Avoid placing catheter in areas of flexion. You see that?

A Yes.

Q That's why you don't want to put it in the elbow, right?

A Or the hand.

Q Does it say don't put it in the hand in there?

A It says areas of flexion. It doesn't say elbow. You mentioned that so I mentioned the hand, which is where it was in this baby because, obviously, the hand flexes. So that would be another area of flexion.

Q You see on one twenty-seven where it says extravasation as vesicant solutions?

A Yes.

Q Remember we just talked about that?

A Correct.

Q In your deposition -- and that was under oath, correct?

A Yes.

Q You testified that you had no opinions that Nurse Downing intentionally tried to hurt this child, correct?

A Correct.

MR. KREIL: Your Honor, I'm going to object. I think he needs to show her the question if he's going to talk to her about her deposition.

THE COURT: Yeah.

MR. KREIL: At least he didn't impeach her with it, but I mean --

THE COURT: You can just ask her the question straight out.

MR. TANNER: Okay. And I think she answered it, but I'm happy to ask it again.

THE COURT: Yes, sir.

BY MR. TANNER:

Q You have no opinions that Nurse Downing did anything intentionally to hurt this child, correct?

A Correct.

Q You want to flip over to page one twenty-six in policies and procedures for infusing nursing of the pediatric patient? You see the bullets?

A Yes.

Q All right. The second bullet says small-gauge catheters -- you see that?

A Yes.

Q And then in parenthesis, 24 gauge or smaller. See that?

A Right.

Q And that was the catheter that was used for this patient, correct?

A Yeah.

Q May not provide a positive blood return. See that?

A Yes.

Q Especially in neo-nates, correct?

A Uh-huh, correct.

Q And he would have been considered a neo-nate, correct?

A Correct.

Q Use additional parameters such as flushing, evidence of pain, swelling or edema to determine patency, correct?

A Yeah. So you can't use a blood return to check alone. It should be used in conjunction with other measures to provide, make sure that the IV's in the correct place. And it says may not provide a positive blood return.

Q But you've never tried to get a blood return with a 24 gauge needle on a pediatric patient, correct?

A I've gotten blood returns from a 24 gauge needle in an adult.

MR. TANNER: Your Honor, you know, she again --

THE COURT: If you would just answer that question

previous matter.

THE WITNESS: Not in a pediatric patient.

THE COURT: Thank you, ma'am.

Q So you don't know if it would collapse the vein do you, Nurse Stobbs?

A I don't believe that it would collapse the veins.

Q But you've never done it?

A No.

Q Okay. And all the literature says that is not an accurate method to determine catheter patency, correct?

A Alone, in and of -- by itself, that is correct.

Q Okay. At your deposition you went on and on about how it was the most important thing, correct?

A In my deposition I said that it was one measure. One of the measures. You can't unbundle those measures.

Q Okay.

MR. KRELL: Your Honor, I need to object. I mean, if he wants to ask her the question then --

THE COURT: I think Mr. Krell wants you without any reference to deposition just ask the question. And then if she doesn't answer that way, you can refer to it, okay?

MR. TANNER: Yes, sir.

THE COURT: Okay. Thank you.

BY MR. TANNER:

Q The medication was administered at 4:27, correct?

A Correct.
Q And Nurse Downing's note is at 4:50 regarding this event, correct?
A Correct
Q And you've reviewed that note, correct?
A Yes.
Q And that talks about the catheter being intact?
A Yes.
Q All right. She did document some swelling?
A Yes.
Q She had a discussion with Ms. Hamilton about what she found?
A Yes.
Q She got the charge nurse in, correct?
A Yes.
Q They called the physician?
A She got the charge nurse in because she was a brand new nurse and had never seen an IV infiltrate from ampicillin?

THE COURT: Ms. Stobbs, you know, if you would answer the question, then you can explain it, okay?

THE WITNESS: Oh, okay.

THE COURT: That's all we need you to do.

THE WITNESS: Okay.

THE COURT: Okay?

THE WITNESS: Sorry.

BY MR. TANNEN:

Q Nurse Downing called the doctor, correct?

A Correct.

Q The IV was discontinued, correct?

A Correct.

Q The doctor made an order for a warm compress to be placed on the hand, correct?

A Correct.

Q At that time, there was no noted redness to the hand, correct?

A Well, the skin fell off the hand practically within the next couple of hours, but no.

Q Is there anything noted at that time at 4:50 about redness to the hand?

A What page are you on. It says 04:50 patient fussy, hand puffy, bruising, swelling, IV was removed.

Q And my question again, anything about any redness?

A No.

Q Do you agree with the literature when it says the infiltration rate is approximately twenty-three to seventy-eight percent?

A I don't know what the -- I agree that I've read that in the literature that you've provided.

Q Do you have any articles to dispute that?

A No.

Q And infiltration is the most commonly identified complication of IV therapy, correct?
A According to the literature that you provided, yes.
Q Do you have any literature to dispute that to the jury?
A No.
Q Does the literature reflect that identifying an infiltration may be difficult even for the experienced clinician?
A Yes.
Q Now, Nurse Stobbs, I think you've testified earlier that you've started thousands of IVs right?
A Correct.
Q Have you ever had an IV infiltrate?
A Yes.
Q How many times?
A I don't know how many times.
Q I presume it was more than one?
A I would say more than one.
Q I presume it was more than ten?
A I don't know.
Q Have nurses at facilities you've worked with had IVs infiltrate?
A Yes.
Q Were you negligent when the IV infiltrated?
A No, because I caught it early-on.

Q Were the nurses you [illegible] that [illegible] IV infiltrated?

A No.

Q Do you agree with this statement IV infiltration may be a potential risk of having an IV?

A It's a potential risk, yes.

Q Do you agree with the fact that it happens isn't necessarily negligence?

A If the appropriate safety measures are put in place to ensure that it was in the correct location and it infiltrates, it is a risk of the procedure.

Q But you would agree that the fact that it happens is not necessarily negligence, correct?

A Correct.

Q And those are your words from your deposition, correct?

A Correct.

MR. TANNER: Nothing further, Your Honor.

THE COURT: Thank you.

Mr. Krell.

(Mr. Krell reviews notes)

THE COURT: And Mr. Krell, I know you've got questions that you need to ask, but if you don't mind, I think the jury would like to take a break.

MR. KRELL: Yes, sir.

THE COURT: Do you mind if we take a --

MR. KRELL: No, sir.

THE COURT: Okay. All right.

Ladies and gentlemen, we're going to take about a ten-minute break, let y'all get up, stretch your legs, go to the restroom if you need to. Remember what I told you earlier on is you cannot talk about any of the testimony that you've heard so far, okay? If y'all will go back in there. I'll get y'all back out in ten minutes, okay?

(Jury out at 3:22 p.m.)

THE COURT: Ms. Stobbs, you are not trapped in that chair, okay?

THE WITNESS: Okay.

THE COURT: But you cannot talk to anybody about your testimony.

THE WITNESS: Okay.

THE COURT: You can get up. You can go to the restroom. If you need to, you know, look through your notes and kind of go through, you can do that. But you can't talk to anybody about your testimony, okay?

THE WITNESS: All right. Okay.

THE COURT: All right. But I know you need to stretch your probably legs after sitting --

THE WITNESS: Thank you.

THE COURT: Yes, ma'am.

THE WITNESS: Appreciate it.

at 3:22 p.m.)

(Court in session after short break at 3:45 p.m.)

THE COURT: Mr. Krell, your redirect is going to be limited to his cross, even though I know that like this, but I just wanted to -- you know.

And your recross is going to be limited to his redirect, okay?

MR. KRELL: Yes, sir. They're fussing at me to be short so --

THE COURT: Huh?

MR. KRELL: They're fussing at me to be short so it should be.

THE COURT: When has an attorney ever listened to another attorney.

MR. KRELL: I'm going to try.

THE COURT: All right. Are y'all ready to bring the jury back in? You ready?

MR. KRELL: Yes, sir.

THE COURT: You ready?

MR. TANNER: Yes, sir.

THE COURT: Okay. Yeah, bring them back in please?

THE BAILIFF: Yes, Your Honor.

THE COURT: Thank you.

MR. KRELL: Sir?

THE COURT: Oh, no. I was just wondering what is this? Is this that still --

MR. KRELL: It's my exhibit with the policies and procedures.

THE COURT: Oh, okay. Oh, I thought it was still the same thing. Okay. All right.

All right. And Nurse Stobbs you haven't talked to anybody about your testimony, have you?

THE WITNESS: No.

THE COURT: Okay. Thank you.

(Off record discussion)

(Jury in at 3:45 p.m.)

THE COURT: All right. Ladies and gentlemen, we're going to continue with the examination of Nurse Stobbs, okay?

Mr. Krell.

MR. KRELL: Thank you, Your Honor.

THE COURT: Yes, sir.

MONICA STOBBS - REDIRECT EXAMINATION

BY MR. KRELL:

Q Briefly, Ms. Stobbs, let me turn your attention to the Assessment of an Infant with Peripheral Intravenous Device article, please?

[illegible]

Q Yes, it is?

A And what is the title? Assessment -- I've got it.

Q How many pages is that document?

A It looks like about two, three pages.

Q Okay.

A Two and a half.

Q Were you provided any footnotes?

A No.

Q If you would, please read the third paragraph on the first page -- the first sentence, please?

A On the first page?

Q Yes?

A The existing clinical research studies --

Q The one above it?

A The one above it. Precise complication rates are difficult to determine because of significant inter-facility variations in reporting. A lack of consistent definitions for complications and reports focused on select complications.

Q Thank you. And then if you go down to where the paragraph that starts infiltration is the most commonly identified -- do you see the note?

A Yes, sir.

Q And that talks about twenty three to seventy-eight percent. That's of reported incidents. That's not when you go to the hospital and get an IV you're going to infiltrate twenty-three to seventy-eight percent of the time. That's just of the reported infiltrations?

A Correct.

Q Okay. So you don't go into the hospital and expect seventy-eight percent of your patients be infiltrated?

A No. But as a nurse you're aware that it is a potential complication. It can happen commonly. And because of that, you have to put the proper rules in place.

Q And that's what this case is about. It's about monitoring and flushing, correct?

A Right.

Q And you're supposed to flush this IV on R.J. each time before a medication is given?

A Yes. To make sure that it's in the vein.

Q And you're supposed to document it?

A You have to document it. If it wasn't documented, it wasn't done.

Q And in this case was it done?

A It wasn't documented and it wasn't done. I do not believe that it was done.

Q Thank you.

THE COURT: Anything?

MR. TANNER: Nothing on juror's, Your Honor.

THE COURT: Thank you, ma'am. You may step down. Are you ready to call your next witness, Mr. Krell?

MR. KRELL: Tekayah Hamilton.

THE COURT: Ms. Hamilton. And Ms. Hamilton, she's got a lot to pick up so don't hurry, okay?

MS. HAMILTON: Okay.

THE COURT: Okay.

MR. KRELL: Your Honor, may Ms. Stobbs be excused?

THE COURT: Any objection?

MR. TANNER: No objection, Your Honor.

THE COURT: Have you got everything, Ms. Stobbs?

THE WITNESS: Yes, I do. Thank you.

THE COURT: Thank you for coming. You are excused.

THE WITNESS: Thank you.

THE COURT: Thank you.

All right. Ms. Hamilton, you remember you've got to stop right there, put your left hand on the Bible.

THE WITNESS: (Complies)

THE COURT: Raise your right hand.

THE WITNESS: (Complies)

THE COURT: The clerk's going to swear you in.

THE WITNESS: Okay.

(WHEREUPON, Tekayah Hamilton was s

duly sworn)

THE COURT: All right. Ms. Hamilton, that was very good. That was the right loudness and everything. So you need to keep speaking like that, okay?

THE WITNESS: Yes, sir.

THE COURT: Okay. Thank you, ma'am.

TEKAYAH HAMILTON - DIRECT EXAMINATION

BY MR. KRELL:

Q Tekayah, where are you from?

A Santee.

Q And did you go to school in Santee?

A No, sir, I went to -- I graduated from Holly Hill-Roberts in Holly Hill.

Q What year did you graduate?

A In 2003.

Q And do you currently work?

A Yes, sir, I do.

Q All right. And what do you do?

A I'm an assistant manager at the Family Dollar in Holly Hill.

Q How long have you done that?

A I've been the assistant manager for a month, but I was head cashier for five months.

Q All right. And do you have any children?

A Yes, sir.

Q And how many children do you have?
A I have six.
Q Okay. And you have a child named Robert?
A Yes, sir.
Q And what does he go by?
A R.J.
Q How old is R.J.?
A He's three.
Q And was R.J. in court earlier today?
A Yes, sir.
Q And did you have to take R.J. after about -- with him being thirty days old at the time to the hospital here in Orangeburg?
A Yes, sir, I did.
Q Tell us what happened?
A He was running a fever off and on that day. And I took him to the Santee Health Clinic and they admitted -- they admitted him into The Regional Medical Center. And upon arriving they checked us in and everything, and then they took us in the other room and put the IV in and brung back.
Q And that was on the 25th of October of 2014?
A Yes, sir.
Q And how did he do during his stay in the hospital?
A He was okay. He was off and on. The fever was still running off and on and he was whining and crying.

Q Were you with him the whole time?
A Yes, sir. I was.
Q Any complications prior to October the 28th, 2014?
A No, sir.
Q On the afternoon of October the 27th, 2014 -- you've heard Nurse Stobbs testify to Mr. Tanner's question, that the nurse had checked his site and it look all right, correct?
A Yes, sir.
Q That's his IV site? Where it has an infiltration score, as you've heard of zero, correct?
A Yes, sir.
Q All right. And you heard the phlebitis score was zero, correct?
A Yes, sir.
Q Now, bring us to and put us in the room, if you can, at 4:27 approximately on the 28th. Tell us what happened?
A Okay. He was laying in the bed and he was crying, like really crying. I mean, it wasn't not like just crying. And when the nurse finally came back -- the IV beeped and when she did not came, I first pressed the button, the beep on the bed. And when she finally came, she said she was down the hall. And she finally came and she check him and she changed the IV thing and she left out. Then she came back with another lady and they was talking and she say they was

-- I was upset because like, I didn't know what was going on. And his hand was just swelled up and so she didn't -- the young lady, she didn't remove this thing from his hand. They called the doctor in and a little latter on, I'd say about two or three hours later, that's when the doctor came in and removed it. And his hand was just stuck and it was just big and swell up. And so I got more upset. It look like everybody was just standing around oh, this, that and the other and then they go off and whisper. Meanwhile, while they doing that. So I had called my sister and ask my sister come and -- because she was there at OCT, to come here now because something wrong because my baby hand all swell up, and that. So I asked her to come over, you know, because ain't nobody here want to -- they didn't want to do anything and my baby's sitting in here crying -- I'm sorry -- at the time.

Q Do you need a tissue?

A Thank you.

Q You need a glass of water?

A (Witness pauses)

Q You want a little water?

A No, sir. I'm fine.

Q Okay. Let's just go slow, okay, Tekayah?

A Okay.

Q We'll go at your pace.

A Okay.
Q Up until 4:27 that morning, R.J. was okay?
A Yes, sir.
Q He's administered the medication at 4:27, correct?
A Yes, sir.
Q The medication goes through, correct?
A Yes, sir.
MR. TANNER: Your Honor, I object to leading the witness.
THE COURT: Yeah. Yeah. Just change your question. She can tell it.
MR. KRELL: Yes, sir.
BY MR. KRELL:
Q What happens after the medicine completes?
A The machine went off and it buzzed a couple of times. I can't remember exactly how many minutes apart was it, that it just kept going off. She said she was down the hall so she can't hear it, but I did call up there twice and she finally came back and she checked it. And then that's when she left, came back and get another nurse, and they told me they was going to call the doctor then.
Q And after they removed the dressing, what did his hand look like?
A His whole hand was just swell up and on top was a big black scar and it was a bubble. It was like a big lump

sitting on top of his hand full up with fluid. And the whole hand had turned black.

MR. KRELL: Your Honor, may I show the witness some documents, please?

THE COURT: Sure.

BY MR. KRELL:

Q I'm going to show you these two documents and ask if you could identify this, please?

A Yeah. And it had puss.

Q What's that?

A That's how his hand looked. The back of his hand.

Q Whose hand is this?

A R.J.

Q And do you know who took that photograph?

A His daddy took it.

Q Okay. His daddy took it?

A Uh-huh. (Affirmative response)

MR. KRELL: Your Honor, at this time I move to admit Plaintiff's Exhibit No. 1 into evidence.

MR. TANNER: Same objection I made earlier, Your Honor.

THE COURT: And I note your objection on the record, but it is in evidence as a true and accurate copy of the hand that day. Your objection is preserved.

MR. TANNER: Thank you, Your Honor.

MR. KRELL: Thank you, Your Honor.

(Plaintiff's Exhibit No. 1, photo, was marked and entered previously)

BY MR. KRELL:

Q And if you could describe that document as well?

A And that was when I was holding him up and they did the picture of a record of it.

Q Whose hand is that?

A It's R.J.'s.

Q And who took the photograph?

A His dad.

MR. KRELL: Your Honor, I've move to put Plaintiff's Exhibit 3 into evidence.

THE COURT: Okay. And again, I'm noting your objection.

(Plaintiff's Exhibit No. 3, photo, was marked and entered previously)

MR. KRELL: Did we do 2. I'm sorry? It's out of order. I'm sorry.

MR. TANNER: Thank you, Your Honor.

THE COURT: Okay.

BY MR. KRELL:

Q Now, prior to 4/27 he was doing just fine?

A Yes, sir. He was fine.

Q And does this accurately depict what his hand looked

like following 4:50 a.m.?
A Yes, sir.
Q These are all with infiltration scores of zero earlier in the day, right?
A Yes, sir.
Q And that would be Plaintiff's 3. Does that accurately reflect how R.J. looked?
A Yes, sir.
Q And when was that taken?
A I think it was that picture right there because it bust the following day, so it'd be like the 29th.
Q Now, as a result of those injuries did R.J. have follow-up care?
A At the wound center, yeah.
Q And did he have about fifteen visits?
A Yes, sir.
Q And when he went to see the wound care specialists, what would they do to the wound?
A They unwrap it and they'll clean it and --
Q They clean it, right?
A Yes, sir.
Q And when they clean it they get in there, right?
A Yes, sir.
Q And how did that make R.J. feel?
A He cried every time.

MR. TANNER: Objection Your Honor as to how the child felt. Obviously, she's speculating.

THE COURT: Well --.

MR. TANNER: If he rephrases it, possibly.

THE COURT: Well, he --

BY MR. KRELL:

Q Describe R.J. when they cleaned the wound.

THE COURT: Okay. Thank you for rephrasing it. How did he react when they cleaned the wound?

A He cried.

BY MR. KRELL:

Q Could you tell -- and as a mother, you gave birth to him. Could you tell if he was in pain?

A From the way he cried, yes, sir, I know my baby was in pain.

Q And they did that fifteen times?

A Yes, sir.

Q On different occasions?

A Yes, sir.

Q I show you another photograph we've marked.

THE COURT: This will be 2?

MR. KRELL: No, this is actually No. 1, Your Honor.

THE COURT: Okay.

MR. KRELL: But we just marked them out of

chronological order. Excuse me.

THE COURT: I think that the --

MR. TANNER: I thought --

THE COURT: Huh?

MR. TANNER: I thought No. 1 is --

MR. KRELL: It is. I just --

THE COURT: Yeah. The one he just showed you is 1, I believe. The last one's going to be --

MR. KRELL: 2.

MR. TANNER: 2, right?

THE COURT: 2.

COURT REPORTER: That's in.

MR. KRELL: I was showing it to the jury first, Your Honor. I apologize.

BY MR. KRELL:

Q If you could describe that photograph for us, please?

A That's, I think this is his last day at the wound center. I think in the wound center. And it's starting to close up. It's still swelled, but that's how his scaring is on his hand now.

Q And whose hand is that?

A R.J.'s.

MR. KRELL: Your Honor, I'd move to admit Plaintiff's 2 into evidence.

THE COURT: Okay.

MR. TANNER: Same objection as my --

THE COURT: It is in evidence and we're preserving your objection, Mr. Tanner. Thank you, sir.

MR. KRELL: Thank you, Your Honor.

(Plaintiff's Exhibit No. 2, photo, was marked and entered previously)

BY MR. KRELL:

Q And that's R.J.'s, what hand, left or right?

A The right hand.

Q It's the right hand or the left hand?

A His right hand.

Q Does R.J. have any complications from his scar?

A He do. I do a lot of hand motion things with him because his hand does cramped up. And he doesn't complain. Like it's itching, he'll tell you, and I have to massage it. And I got him a little ball that he had for a while that he would do it with his hand because it was. He could not sit still because it hurt, and he'll be like this right here. And then he'll do something like that, and then I massage it and give him his ball so he can exercise his hand because I don't want his hand to get stuck like this. So I do do hand exercises for him. And as I say sometime he do have itching and irritation under the skin. He just say it really itch or he'll say mommy, it hurts.

Q How old is he?

A Three.

Q You've heard Mr. Tanner talk about some injections into this scar during his opening. How do you feel about R.J. having that scar injected?

A I don't even want him -- because he done been through so much and I don't want to keep putting him through so much and really, I'm scared that something else might happen. I don't know. And I think he said it's just -- he really did something different. But to me, I don't feel like I should have to do it because I don't know what all it would do. You know, I was scared he'd get it at the time because he done been through so much. I mean, it wouldn't even be a -- He may get home with a -- with his hand wrapped up arms wrapped, can't do nothing. But -- he couldn't crawl with his hand out. He always had to have it -- so I'm like this here, constantly watching that he doesn't do nothing or hit it to make it bleed or make the stuff come out. Anyway, he didn't really crawl like he wanted because I constantly had to get him. And there was a whole year I didn't work because I had to make sure he was okay. You can't just leave the child with somebody in that predicament. I didn't trust nobody.

Q Is he able to go in the sun?

A Sir?

Q Is he able to go in the sun with that scar?

A I don't let him go out like that. But sometime his hand is -- and how it's tightened up in here. If you missing -- be outside playing, kids on the trampoline, or they're playing basketball too much. And he hit it right, who's to say that something else won't happen. Like, I'm just on -- of just -- I don't know what to do. So my baby's daddy told me he goes, keep a close eye on him. If my mama watch him when I'm at work, you wanting him to go out and she wouldn't want him to go outside. I mean, you got to go outside to make sure you watch him because he couldn't go run and try to follow the other children to climb up on the trampoline or climb a tree per se. It's just a whole lot things so, no, I didn't get it injected because I didn't know.

MR. KRELL: Your Honor, with the Court's indulgence, we'd like to bring R.J. in so that the jury can take a look at the --

THE COURT: At his hand now?

MR. KRELL: Yes. I'm sorry.

THE COURT: Any objection, Mr. Tanner?

MR. TANNER: No, sir.

THE COURT: Okay. Yeah, if you'd bring him on in.

[redacted], brought into the courtroom)

THE COURT: And Mr. Tanner, do you want to see his

hand first or do you want the --

MR. TANNER: Yeah, we've got a picture of it.

THE COURT: Could you let Mr. Tanner see his hand before you show it to them?

MR. TANNER: Yes, sir.

THE COURT: Okay. All right.

MR. KRELL: Do you want me just to walk over to the jury?

THE COURT: Yeah. Yeah. If you'd just walk over and let him show the jury.

BY MR. KRELL:

Q Tekayah, is this R.J.?

A Yes, sir.

(Mr. Krell presents [redacted], to the jury)

MR. KRELL: Thank you, Your Honor.

THE COURT: Okay. Has everybody in the jury, y'all could all see his hand?

JURY: (Affirmative response)

THE COURT: You could see his hand?

JURY: (Affirmative response)

THE COURT: Okay. I just wanted to make sure everybody saw it. Okay. All right.

[redacted], taken out of the courtroom)

THE COURT: All right. Anything else, Mr. Krell.

MR. KRELL: No, sir.

THE COURT: Huh?

MR. KRELL: No, sir.

THE COURT: All right. Mr. Tanner anything on cross?

MR. TANNER: Yes, sir. Just briefly.

THE COURT: Yes, sir.

TEKAYAH HAMILTON - CROSS-EXAMINATION

BY MR. TANNER:

Q Thank you for being here, Ms. Hamilton. R.J.'s father is Robert Lee Middleton, Sr.?

A Yes, sir.

Q And are y'all married?

A No, sir.

Q R.J. has rickets disease as well?

A Yes, sir.

Q Can you explain to the jury what that is?

A Well, he got fragile bones. And he got the bow-legged -- it's bow-legged syndrome.

Q Does he have to get medical treatment for that?

A He's just on vitamin D.

Q He's seeing some doctors at the medical university for the Rickets disease though, isn't he?

A Yes, sir.

Q Okay. A couple of different doctors, right?
A Yes, sir.
Q And you take him from -- you live in Eutawville; is that right? Holly Hill?
A No, sir. I live in Santee.
Q I'm sorry. Santee. You take him to Santee and Charleston to see the doctors at MUSC?
A Yes, sir.
Q And that's been going on since, what, 2016?
A Yes, sir.
Q Okay. And he sees a couple of different doctors at MUSC, right?
A He sees two different doctors.
Q Okay. Dr. Dawes, does he still see Dr. Dawes?
A No, he's gotten released from Dr. Dawes.
Q Okay. Does he Dr. Paulo?
A Yes, sir.
Q And there was a while there that you were taking him to Charleston about every month for the rickets; is that right?
A Yes, sir.
Q You understand that R.J. first came to the hospital from Santee because of possibility of sepsis, right?
A No, I did not know what his diagnosis was at first because nobody knew. They said they was still running test.
Q Did they explain to you that they were giving him IV

because there was a potential that he could have sepsis?
A They didn't say sepsis. They say because he could have some kind of viral infection.
Q Have you looked at R.J.'s medical records?
A No, sir. I haven't.
Q You do recall him spiking a fever of almost a hundred and three degrees?
A Yes, sir.
Q And do you recall talking to Dr. Bolton in the hospital once you got to Orangeburg from Santee?
A Yes, sir.
Q And she told you that they were going to do an IV and you would have consented for the IV, correct?
A Yes, sir.
Q All right. And they started those IV medications around October the 25th; is that right?
A Yes, sir.
Q And he was discharged from the hospital on October 30th, right?
A Yes, sir.
Q Do you recall this picture being taken?
A I can't remember that date. That was after all the visits from the wound center.
Q Okay. And that would have been in Orangeburg?
A Yes, sir.

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Q And he was, in fact, released from the Wound Center, right?
A Yes, sir.
Q Didn't have to have any operation or anything like that, right?
A No, sir.
Q And who is Dr. Peter DeVito?
A He's a plastic surgeon.
Q Okay. Where is Dr. DeVito?
A He's located in North Charleston.
Q And did someone refer you to Dr. DeVito?
A Yes, sir.
Q Okay. And did you see Dr. DeVito on February 2nd of 2015?
A Yes, sir.
Q And it was Mr. Krell, your lawyer, that referred you to the doctor, right?
A Yes, sir.
Q None of the doctors at the wound center told you to go see Dr. DeVito, did they?
A After they released him they say nothing else they could have done. So --
Q And Dr. DeVito saw [redacted] again on March 2nd, 2015, right?
A Yes, sir.

Q And at that time he had recommended the steroid injections?

A Yes, sir.

Q And Dr. DeVito told you that would help flatten out the scar?

A Yes, sir.

Q Did R.J. receive any of those injections after March 2015?

A No, sir.

Q Did he have any steroid injections in 2016?

A No, sir.

Q Did he have any steroid injections in 2017?

A No, sir.

Q Even though that would help his scar?

A Maybe it would, but it -- I don't know. Like I say, I wasn't taking a risk because I was scared. I wasn't taking no risk and like you just said about going back and forth with him with the Rickets disease. And I didn't want my baby to be on steroids. And, you know, I didn't got several shots like I said before and maybe it would have helped and maybe it wouldn't. You never know what it -- Yes, I was scared because I never had to went through nothing like that. And so I didn't do it.

Q But you saw Dr. DeVito based on the referral from your lawyer, right?

A Yes, sir.
Q Did you trust what Dr. DeVito was telling you?
A I did.
Q Okay. And he thought that the steroid injections would be of benefit to your son, right?
A Yes, sir.
Q And you want your son -- you want his scar heal, don't you, Ms. Hamilton?
A Yes, sir.
Q Your son saw Dr. Davis in March 2018 in Columbia. Do you remember Dr. Davis?
A Yes, sir.
Q And Dr. Davis was appointed by this Court to do an independent medical examination; do you recall that?
A Yes, sir.
Q Okay. And you took him up there and Dr. Davis saw R.J., right?
A Yes, sir.
Q Okay. And you had an opportunity to speak to Dr. Davis?
A Yes, sir.
Q Okay. And Dr. Davis issued a report; is that right?
A Yes, sir.
Q And that report, I believe, was dated March 28th, 2018; is that right?

A Yes, sir.
Q And Dr. Davis noted in his report that R.J. had a well-healed scar, right?
A I'm not sure what his report said.
Q All right. Do you remember Dr. Davis telling you at the time that R.J. -- when he saw him that R.J. denied pain, burning or itching with his scar?
A R.J. explain to him everything that was bothering him because he can talk.
Q So if Dr. Davis noted that R.J. when he saw him denied pain, burning and itching, that would be accurate of what R.J. told Dr. Davis?
A He didn't deny it. Because when he asked him if it itched and then Dr. Davis asked who scratch it for you. He said I tell my mama to scratch it like I tell my mama to scratch my back. So, no, R.J. didn't deny it because R.J. the one who brought up the subject about his hand hurting and itching.
Q All right. So it's your testimony that Dr. Davis didn't accurately put that in his report?
A I'm not sure what he put in his report because I didn't read his report. I'm telling you what happened when I was there and what happened.
Q Okay. Do you remember Dr. Davis doing some muscle test to R.J.?

A Dr. Davis told R.J. go stand by the wall, hold his hand up. And he took his light and shine it on R.J.'s hand. And he said hey, buddy can you do this? And R.J. show him his hand. Then he took his hand and do some kind of hand motion out. He took the pen and he went on he say he would have to have surgery and he'd have to do a Z, a Y and X's. I understand XYZ. I don't know how you would have to do surgery on his hand. But he actually took R.J. hand and did the hand motion. No, he didn't. Did he say anything further after he said like what the surgery he would have to do? No, he didn't. He said, all right. I'll get the paperwork to your lawyer. Nice meeting you. Nice meeting you, Mr. Davis and we left.

Q And it's your testimony that you haven't read his report?

A It's my testimony.

Q Did you feel that his report may help R.J.?

A I'm not sure because I didn't read his report so I can't say what his testimony would do or won't do.

Q I guess it's just interesting that after Dr. Davis' report you then went to see Dr. DeVito again on April 23rd this year. Do you remember seeing Dr. DeVito on April 23rd?

A Yes, sir.

Q When did you make that appointment, Ms. Hamilton?

A I had an appointment with him before but I couldn't get

to the appointment because that's when Mr. Krell -- that I was going back and forth with R.J. with his rickets disease. And I couldn't stop that because I had to make sure he was getting his medicine and staying on top of it.

Q Do you know when you had that appointment, when you made it?

A No.

Q Because the last records I have from Dr. DeVito don't show any appointments after March of 2015?

A I said I missed an appointment. I can't remember exact what date that was when I missed it. I can --

Q You think -- I'm sorry.

A I can't --

Q I cut you off. I apologize. You can finish.

A You're fine. I can't remember. I know I missed the last appointment I had to have with Dr. DeVito. I can't remember when it was or what it was. Like I say, I was doing the back and forth with him.

Q Because you were going to Charleston --

A Right to see Dr. Dawes and Dr. Paulo.

Q And Dr. DeVito is in that Charleston area, isn't he?

A Not where Dr. Dawes office is.

Q Well, he's in North Charleston you testified to?

A Yeah, I think that's North Charleston -- downtown Charleston.

Q So the Charleston metropolitan area?
A Right.
Q Do you think the appointment was from three years ago in 2015?
A I'm not sure. I can't say yes or no. I can't remember.
Q It just seems a little odd to me that you don't see Dr. DeVito for three years. You see a different doctor that the Court appoints in Columbia that tells you --
A It's not odd because like I said I missed an appointment with Dr. DeVito and I explained to Mr. Johnson -- I spoke with Mr. Johnson probably twice about that, but I was also staying in touch with Ms. Debbie and let her know what was going on. And she understood that I had to get that straight and make sure he stay on his medicine.
Q Okay. But R.J.'s not on any medicine for his hand, right?
A No.
Q So the reason you went back to the Dr. DeVito just a few weeks ago wasn't because you got Dr. Davis' report?
A I'm pretty sure it wasn't because it's not like he said this and that. He was just doing a follow-up appointment.
Q Even though you didn't have any appointments with Dr. DeVito in 2017?
THE COURT: Mr. Tanner, we've gone over this

enough.

BY MR. TANNER:

Q You don't have any plans for surgery for R.J., do you?

A No.

Q Okay. Thank you, Ms. Hamilton.

THE COURT: Anything on redirect?

MR. KRELL: Yes, sir.

THE COURT: Okay. Limited to his cross again.

TEKAYAH HAMILTON - REDIRECT EXAMINATION

BY MR. KRELL:

Q Regarding future surgeries certainly you don't have any plans while he's a baby, do you?

A No.

Q Maybe when he gets older?

A Correct.

Q How about if he gets older when he's a teenager?

A Yes, when he gets older, yes but not right now because I don't want him to get surgery because he's still young.

Q Do you know how Dr. Davis got involved?

A No, sir.

Q Do you know if he was asked by the Court or asked by the attorneys?

A No, I didn't know who he was appointed by.

Q He could have been consented to by us and by Mr. Tanner?

A Yes, sir. I went in with the intentions thinking that it was somebody else.

Q We agreed to it, right?

A Yes, sir.

Q Thank you.

THE COURT: Anything on recross?

MR. TANNER: Just briefly.

TEKAYAH HAMILTON - RECROSS EXAMINATION

BY MR. TANNER:

Q If surgery would be better for R.J. when he's younger, would you be in favor of that?

A I wouldn't want to. We can sit down and talk about everything. I wouldn't --

Q Okay. Mr. Krell asked you and you said you'd think about it when he's a teenager.

A That's what I say we sit down and talk about everything, I would consider it. I didn't just came out and say yes, sir, I'll let him go ahead and get it since he young. I said I would consider it, getting it done if I could sit down and talk over everything and see how it plays out. No, I'm not going to just jump into surgery just because.

Q Yes, ma'am. And do you remember in your visits with Dr. DeVito in 2015 any discussions of surgery when R.J.'s younger?

A Dr. Devito also -- he say do you want to get surgery done? And I say no, not this early. That's --

Q When you saw -- I'm sorry.

A Because he just got fresh from the wound center and he done been through so much.

Q When you saw Dr. DeVito just a few weeks ago did you discuss having surgery for your son now?

A No, I brought it up to Dr. -- Mr. -- Dr. DeVito give me another appointment to come back to him and go into further discussion. So at that morning he just did a scan. He check his hand and wrote on it and asked him to move his hand around and we got an appointment.

Q Do you know when R.J. goes back to Dr. DeVito?

A It's either June 7th or July the 7th.

Q Okay. Thank you, Ms. Hamilton.

A Uh-huh.

THE COURT: All right.

MR. KRELL: Nothing further from Ms. Hamilton.

THE COURT: You may step down. Thank you, ma'am. Plaintiff ready to call its next witness.

MR. KRELL: Your Honor, this is -- I think Mr. Williams discussed with you, Dr. DeVito's scheduled for tomorrow morning. He will come in tomorrow morning. He couldn't come in this afternoon due to surgery. I think he had surgery with patients, but that's our final witness

would be Dr. DeVito.

THE COURT: All right. And did y'all do a video?

MR. TANNER: It's not a video. It's de bene esse.

MR. KRELL: They're going to read the deposition of Dr. Davis.

THE COURT: Okay. And that's going to be your witness?

MR. TANNER: Yes, sir. I took his deposition. He was appointed to do -- so -- but, yeah. I took his deposition. It's a de bene esse.

THE COURT: Well, let me ask the question. Do y'all have any -- how long would it take to read the deposition.

MR. TANNER: It's short, Judge. I mean, short. I would think maybe twenty minutes.

THE COURT: Would y'all have any problems with taking it out of order? Anybody? Any problems with taking it out of order?

MR. TANNER: No, sir.

THE COURT: Okay. All right.

MR. KRELL: Could we take a very brief recess to discuss this. There's some objections that are in that deposition that maybe we could work out.

THE COURT: Okay. Yeah. All right. Ladies and gentlemen, we're going to try and take a brief break. I

know the last one lasted a little longer. I had people waiting in my office. They'd been waiting back here for me to do something. This shouldn't last that long. Remember, you can't talk about anything you've heard so far. So if y'all would go back to the jury room. Thank y'all.

(Jury out at 4:26 p.m.)

THE COURT: Okay. Y'all look it over and work it out.

(Court in recess for short break at 4:26 p.m.)

(Court in session after short break at 4:35 p.m.)

THE COURT: Are we ready?

MR. TANNER: ??? deposition transcript opening outside the jury.

THE COURT: I'm sorry about that. We can do that if you want to wait. One thing I do want to mention is I know we're taking this out of order. And so normally, at the end of the plaintiff's case you make your motion for directed verdict. You're not giving that up or waiving that?

MR. TANNER: No, so I'll be making that --

THE COURT: Okay.

MR. TANNER: -- based on what they said, Dr. DeVito's going tomorrow so I'll make those motions at that

time.

THE COURT: Okay. And then tomorrow you're going to have Nurse Downing and --

MR. TANNER: My expert, Nurse Hurley.

THE COURT: Okay. And Dr. DeVito is going to be in here first thing in the morning?

MR. KRELL: Yes, sir.

THE COURT: What time do you want to be here?

MR. KRELL: Whatever time the Judge tells us to be here, we'll be here.

THE COURT: Well we'll just do 9:00 in the morning.

MR. KRELL: That's fine.

THE COURT: Will that be all right?

MR. KRELL: That's perfect.

THE COURT: Okay. All right.

(Off record discussion)

(Court's Exhibit No. 2, Dr. Donen Davis deposition, was marked)

(Defendant's Exhibit No. 1, Dr. Donen Davis report, was marked for ID previously)

(Defendant's Exhibit No. 2, photograph, was marked for I.D previously)

THE COURT: And David, Michael, I'm going to explain to the jury that we're taking this doctor's

testimony out of order, okay?

MR. WILLIAMS: Okay.

THE COURT: Okay. Ms. Hamilton's already gone? She'll be back?

All right. I'm going to bring the jury back in?

MR. KRELL: We've got Ms. Hamilton back in.

THE COURT: Okay.

Okay. Plaintiff ready?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: Defense ready?

MR. TANNER: Yes, sir.

(Off record discussion)

THE COURT: Okay. All right. Bring the jury o in.

THE BAILIFF: Yes, Your Honor.

THE COURT: Thank you, ma'am.

(Jury in at 4:35 p.m.)

THE COURT: All right. Ladies and gentlemen, what we're going to do next is a deposition was taken by the defendant of Dr. Davis. He's another plastic -- he is a plastic surgeon. And since we still have time today and some of the other witnesses were not available this afternoon, rather than waste time, we're taking witnesses out of order, okay? So this witness, Dr. Davis, is not a plaintiff's witness. He is a defense witness, okay? And

we're doing this the old fashioned way. And let me tell you what the old fashioned way is. You go to the doctor's office. You take his deposition. If the doctor can't make it here, somebody else is going to read the deposition as if he were the doctor, okay? And the only thing he can do is read what the doctor said, okay? And so this is as if the doctor's here, the doctor's under oath. And Mr. Tanner, so you're ready to call your first witness?

MR. TANNER: Yes, sir. Your Honor, I'd call Dr. Donen Davis, J.D., M.D.

THE COURT: Okay. Come on down.

MR. SHAKIBANASAB: (Complies)

THE COURT: And did they swear him in in that deposition?

MR. TANNER: They did. And do you want me to read all of that into the record, Your Honor.

THE COURT: Well, put your left hand on the Bible. Raise your right hand. It's going to take me a while to get there.

MR. SHAKIBANASAB: (Complies)

THE COURT: You swear that you're going to read that deposition accurately?

MR. SHAKIBANASAB: Yes.

THE COURT: Okay. All right. Thank you, sir.

MR. TANNER: May it please the Court?

THE COURT: Yes, sir.

MR. TANNER: And, Your Honor, for the record, this was a deposition taken of Dr. Davis on April 30th, 2018 starting at 3:54 p.m., at Southern Reporting in Columbia, South Carolina.

THE COURT: All right.

MR. TANNER: And Dr. Davis was duly sworn and cautioned to speak the truth, the whole truth and nothing but the truth.

(De bene esse deposition of Dr. Donen Davis taken 4/30/18 read into the record. Questions by Mr. Tanner. Answers by Mr. Shakibanasab)

Q Dr. Davis, thank you. We are in Columbia today; is that correct?

A Yes, we are.

Q All right. My name is Michael Tanner. Again, I represent The Regional Medical Center. I met you briefly before we started the discovery deposition, which just concluded; is that correct?

A Yes.

Q Okay. Will you please state your full name and professional address for the record, Doctor?

A Donen Davis. And my office address is 1850 Laurel Street, Suite B, Columbia, 29201.

Q And what is your profession?

A Plastic surgery.

Q All right. Tell me about your educational background. You grew up in Columbia?

A I grew up in Columbia. I graduated from Richland Northeast High School in 1980. Went off to the University of Georgia, but finished undergraduate at the University of South Carolina 1984, then went to the University of South Carolina School of Law graduating in 1987, practiced law here in Columbia, and then went to medical school at MUSC graduating in 1995. Then went and did a full general surgery residency followed by a plastic surgery fellowship.

Q Let me stop you there. Where was the general surgery residency?

A It was in Atlanta.

Q And how long is a general surgery residency?

A Five years.

Q All right. And you've provided a C.V., which is a fancy Latin term for resume; is that correct?

A Yes, sir.

Q And I believe that shows you completed your residency from July '95 through June of 2000. Does that sound about right?

A Yes.

Q All right. And you were the chief resident for your last year; is that right?

A Yes.
Q Explain to the jury, what's significant about being the chief surgical resident?
A Residency is -- you're a doctor when you graduate from medical school, but you're a doctor in the book sense only. And so the way residency programs in the United States work is graduated responsibilities starting from internship all the way through until you graduate. Your final year you can be elevated to the level of chief resident. The chief resident really is somebody, although supervised, more distantly supervised. You're sort of running your own clinic at that point with mild supervision so that you can learn to make those choices properly for patients.
Q And that would have been done something you have done at the Atlanta Medical Center your final year?
A Yes.
Q All right. And then you mentioned that you had a fellowship after your general surgical residency?
A I did.
Q And was that at the medical university?
A In Charleston, yes.
Q And that was in plastic and reconstructive surgery?
A Correct.
Q And that's a two-year program?
A It is.

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Q All right. And what did you learn in your fellowship training?

A Well, it's -- so there are two different types of plastic surgery in the United States. I did full-body plastic surgery and reconstruction, so from head to toe. Basically, in that you are trained in burn surgery, cancer surgery, trauma surgery, reconstructive surgery, cosmetic surgery, and the hand surgery.

Q And on your C.V. you also state hand and microsurgery? What, is microsurgery a part of hand surgery? Explain that for the jury, please?

A It doesn't necessarily have to be hand specific. So, you know, plastic surgeons invented all of those hand transplants, the finger transplants, the face transplants, all of that would be micro. So would some of the other reconstructions we do. Some of the breast reconstructions are micro. Face reconstruction, somebody has cancer of the mandible or the tongue and throat, those would be micro surgeries. So that just means that you're re-approximating and -- things that are so tiny that you would need magnification to do it.

Q All right. Any additional formal training after your fellowship?

A Not after, but during those two years I did also an extra rhinoplasty mini fellowship and an extra micro mini

fellowship.

Q And just for jury purposes, rhinoplasty is nose operation?

A Nose.

Q All right. And then after finishing your fellowship, you went into private practice?

A I did.

Q And you practiced with associates with Plastic Surgery of the Carolinas for two years; is that right?

A Just under two years, yeah.

Q All right. And then you mentioned that you had a fellowship after your general surgical residency? I'm sorry. And since June of 2004, you've had your own practice?

A Correct.

Q And that is the current practice that you're still engaged in today?

A I am.

Q And you're still also a licensed member of the South Carolina Bar?

A Yes.

Q Any partners in your practice?

A No.

Q And your licensed to practice medicine in South Carolina?

A I am.
Q And are you currently licensed to practice medicine in any other state?
A No.
Q And have you previously been licensed to practice medicine in any other states?
A Yes, I was licensed in Georgia as part of the residency.
Q And then when you moved back to South Carolina, you let that license lapse?
A I did.
Q All right. And are you board certified?
A Yes.
Q In what specialty?
A Plastic and reconstructive surgery.
Q Explain to the jury what it means to be board certified in those fields?
A So there are only -- The American Board of Medical Specialties, ABMS, defines which specialties are qualifying for certification. And then each one of those specialities has their own requirements once they are a member of the American Board of Medical Specialities. And for plastic surgery in the United States, you have to -- in my area you had to be fully -- already fully trained in one of the three disciplines prior to going. You had to be fully trained in

general surgery, (inaudible) or orthopaedic surgery, then apply for plastics, and then complete a certain number of cases at years end and examinations to achieve board certification, the final being an oral examination.

Q And you have completed all of the prerequisites to being board certified?

A I have, and now we have recertification and I've been re-certified.

Q All right. And how long is your certification good for?

A Ten years.

Q Ten years, and then you're eligible to reapply for recertification?

A Every ten years.

Q When is your board certification up for renewal in the next time, do you know?

A Well, see so you do a little bit every year, but the finality of it is, is in the ninth year, right before the tenth year last, that would be my next one. I think it is 2025.

Q And as a part of your treatment have you, in your medical career, ever treated patients who have ever had an IV infiltration or extravasation?

A Yes.

Q And are those terms synonymous and basically differing

with a solution involved?.

A Yes, I think that again those are interchangeable. People would have used them probably, slightly, you know, they would use for the same purposes.

Q And have you also in your medical career provided assessment and treatment to patients that have had scaring?

A Yes.

Q And treated scaring on their hands?

A Yes.

Q All right. And you were court ordered in this case to perform an independent medical examination on [redacted], correct?

A Yes.

Q Did you prepare such an examination?

A I did.

Q And that was at what time in this year, do you know?

A I think it was -- it was in March of this year, I think.

Q And did you issue a report?

A I did.

Q And that report is dated March 28th, 2018?

A Yes.

Q All right. And that would have been the report you did after your examination of [redacted]?

A Correct.

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Q All right.

MR. TANNER: At this time, Your Honor, I'd move to qualify him as an expert in plastic surgery.

THE COURT: Any objection?

MR. KRELL: No, sir.

THE COURT: Okay. Then he is so qualified as an expert in plastic surgery.

And ladies and gentlemen, you remember the earlier statement I made about expert witnesses giving opinion? This applies to Dr. Davis as well.

Okay. Thank you.

MR. TANNER: Thank you, Your Honor.

Q All right. Dr. Davis, you haven't been provided with any of the underlying medical records in this case, have you?

A No.

Q Let me sort of explain this, what the records indicate and I have a series of questions for you. When you saw Mr. [redacted], was his mother present?

A Yes.

Q All right. And did she go over any of the facts that lead to your being court appointed to perform this independent medical examination?

A No.

Q Did she tell you that when he was approximately thirty

[illegible]

[illegible]

[illegible]

A No.

Q All right. Did she tell you that he was admitted for a full sepsis work up including empiric antibiotics?

A No.

Q Can you explain to the jury what is your understanding of sepsis?

A Sepsis is when the body is reacting to an infection that is blood-bourne system only.

Q All right. And is that a process that can become life threatening and fatal?

A Yes.

Q And given R.J.'s young age with that fever, would he be at a higher risk for developing sepsis?

A Ask me that again?

Q Given his young age when he had that temperature spike of a hundred and two point six, would he then be at a higher risk for potentially developing sepsis?

A Yes.

Q Answer?

A Yes, because of at -- at that age you do not have a full immune system.

Q And would you agree that the literature reflects that sepsis is best treated with broad-spectrum antibiotics?

A Until isolating the particular bacteria, yes.
Q Okay. And what is your understanding of claforan and ampicillin, are those considered broad-spectrum antibiotics?
A Well, yes. They are different and yet they would cover the majority of the infectious disease.
Q And is the use of IV administered antibiotics for a potentially septic patient an appropriate method to administer antibiotics?
A Yes.
Q And does the placement of an IV have known potential complications?
A Yes.
Q And can you explain to the jury what the potential complications in an IV would be?
A Well, so even though minimally invasive, an IV is anything that breaks the skin, it's somewhat invasive. And so to be able to present a patient with either fluids or medications in a liquid form, that is non-internal, you have to cannulate the blood vessel and we would rather that be a venous blood vessel. And venous blood vessels are sometimes difficult to find and/or fragile.
Q Doctor, I believe you testified in your discovery deposition that you have treated patients who have either an infiltration or extravasation in your residency?
A Yes.

Q All right. And is that similar to what [redacted], suffered?

A That's what I've been told, yes.

Q Okay. And you testified you prepared a report?

A Yes.

Q Tell me -- explain to the jury what type of physical examination?

A This is a standard exam that a surgeon would perform, which is the flex examination based on the complaint. So I was not attempting to interpret whether or not --

MR. KRELL: That's a misread. He said flexed. It's fixed.

MR. SHAKIBANASAB: Oh, pardon me.

THE COURT: Could you reread it?

MR. SHAKIBANASAB: May I start?

THE COURT: Yeah.

A This is a standard exam that a surgeon would perform, which is a fixed focused (sp) examination based on the complaint. So I was not attempting to interpret whether or not he has diabetes or high blood pressure, specifically that he had scaring on the back of his right hand.

Q And that would be the nature of your examination?

A Yes.

Q All right. What sort of testing did you perform on [redacted]?

A So I went through a list of tests that are designed to elicit things that have to do with functionality of the hand.

Q And can you explain to the jury what those specific functional tests would entail?

A Yes. So the hand is -- it's very -- it is one of the most intrinsically mobile parts of the body. So you want to know if the person has both abduction and adduction of the fingers, that's either bringing them to the middle or spreading them out because that requires different -- both nerves and muscles to do that. You want to know that a person can both press and extend each finger, which is both a muscle and a tendon-ness issue. You want to know if a person has muscular strength. You want to know if the person has range of motion pressability to each one or both -- excuse me -- one of, both of the joints and there are multiple joints to a hand, starting at the wrist and going up to the end of the fingertips. And you want to look at the quality of the soft tissue and the skin and the fat and the muscle that are overlying each of those parts.

Q And you performed those various and sundry tests with [redacted]

A I did.

Q All right. And you prepared a report; is that right?

A Yes.

Q Do you have a copy there in front of you?
A I do.
Q Can you tell me your findings from your independent medical exam, please, Dr. Davis?
A Well, so he was approximately three years old and the dorsal or the back side of his hand had scar tissue. And that area of the scar tissue is between his wrist and his -- what the public would call knuckles. But the metacarpophalangeal joint, the scar tissue was an area that was not consistently one thing. Some areas were thin. Some areas were thick. Also there were portions of the scar tissue that were not the same color as the rest of the back of the hand. Some areas were darker than the parts of the back of the hand. Some areas were lighter in color.
Q Let me stop you there for a second?
A Yes.
Q Real quick. Did you make any comment in your examination about whether [redacted] scar was healed or not healed?
A So based on a conversation that I had with his mother, really about whether or not there have been any break-down to the tissue after the initial healing and time since initial healing, and on my exam I was able to determine that he had, what we would call a well-healed or a mature scar that should be stable from this day forward.

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Q And is that your opinion to a reasonable degree of medical certainty, most probably?

A Yes.

Q All right. And can you continue with your report? I'm sorry?

A Well, so that -- several other things that I elicited from the exam were devoted to the functionality of each finger and wrist and the strength of his hand and sensation to the hand. And I was not able to find defects --

MR. KRELL: That's wrong.

MR. TANNER: Deficits.

A Deficits to any of those.

Q Did you ask him if he had any pain in his hand?

A I did.

Q And what was his response?

A He denied any pain.

Q Did you ask him if he had any burning sensation to his hand?

A I did.

Q And what was his response?

A He did not have any burning.

Q Did you ask him if he had any itching to his hand?

A I did.

Q And what was his response?

A His response was no, but his mother did tell me that

she -- that he would sometimes ask her if it was okay to scratch it.

Q And you testified a second ago that you had tested each finger. What was the strength on each finger?

A So the way we try to do that in our physical exams is to determine if you have zero ability to contract the muscle, we would call that zero out of five strength. And if you had normal strength it would be five over five. That's not super normal, it's just normal. And people can be the variation between zero to five.

Q And what was your finding as to [redacted]?

A So I could find no diminished grip strength on any of the muscular tests that I performed with him.

Q Okay. What is the significance of grip strength of five out of five?

A Well, so that implies that he should have normal functionality of the muscle. He also showed normal functionality of the tendons that were -- that's sort of a separate issue.

Q And --

A But a part of the exam.

Q And so in functionality terms, what's the use of his hand?

A Right. So the hand generally moves in multiple

directions. And so you need to be able to spread your fingers out. You need to be able to pull them in. You need to be able to bring in your fingers. That's called flexion. When you make a fist or extend your fingers, when they're out straight, all of that is a combination of both muscle strength and tendon functionality.

Q And did you find any impairment of tendon functionality?

A I did not.

Q And presuming that [redacted] doesn't have any injury to his hand with respect to him, do you have an opinion on whether or not he would have normal functionality throughout the rest of his life?

A Based on the exam, he should have normal functionality throughout the rest of his life.

Q All right. Your report mentioned no evidence of tendon rod deformities or restrictions. Can you explain what that is in layman's terms for the jury?

A Tendons are necessary to manipulate the fingers and we have tendons on other parts of the body. But on this for him particularly, it's the fingers that I was concerned with or being able to full range his wrist. And so if he was to have had some damage that caused the tendon to either adhere to the -- just the external scar itself or the tunnel that each tendon is surround by, the sheath to adhere to the

tendon, then he would have not been able to perform some of those tests during the exam.

Q And so would it be your opinion that he will, since he was able to perform those tests, that he does not have an insult to the tendon's sheath?

A Yes, because of the mature nature of the scaring there's no -- there would be no reason that he would now lose the ability to use the functionality of the tendons.

Q Okay. And explain to the jury the significance of the fact that you're of the opinion that he has normal range of motion with his wrist?

A So, again, the wrist does not -- it doesn't -- you don't have a hundred and sixty-degree motion both anterior, posterior with the wrist, but he had the normal range, the range in his wrist as any person would. And that range is really not different at his age than it would be for an adult patient.

Q And so the scar that he externally does not -- that he has externally does not impact upon his range of motion in his wrist?

A He should have no -- nothing inhibiting his full functionality of the wrist.

Q All right. And did you recommend some possible treatment options for [redacted], as a result of this?

A Yes. So when you have a scar that is not matching the skin height, texture and the color of the remaining skin on his back of his right hand, then there are techniques that will potentially get it to be more similar.

Q All right. What were those techniques.

A The non-surgical versions would be a series of steroid injections and silicone and massaging of the scar tissue. And the surgical techniques of those would be to try and remove all of the scar that currently exists and replace it with a scar that would feel -- with more similarity to the height, texture and color as the rest of his hand.

Q And if you're implementing a treatment plan on this child, what would be your first course of treatment?

A Well, I would try the steroid injection. A three-year-old may not allow you to try that in the office because it could be uncomfortable. If that was not feasible, then it would be a surgical excision and try to create him a new scar.

Q All right. A surgical excision would have been done in a hospital setting?

A At that age that would be the only appropriate way.

Q And that would be under general anesthesia?

A Well, the anesthesia department gets the vote on that. But in general, that would be more likely than not at his age. We do -- on hand surgery, again, on a more mature

patient we just do a regional block but I would not expect that on a three-year-old.

Q And when you envision to have that surgical revision that he would need to undergo an IV during that procedure?

A Yes.

Q And do you have an opinion as to the cost of the surgical revision and any post-operative follow-up including steroid injections?

A I do.

Q And what would that cost be?

A Based on my twenty-plus years of doing surgery and knowing the costs in the community, it was my estimate is seven thousand five hundred and seventy-six.

Q All right. And that would include all the operative and post-operative care?

A And steroid -- and steroid injections, yes.

Q And that would include the anesthesia component as well?

A Yes.

Q All right.

MR. TANNER: I'll offer your report as Defendant's 1 at this time.

MR. KRELL: No objection.

(Defendant's Exhibit No. 1, Dr. Davis' report, was marked and entered previously)

THE COURT: All right. Thank you. You may step down.

MR. TANNER: Oh, we're not done.

THE COURT: Oh, we're not. Oh, I'm sorry. Excuse me.

MR. TANNER: I'm going to publish that to the jury, Your Honor.

THE COURT: Y'all tell me what's going on whenever y'all want to, okay? I'm sorry. Go ahead.

Q Dr. Davis, earlier in your discovery deposition, we were talking about Dr. Peter DeVito treating [redacted], in February and March of 2015 and recommending inter-lesional corticosteroids. Do you have an opinion on if whether that treatment plan would have been implemented, what his condition would be like now in 2018?

A Definitely. Our research shows that the earlier in the healing process you use steroids as a method to flatten the scar or prevent thickening, then the higher success you would get.

Q So would it be -- do you have an opinion to a reasonable degree of medical certainty if those steroids would have been used, if his appearance of the scar would have improved in 2018?

A Yes.

Q And what would your opinion be?

A That would have been the best, the most likely way to have a better appearance.

Q And if Dr. DeVito would have implemented the steroid regime, do you have an opinion on whether or no[redacted] scar would be softer?

A If the steroid did what we intended for it to do, it would be softer.

Q All right. And do you have an opinion on if Dr. DeVito had implemented the steroid treatment, whether the scar would be as thick as it currently is in 2018?

A My opinion would be consistent with my other opinions about steroid use for scar tissue, that it is our number one treatment. It does not always work but it is our number one treatment for just the same thing, for the scar to be less thick and to be softer.

Q At this stage if[redacted] doesn't avail himself to any of those treatment options, do you have an opinion to a reasonable degree of medical certainly on whether or not the scar will get better or worse?

A I do have an opinion.

Q And what would that be, sir?

A Based on the length of time since injury and healing, it should not get any worse.

Q It should sort of remain the same?

A Correct.

Q All right. And as a part of your examination, did you take photographs of [redacted]?

A I did.

Q All right. I'll pass this photograph to you. Did that photograph accurately and truly represent the condition of [redacted] hand when you performed the IME.

A As best as I can tell. I, you know, I'm not a professional photographer and I really take these pictures, in my mind, as a temporary way to make sure that when I do the evaluation I can be complete.

Q And you, yourself, took the picture?

A I did.

Q You didn't put it through any photoshop or digital enhancement process, did you?

A No.

Q And that's part of your IME that you did on that day?

A Yes.

MR. TANNER: All right. I'll offer that at this time as Defendant's 2.

MR. KRELL: No objection, Your Honor.

THE COURT: All right. Defendant's 2 is in without objection.

(Defendant's Exhibit No. 2, photograph, was marked and entered previously)

Q And Doctor, do you have an opinion to a reasonable

degree of medical certainty and most probably whether [redacted], will be able to throw a ball?

A Based on my exam, he should be able to throw a ball.

Q And do you have an opinion most probably whether he'll be able to catch a ball?

A Again, based on my exam, I see no reason he could not catch a ball.

Q Based on your exam, is there any reason why he couldn't play a piano?

A No.

Q Any reason why he couldn't hold a fishing pole?

A No.

Q Any reason why he couldn't write or print his name?

A No.

Q Any reason why he couldn't grab some crayons and color or draw a picture?

A I saw no functional --

MR. TANNER: Deficits.

A -- deficits.

Q Any reason why he wouldn't be able to shoot a basketball if he so desired?

A No reason.

Q Any reason why he would not be able to drive a car?

A He should be able to drive.

Q Any reason why he wouldn't be able to pass or catch a

Football?

A I see no reason that he couldn't.

Q Any reason why he wouldn't be able to play any type of musical instrument?

A None that I can tell.

Q And the opinions that you've stated to the jury today, are they your opinions to a reasonable degree of medical certainty, more probable than not?

A Yes.

Q Thank you for time, sir.

THE COURT: Have you got --

(Cross examination read by Mr. Krell)

Q Doctor, besides functionally that you've just discussed with Mr. Tanner, in your experience as a plastic surgeon, can scars have a psychological effect on people?

A Yes.

Q Based on your treatment of people with scars, can scars on someone affect their ability or affect how they see themselves?

A Yes.

Q And how can it?

A Well, so all injuries will result in scar tissue.

Q All right.

A All injures for a healing person. If you're going to heal, you're going to have scar tissue. And people do

relate to them differently. You know, there would be no way for me to predict how one person relates to others, but it would not be a surprise that it would be something that someone would not feel good about.

Q It's more likely than not to have a negative impact than a positive impact?

A Right.

Q On someone, correct?

A Yes.

Q That's to a reasonable degree of medical certainty, correct?

A Yes.

Q And so just functionality, from shooting a basketball or going fishing, that's one level, but there is a completely different level to having a scar, correct?

A Right. So the way the patient feels about the scar would be completely different than whether or not there's a functional component.

Q Right. And in your report you described the scar as being itched or being scratched, correct?

A The mother wanted me to know that he would sometimes ask her if he can scratch.

Q And this was almost four years after the initial infiltration, correct?

A Well, at least three. Yeah.

Q At least three?
A Yeah.
Q And he's still having problems?
A That's -- yes, she's informed me of that?
Q Yeah?
A Yeah.
Q And having -- wanting it scratched or having it itch, that's a symptom of scaring --
A It can be?
Q Correct?
A Yeah.
Q How about in this case, do you have an opinion?
A Well, you would -- anybody who has a thick scar tissue that tells you that they itch, you would believe that that is related to the thickness of the scar tissue.
Q And in this case for R.J., do you have an opinion regarding --
A Well, he does have some thick scar tissue. I don't have an opinion about how he felt about it because he did not answer me when I asked him does it itch?
Q But mom, mom did?
A Mom did.
Q And he is a child of tender age?
A Right, yes.
Q So?

A Yes.

Q Okay. And the mom did say that he wants her to scratch it?

A Correct. Correct.

Q Okay. That's what's in your report, correct?

A Correct.

Q And that's Exhibit 1 to your testimony, correct?

A Yes.

Q Okay. We also have a note from Exhibit 1 that the scar felt tight. Did that come out during your direct exam?

A I don't know if came out during the exam, but --

Q I don't know either. You, during your direct examination?

A During my physical findings he told me during all those functionality tests that I gave him that it sometimes felt tight.

Q What does that mean to you as a doctor?

A Well, I -- the way I would interpret that personally -- and he obviously is three, he did not -- he was not as fluid in his discussion. But the human body is sort of fluid until there is an injury and then it is less fluid. And so I would not be -- it would not be a surprise to me if somebody with scaring felt tight, less fluid.

Q And he was able to describe it in such a way that you interpreted that it felt tight, the scar?

A Right, yes.
Q And that tightness is certainly related to the infiltration, correct?
A Well, it would be believable that it was due to the scar tissue.
Q You believe it, correct?
A Yes.
Q Okay. And that's given to a reasonable degree of medical certainty?
A Yes.
Q Okay. Now, with all the treatment you've described, the steroid treatment, getting a three-year-old to take steroid treatments are going to be very difficult, correct?
A Well, you would not want to make it scary to them. And, yes, so I think anything that has to be -- we're giving somebody a shot at that age --
Q Uh-huh.
A -- it is --
Q Wouldn't you agree with --
A -- intimidating.
Q Sorry. Wouldn't you agree with me that in this case that giving R.J. steroid shots is not going to have -- would not be an easy thing to do?
A I would totally agree with you that it's not easy.
Q Right?

A But it is, again, something that I would offer at any age. I would not offer it, as a doctor, based on age.

Q All right. You always offer it because that's the correct course of treatment, correct?

A That's right.

Q But in reality there's not a way to get a three-year-old to take those injections is there?

A Oh, well, no. So every -- I can only speak for myself.

Q Right.

A Not other surgeons. But there would be several ???. If I was with the family and they were agreeable to it.

Q Uh-huh. (Affirmative response)

A So we might just try to give him benadryl when he came in.

Q Right.

A We might want to hold him still and do it. But there again -- or we might give him some kind of anesthetic like in an outpatient anesthetic setting. But really that is somewhat dependent on the patient cooperating. Somewhat dependent on parents' own view of that. Obviously, for my own office I would discontinue anything that I thought was too traumatic to the child, but the parent has a lot of -- they have some weight in that discussion.

Q Right. Do you have an opinion whether or not these type of steroid injections are too traumatic for a three-

year-old child?

A Without something like a benadryl or something more than that, definitely just doing it, it would be -- it would not be successful at that age. He would not participate.

Q Benadryl is a medication for itching, right?

A Well, but we use it for sedative reasons too.

Q Okay.

A On young people, you know. There is the occasional person that has the reverse effects from it, but it is very sedating.

Q Okay. So you'd have to sedate the child in order to get these steroid injections?

A Yes, right.

Q You also said you can physically hold him down?

A Definitely. That happens more than probably you're assuming that it would.

Q Okay.

A It happens almost to everyone when we take the stitches out with a young child. It is more risk than reward to put them to sleep just to take a stitch out.

Q Uh-huh. (Affirmative response)

A And so there are plenty of times where you do have to physically, you know, restrain a child.

Q And when you give this steroid injection for a scar like R.J. has, how do you do it?

A Well, so, yeah. So there are different types of corticosteroids. That's not really germane but you want to put it directly into the lesion, which is the fibroblast, cells that are thick cells. So you inject it, you know, with a --

Q You take a needle and you stick it in the scar?

A And then you inject.

Q And then you inject?

A Yeah.

Q And you just do it one at a time or is it a series of injections around the whole scar?

A Well, only into the thick areas.

Q Okay.

A And so it really depends on -- but, yeah. The length of the needle does not cause pain, it's the, more of the gauge of the needle that does, so --

Q Is that the --

A It's not --

Q -- thickness or --

A Yes, the diameter. So you don't need a large diameter needle with the steroids or liquid. And if you had, you know, depending on the person -- so for him at his age if you have a one and half inch needle, you could probably inject the whole area through one entrance, one injection.

Q So he would just need to have one stitch?

A Probably so, based on the size of his hand, yes.
Q All right. Now, you also talked about surgery, correct?
A Yes.
Q That he probably needs?
A Well, so it's not -- it's more about not need, it's the wrong word, but --
Q Uh-huh. (Affirmative response)
A -- if a person comes to me and would like to improve the look of the scar and not, you know, like we said before not necessarily that there's a functional problem, but the look of it.
Q Uh-huh. (Affirmative response)
A Then we only have a couple of options available. Whether or not you do stuff externally or remove the scar through an excision.
Q And if you do either technique, the steroids or the scar revision, R.J.'s still going to have a scar there for the remainder of his life, correct?
A Yes.
Q And that's -- you have an opinion that he'll have a permanent scar for the remainder of his life, correct?
A I'm of the opinion that he --
Q And what --
A -- will have --

Q What -

A -- a permanent scar.

Q Okay. And that opinion's given to a reasonable degree of medical certainty?

A Yes.

Q So regardless of the steroids, regardless of the surgery, he's going to have a scar for the remainder of his life, correct?

A He's going to have a scar but if I do surgery on him, the only goal of that surgery is that it would be a better appearing scar.

Q All right.

A But he would definitely have the scar still.

Q No more questions.

MR. TANNER: Nothing further from this witness.

(End reading of Dr. Davis De Bene Esse Deposition)

(Court's Exhibit No. 2, Dr. Donen Davis De Bene Esse Deposition was marked)

THE COURT: All right Thank you. Thank you, Mr. Shakibanasab. You may step down.

All right. Ladies and gentlemen, you've heard all the testimony you're going to hear today. I need for y'all to be back in the jury room at 9:00 tomorrow morning and then we'll pick up with the case. And remember you can't talk to anybody about it. You can't talk among yourselves about the

(Court in session May 8, 2018 at 9:00 a.m.)

THE COURT: Are y'all ready?

MR. KRELL: Yes, sir, Your Honor.

THE COURT: Okay.

MR. KRELL: We just have one matter to take up. Michael and I spoke and the life expectancy of this child -- he's three years old. From the date of trial forward would be 73.76 years and we'd ask that you take judicial notice of that.

THE COURT: Yeah. I think that's what we got in the --

MR. KRELL: In the charge?

THE COURT: -- in the charge. I know it's 73-something.

LAW CLERK: .76.

THE COURT: Yeah. Okay.

Anything else?

MR. KRELL: That's it, Your Honor.

THE COURT: Okay. Let me just tell y'all what my expectation is. My expectation is we're going to finish up with witnesses this morning and we're going to do the -- it'll go to the jury some time this afternoon.

MR. KRELL: Nothing from the plaintiff on that.

THE COURT: I mean, just so y'all could kind of

MR. KRELL: Yes, sir.

THE COURT: I like for y'all to have time to think ahead rather me surprise you, you know, okay?

MR. KRELL: Yes, sir. Thank you.

THE COURT: All right. Okay. If you'd bring the jury on back out.

THE BAILIFF: Yes, Your Honor.

THE COURT: Thank you, ma'am.

(Jury in at 9:05 a.m.)

THE COURT: All right. Ladies and gentlemen, I hope y'all had a good evening. Okay. Today we're going to continue with the plaintiff's part of the case. I don't know if y'all remember, we took one witness out of order yesterday. So right now this morning we're going to continue with the plaintiff's case.

And is plaintiff ready to call its next witness?

MR. KRELL: We are, Your honor. We call Dr. Peter DeVito.

THE COURT: Dr. DeVito. Dr. DeVito, do you see where that Bible is?

THE WITNESS: Yes, sir.

THE COURT: If you'd stop right there. Put your left hand on the Bible, raise your right hand. The clerk's going to swear you in.

THE WITNESS: (Complies)

(WHEREUPON, Peter DeVito was sworn to tell the truth.)

PETER DEVITO - DIRECT EXAMINATION

BY MR. KRELL:

Q Good morning, doctor?

A Good morning.

Q What do you do for a living?

A I'm a plastic and reconstructive surgeon.

Q And how long have you been a plastic and reconstructive surgeon?

A Almost fifty years.

Q Where did you go to college?

A I graduated from Princeton University. Medical school was Duke University, and I did my internship in general surgery at Yale. And I was one of the two plastic surgery professors at the medical university and ran the residency during the 70s. And I went into private practice in 1980 and was chief of plastic surgery at Roper Hospital for fourteen years. And I've been chief at St. Francis Hospital. Those are the two biggest hospitals in Charleston, over twenty-five years now. I'm a senior advisor to the South Carolina Society of Plastic Surgeons.

Q Do you typically treat patients with scars?

A All the time. My whole life.

Q Your entire life. Besides being a plastic surgeon, you also had - started out in pediatric surgery, correct?

A Yes. I had a love for pediatric surgery, came very close to doing pediatric surgery, but I had a hard time dealing with cancer.

Q Cancer in children?

A That was a killer. And my wife said you can't do this. It's going to kill you. So I went into reconstructive surgery.

Q Over the course of your --

A Pardon?

Q Over the course of your fifty-year medical career in plastic surgery, have you had the opportunity to operate and treat people with scars on their hands?

A Absolutely. I was the actual burn reconstruction surgeon at the medical university when we had our own burn unit. Back then, everything did not go to Augusta. In those days, we had our own burn unit and we may get our own burn unit again for Charleston. It was one of the best in the nation?

Q And have you ever written any articles or journals regarding plastic surgery?

A Yes, sir.

Q Regarding surgery, plastic surgery on patients' hands?

A Well, I wrote the emergency room manual sections on

hand injuries and face injuries. And taught those topics to the medical students.

Q You teach as well or you did teach?

A I still do.

Q Oh, you do?

A Yes.

Q Are you familiar with Dr. Davis? You taught him?

A He was one of my residents, rotated with me.

Q And that's the gentleman -- we read his deposition yesterday.

A Dr. Donen Davis, right.

Q He did rotation with you?

A He did. Good -- a very good man. Good surgeon.

Q All right.

MR. KRELL: At this point, I'd move to introduce Dr. Peter DeVito as an expert in plastic surgery.

MR. TANNER: No objection, Your Honor.

THE COURT: All right. Ladies and gentlemen, y'all remember yesterday when I told y'all about expert witnesses testimony? I'm not going to read it again but it applies equally to Dr. DeVito today, okay?

All right. He's your witness.

MR. KRELL: Thank you, Your Honor.

BY MR. KRELL:

Q Dr. DeVito, did you see [redacted]

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A I did.
Q Did I set up an independent medical exam with you?
A I believe so.
Q And were you paid for that?
A Yes. We charged the standard fees of the Charleston County Medical Society. We adhere to that suggestion of medical legal fee schedules for reports and appearances and testimonies and --
Q So isn't -- the fee is five hundred dollars. Does that seem about right?
A I believe that's what it is now. I don't keep up with it. The office up front just deals with that.
Q In your chart you have it where it reflects that the independent medical exam fee is five hundred dollars? If you could --
A It's probably in here somewhere, Mr. Krell. I don't have the bills.
Q Okay.
A The only thing I have are the notes that I dictated but there's probably a bill summary. Here it is. It is. Yes. 1/26/15, charged five hundred dollars, credit five hundred dollars, Attorney Krell.
Q And when did you see R.J. for this independent exam?
A When did I see him the first time?
Q Yes, sir.

A I saw the little boy on February the 2nd of the year 2015.

Q How was he doing at that time?

A Well, he was four months old and the history on it -- I took the history from the parents, and he had sustained a full thickness skin slough, loss the tissue off the back of his hand, basically a third degree burn. And I thought the scar was very thick. It was definitely what we call hypertrophic and it was bordering on keloid formation. I felt it was a keloid?

Q What's a keloid?

A That's a good question. The difference between a hypertrophic scar and a keloid, the hypertrophic scar is a very thick scar, a scar that's abnormally thick and angry. Keloid comes from the Greek word meaning crab and it actually scar tissue that invades a little normal surrounding skin. And some of them can become very violent. They're very symptomatic but that is the term for keloid. It's actually a tumor of scar tissue.

Q When you say symptomatic, what do you mean symptomatic?

A Well, the old French Literature in the 1700s, when these scars were being described, the patients described it as if somebody were putting hot needles to the skin. Those are the symptoms of this type of a scar, a keloid. They burn, they itch. They're very symptomatic.

Q I'm going to show you some photographs that we've marked. The first one I'm going to show you is Plaintiff's Exhibit 1. We've got the blow-up. I'll put it up for the jury. Would it be easier if you came down and pointed things out?

MR. KRELL: And I'll ask the Judge if that's okay?

Q If you'd like to come down and point --

THE COURT: Whatever makes it easier for you to explain, Dr. DeVito.

A Sure. (Witness steps down)

BY MR. KRELL:

Q If you would please, describe to the jury what we're seeing in this photograph?

A This is a full-thickness slough of tissue. All layers of the skin, sweat glands, hair follicles, everything, straight down to the extensor tendons. And I would imagine that these are extensor tendons where this grumous material, this purulent looking, yellow stuff, which does not have any vascularity or blood supply, is covering these extensor tendons, which you can actually see under the dorsum of your hand. These are the edges of the wound, the different layers that are sloping down. But this is a wide open, full thickness wound on the back of a hand, extending from the metacarpophalangeal joints, the knuckles, all the way to the dorsal flexion crease of the wrist.

Q Do you have an opinion, Doctor, whether or not that would be painful?

A The actual third degree, where the full thickness loss, the nerves have been damaged. So this central area is not painful. Around the periphery it is painful where there's still neurologic intact. And there is no excess skin on the back of the hand. On the dorsal of the hand, if you take your hand and you pinch the skin above it and you hold it, you think there may be some excess. Then make a fist, you can't hold that skin any more. There is no excess skin on the back of that hand. So this wound, how do you get it to heal. It's too contaminated for a skin graft or a skin flap. So it has to take a lot of wound care, and it takes all kinds of time for a wound to heal by what we call a marginal epithelialization, thin sheets of epithelium, the skin growing in from the sides, then it'll form a thick scar and this scar is symptomatic. This is a rough wound over a mobile extremity in an infant.

Q I'm going to show you another photograph doctor and ask you --

A And this wouldn't accept a skin graft, so you couldn't get it to heal right away. It's not ready for it, yet. It would have to be prepared.

Q I show you what's marked as Plaintiff's Exhibit 3. And If you could describe for the jury what you see in this

photograph?

A Okay. There's some granulation tissue that's growing over the extensor tendons. So the tendons are not exposed at this time, which is fortunate. Of course, if the wound got infected, the whole thing could break down get tendinitis so -- But right now we have this wide open wound. It doesn't have any skin. It's over the dorsum of the hand, the back of the hand. And the edges are -- it looks like they may be starting to close in. You can tell by the bacterial count within the wound if it's contaminated. When the skin starts growing in from the sides, that means the wound is cleaning up. And that it's not really infected.

Q Is that painful?

A The whole nature of the wound is painful.

Q Thank you. If you want to have a seat, I'll ask you some more questions from the witness stand. You may be more comfortable from the witness stand --

A Thank you. (Witness takes stand)

Q One the February 2nd, 2015 note, you were talking about the keloid scar.

A This is the February 2nd note?

Q Yes, sir?

A Yes, sir.

Q You said there was also hypertrophic scarring bordering

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on keloid formation?

A Yes, sir.

Q What did you next find?

A Let's see here.

Q You talked about steroid injections?

A Yes, sir?

Q And we talked a lot about that yesterday. Tell us about steroid injections with the age of R.J., and what these injections could do or couldn't do?

A That's another excellent question. How do you treat a keloid scar to help get it down. Keloid scars can occur in, really, anybody. Mediterranean people with dark skin, redheads are notorious for forming keloids. It isn't always a black person that will form keloid scars. Keloid scars are a problem, and they're also a problem in certain areas more than others. For instance, on the sternum or on the deltoid area, where there's a lot of motion, people may form hypertrophic scars and keloids when they may not form them on the abdomen or where the tissue tensions are soft. So how do we treat keloid scars. Well, we tried radiation in the past, but that has side effects on a growing child, on bone growth. And well, that can be a problem. We've know that corticosteroids can help soften scar tissue, cortisone type medication, but how do you get it into a hard scar. Trying to penetrate a hard scar with a needle and syringe is

very difficult. It's like trying to inject the paint on this wall or something. If you can get the hypodermic needle into the scar and then to try to push the cortisone type medication into the scar, you might not get much in or it may penetrate and go into the deeper soft tissue areas where it's not needed --

Q And you're trying to do this with a three-year-old?

A Yeah. I'm trying to do it with a three-year-old. I brought to Charleston and actually used it and a lot of people use it now, it's called a derma jet. And it's actually a form of an older bit of an old -- a French vaccination gun where we can actually inject the cortisone under high pressure without a needle. It injects a tenth of a cc and you can get it into the scar. And it'll penetrate the scar itself. And once it gets into the scar over a period of a week or two, it'll start to soften the collagen, the scar tissue in there. And it'll start to make the scar lighter in color, if it's hyper pigmented. And it's really a good way to soften a scar and repair it, but it's painful.

Q It's painful?

A It's painful. As soon as you inject that scar, it triggers these electrical shocks and the paresthesias and you can't get as much in that scar when it's hard. As it starts to soften, it doesn't hurt as much and you can get more in. It's exactly the opposite from what you might

think. But for a child, these are painful sessions. And, you know, as soon a child would walk in and see a white coat they'll start crying, because they associate, you know, the white coat with pain. Oh, he's here. I'm going to -- you know, and they're already crying. We've tried wearing different colored coats or little fun pins and things to make them happy. And if you don't keep doing it every few weeks, you lose the softening effect and it can come back. And they're seasonal too. In heat and humidity, where we live in this humidity here, these things can flare up again. You know, if there's burn scars on the back, kids are scratching their backs on the edge of the door and the wall. They're very symptomatic scars.

Q As of February 2nd, 2015, what was your course of treatment for R.J.?

A Well, I don't think I ever initiated treatment for the child.

Q Well, what are you recommendations?

A I felt my recommendations were that this keloid scar was going to need aggressive initial treatment with corticosteroids. Another thing is why don't you excise it when it's thick and angry? Because it's going to come right back again. The same thing is going to happen. Unless you get it under control, then do the surgery, then it's going to come right back. There was one other thing I failed to

mention and that's compression. It'll also help. You've seen a lot of burn patients with these masks on where they have a lot of burn scars and just their eyes are exposed. These Jobst elastic supports, which are uncomfortable to wear, exerting pressure on a thick scar can also help to flatten the scar and soften it up. And also silicon sheeting can also help. But they are uncomfortable to wear and they're hot.

Q You then saw him a month later in March of 2015, correct?

A Yes.

Q And how was he doing then?

A Well, it was still hyper pigmented, which was dark; hypertrophic, which means thick, contractured. These things never restore skin tones again. They always -- they just don't look right. It's a patch of tissue that doesn't blend in. And at that time, the scar was not softening. So I felt that treatment with intra-lesional corticosteroids was appropriate and probably will continue to be appropriate indefinitely for this wound, for this child.

Q When you say appropriate at this point, is it appropriate for R.J. as a three-year-old or is it down the road? What --

A Both. Both.

Q If his mother doesn't want him to go through the pain

of the shots for the corticosteroids, do you have any problems with that?

A No. Very understandable.

Q Let me show you --

A it's a dilemma.

Q A painful dilemma?

A Yes.

Q Let me show you what's been marked as Plaintiff's Exhibit 2. And we've also got a blow up. And I'd like you to just step down if and explain this photograph to the jury?

A (Witness steps down)

Q And what we're looking at and how does someone either as a plastic surgeon go in there and try to help?

A Okay. You remember, we had that big area? Now it's shrunk down and you would think that's healed. But remember, when you're pinching your hand and you thought you had a lot of excess skin there and you made a fist, the skin just disappears. So this is a scar contracture. The hand is kind of dorsal flexed and there's no pliability there. So if you tried to take that scar out of there and hopefully not expose the tendons -- if you try to get the whole scar out you'd probably have to take it off from around the extensor tendons also. You would try to recreate the defect and you would wind up with a big opening again if you were

going to put a skin graft on that thing. That's how much skin is missing. So this is contracted down. It's not open. You know, it's not infected, but it's a tight restricting scar and it is limiting his grip.

Q Do you have an opinion to a reasonable degree of plastic surgery certainty whether or not that scar is permanent?

A Yeah. Once there's a scar there's always a scar.

Q How about if you did scar revision surgery?

A There's always a scar.

Q When was the last time that -- if you would, take the witness stand and refer to your chart again.

A (Witness takes stand)

Q R.J. didn't return to see you until April 23, 2018, just a couple of weeks ago?

A Yes, sir.

Q Between March 2nd, 2015 and April 23rd, 2018, would the scar have had time to develop or heal? Is that a proper way to say? It may be an inartful question? Could you explain to us what happened?

A Well, the scar would have -- it would have time. It's not going to -- it wouldn't change. The firmness, the thickness, it really wouldn't have a chance to change very much. It might lose some of the erythema, some of the redness.

Q Okay. Was the scar symptomatic at that time?

A Oh, the same thing with the itching and burning. I couldn't even examine the child. When I went to approach it -- I was trying to check the skin tensions by pulling the skin together and he withdrew and it was really an ordeal.

Q What do you mean withdraw?

A He just pulled his hand back. It's a source of pain for him.

Q How does mother say he was doing at that time?

MR. TANNER: Objection, Your Honor. It's hearsay.

BY MR. KRELL:

Q What does your note reflect?

A I don't know.

THE COURT: As long as you rephrase the question we're fine.

BY MR. KRELL:

Q What does your note reflect about whether or not the scar was painful?

A His mother has noticed the child scratching at the scar and he does complain to her that it is painful. It's just -- and burns. The overlying epithelium is very thin, prone to breakdown of even slight excoriation. And as I mentioned, it's not normal skin anymore. It doesn't have any roots, reedy ridges. There are no sweat glands. There are no hair follicles, so there's nothing that goes down

deep into the skin that gives it pliability. So even slightly bumping the hand on the back of something will cause an excoriation breakdown, a blister, an ulcer.

Q And you recommend surgery?

A Yes. Surgery is going to have to be involved with this if this scar is going to require release, reorientation. And whether or not to replace tissue or not is another thing, whether it's going to need skin grafting, split thickness grafting, full thickness grafting, a flap or something or whether it can be stage resected, taken out in a couple of stages in an attempt to regain more pliability following the stretching of the skin, but I --

Q Do you have an opinion to a reasonable degree of plastic surgery certain that following the surgery the recover is painful or not?

A Well, yes. There's pain.

Q And we're still talking about a three-year-old child. Whenever you deal with surgery, this is a child of tender years.

A Yes, sir.

Q Have you had a chance to review Plaintiff's Exhibit 6, which is the wound care records from --

A Yes, sir.

Q -- the Wound Center. Have you looked at all --

THE COURT: That's plaintiff's 6?

MR. KRELL: 6, Your Honor.

BY MR. KRELL:

Q You've had a chance to review those?

A Yes, sir.

Q Do those seem reasonable and necessary?

A Yes, sir. A very good attempt to prevent and keep that wound from getting infected.

Q I show you a document and if you could describe that document for us, please?

A Yes, sir.

Q Is that the bill associated with the wound care?

A Yes, sir.

Q Does that seem reasonable and necessary?

A It seems very reasonable and much better than the Charleston bills. That's very reasonable

MR. KRELL: Your Honor, I'd move to move this bill into evidence as Plaintiff's Exhibit 7.

MR. TANNER: No objection.

THE COURT: Plaintiff's 7 is in evidence without objection.

(Plaintiff's Exhibit No. 7, Wound Care bill, was marked and entered.)

BY MR. KRELL:

Q Doctor, we talked about surgery and treatment, do you have an opinion on the cost of these treatments?

A Well, the office did a cost estimate at that time and it's hard for me to keep up with hospital costs. I know what surgeons charge because we have a fee schedule.

Q Right?

A A lot of people feel that a doctor can charge whatever they want to, but we're kind of locked into a fee schedule. Just like you think we can fly around in an airplane in those friendly skies anywhere you want to, but you're locked into an altitude, in a corridor and a speed, and you're stuck there. And so these fees that are generated from my office come from the relative value fee schedules for the surgeons. And the hospital fees we try to estimate and keep up with them.

Q After seeing R.J., you know, twice in 2015 and then just several weeks ago, do you have an opinion to a reasonable degree of plastic surgery certainty what your fee would be to -- your surgical fee would be?

A The surgery on that scar would be, at that time, twenty-five hundred dollars. That would be just for the one procedure.

Q Is there more procedures?

A It could be.

Q So that twenty-five hundred is on the low end?

A Yes. Yes, sir.

Q Okay. And then how about the associated costs,

hospitalization, anesthesia? You've got a range here of four to twelve thousand?

A Yes, sir.

Q After seeing R.J. during the course of the past three years, would the twelve thousand dollars be more reasonable?

MR. TANNER: Objection, Your Honor. He's leading the witness. He's not --

THE COURT: If you'd rephrase the question, please, sir?

Q How much is it going to cost to fix R.J.'s hand?

A Well, it would depend upon the procedure. If the procedure would be able -- you know, a stage resection with straight suturing and the discharge the following day. However, the wound expanded and needed a skin graft, a full thickness skin graft and then having to take care of the skin graft would require extra days of hospitalization. You have the anaesthesiologist, which is another doctor that's involved in keeping the child asleep, which is not an easy thing to do, and the extra tests that he would want to do it. The hospital charges could absolutely explode.

Q It may be more than what's in your estimate?

A Absolutely. It's amazing how they can keep going up. I can't keep track of them.

Q All right. Let me show you some documents. I think it's Plaintiff's Exhibit 8.

A Yes, sir.

Q Does that accurately reflect your visit on that date in this matter?

A Yeah. This is my initial office note.

MR. KRELL: Your Honor, at this time I'd move Dr. DeVito's charge into evidence as Plaintiff's Exhibit 8.

MR. TANNER: They've got two copies of the same note.

THE COURT: Well, if you'd look it over, Mr. Tanner and make sure we've just got --

MR. TANNER: No objection.

THE COURT: All right. Plaintiff's 8 is in evidence without objection.

(Plaintiff's Exhibit No. 8, Dr. DeVito's initial office note, was marked and entered)

BY MR. KRELL:

Q Thank you, Doctor. Please answer any questions Mr. Tanner may have.

THE COURT: Mr. Tanner.

MR. TANNER: Thank you, Judge Dickson. May it please the Court.

PETER DEVITO - CROSS-EXAMINATION

BY MR. TANNER:

Q Thank you, Dr. DeVito. How are you this morning?

A I guess I'm doing all right, Mr. Tanner. How are you?

Q Thanks for coming to Orangeburg today. You first saw this child based on Mr. Krell asking you to see his client, correct?

A Yes, sir.

Q And you're good friends with Mr. Krell's dad, right, who's a lawyer in Charleston?

A Well, I've been in Charleston for fifty years and everyone knows everyone in Charleston.

Q Did you take any photographs when you examined the child?

A No.

Q So none of these photographs that you've shown and explained to the jury you took?

A No.

Q Okay. And when the child first came to you in February 2015, his hand didn't look like that, did it?

A No, sir.

Q And this other one where they expose tendons, when he saw you, his hand didn't look like that either, did it?

A No, sir.

Q And do you know when the picture was taken of this scar?

A No.

Q Did it look like that when you saw him in February of 2015?

A It was thick and it was a mass.

Q Okay. You testified earlier that it was keloid and I think you used the term tumor and it sort of surprised me. And you said it was going to be growing. If that was the case, it hadn't grown much beyond what this -- in this photograph, has it?

A The -- I used the term tumor because it's an explosive growth of scar tissue. And I mentioned the word keloid, seeming like crab. And if you look at that picture right there --

THE WITNESS: Am I allowed to pick the picture up to show the jury?

MR. TANNER: I'm sorry. I'll get it for you. Which one do you want, sir?

THE COURT: Yeah. He'll get it for you.

I think it's 2. Would you double-check? Is that Plaintiff's Exhibit --

MR. TANNER: 2, yes, sir.

THE COURT: Okay.

THE WITNESS: If they could see that and if I could stand up?

THE COURT: Yeah, you want to step back down, yeah.

THE WITNESS: Thank you.

A (Witness steps down) He also mentioned that -- how

this picture, this would have been earlier on and it still had a lot of the dead tissue that was on there. When I saw the child, the scar was healed. There was no open area.

BY MR. TANNER:

Q That would have been healed by February of 2015, correct?

A Yes. I guess so. When I saw him on that day, there was no open area.

Q Well, that was the first day you saw him, right?

A Yes, sir.

Q Okay.

A And you can see where these extensions are, the scaring.

THE COURT: Ma'am, you can move over if you want to see. You're not stuck in that seat.

THE WITNESS: I'm sorry.

THE JUROR: Okay.

THE COURT: Okay. All right.

A And you see those extensions where it looks like this thick scar tissue under there, it's invading normal skin that's right in -- it's going right into what should be normal type skin. And that Greek word, the keloid, crab almost looks like a crab. That's a keloid. And some people feel that it's a tumor of scar tissue because of the way it grows. And some people say gee he feels like a baby. Well,

young children and babies may feel more violently than grownups. And certain individuals are more prone to forming scars like these. Not everybody forms a scar like this, but I mentioned certain areas that do form these kinds of scars, the sternum, deltoid, that's a rough start.

Q Okay.

COURT REPORTER: Mr. Tanner, what is the exhibit number on that photograph that Dr. DeVito used?

MR. TANNER: 1.

COURT REPORTER: Thank you so much.

MR. TANNER: Yes, ma'am.

BY MR. TANNER:

Q Did you take any pictures when you saw him just recently?

A No, I took no pictures.

Q But you did an independent medical exam?

A Yes.

Q All right. I want to show you what's already been admitted as Defendant's Exhibit 2. Is that similar to the child's hand when you saw him back just a few weeks ago?

A Yes, sir.

Q And that would be the same picture?

A Yes, sir.

Q But you didn't take any photographs to show how the scaring was?

A No.

Q When was that appointment made for you to see him on February 23rd, 2018?

A I don't know when it was scheduled.

Q Because he hadn't been to your office since almost three years, over three years, right?

A Correct.

Q Were you provided with Dr. Davis' independent medical examination?

A I saw it.

Q You said he was a good student. He was a good surgeon I believe you testified to, correct?

A Yes.

Q You mentioned earlier the derma jet. Is there an age limit when a child or person can have the derma jet injection?

A No.

Q So theoretically he could have had the derma jet back in February of 2015?

A Yes.

Q At that time, he'd have been four months old, right?

A Yes, sir.

Q So there probably wouldn't have been the same apprehension of seeing a doctor in a white coat and getting that procedure would you -- is that --

A With the derma jet?
Q Yes, sir.
A The derma-jet is as painful as a needle. It's just that it's not a needle. It's injecting the cortisone under high pressure and it helps the physician to get the medication into the scar itself, rather than to try to do it with a needle and syringe.
Q Yes, sir. You had mentioned when Mr. Krell was asking you questions though if the child at age three, almost four, come in and see you in the white coat, he can be upset. And so my question is if you'd done this when he was four months old, presumably he wouldn't have had that same apprehension, right?
A Oh, no. He could still have apprehension because the derma jet treatments are painful. And, you know, I did it. I gave him the pain and he'd see the white coat and the white coat, pain -- it's emotional scaring that --
Q Well, but almost four years later he might not remember it, correct?
A No.
Q You would agree that it --
A He would remember it.
Q -- that it was your recommendation back in February of 2015 to have steroid injections, correct?
A Yes. And I still do.

Q And that would have been your recommendation to Ms. Hamilton?
A To treat the scar, yes.
Q You thought that would benefit her son, right?
A Yes.
Q And to date he hasn't had any injections?
A No, not yet.
Q And when he came back in March you again recommended him to have the steroid injections, correct?
A Yes, sir.
Q And you felt at that time that it would benefit, benefit the child?
A Yes, sir.
Q And you mentioned earlier the jell, the sheeting. And that was what Dr. Davis recommended from his report that you read, right?
A Yes, sir.
Q I don't see anything in your report that he has any loss of functionality, correct?
A I really didn't examine him about that. He wouldn't even let me touch the wound. So I suspect he has some limitation, utilization of that hand compared to a child who doesn't have a hand that's injured like that.
Q But you don't have anything in your report --
A But I don't have anything in my report about it.

Q And were there any appointments scheduled between March 2018 and April 2018, right before trying this case?

A I don't believe so.

Q Thank you, sir. No further questions.

THE COURT: Anything on redirect limited to his cross.

MR. KRELL: No further questions and we'd ask if Dr. DeVito could be excused.

THE COURT: Any problems with that?

MR. TANNER: No objection.

THE COURT: Thank you, Dr. DeVito.

THE WITNESS: Thank you, Your Honor.

THE COURT: Yes, sir.

All right. Is the plaintiff ready to call its next witness?

MR. WILLIAMS: We have one matter. Your Honor, we'd like to read a request for admission in regard to the statute.

THE COURT: Okay.

(Off record discussion)

MR. WILLIAMS: Your Honor, I'd like to publish a request for admission.

THE COURT: All right.

Do you know what --

MR. TANNER: I don't know which. I mean, I know

Q And were there any appointments scheduled between March 2015 and April 2018, right before trying this case?

A I don't believe so.

Q Thank you, sir. No further questions.

THE COURT: Anything on redirect limited to his cross.

MR. KRELL: No further questions and we'd ask if Dr. DeVito could be excused.

THE COURT: Any problems with that?

MR. TANNER: No objection.

THE COURT: Thank you, Dr. DeVito.

THE WITNESS: Thank you, Your Honor.

THE COURT: Yes, sir.

All right. Is the plaintiff ready to call its next witness?

MR. WILLIAMS: We have one matter. Your Honor, we'd like to read a request for admission in regard to the statute.

THE COURT: Okay.

(Off record discussion)

MR. WILLIAMS: Your Honor, I'd like to publish a request for admission.

THE COURT: All right.

Do you know what --

MR. TANNER: I don't know which. I mean, I know

-- if he'll refresh my recollection.

MR. WILLIAMS: Mr. Tanner sent requests for admissions on December 14th, 2015.

THE COURT: Would you show him so that he'll know what we're talking about.

(Off record discussion between counsel)

MR. TANNER: Yeah. And I think that's probably a matter we need to take up outside the presence of the jury, Your Honor.

THE COURT: Okay. All right.

All right. Ladies and gentlemen, I'm going to let y'all go back into the jury room for a second. Again, remember, you cannot talk about any of the testimony you've heard so far, okay? I'll get you back out here as soon as we can. Thank you.

(Jury out at 9:51 a.m.)

THE COURT: All right. Can y'all -- go ahead. You want to show me the request to admit.

MR. WILLIAMS: I'm sorry, Your Honor.

THE COURT: Thank you, sir. Okay. What do you -- you want these -- okay. All right. So Mr. Tanner, you sent these to --

MR. TANNER: I sent those. The whole purpose behind those was for the independent medical examination

under Rule 35; that's the hundred thousand dollar figure is the trigger that triggers that whole -- I certainly, I don't think that the plaintiff can say well, we think it's worth a hundred thousand dollars and publish that to the jury when that was -- the purpose of that was the independent medical examination, which we subsequently filed a motion on.

THE COURT: All right.

MR. TANNER: It would certainly also simply confuse the jury based on the medical bills that they've put in, to just try to limit it to those black and white figures.

THE COURT: Who's going to speak?

MR. WILLIAMS: Your Honor, I will. First, the issue is he's not -- I mean, the rule is clear. The Rule 36 says in our state, requests to admit are not -- or that are not sent to the jury. Rather, the proper course of action is to publish the admissions to the jury. The issue that we've got here is he used the request to admit, which creates a stipulation of this court. When we agreed to the stipulation, it is thereby stipulated and it's, according to the rules, to be published to the jury. The request to admit that we wish to publish has nothing to do with the need for an IME. The need to substantiate an IME is a matter of controversies in excess of a hundred thousand dollars. The stipulation was the actual damages exceed one

hundred thousand dollars. To have that stipulation entered into this court but then argue something different is a fatal issue, Your Honor, which I don't believe should be allowed. That would be misleading the jury when you've got a stipulation that there's in excess of a hundred thousand dollars in actual damages.

THE COURT: All right.

Mr. Tanner, anything else?

MR. TANNER: It's not a stipulation, Your Honor. It's a discovery tool. And, again, to publish that to the jury I think is highly prejudicial because it's going to confuse them because it -- you know, it's just not -- it is not a stipulation. It's not me agreeing. It is a discovery request and they have answered it, but it's certainly not a stipulation. And I think at this point in time, I think to publish that is just going to lead to a highly prejudicial effect and under Rule 403 any value is going to be outweighed by the prejudice.

THE COURT: But, again, the whole purpose of this, I thought the request to admit was to get things --

MR. TANNER: To get facts -- I think if it was a factual matter, you know, did he have a scar? Then I think they could use it but damages are subjective. And in order to get to that point -- there's no way to get to the IME, I don't think, unless you have something regarding their view

of the case. And all this is, is their view of the case. It's certainly not the hospital's view of the case. So, again, all you're doing is you're, I think, reemphasizing for the jury -- they think the case is worth more than a hundred thousand dollars.

THE COURT: Well, just out of curiosity, why wasn't that -- I mean, why wasn't something put in here saying this is limited to the IME or why wasn't that kind of stipulated?

MR. TANNER: I guess because, again, it wasn't a stipulation. It was more just a request.

THE COURT: All right. Well, I got -- I'm just looking, you know, back through the notes after 36. From one of the cases, Scott versus Greenville Housing says requests to admit are not submitted to the jury, while the proper course of action is to publish these admissions to the jury. And I haven't read that case. I haven't looked at it to see what those admissions were. But if y'all would give me a second, let me -- let me just pull that. I'll be right back out here so we can look at that, okay?

I'm assuming nobody's got any other cases that y'all want to show to me, right?

(No response from counsel)

THE COURT: Okay. I'll be right back. Okay. Thank y'all. We'll stand down for a second.

(Court at ease)

THE COURT: All right. Going back to publishing these?

MR. WILLIAMS: Yes, sir.

THE COURT: Here. This is your copy or what you gave me earlier. Oh, y'all can be seated. I'm sorry. I'm sorry. I get -- when I get kind of behind I get really -- move faster. It looks -- from my reading of the rules, it appears that the admissions can be published or it should be published. Normally, speaking if you want to make a motion to change the admission or like that, it has to go to the merits and this goes to damages and not the merits. And usually the person that is complaining about the admissions is the person that actually answers. Now, I believe that you, Mr. Tanner, had stated most of your objections onto the record, but if you have any additions to that, I'll be glad to hear them right now.

MR. TANNER: May it please the Court, Your Honor?

THE COURT: Yes, sir.

MR. TANNER: Obviously, under Rule 36, as you alluded to, 36(b), you know, the Rule states that the Court may permit withdrawal or amendment when the presentations of the merits would actually be subserved thereby and the party who obtained the admissions fails to satisfy the Court that withdrawal or amendment will prejudice him in maintaining

his action or defense on the merit. And respectfully, I think it does impede my defense on the merits. It's almost like in a sense you're saying to the jury, if you're going to award damages to the plaintiff, you have to give her damages of at least a hundred thousand dollars, which then almost makes it to where you're directing a verdict in liability favor, which is obviously disputed as well as damages. You know, Mr. Williams argued that it was a stipulation. Obviously, the stipulation is under Rule 43(k). It's not a stipulation; it's a discovery tool. The request to admit rule says it has to be a statement of fact. I don't believe this is a statement of fact. It has to be an opinion of fact. I don't believe it's an opinion of fact. It is certainly not an admission. It does not say TRMC admits the value of the plaintiff's actual damages exceed a hundred thousand dollars. So I really think that by allowing that with the jury all it's going to do is confuse them. It's certainly going to prejudice them because then they may be under some belief that they have to give a verdict for the plaintiff. And if they give a verdict they have to give a verdict for at least a hundred thousand dollars. And I don't think -- I think the burden is on them to -- the plaintiff to show that by not publishing that, that somehow they'll be prejudiced in maintaining their action. I don't think they can show that

because certainly they can argue to the jury to do whatever verdict they want. So there's no prejudicial effect in not allowing the admission to go to the jury, whereas by allowing it to go to the jury, certainly would significantly prejudice to the hospital.

THE COURT: And I think those are all good arguments. It's just the way I read the rule. Clearly, I'm going to let them publish it. But I'm going to do everything I can to make sure your objection is preserved, okay?

All right. Y'all ready?

MR. WILLIAMS: Yes, sir. Your Honor, before I publish this, can I explain to the jury what a request to admit is or would like to just so they understand -- I'm happy to do it in a very brief manner.

MR. TANNER: I think all that's going to do is just draw further attention to it.

MR. WILLIAMS: Okay. I'll just read it, Judge.

THE COURT: Yeah. If you'll just read it. I think that --

MR. WILLIAMS: That's fine.

THE COURT: That's fine. Okay.

Bring the jury on in.

THE BAILIFF: Yes, Your Honor.

THE COURT: Thank you.

(Jury in at 10:57 a.m.)

THE COURT: All right. Ladies and gentlemen, I apologize for it taking so long, but it took me longer to decide something than it should have, okay? So right now we're going to continue with a portion of the plaintiff's case. Okay.

Yes, sir.

MR. WILLIAMS: May it please the Court.

THE COURT: And just for the record, you are going to read that subject to the defendant's objection?

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. Thank you, sir.

MR. WILLIAMS: Thank you, Your Honor.

Ladies and gentlemen, Michael Tanner sent to Jonathan F. Krell, attorney for plaintiff, pursuant to Rule 36 of the South Carolina Rules of civil Procedure, please admit the follow statements and/or genuineness of the following documents. Request to admit: Admit the value of the amount in controversy in this action is less than one hundred thousand dollars? Answer, denied.

Request to admit number two: Admit the value and amount in controversy in this action is greater than one hundred thousand dollars? Admit.

Admit -- number three: Admit the value of plaintiff's actual damages exceeds one hundred thousand dollars. Admit.

(Jury in at 10:57 a.m.)

THE COURT: All right. Ladies and gentlemen, I apologize for it taking so long, but it took me longer to decide something than it should have, okay? So right now we're going to continue with a portion of the plaintiff's case. Okay.

Yes, sir.

MR. WILLIAMS: May it please the Court.

THE COURT: And just for the record, you are going to read that subject to the defendant's objection?

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. Thank you, sir.

MR. WILLIAMS: Thank you, Your Honor.

Ladies and gentlemen, Michael Tanner sent to Jonathan F. Krell, attorney for plaintiff, pursuant to Rule 36 of the South Carolina Rules of civil Procedure, please admit the follow statements and/or genuineness of the following documents. Request to admit: Admit the value of the amount in controversy in this action is less than one hundred thousand dollars? Answer, denied.

Request to admit number two: Admit the value and amount in controversy in this action is greater than one hundred thousand dollars? Admit.

Admit -- number three: Admit the value of plaintiff's actual damages exceeds one hundred thousand dollars. Admit.

Thank you.

THE COURT: Thank you, sir?

Any other witnesses on behalf of the plaintiff.

MR. WILLIAMS: Your Honor at this time we'd call Jamie Beth Downing.

THE COURT: Okay.

Where's Ms. Downing.

MR. TANNER: I didn't know y'all were going to call her in your case.

MR. WILLIAMS: I listed her in our pretrial brief as a witness. Can we have somebody maybe announce for her if she's here. Do we know where she is?

THE COURT: Do you know where she is?

MR. TANNER: I think she should be on her way. Let me go and check if I may have a few minutes.

THE COURT: Yeah. Go ahead.

MR. TANNER: (Exits courtroom)

(Court at ease)

MR. WILLIAMS: May I look at the exhibits for a second just to organize them?

THE COURT: Sure.

(Court at ease)

THE COURT: Mr. Shakibanasab?

MR. SHAKIBANASAB: Yes, sir.

THE COURT: Would you go get Mr. Tanner and tell

him to come back in here. I think I want to just let the jury go back to the jury room while we wait. And I want to make sure he's in here while I do that.

MR. SHAKIBANASAB: (Exits courtroom)

(Court at ease)

MR. KRELL: Your Honor, it may be beneficial that we rest and if she's going to be present we can handle our questioning during cross-examination to speed things along.

THE COURT: You go get Mr. Tanner and tell him that, that'll be fine.

MR. WILLIAMS: Sure.

THE COURT: Y'all work it out.

MR. WILLIAMS: (Exits the courtroom)

(Court at ease)

THE COURT: Unfortunately, we don't have commercials when we have down time. That's why we keep y'all back there most of the time while we do this.

(Counsel enters courtroom)

MR. WILLIAMS: May we approach? I think the witness is here, Your Honor.

THE COURT: Oh, okay.

(Off the record bench conference with counsel and the Court.)

(Court at ease)

THE BAILIFF: Your Honor, may they step back? One

got to --

THE COURT: Huh? Oh, yeah. Somebody's got --

THE BAILIFF: Take them back out --

THE COURT: Yeah. Yeah.

THE BAILIFF: Okay.

THE COURT: Yeah. Y'all go on back. We'll be right back out. Right back.

(Jury out at 11:04 a.m.)

(Court at ease)

MR. TANNER: Ms. Downing's here, Your Honor.

THE COURT: Okay. The jury had to go back to the -- some people needed to take a break, so y'all bear with them. They're going to be back -- as soon as everybody's through, yeah, if you could get them on back out here.

THE BAILIFF: (Affirmative response)

(Court at ease)

(Jury in at 11:10 a.m.)

THE COURT: All right. Ladies and gentlemen, we will get ready to continue with the plaintiff's case. Mr. Williams, you called Ms. Downing?

MR. WILLIAMS: Yes, ma'am. Yes, sir. Excuse me. Jamie Beth Downing.

THE COURT: Ms. Downing, come on down please, ma'am.

THE WITNESS: (Complies)

THE COURT: Ms. Downing, you see where that Bible is right there?

THE WITNESS: Yes.

THE COURT: Okay. If you'd stop right there, put your left hand on the Bible.

THE WITNESS: Uh-huh. (Affirmative response)

THE COURT: Raise your right hand.

THE WITNESS: (Complies)

THE COURT: The Clerk's going to swear you in.

(WHEREUPON, Jamie Downing, was duly sworn)

THE COURT: All right. And Ms. Downing, you might need to talk just a little louder, okay?

JAMIE DOWNING - DIRECT EXAMINATION

BY MR. WILLIAMS:

Q Ms. Downing, my name is David Williams, I'm going to stand over here just so you can more or less speak to the jury in this case. For starters, where do you live now?

A I recently relocated to Greensboro, North Carolina.

Q Okay. And are you still a nurse?

A I am.

Q All right. Do you recall treating R.J. at The Regional Medical Center?

A Yes. Vaguely.

Q Okay. And while you were treating R.J. at TRMC, you

had begun working full time shortly before that?

MR. TANNER: Objection, Your Honor. They called her as a witness. They're leading her. He's asking leading questions on direct.

MR. WILLIAMS: Your Honor, at this time she's an adverse witness. I'd make a motion to treat her as an adverse witness, and therefore be allowed --

THE COURT: Well, right now, she hasn't -- if she starts showing any reluctance to answer like that, I'll address that. Right now, if you'd just ask her regular questions.

BY MR. WILLIAMS:

Q How many days a week did you work at the time of this incident?

A At the time I worked about three twelve-hour shifts, about thirty-six hours a week.

Q Okay. So three days a week you'd work. And how many weeks had you been working at The Regional Medical Center?

A I can't tell you exact weeks, but I'd started back in August so probably less than two or three months.

Q Okay. And when you started, you began a couple week training session?

A Yes. And so the way The Regional Medical Center orientation works, you start with a hospital-based orientation, which is about two weeks. And then you do a

shift, so the first two weeks, eight weeks.

Q Okay. So about ten weeks after you started before you became on your own?

A Yes, that's correct.

Q And you started in August?

A Yes.

Q So that would be in mid-October you would be on your own?

A That sounds about right.

Q Do you know about the date that this incident occurred?

A I think it was the end of October.

Q And that's assuming you started at the beginning of August; is that right?

A I believe so. I don't have a calendar in front of me to count weeks.

Q And so is it fair to say within a couple of weeks that you would have treated R.J. on your own?

A I'd only been there for a few months, so that sounds about accurate, yes.

Q And during your two-week training, were you given policies and procedures?

A So for the first two weeks it would have been hospital-base training, that is the time you review all the hospital policies.

Q And when you did your six to eight week training with

another nurse, you went specifically through the policies and procedures?

A You specifically care for patients on the floor, and learn the policies in the two weeks prior and implement that into your care of the patient. So you're giving direct patient care.

Q So you would expect during that training that they would show you all the policies and procedures?

MR. TANNER: Object, Your Honor. Improper form.

BY MR. WILLIAMS:

Q Did you review all the policies and procedures?

A Yes.

Q Did you have a nurse tell you how to interpret the policies and procedures?

A So the way a hospital policies and procedures are written, they're not -- there's not room for interpretation. They are direct instructions on the way you should perform a procedure.

Q Okay. So there's no room for interpretation as you read it as whatever it reads, correct?

A Correct. That is the policy of the hospital.

Q Whether it's an infant or an adult are you told to assess the IV the same way?

A So IV assessment, I don't believe -- it's not a full step by step policy. There are recommendations on when IV's

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should be assessed, who they should be assessed on, how frequently. But a true nursing assessment of an IV is something that is more for the nursing school, practiced through nursing school and done through the nursing practice. It's not something that is step-by-step taught through a policy. It's something you repetitively do throughout your nursing practice and training.

Q Sure. But my question is, in your assessment, is there anything different from with infant as opposed to an adult in the assessment of the IV site?

A Yes. Pediatric IV's are very different than adult IV's. With pediatrics, your patients are very small and very mobile, so one factor their veins are very small, they're very mobile. They're very fragile. So in assessing a pediatric IV's you're going to do a more frequent assessment and you're also going to be more understanding of how this patient's probably going to move more. They don't understand what they're doing. Obviously, a baby, pulling at his IV is not intentional or pulling at a site isn't intentional. So you're very aware of that when assessing a pediatric IV, whereas you might have adult patient who's lucid, their veins are more stable. Their veins are bigger. They're able to use bigger catheters, we call them. That's the part of the IV that stays in the vein. So it's very different assessing an adult and a pediatric patient.

Q Tell me, what are the steps to assess an IV site?

A So to assess an IV sited means to check it. So to assess an IV; kind of eyes, feel, kind of going through everything. So you're first is going to look at the patient. Where is the IV site? So I know with [redacted] it was in his hand. So you're first going to look at that hand. If this is the first time you're coming onto the shift, you're going to do a very thorough assessment, say this is where it is. This is the way it looked when I first saw it. And your assessment throughout the night are going to be kind of based off of that. So you're going to look at the position of the IV. There are little (inaudible) at the bottom of an IV, so especially pediatrics there's a little tiny triangle. So a way to see if it's in the same position is to look at that triangle. And you kind of want it pointed in the same spot. There's going to be a clear dressing over it. You want to make sure that dressing is intact. That there no -- any fluid or anything that looks, other than normal. So you want to make sure that dressing is intact. There's specifically extra tape in a pediatric IV that's going to be moving a lot, and you want to make sure that tape is still there and that it's secure. You're also going to see if there's anything stabilizing it. So a lot of times pediatrics they will have an arm board. So that will cushion, that stabilizes the arm

and the hand to keep it straight. So you want to make sure an IV -- it's like a little straw that goes into another little straw and it's very flexible. So sometimes you need to hold that in the same position. So that's what you're going to do when you're looking at it. If there's any tubing hooked up to it, you want to make it's intact, there's nothing changed or abnormal about that IV tubing. You're going to look at it and touch it. You want to feel the top of it and feel around it. It should be consistent with the patient's other extremities. So if this hand was soft and smooth and warm, then it should be soft and smooth and warm. You're going to feel for any kind of swelling, any temperature changes. You're going to keep looking at it, touching. And then you're going to check for something called PEC, so making sure that straw is open so that we're able to flush fluid in and out of it. So you would clean the site and then flush it with normal saline, which is like salt water. So a small amount, about a millimeter, of normal saline just making sure that IV is flowing the way it's supposed to. And so that's going to kind of give you an idea. And you're still going to keep touching and feeling the site as you're flushing it to notice for any changes since that would indicate that the catheter isn't where it's supposed to be. So if you notice any sign and if it's cool to the touch, that means you're touching fluid,

you're not touching skin. So you continuously monitor that while assessing the IV. And if all that's good and it looks like it did the first time you saw it, you're not seeing any additional discomfort from the patient, sometimes that salt water can be a little irritating, so you kind of have to assess that, especially in a pediatric patient who can't talk to you. So it can be a little irritating the first time you do it, if the patient initially kind of (inaudible) you'd flush it a little bit more and a lot of times they kind of calm down a little bit after that first irritation because it is salt, so it can be a little irritating, so. You're probably doing a lot of things. You're looking, you're touching, you're feeling, you're seeing, you're flushing. Sometimes those pediatric IVs, especially in the hand, they can become kinked. So sometimes it takes a little manipulating, maybe even to tape the hand a little bit more on the arm board, open that straw back up. And so it's just kind of a give as you go. And you just kind of have to keep reassessing. But that first, initial assessment, you're really going to have a good idea of where that placement is so then throughout the night you can continue to look at that same placement for reference in your assessment.

Q Ms. Downing, you had a rather lengthy explanation. Can you tell me any of those steps you don't do for an adult?

A So you would do it with an adult. So you typically wouldn't have an arm board with an adult patient if the were lucid. The thing to take out of it with pediatrics is that it is much --

MR. WILLIAMS: Your Honor, at this point I'd ask you to instruct her to answer the question yes, no or at least allow me to treat her as a hostile witness.

MR. TANNER: I think she's trying to answer his question.

THE COURT: Well, I think you were asking her to differentiate -- the difference and I thought she was explaining that. What was she doing --

MR. WILLIAMS: Well, she's talking about an arm board. I've asked her about what's different in the assessment of the IV site and what -- I think she's admitted that there's nothing really different about the assessment of the IV site --

THE COURT: Well, I don't know --

MR. TANNER: Because he interrupted her before we could hear her answer.

THE COURT: Well, you just hold on. Ms. Downing. It is Downing, right?

THE WITNESS: It is.

THE COURT: Okay. Ms. Downing. I'm sorry. When Mr. Williams is asking you the question, if you would just

address that specific area. And right now he's asking you about assessments. So if there is a different way that you assess adults rather than children in putting in the IV, that's what -- if you would just address that.

THE WITNESS: Absolutely.

THE COURT: Okay.

THE WITNESS: Sorry.

A It's just that it's a little complicated in talking about adults and pediatrics. So adults, you would check an arm board if you an arm board. You don't typically have one, which is why I mentioned it. Also before administering a medication you have to for a check for blood return in an adult patient. You're not able to do that in pediatrics because for risk of collapsing the vein or compromising the site. You wouldn't do that with a pediatric patient like you could do with an adult if you're about to give medication. You could assess a patient differently for pain. And as an adult, you can ask them if they feel tender at the site. Yo can't do that with pediatrics. I think it more comes down to being able assess a pediatric patient versus an adult rather than specific things you do.

BY MR. WILLIAMS:

Q Sure. But you touch and feel both an adult or a child's hand?

A Yes.

Q You check for patency?
A Patency?
Q Patency, excuse me?
A Yes. Making sure the IV is flowing well.
Q And do you clean the site?
A Yes.
Q And you always flush before you administer the antibiotic?
A You would always flush an IV before administering any medication.
Q So you always flush at least four hours?
A Yes. And that's the hospital policy. It's either you would flush with the normal saline of if they were getting a medication, it's just making sure the IV is being used every four hours to maintain the site.
Q Okay. So is the administration of the ampicillin a suitable flush?
A So that's kind of a tricky question. So it would meet the hospital policy that you would need to use the IV every four hours, but you would need to flush it prior to giving the medication to assess the site. So that's kind of considered part of the entire procedure.
Q And you're required to note that you flushed the site is that right?
A So flushing a site is part of your assessment so it's

not -- as -- that is not in the Cernel (sp) data base for that flush to be documented. The four-hour flushes do task, so everything comes up with a flow sheet. So there is no way -- so assessing the IV is part of the procedure of giving the medication, so there is not a specific spot to say, yes, this amount of saline was flushed prior to giving the medication because that's -- it's just part of the procedure.

Q Before the time of the incident that we're here today about, had you noted that you flushed the IV before administering ampicillin.

A No. So like I said there's no task or flow sheet that pops up for me to document that information in the charting system.

Q So The Regional Medical Center mandates in their procedure manual that you're to document when you flush, but there's no way for you to document it?

A Okay. The Regional Medical Center policy documents that the IV is flushed every four hours. And that is done through the medical administration record. So the flushes are documented every four hours and they're automatically populate and the medications populate on there as well. So that's where that would be documented. When you're doing a medication and flushing it, -- There's no way to give the medication without flushing the IV first, so it's considered

part of that procedure.
Q Does your policy and protocol indicate that you're to flush prior to administering medication?
A I'm sorry, that I don't know it -- memorized off the top of my head.
Q Okay. And does your policy and procedure number twelve say that flushing the INT with the saline is to be documented on the D mark?
A (Witness pauses)
Q At the very bottom?
A Yes. So this section of the policy is referring to INT flushes that are used, those every four-hour flushes if you're not giving a medication. The INT policy protocol for flushing above says to instill the saline flush and doesn't mention documenting. So here at the bottom it's just talking about whether just flushing the IV and you're not actually giving a medication with it, just that that's documented in the MAR, (sp) that's something to be given every four hours.
Q So earlier you said there's no room for interpreting these policies; is that right?
A Right. This is written and you follow these policies.
Q And that policy says flushing the INT with saline is to be documented on the MAR; is that right?
A Yes, absolutely for when you are just giving a flush

and not giving a medication.

Q Okay. Does it say that in that policy?

A As a nurse interpreting this policy, as someone who has managed multiple IV's, yes. This is what it means to a nurse.

Q As a nurse who's managed multiple IV's for two weeks, three weeks?

A So that's not a correct statement. So as a nurse, you're in nursing school for two and a half years. I did multiple IVs. This is not the first time I've ever managed an IV.

Q Okay. But do you agree that nothing in the policies and procedures says anything other than it's to be documented on the MAR every time you do a flush?

MR. TANNER: Objection, Your Honor. It's been asked and answered at least two or three times.

THE COURT: Well, I'll let her finish answering that. Thank you.

A Yes. So I understand the spot -- It's in a different section of the policy. It's not referring to when you're administering a medication. This is specifically referencing when you're just flushing an IV, to give the flushing. It's not associated with a medication. So this is saying the saline must be documented in the MAR for these four-hour flushes as they are the only thing I see given at

the time. If you're also doing that medication, it's going to be in the MAR, so you are going to see that flush or something being given to that IV every four hours. So this is just making sure if you're just flushing the IV to meet this policy, that it is documented in the MAR. If you're giving medication, it's documented into the electronical medical record as well. So it is included in a different aspect, a different spot in this policy. This section doesn't refer to that.

Q Okay. Can you explain to the jury what a vesicant is?

A So a vesicant is a solution that can be irritating to the veins.

Q If it doesn't make its way into the veins what can it do?

A Well, it can go under the skin and it can cause burning.

Q So it burns, right?

A Yes.

Q Would it be more appropriate to document when you flush in preparation for a medication that burns as opposed to just randomly flushing?

A No, because it's our policy as a nurse to always flush before any medications. It's consistent throughout your practice. It's not necessary to document on one medication versus another if you're going to do it for everything.

Q So it's your testimony you never documented that you flushed prior to administering the medication?

A No.

Q Is that a no that that's not a correct statement?

A No. It's a correct statement, I can't -- There is no reason to do it. I can't say it never got -- happened because there was a flush that was populating at the same time, but I never physically documented a note that said, IV flush prior to administering medication because your assessment is there.

Q You had never seen an infiltration before [redacted] is that right?

A That's an incorrect statement. I'd seen an IV infiltration before. I'd never seen an IV infiltration with ampicillin before.

Q Okay. Did you testify in your deposition that you'd never seen an infiltration before?

A No, I said I'd never seen an IV infiltrated with ampicillin before.

MR. WILLIAMS: I beg the Court's indulgence for one second.

THE COURT: Sure.

BY MR. WILLIAMS:

Q All right. So you've never seen a burn like this before; is that right?

A I never had. And I actually never saw [redacted] in person after the event.

Q How many infiltrations had you seen prior to this incident?

A I couldn't give you an exact number. I would say over ten, probably closer to twenty.

Q So twenty. Over what period of time?

A Since starting nursing school so probably about two and a half years.

Q Okay. And in this case, why did you get the charge nurse?

A Because I had never seen an infiltration of the ampicillin before and I knew it was a vesicant. I also saw a small discoloration that looked like bruising and I'd never seen that with an infiltration before. I knew that the catheter had to be removed, but I wanted to make sure that we were following -- in compliance with the hospital policy and I was doing everything that needed to be done.

Q Tell me, what's the reason for the need to keep accurate medical records?

A So accurate medical records is like taking a picture of a hospital stay. They conform to document what was done and for further treatment. So, you know, like what medications people receive, if that treatment worked or not, how the patients responded to that medication. It's important for

the long-term care of patients and treatment in the future.
Q And if the record says you did something, would you want people to assume that you did it?
A Could you rephrase your question?
Q Sure. If the record says you did something, what does that mean in your mind?
A Well, it obviously that you documented it and you did it.
Q Okay. If a record doesn't say you did something, how do you interpret that?
A It'd would be different to say that Jamie did not do this versus it not being in the chart. And so there are some things as a nurse you chart by exception. So it's very important to keep as well as thorough medical records, accurate medical records, also concise medical records, so if a patient's readmitted to the hospital seeking treatment later, they're able to look at these medical records and find the information they're looking for. So you want to make sure you're including information that is helpful for that and that you don't need to be redundant and include the same thing over and over again. Because when you're trying to find that abnormal information, that changing pertinent information, you want it to be easily accessible for the better treatment of the patient.
Q Have you ever documented that you failed to flush an

IV?

A No, because I never would have given a medication without flushing an IV.

Q Okay. And if you remembered to document that you didn't flush it, you would just flush it, right?

A There's no way to go back, if that makes sense. There's no way to say I didn't flush an IV. I'm going to go do it now. It's part of your medication policy and procedure in my practice as a nurse. You wouldn't give a medication without first flushing the IV.

Q Do you remember flushing the IV before administering this ampicillin?

A I don't specifically remember the morning. I remember afterwards, day. But I know my practice as a nurse and I know that I flushed that IV. I don't think the medication really would have infused with the extension flaps and the tubing that's used at The Regional Medical Center if that IV hadn't been flushed.

Q Okay. But sitting here today you can't tell the jury that you remember flushing this IV?

A That's correct. It was about four years ago and I don't specifically remember flushing the IV. But that is my practice as a nurse and the procedure you have ingrained in you in nursing school. And as a pediatric nurse, you care for your patient. So knowingly not flushing the IV, it

makes no sense. It makes no sense not to do that.

Q Do you agree that the vesicant, the ampicillin, the medicine that causes the skin to burn, that you administered was what caused this injury?

A Yes.

Q And sitting here today do you know what happened, other than the vesicant, the burning medication, went somewhere other than where it was supposed to go?

A No. There is no way to really know why the medication after starting to infuse then did not go inside the vein. There's no way -- the IV could kink. The IV could move. The medication could irritate the vein. There could then be a tear in the vein. There are just so many things that can happen with a pediatric IV in a very short period of time. There's no way to say why this medication, after the initial assessment went where it wasn't supposed to go.

Q Okay. It didn't go to the vein; is that right?

A So it initially did. The burn indicates, the infiltration indicates at some point during the infusion the (inaudible) was no longer where it was supposed to be.

Q Okay. Are you aware of the nurses' practice act?

A Yes.

Q What does its rule?

A So I'm not familiar with the specific wording but the gist of it, and each state has their own nursing practice

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act is to provide safe care for your patients and the way they recommend to do that in North Carolina. Not North Carolina, sorry. South Carolina.

Q Does it say your duty is to do no harm?

A I believe that.

Q Are you familiar with Mr. Tanner's articles, the policies and procedures from Infusion Nursing for Pediatric Patients?

MR. TANNER: Your Honor, I would object. They're not my articles. I didn't offer them.

THE COURT: All right. Okay.

A I think --

THE COURT: Wait a minute.

THE WITNESS: Oh, sorry.

THE COURT: No, I was just --

THE WITNESS: Okay.

THE COURT: -- I will note your objection that they're not your articles. So if you'd just refer to what they were?

MR. WILLIAMS: Sure.

BY MR. WILLIAMS:

Q Are you aware of the articles Mr. Tanner provided such as Assessment of an Infant with Peripheral Intravenous Device?

A I had a chance to look them last week, but I haven't

read the entire article.

Q At the time of this treatment of [redacted], you hadn't read that article?

A No, I hadn't.

Q Okay. Have you read the one Intravenous Extravasation Mechanisms Management and Prevention?

A No, I haven't.

Q Have you read the one Infusion Therapy of the Infusion Nurse's Society?

A No, I haven't.

Q Okay. Sitting here today, have you read those?

A No, I haven't. So reviewing the texts of articles aren't necessarily common practice. I'm sure we'll be having an expert in the field in reviewing literature or doing quality improvement, different settings it would be appropriate to review those articles. Typical nursing practice you're review the policies of the hospital, you have your information you've learned in nursing school how to practice as a nurse, and training and that's the real source of information for IV management.

Q Sure. And sitting here today you have some different certifications that you didn't have at the time you were treating [redacted] is that right?

A Right. I'm a certified pediatric nurse and certified nurse educator.

Q And at the time of this incident -- that didn't happen until you went and worked at MUSC; is that right?

A No. It's not associated with the hospital that you work at. It's the number of hours and the amount of training and studying you've done to take the exam. So I haven't taken the exam yet, no.

Q And you did that once you left The Regional Medical Center?

A Right. And it's a certification that is -- I wanted to be a pediatric nurse. I wanted to be a pediatric nurse my whole life.

Q And sitting here today just to be clear with the jury, you weren't certified as a pediatric nurse at the time you treated [redacted] is that right?

A No, not certified but I had multiple hours of training as a pediatric nurse.

Q Tell us about this computer system, would it prompt you indicate to whether you flushed the IV?

A No. As we discussed before there's no flow sheet associated with the medication administration for flushing an IV.

Q Okay. So explain -- is it my understanding the IV wasn't patent at 4:45?

A So I think you're referring to the flush that was charted against. So at that point, I believe in that

patient that started right around 4:27 off the top of my head, that that patient ran for about twenty minutes. When those task you have kind of a window of administering those medications, obviously it wouldn't be appropriate to give an IV flush for a medication that's already infusing. At that point, that infusion was done you would give that flush after finishing the medication. The IV was infiltrated and it would not be appropriate to flush the IV out knowing we had a bad site.

Q Sure. Is it fair to say the record indicates that the IV wasn't patent at 4:45?

A That is not what that documentation says, no. It says that it's not appropriate to give that flush at that time. The assessment later, I think that was documented at 4:50, documented that the IV wasn't patent.

Q Okay. The 4:45 number, where would that have come from the record?

A So when there's -- when an IV order is placed by a physician, there's saline flushes automatically tasked every four hours. So whenever the IV is initially ordered the saline flushes associated and kind of just a set that's the physician orders. So they would automatically be happening every four hours. So that is that task. So it technically could have been charted against because you already flushed the medication when giving, using this IV or it could be

charted after. But it just automatically tasks regardless of what else is ordered or going on with the patient.

Q And I earlier asked you if the computer system automatically prompted tasks and you would flush?

A It didn't. So that was not a task. That was prior to the medication. That was a task I was tasking every four hours. That was not associated with the medication.

Q But again, the computer system prompted that task, correct?

A It did. It was for every four hours flush but it was after the medication was administered.

Q And that occurred at 4:45, correct?

A Correct. That's the time that it tasked.

Q And you started this medication twenty minutes prior; is that right?

A I believe that was 4:27.

Q Okay. So the medication would have run until 4:47; is that right?

A Yes.

Q Okay. And you didn't enter the room until 4:50; is that right?

A No, I would have went in as soon as the alarm sounded. It's documented -- you do the best you can as charting real time. Obviously, at the moment the more pressing circumstance would be to assess the patent and follow proper

procedures for removing an IV. The 4:50 documentation would have been documented after, honestly. So I, as a nurse, probably rounded three minutes. And I'll be honest in that. But it -- at the more pressing time I was caring for the patient at 4:47 or it would have been removed (inaudible).

Q You agree that the mother was paging you, trying to get you into the room?

A I do not recall that. There are multiple nurses on the floor at a time. You're not always sitting at the nursing desk but pretty commonly there's someone is and someone would have gone in there. From my memory, mom was holding the child when I went back in there kind of going back forth with everything you would expect. A new mom with a new baby in a hospital for a couple of days. But if I had been paged in there earlier, someone would have been in there whether it was a nurse or a nursing assistant, or a charge nurse, another nurse if I was with a patient would have been in there.

Q Do you recall going in there and the baby's screaming and the mother's upset?

MR. TANNER: Your Honor, he's -- I haven't objected every time, but he leading the witness again. He's chosen to call her on his case and he's got to ask open-ended front questions.

THE COURT: If you'd just ask her what she

remembers about the mother.

BY MR. WILLIAMS:

Q Well, what do you remember about the mother?

A Yes, I remember her. And I really in my heart remember mom being agitated and just exhausted. I remember talking to mom, explaining kind of what infiltration is and why we're removing it and why we're putting a compress on it, that we're going to call the doctor, but we're not going to restart the IV and that was mom's question, as well. There was not frequent calling or paging. Someone would have been in there. I remember going in there talking with her about the IV, calling the charge nurse as for removing. Mom very receptive to all the information we were giving her and just kind of going over what this means and that we're going to call the doctor and that this is what this is going to look like. So that is what I remember.

Q Okay. You'd been in the room starting this IV medication and you stayed in there for about thirty seconds?

A So, I can't tell you exactly how long I was in there. It was long enough to start the medication, I watched the patient, watched the pump, do some documentation on the computer and step out. So I would think it was anywhere from thirty seconds to a minute to a minute and a half.

Q Okay. And you weren't here to hear mother's testimony

about what she recalled, were you?
A No, I wasn't here.
Q You just got here a short time ago?
A Yes.
Q Okay. Did R.J. do anything to cause this?
A No.
Q Did Ms. Hamilton do anything to cause this?
A No. IV infiltration is a known risk of IV therapy. Nobody did anything to make this happen.
Q Is it my understanding that this site went from a zero to this?
A So a zero describes an IV that is -- I'm assuming you're referring to the infiltration and phlebitis score, which is used in the assessment of the IV. So that is used to assess the IV properly throughout. That's kind of a quick way to say no there's no inflammation, no there's no swelling. There's no sign that this IV is not working properly. So when starting an IV and IV's working well and being used, it's going to be a zero. So it's always going to start at a zero. So, yes. So any sign, like you just discussed about the vesicant. So what happened when a vesicant is -- extravasation, but basically it is an infiltration of a vesicant. So this vesicant goes outside of the vein and under the skin. The initial presentation is going to be the same as just a normal fluid. So it's --

it's swollen. It's cool to the touch. There might be some discoloration. There might be a knot. There was like small bruising and the medication is localized. So the longer this medication sits there, it's going to change, which is why we frequently assess these IVs and we assess these site and document them. So, yes. The initial presentation was mild swelling with a dark spot that's been noted. But it changes because of the medication that can burn. So an assessment every thirty minutes is probably going to be different than the one that was done previously before it. So it did start at a zero, the IV was flushing well. It was patent. It was able to be used. It was everything you need an IV to do until it's not and then you notice this swelling and that's when it's removed, but things change progressively, yes.

Q What is the scale of the infiltration score?

A I would need to see it. So it's on the bottom of the flow sheet in Cerner. I think it's a zero to five, infiltration and phlebitis, which refers to how the irritation of a vein. And it has different kind of categories. I think a one is swelling less than one inch. There is specific criteria that's used that's available to you every time you're rating the site.

Q So it's a zero to five. And it was a zero. It went from a zero to this; is that right? A simple yes or no is

what I'm asking?

A Right. But it's not a simple yes or no question because it progressively changes, it doesn't go from zero to that, no. It takes hours and it takes time.

Q In the amount of time from when you administered this medication, it went from a zero to this; is that right?

A That is not correct. I did not see his hand that way.

Q So you didn't monitor his hand before administering the medication?

A Yeah, I did monitor his hand before administering the medication. This picture was taken, I'm not sure when, but hours following the administration -- the medication was administered around 4:27. The IV was removed right around 4:50 and then my shift was over at 7:00. So I would've assessed the IV up until reports to the next nurse, which was around 6:45. So the IV continued to change because he still had his medication. That was there.

Q Maybe I should ask, did it go from a zero to this?

A So my --

Q Or --

A No. The IV site that I had was documented in the chart. It was mild swelling with a dark spot. A compress was applied and that is the way it looked when I left from my shift.

Q Okay. Is what caused this a five plus this or where is

this on the chart?

A So five plus, it's hard without actually seeing the grid. It is the same injury. It is not that there would be subsequent injury. And the amount of medication went under the skin that damaged tissue and that takes some time. So the IV site changed throughout the next couple of hours and was monitored. So it did start at a zero. I couldn't tell you what a five looks like without seeing a chart.

Q But when you administered the medication it's your position it was a zero. But once you gave this medication it continued to do damage to cause this?

A So when I initially assessed the IV, it was a zero. So it was flushing well. It was a good IV site. The medication was given. After medication was given in the IV site, as that was assessed, there was a small -- It was, I think mild inflamation is the word I used. And it had a score of a one and a one and that was documented. The IV was removed and then it was documented throughout the next shift, would be another nurse documenting -- would have been assessing of the IV site, of how it changed. So it's the same medication. There's no way to really know what the extent is going to be throughout monitoring and assessing. So it didn't go from zero to this on my shift. I think that this would take time.

Q But [redacted] didn't do anything wrong, correct?

MR. TANNER: Objection, Your Honor. He's asked and answered this multiple times.

THE COURT: She's already said he didn't.

MR. WILLIAMS: Okay.

BY MR. WILLIAMS:

Q And this medication required a flush before you gave it?

A It did.

Q But you don't specifically remember giving that flush?

A So I remember many a times giving -- I do not remember this specific morning, no. I remember many times administering an IV medication via syringe pump and in my practice as a nurse. Like I said, I do not think that -- without flushing it first and the medication would have never been given, so common practice as a nurse.

MR. WILLIAMS: Nothing further, Your Honor.

THE COURT: Okay.

Anything on cross?

MR. TANNER: Can we have just a comfort break for a couple of minutes?

THE COURT: Okay. That probably wouldn't bother anybody, I don't think. All right.

Ladies and gentlemen, we're going to take like a five-minute comfort break. And then we'll get y'all back in here, okay? Remember, you cannot talk about any of the

testimony you've heard so far. Thank you.

(Jury out at 11:46 a.m.)

THE COURT: You can stand up.

THE WITNESS: Can I stand? All right.

THE COURT: No, no, you did good. You can stand up. You can stand up. But you don't go anywhere -- wait one second before you go anywhere, okay?

THE WITNESS: Okay.

THE COURT: All right. Ms. Downing you're not trapped to the chair. You can get up and walk around.

THE WITNESS: Okay.

THE COURT: But you can't talk to anybody about your testimony.

THE WITNESS: Got it.

THE COURT: If you need to go to the restroom to do something like that --

THE WITNESS: Okay.

THE COURT: -- you can do that but you just can't talk to anybody. Okay.

THE WITNESS: Okay.

THE COURT: All right. Stretch your legs if you need to.

THE WITNESS: I do.

THE COURT: Okay. Thank you, ma'am.

THE WITNESS: Thank you.

THE COURT: Yes, ma'am.

(Court in recess for a short break at 11:46 a.m.)

(Court in session after short break at 11:53 a.m.)

THE COURT: Is the plaintiff ready?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: Is the Defense ready?

MR. TANNER: Yes, sir.

THE COURT: If the jury's ready, bring them on out.

THE BAILIFF: Yes, Your Honor.

THE COURT: Okay.

Mr. Tanner, about how long is your -- is --

MR. TANNER: I'm not going to have a very long examination of Nurse Downing.

THE COURT: Well, yeah. But how about Nurse Hurley?

MR. TANNER: Hurley? I don't know, about forty-five minutes, an hour.

THE COURT: That'd be your direct?

MR. TANNER: I would think she could be done everything in an hour.

THE COURT: Oh, okay. Okay. All right. Okay. All right.

(Jury in at 11:53 a.m.)

THE COURT: All right. Ladies and gentlemen, we're going to continue with the examination of Ms. Downing.

Mr. Tanner.

MR. TANNER: May it please the Court? Thank you, Judge Dickson.

THE COURT: Yes, sir.

JAMIE DOWNING - CROSS-EXAMINATION

BY MR. TANNER:

Q Thank you Nurse Downing, I appreciate you coming back from Greensboro today to be with us. You were explaining to the jury -- Mr. Williams was asking you about this blowup, which I can't remember which Exhibit this is, but this isn't the way the child's hand looked during your shift was it?

A No.

Q Okay. I'm going to show you this picture right here of a healing wound. That's not what it looked like during your shift, is it?

A No. You can see that there's tissue that's healing there. So that would have been --

Q This would have been --

A -- significantly later.

Q -- significantly later in the healing process, correct?

A Yeah.

Q Where were you born, Nurse Downing?

A I was born in (inaudible) Massachusetts.
Q Okay. But where did you grow up?
A I kind of grew up all of the place. lived in Massachusetts for a while. I lived outside of Fayetteville, North Carolina for a while. I finished High School right outside of Savannah. I went to college in Athens, Georgia. Then Charleston. And several months ago I moved to Greensboro, North Carolina.
Q Okay. So you went to high school and spent your formative years in Georgia?
A Yes.
Q Okay. And did you always want to be a nurse?
A I did. So I like many young women. I always want to care for people. That's kind of where you're rooted, and then I good in both math and science so you're edged towards medicine. But I was able to volunteer with a couple of groups in high school, specifically, I was able to volunteer with the Low Country Down Syndrome Society. There's a teacher of mine who was on the board and had a child with down syndrome and was able to attend their events, and there was a bunch of games and interactive participations for the kids to be there and all of their families were there. So walking around and seeing the impact that having this whole community together, but I think that's really what lead me towards nursing versus doing research with science or doing

medicine, because I felt like as a nurse you really get to spend time with families. And you get to educate them and really create impact in the community of families and follow them long-term. And so that's kind of what lead me to nursing. It was always kind of in the back of my head, but really lead me towards pediatric nursing, the idea of working with families.

Q Okay. And does the practice of pediatric nursing have something called PALS?

A It does. PALS is the life saving support during a pediatric emergency.

Q And that's a certification you have?

A That is a certification I hold. So I am a certified pediatric nurse, like we discussed and I've got that. Which says that you are an expert in the pediatric nursing field, that you have significant hours. I think it's -- I've worked over a thousand clinical hours directly caring for pediatric patients, that you are well-versed in all therapy applications. And so different medicine, different procedures, but that you are widely-versed and It's an awful two-hundred question test that takes you three hours. It's something you keep up with, with continuing education but it's really saying that you've cleared out pediatrics and that you are an expert in that field.

Q And you've kept that certification up currently?

A Yes.

Q And you went to nursing school at Georgia Regions; is that right?

A Yes. So the school changed names a couple of times but it was the Medical College of Georgia, the Regions University is where I graduated from.

Q And that was my question. Is that the same thing that people know as the former Medical College of Georgia?

A Yes. So the curriculum has changed a little bit since I've been there. When I was there it was a five semester program. It's gone down to four. But it's the same administration and faculty.

Q Okay. You testified earlier that the cannular that's in the IV site is straw-like; is that right?

A Yes.

Q And the needle you used was a 24 gauge needle?

A Yes.

Q Let me show you something Nurse Downing. You testified earlier to an arm board. Is that what this is?

A Yes. That's an arm board that would typically be used on a types of patient.

Q And would this have been similar to the arm board used on [redacted]

A Yes.

Q And that would be placed under the hand when the IV was

started?

A Yes. And so it's soft and it allows kind of for that positioning. IVs are -- I like to use straws. When you're working with kids you try to think of things that are relatable. But an IV, cannular, which I think they have here is like a small straw. And then a vein you can kind of think of is a little baby straw. And so the arm board would provide stability to the hand, being able to straighten out that vein, obviously. A small baby can't really keep their hands straight and it helps them from bending frequently and irritating the site as well.

Q And what am I holding in my hand now, Nurse Downing?

A So that is a 24 gauge three-quarters and five-eights inch cannular from an IV start. So that yellow piece and then the actual clear small piece is the straw piece that actually stays in the vein. And the second part of that tubing is the extension so that's connected. It helps keep the pressure there so that the site doesn't come compromised with clots and things like that. It's also higher access it to get medication.

Q And is that where you would also do the flush?

A Yeah.

MR. TANNER: Judge, I just want permission -- I'd like Nurse Downing to step down and show the jury the 24 gauge needle?

THE COURT: Sure.

A (Witness steps down)

Q Now, again, if you can explain the yellow part. That is the catheter tube, correct?

A Okay. The catheter is actually this clear little piece. Earlier when I was describing a triangle, this is what I was talking about. So it would be placed on the hand there. So it would be very -- kind of telling if the vein -- if the catheter is positioned a different way. It kind of has this little trick catheter. If it was straight before and it's twisted that way, there'd be concern that it's not where you left it, and so that means that's a change. And then this would stay there. This would be secured down. But this isn't actually in the vein and as you can see, it's really quite small, which is great when you're inserting it. And it helps you feed it in without damaging the vein, but it can be kinked very easily. It also causes pressure and so over time with frequent movement, it just can bend and sometimes have a mind of its own. So you want to assess it frequently because this is -- can be ever changing, because it's not super stable. And then that is the pressured extension (inaudible). And what to make sure is that there is positive pressure. If not, you can have blood coming out the back and then that blood could clot. And so by having this extension back here, it's

making sure the pressure is positive. And so you're preventing clotting and then also it's better, comfortable -- from being exposed to infection in the hospital. But this is where you would clean, attach a small syringe that has the normal saline in it and flush. And you're always checking just kind of the integrity of this whole structure when assessing.

Q So this would be -- essentially, this would have been in [redacted] hand, correct?

A Correct.

Q And first, there would have been a needle on the other end of this, right?

A Correct.

Q And then obviously the catheter would go under the skin, correct?

A Right.

Q All right. And then the extension set you would actually take a syringe with normal saline and do your flush before you administer the medication, correct?

A Correct.

Q And that was always part of your nursing practice and habit, correct?

A Correct. There's no way to really tell if the site is open and flowing without flushing it. And so it would not be (inaudible) to give the medication without flushing it

first because you don't know if it's going to go where you want it to.

Q And you wouldn't give a medication without flushing it first anyway, right?

A No.

Q Because that's not how you were taught. That's not how you're a nurse, correct?

A Correct.

Q All right. So when you administer the flush, you would inherently -- you would be touching his arm to make sure it was still warm, right?

A Right.

Q You'd be making sure that there's no swelling, no redness?

A Correct.

Q Okay. And then you would do the flush through there with saline and then you would hook up the IV tubing?

A Right.

Q And then administer the ampicillin?

A Correct.

Q And that was 4.25 milliliter; that's correct?

A Correct.

Q All right. You can have a seat Nurse Downing.

A (Witness takes stand)

Q At no time during your treatment of R.J. was his

infiltration score anything other than a zero, correct?

A I believe I charted it after the incident, it was a one. But before that, no.

Q I'm sorry. That was a poor question. Before the medication administration, it was never charted at anything other than zero, correct?

A Correct.

Q And Mr. Williams had asked a number of questions about five. It was never documented as a five, was it?

A I haven't reviewed the whole chart as far as what other nurses documented. I do not believe so, but I know on my shift it was zero and then once we noted the inflammation had scored a one.

Q And so at no time during your treatment of [redacted], was the infiltration score a five?

A Correct.

Q Because if it was, you wouldn't have given medicine, right?

A Well, correct.

Q And likewise when we're talking about the flush and let me show you this. This would have been your 4:04 assessment?

A Correct.

Q And that would have been when you documented everything, those should be part of your hourly assessing of

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the IV?
A Yes.
Q And documented no -- infiltration score of zero, phlebitis score of zero, correct?
A Correct.
Q And then again when you would have gone in there, just twenty-three minutes later, you would have reassessed the IV as we explained, correct? You would lay hands on it?
A Yes. Yes, sir, right. The tubing even connects t[redacted] what we would call an INT. So it's just saline inserted. The tubing actually, we're going to need him to have that for the medication. So you would need to go in and touch the IV, assess it, and then later hook up the medication.
Q And then that's when -- then when you would flush the IV, correct?
A Correct.
Q And then given the ampicillin.
A Yes.
Q Thank you so much, Ms. Downing or Nurse Downing for coming back here.
THE COURT: All right.
MR. WILLIAMS: I want to grab an exhibit, Judge, give me one second.
THE COURT: Take your time. I just remind you

that your redirect is going to be limited to his cross.

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. Thank you, sir.

MR. WILLIAMS: I'm just going to pull -- is it all right if I pull two documents out of this Exhibit 4?

THE COURT: As long as you put them back.

MR. WILLIAMS: I'm going to do that. It's TRMC 005 and 006.

JAMIE DOWNING - REDIRECT EXAMINATION

BY MR. WILLIAMS:

Q If you would look at those real quick?

A (Review documents)

Q Prior to this incident what was the last time that it -- you said these flushes were the four-hour flushes on there; is that right?

A Correct.

Q What was the last time you did a four-hour flush?

MR. TANNER: Your Honor, I would object. For the record, I think it was sort of outside of the scope of my cross-examination.

MR. WILLIAMS: Well, he asked her if she did a flush before administering medication.

MR. TANNER: I asked her if she had flushed before she administered, but I didn't talk about the four-hour flushes that are part of the medication --

MR. WILLIAMS: He discussed that, Your Honor.

THE COURT: Well, I'll let him ask that question, but we're going to keep it short on this, okay?

A (Reviews exhibit) So, there would be a four-hour flush at midnight, flush target and I charted it after I flushed after the Claforan, which was the other antibiotic he was getting. It tasked right after that medication was administered and so it was charted then, flushing out the IV after.

BY MR. WILLIAMS:

Q And I want to be clear for the jury at midnight is when this flush occurred here and you were supposed to do one four hours later; is that right?

A That's right. So in nursing there are --

THE COURT: If you'd just answer his question about that part.

THE WITNESS: Okay.

THE COURT: You want to repeat the question?

MR. WILLIAMS: Sure.

BY MR. WILLIAMS:

Q At midnight, you did a flush and you were supposed to do one four hours later?

A Correct, you have an window as a nurse to administer a medication.

Q And at 4:00 a.m. would be at four hours after midnight;

is that right?

A Correct.

Q And you administered the medication that caused this injury at 4:27; is that right?

A Yes.

Q And the system prompted you and said you didn't enter the four-hour flush at 4:47; is that right? Or 4:45?

A Do you have the following page with the flush on it?

Q Yes, ma'am.

THE COURT: Would that be 007?

MR. WILLIAMS: Well, I believe it's the backwards way, so that means 004. That could be wrong.

THE COURT: I have no idea.

Q Is this what you're looking for?

A That's it.

Q They're in reverse chronological order.

A Right. So the next flush was tasking at 4:45. So, yes, that was given at midnight and then the medication was given at 4:27.

Q 4:27. But the flush, the four-hour is going to happen at 4:00 a.m.; correct?

A So, it's a system based -- I can't tell you when it was supposed to be given. It's incumbent on when the physician ordered the IV. So if the physician might order the IV at 8:00 p.m. or 8:45, it would task out a forty-five minute

mark with, every four hours. So I can't tell you exactly when. I would have to see the original orders.

Q And the policy doesn't say an hour limit, does it?

MR. TANNER: Your Honor, I think this is far -

THE COURT: Okay.

MR. TANNER: -- far afield from my questions.

THE COURT: And we are going beyond the cross.

MR. WILLIAMS: Okay.

THE COURT: Okay.

MR. WILLIAMS: Nothing further, Your Honor.

THE COURT: All right. Thank you.

MR. WILLIAMS: Let me put those back real quick so I --

THE WITNESS: Here --

MR. WILLIAMS: Sure. Thank you.

THE COURT: Yeah. Put those back in reverse chronological order.

Okay. All right. And anything on recross?

MR. TANNER: No, sir.

THE COURT: Nothing?

MR. TANNER: No, sir.

THE COURT: Okay. All right. You may step down. Thank you, ma'am.

MR. TANNER: Your Honor, I would ask if Ms. Downing can be excused?

THE COURT: Any objection to her being excused, Mr. Williams?

MR. WILLIAMS: No objection.

THE COURT: Okay. All right. Thank you, ma'am.

All right. Ladies and gentlemen, what we're going to do is -- as it's eating time. I don't know if it's eating time for y'all time but it is eating time for me. And the other thing is I've got to take up some matters with the attorneys outside of your present. So I'm going to let y'all go eat lunch. I'll ask y'all to again be back here at 1:30 like you were yesterday and we'll get ready to -- I'm anticipating -- so, you know, I didn't say assume, because you know what assume does to, but I'm anticipating that when we come back we've just got one more witness to do, then we'll do closing arguments and my charge to y'all. And hopefully, some time this afternoon, this case is going to go to y'all so y'all can begin your deliberations. Until that time, you cannot talk among -- very good. You cannot talk among yourselves about this and you can't do any independent investigation and you can't talk to anyone else, okay? So y'all go enjoy lunch and come back and we'll be working during the lunch hour while y'all are enjoying yourself, all right.

(Jury out at 12:10 p.m.)

THE COURT: And I guess y'all should have said

y'all rested, shouldn't you?

MR. WILLIAMS: We do, Your Honor.

THE COURT: Okay. Thanks. Don't get ahead of myself.

All right.

MR. TANNER: I have a motion.

THE COURT: All right, sir. What is your motion?

MR. TANNER: I have a motion for a directed verdict.

THE COURT: Okay.

MR. TANNER: Based on the testimony of all the witnesses, in particular, Nurse Stobbs, plaintiff's expert, I do not feel that the evidence presented to the court and the inferences reasonably derived therefrom have shown that plaintiff has prove gross negligence, which is the standard in this case, given that the hospital is a governmental healthcare facility. There was no question submitted to Nurse Stobbs about gross negligence. I asked her about if an IV infiltrated, does that mean you're negligent and she said, no. Therefore, it's sort of axiomatic that if you're not negligent you certainly can be grossly negligent. They elected to call Nurse Downing in their case in chief. She testified that she flushed the medicine before she gave it to the child. There is an absence of any and all evidence of gross negligence. Nurse Stobbs had no opinions on

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whether or not Nurse Downing had intentional conduct. Obviously, the gross negligence standard, as the Court knows, doing something intentionally that one knows not to do or the intentional not doing of an act or it is my favorite of her deposition would be the absence of slight care. And clearly all the testimony in this case by the expert, by Nurse Downing, is that she certainly did slight care. She testified at length in front of the jury about all the assessing she did. All the checking for redness, all the documentation, how she managed and monitored this IV. And they -- again, they have nothing sort of even bootstrapping together to get to that gross negligence standard. As a matter of law, I respectfully do not feel that the jury can considered this because of the tort claims definition in 15-78-6025. Clearly, this is a patient in a hospital. The hospital has a duty of due care, with supervising and monitoring. Supervising and monitoring are one in the same. And the case of Ethridge versus Richland School District One certainly leads the court that when there's only one reasonable inference the normal question of law and fact, but in this case when you only have one inference, then it becomes a matter of law for the Court. And I think respectfully, because they didn't get Nurse Stobbs to say that there's evidence of gross negligence, there is nothing for this Court to consider, other than as a

matter of law that they have not met their burden of proof and not met their burden for the jury to continue with any sort of submission of this case to the jury.

THE COURT: All right. Anything in response from the plaintiff? Whose going to --

MR. WILLIAMS: Judge, the first issue I think ir raised is Michael wanted our expert to get on the stand and make a legal conclusion to be able to bind it over to the jury's hands. I don't think that's the requirement. In fact, I think that would be a serious error to allow an expert to testify concerning the law in the case, and it's only Your Honor who can charge the jury on the law. To use a term like gross negligence is a legal conclusion. But the evidence is clear. We've got everything down to a system the first testimony that you can't interpret these rules. And then testify that she interpreted them this way. A system that said you had to do it by this time, the ignore button was pressed. There's nothing more willful, wanton and reckless than to have something that you press ignore when it tells you to do something that your policies and procedures require you to do. I could go one with the testimony, but obviously the plaintiff testified how she was pressing the call button. She was screaming. She was irate that her baby was sitting in her hands burning. And her excuse was she was in another room. I think there's nothing

more clear that this is a jury question. I think the law says that the jury gets the case to determine whether or not gross negligence -- and I don't agree with the definition of gross negligence. It doesn't have to be intentional. It can be reckless disregard, reckless disregard of policies and procedures. Reckless disregard of the information you are provided, that causes this kind of damage.

So I think we've met certainly our burden of proof to get it in the hands of the jury, but I don't concede that this is a gross negligence standard.. It is a negligence standard when it involves the one claim, which is the negligent medical malpractice administration of medication. And I think the case is clear. I think the tort claim act is clear, that their immunity is waived, except for these exceptions. And sure there's some of our claims that fall under subsection 25 and have a gross negligence standard, but I think we have certainly produced a medical malpractice claim, which is separate and apart. And I think the law is clear that medical malpractice is based on negligence. And, you know, should we be a non -- a private entity, we'd be seeking punitive damages would be the only requirement to gross negligence. So I don't think that's accurate, Judge. And I would reserve the right to continue to argue that up until the time the jury charges are --

MR. TANNER: If I may reply?

THE COURT: Yes, sir.

MR. TANNER: Again, Stewart versus Richland Memorial Hospital is the law of this state. And I've yet to hear a case from the plaintiff that says that is not the law of this state. And that says that the standard is gross negligence. The standard in that case was charged to the jury of gross negligence in breaching the professional nursing standard of care. You know, again --

THE COURT: I'm aware of that. You don't need to go into that. We mentioned this yesterday. And sort of like we put on the record yesterday, you know, Nurse Stobbs mentioned a lot of different things about not noting it on the computer and not staying there five minutes and things like that. To me, that's all questions of who the jury is going to believe. And since it's a factual question that goes along with the earlier rulings of the Court -- and I'm just looking at (inaudible) versus South Carolina DJJ. It says gross negligence is a factually controlled concept whose determination best rests with the jury. And that's the way I'm going to leave it.

MR. TANNER: Yes, sir.

THE COURT: All right? And I deny your motion for a directed verdict.

MR. WILLIAMS: Could we go over one housekeeping matter, Your Honor.

THE COURT: Sure.

MR. WILLIAMS: The only issue -- because of his argument I want to be prepared, we would make a motion to prohibit his expert from making any kind of legal conclusions to the jury. I don't think she has the ability to. I think even if she was a lawyer she'd have the ability to get up and offer an opinion as to a legal conclusion.

MR. TANNER: An expert can give an opinion on ??? issues, Your Honor. I mean, it's in the rules.

THE COURT: But I think it just -- I think he's just -- you're going to phrase just in determination of whether there was negligence or not, just like you ask everything else. I'm assuming you're not going to ask.

MR. TANNER: I mean, I'd like to ask her were they grossly negligent.

THE COURT: Okay.

MR. TANNER: I mean, again, I think she can give that opinion under -- I think it's Rule 1001 on experts.

THE COURT: Something like that, yeah.

MR. TANNER: And certainly negligence and gross negligence.

THE COURT: Okay. All right. I'll think about it over lunch. As a general rule the -- you know, an expert can give an opinion as to the ultimate issue in a case, you know? So that's what the rule says, okay? Now, you know,

when we left off yesterday I said I still believe that the patient's going to be required to show gross negligence. We've talked about that. So unless y'all -- y'all are going to have to give me a case or something. Have y'all had a chance to look over the charges?

MR. WILLIAMS: Very, very briefly, Your Honor. We have a little bit to work on with regard to that.

THE COURT: Okay. All right. Well, if y'all will look them over so that we can talk about that. I also need for y'all to give me an idea of how you want the verdict form to look. I generally believe simple is best, but I don't know what y'all going to want, okay?

MR. TANNER: Yes, sir.

THE COURT: Okay. So, all right. We'll see y'all in about an hour, okay? Thank y'all.

(Court in recess for lunch at 12:31 p.m.)

(Court in session after lunch at 1:30 p.m.)

THE COURT: One of the last things that happened right before we left is we were talking about the expert talking about the ultimate issue in a case. And I said that yes, they can address the ultimate issue in the case. But Mr. Tanner, you mentioned something to me that you wanted to ask her whether or not she was grossly negligent.

MR. TANNER: Yes, sir. And I had asked the plaintiff's expert. You know, we talked about, just colloquialism, about in an infiltration that doesn't mean you're negligent. And so it's my intention to ask my expert was she negligent, and then was she grossly negligent.

THE COURT: Okay. And, you know, obviously I was not -- you're asking negligence in some kind of non-legal sense of negligence. See, here's my problem, okay? And I didn't -- your nurse is going to testify to the standard of care of nursing in a pediatric situation, I assume?

MR. TANNER: Correct.

THE COURT: Okay. And so when you're asking her questions like that, you're going to ask her did she deviate at all from the standard of care?

MR. TANNER: Yes, sir.

THE COURT: Did she even slightly deviate from the standard of care? Did she do anything wrong whatsoever that you can think of in reviewing the records.

MR. TANNER: Yes, sir.

THE COURT: Right?

MR. TANNER: Yes, sir.

THE COURT: Okay. She's not going to be qualified, I don't think -- I mean, she doesn't have -- and, of course, she's not a lawyer, right?

MR. TANNER: No, sir. And other than that's how

we've always done it as the only reason I know how to tell you.

THE COURT: Okay.

MR. TANNER: I got your ruling. I'm being respectful of your ruling. I'm not arguing with you about that. The only thing I wanted to do is in recognizing your ruling, I think I need to proffer that just in case we needed to go up --

THE COURT: And I want you to do that. And actually, you know, when you asked those questions the plaintiff didn't objection, you know. And I, quite frankly, was, you know, just --

MR. TANNER: Doing other judicial matters, right?

THE COURT: Well, no. I was listening but I -- you know how -- you know how in the Bible it says it's more than just hearing, it's listening or something like that or listening or hearing. I never can figure that out, which shows you how well I do with my Bible reading. But I don't think -- if he asked a question like that, I think you can get into it on redirect. But as far as direct, I think you go over everything, that she didn't do anything wrong and don't do that. Because I think you can ask whether or not she was negligent without asking that.

MR. TANNER: Like I said, whether or not I could properly do it before, I just did it. I would always ask

did they breach the standard of care? Were they grossly negligent. So I'll just ask the negligence questions on the proffer. That way, it's not heard.

THE COURT: Yeah. If you don't mind just to protect the record that way.

MR. TANNER: Yes, sir.

THE COURT: But I think -- my own take on it is the jury is going to listen more, did she do anything wrong? Did she break anything -- negligence is a --

MR. TANNER: Foreign concept?

THE COURT: Yeah. Uh-huh. Okay? All right. So are the plaintiff's ready to go?

MR. WILLIAMS: Yes, sir.

THE COURT: Defendant ready to go?

MR. TANNER: Yes, sir.

THE COURT: Okay. Yes, ma'am. Is the jury ready?

THE BAILIFF: Yes, Your Honor.

THE COURT: Okay. Bring them on in.

THE BAILIFF: Yes, sir.

THE COURT: Yes, ma'am.

And, Mr. Tanner, thank you for being so accommodating, you know.

MR. TANNER: Glad to help you, Judge.

THE COURT: A Judge needs all the help he can get. Okay. You said you think it'll take about an hour, an hour

and fifteen altogether? Okay. Well, we'll find out.

Who's doing cross?

MR. KRELL: I am.

THE COURT: Okay. He's been quicker than Mr. Williams, I've noticed.

MR. WILLIAMS: Yeah, I'm slow.

(Jury in at 1:39 p.m.)

THE COURT: All right. Ladies and gentlemen, we're getting down to the defendant's part of the case, okay?

And so, Mr. Tanner, are you ready to call your first witness?

MR. TANNER: Yes, Judge Dickson. Thank you.

THE COURT: Yes, sir.

MR. TANNER: I call Cindy Hurley at this time.

THE COURT: All right. Ms. Hurley, you can put that down before we swear you in, okay?

THE WITNESS: Yes, sir.

THE COURT: Put your -- yeah, you've been watching them.

THE WITNESS: I have.

THE COURT: Oh, good. Good.

All right. Yes, sir.

(WHEREUPON, Cindy Hurley was sworn to tell the truth.)

CINDY HURLEY - DIRECT EXAMINATION

BY MR. TANNER:

Q Good afternoon, Cindy. Thank you for being here.

A You're welcome.

Q Can you please tell the jury where you live?

A I live in Lexington, South Carolina.

Q And where were you born, Ms. Hurley?

A I was born in Columbia.

Q And what is your occupation?

A I'm a registered nurse.

Q Tell the jury about your educational background?

A Well, I graduated from high school in Columbia at Cardinal Newman. I went to the University of South Carolina, graduated thirty-nine years ago yesterday from the nursing program.

Q Congratulations.

A Thank you. Since then, I've worked.

Q As a registered nurse?

A As a registered nurse.

Q And after you graduate from the University of South Carolina, did you take the nursing boards?

A I did.

Q Did you pass them?

A I did.

Q Do you have a nursing license?

A I do.
Q Have you had a nursing license since you graduated?
A I have.
Q Have you started an IV on a pediatric patient, such as R.J.?
A I have started IVs on children.
Q Do you have an estimate of how many times you've started --
A A hundred. More.
Q Have you monitored an IV and managed an IV on a pediatric patient?
A Yes, a lot more. Hundreds of times.
Q Okay. And have you -- in doing that, have you assessed a IV on a pediatric patient, such as R.J.?
A Yes.
Q Any idea how many times you've assessed those IV's?
A Hundreds.
Q Okay. And have you also practiced clinical pediatric nursing?
A Yes.
Q And where did you have that clinical pediatric nursing practice?
A Initially, of course, in school. We go through pediatric rotations and I really got my first basic pediatric nursing when I was working for a general surgeon.

I was a first assistant and we lived in Laurens County, so the hospital, we did -- we didn't ship many babies. We would take care of them there. So multiple times.

Q Did you have other clinical pediatric experience outside of Laurens?

A Yes. When I left Laurens, I went to Lexington Medical Center and I worked there for thirteen years. I started out in what they call the staff pool. And I would go to work in the mornings and they would tell me which floor and where I was going to work that day. It might have been ICU or pulmonary or pediatric, oncology, even the ER, just wherever they needed me, that's where I worked.

Q Okay.

MR. TANNER: Your Honor, at this time, I'd offer Nurse Hurley as an expert in pediatric IV management.

MR. WILLIAMS: No objection.

THE COURT: All right. Ladies and gentlemen, Ms. Hurley has been identified as an expert in pediatric IV management. You remember yesterday I gave you the conditions about expert opinions. This will apply to her as well as it applied earlier witnesses, okay?

All right.

BY MR. TANNER:

Q Nurse Hurley, you were provided some materials in this case?

A I was.
Q And what material were you provided?
A I was provided with a portion of a the medical records from Orangeburg Regional.
Q And were you provided with other materials?
A Yes. Depositions. You want to know each one?
Q If it's easy. If not, we'll get to them --
A Ms. Middleton, Ms. Craft --
Q Nurse Downing?
A Nurse Downing.
Q Nurse Stobbs?
A Nurse Stobbs.
Q All right. And you were present in the courtroom when Nurse Downing testified --
A I was.
Q And you have reviewed the hospital record from The Regional Medical Center from October, the admission from October 25th through October 30th, 2014?
A Yes, sir.
Q Explain to the jury what the reason -- what was the purpose of that admission?
A The baby was admitted through the emergency room, came in with a high fever. I think it was a hundred and two point six. And we worry about babies that are that young. I think he was a week and two days old when his mom brought

him in there sick.

Q I'm sure we could spend hours talking about the rest of the days.

A Right.

Q I know the jury probably doesn't want to hear that. Why don't we just move ahead to October 27th; is that fair?

A Okay. That's fair.

Q Can you tell me, can you tell the jury what shift Nurse Downing would have been working on October 27th, 2014?

A Ms. Downing was working the 7:00 p.m. shift to 7:00 a.m. shift, which would have been the 27th into the morning of the 28th.

Q And when a nurse works nights, that's typical for younger nurse?

A Yes. It's typical for all of us.

Q And when a nurse works nights, do they just show up at 7:00 and leave at 7:00?

A No, sir.

Q What would have been her process?

A Well, in fact, in preparation for this, I actually went through and made notes of every time that Ms. Downing took care of that baby during that twelve-hour shift.

Q Okay. What's the first thing that a nurse does when they come on the floor or the unit regarding their patients. What is that called?

A It's called a shift report or sidebar.
Q And can you explain to the jury how that works?
A Yes. A previous nurse who's had that baby for twelve hours tells the nurse -- both are together and they actually round together. They go and see each patient. R.J. wouldn't have been the only patient that Ms. Downing had. She, I think, in -- I'm not sure how -- I wasn't here for all the testimony, but during depositions I think they could have had three to five patients a piece.
Q Yes, ma'am.
A So anyhow, she did that with five different nurses. But in this case, she started around 6:45, got report.
Q Okay. And what would that report consist of?
A It would consist on how the baby had done that day. What his vital signs were. If there were any lab work that morning, they would have gone over that. Any new orders the doctors might have written that day, multiple things. And the main thing is they would have actually gone to the bedside for a lot of this report. And at that time, they actually assessed the IV together.
Q I'm sorry. I was looking for that IV assessment. When would the first time have been that she would have assessed the IV?
A at around 7:44.
Q And in military time what is that?

A Well, I actually, because I wanted military time confuses me sometimes even after forty years. So what I've done is I've made it in normal time, if that's okay?

Q Yes, ma'am?

A Okay. So 6:45 at night was the shift report and then at 7:30 she did her nurse note. The first IV check was at 7:44.

Q Okay. And is this TRMC 00183 and 184, is this a copy of that IV assessment?

A Yes, sir. It is.

Q I'm going to set the easel up and we can show the jury this. All right. And so this would have been done -- it's time at 19:44, right?

A Right.

Q And, again, in military time that's 7:44?

A Correct.

Q So about an hour really after she got the report, correct?

A Right.

Q And explain to the jury what the IV assessment entails? And if you want to come down and show the jury on the form, whatever is easiest for you --

MR. TANNER: -- with the Judge's permission. :06

A Okay. (Witness steps down) All right. Let's set at quarter 'till 8:00 she does her IV check when she goes in

and she does all of that that she was talking about. She looks at it, she touches it. She probably compares it even to the other hand. And she marks that there's no complications that she can see. There's no drainage there, which drainage would be more than, say, infection. It would be more like you would wonder if maybe some of the IV fluid was leaking out. That would be what -- that would be that. And then the infiltration score, there was no signs of infiltration. There was no swelling, no redness. The phlebitis score also was zero. There's wasn't any -- no blood, no swelling, no indications that there were problems up above the IV. The IV dressing, it was dry. It was intact. And, again, I think she told you about how the dressings are clear so you can see all the way down. And there -- let's see. And she actually charted there was that little extension set on there that she showed you that hooks directly to the IV. So at quarter 'till 8:00 it was great.

BY MR. TANNER:

Q Okay. All right. And if you want to carefully get back on the stand?

A All right. Yeah, I think I might be real careful.

(Witness takes stand)

Q And when was the next time that Nurse Downing would have had an interaction assessment for R.J.?

A At 8:44 the vital signs were done also. And then at

8:50 she confirmed those vital signs. And what that means is the nursing assistant or the nursing tech does the vital signs, but then it's up to the R.N. to make sure that she agrees with those and sometimes we even recheck them. But she agreed with the vital signs so that was at ten minutes 'till 9:00.

Q And what would her next interaction with R.J. have been?

A All right. At 9:19 she gave a flush. And a flush, of course, she explained which is that little tiny bit of water or saline, salt water, that you push through the vein to make sure it's still open.

Q And what time would that be in military time?

A That was 9:19 p.m. so that would have been 21:19 military.

Q And is that one of the four-hour flushes or is that a flush for the administration of medication?

A That was a four-hour flush, but we need to back up to 8:00.

Q Yes, ma'am. Go back to 8:00.

A 8:00 there was a flush on the MAR and I hope y'all understand MAR is the medication records, so if I say that again. Let's see. So she didn't give the flush at 8:00. And the reason she didn't give that dose at 8:00 was because the nurse on the previous shift had given an antibiotic. So

that flush was given before that antibiotic. It was given after the antibiotic. So at 8:00 it really didn't make any sense at all to go flush it again. So then again at 9:19 she gave the flush. So within that four-hour parameter, per the hospital policy and procedure, and I'm sure that we'll get to that too. But the hospital states that every four hours that IVs have to be checked or flushed. And, again, that's for infants, babies. In an adult, I think it's every four to eight hours when they flush. So that is a difference in children.

Q So is there a difference from a nursing perspective in treating children and adults?

A Oh, that is -- there's just so much difference. I mean, babies are not children. Children are not adults. It's all different. Your equipment's smaller. You've got smaller stethoscopes, you've got smaller EKG pads. Everything's little and dainty and lots different.

Q You've read Nurse Stobbs deposition, correct?

A Yes.

Q And where she says -- testified in her deposition and testified in front of the jury, that a vein is a vein is a vein, I believe is what she said. Do you have an opinion to a reasonable degree of nursing certainty, more probable than not on the accuracy of that statement?

A I do. Okay.

Q Can you tell the jury what that is?
A I will. When you look at a baby or a child, we know they have everything we have. They have a brain, they have a heart, kidney, lungs. They have -- we all know that. They have veins and arteries just like we do and they're in exactly the same place, but it also makes sense that they're not near mature as ours are. So when you start to assess a baby for an IV, there is definitely a skill. There's a skill there. You don't always -- you can't see them. Most of the time, sometimes it's very difficult to feel them. So you do little tricks like warming up the hand to make them pop up. And we all know that from dishwater.
Q. And are veins on a child, a thirty-day-old child and an adult, are they similar?
A They're similar because we all have them, but babies are -- just like they're tiny, their veins are very tiny, very fragile, very frail. So when you're inserting an IV you have to be very careful that you don't go through the vein or actually into tissue that you don't want to go into. It's definitely a skill.
Q And is that because the literature reflects that children's veins are small and thread-like compared to adults?
A Yes. And -- yeah.
Q I mean, I didn't mean to interrupt you there.

A No.

Q Go ahead and tell me again what Nurse Downing did after that point in time?

A Okay. So she gave that four-hour flush at 9:19. And at 10:05 she went in and she did another IV check, just like that one. So that means she's been at work since 6:45 and she's already checked -- and we're up to 10:05. And she's already checked that IV once and flushed it. She's checked it and flushed it twice. And that's a little over two hours.

Q All right. And what did she do after that point in time?

A After that time, she checked the baby at 11:00 and he was sleeping in his mom's arms, I believe.

Q Okay. And did she chart that in her notes?

A She did.

Q Now, let me show you her notes. It keeps walking off on me. And this is TRMC 0036.

A Right.

Q Is this called a narrative note?

A Yes.

Q And you testified earlier she would have gotten a report from Susan Craft, right? And that's at 18:45?

A Right.

Q And then at 19:30 patient resting in mother's arms?

A Right.
Q No signs of distress or discomfort?
A Right.
Q Initial assessment complete, vitals stable. Is that what you were talking about earlier, the vital signs?
A Right.
Q Lung sounds clear bilaterally? Explain to the jury what that means?
A You just -- well, first of all the baby's been admitted for sepsis. So we don't know if it's a possible urinary tract infection, pneumonia, anything. I believe mama had Strep B when the baby was born, which is not uncommon at all. So the doctor in the ER has figured all of that in. So that's why we did the lumbar check or the hospital did the lumbar check and the chest x-ray. And, of course, the lumbar check came back in a day or two and it was fine. The chest x-ray was fine. But the reason we listen to the lungs is to make sure that there's nothing, no rattling, good air sounds.
Q All right. And she also reports she had an interaction with Ms. Hamilton. Writes, his mother states he has been drinking well.
A Right.
Q And voiding per patient normal?
A Right.

Q And that says, PIV to R hand flushing well, dressing dry and intact. What does that mean?

A Peripheral IV.

Q That's the IV to his right hand?

A Right hand.

Q And what does it mean when a nurse charts that it's flushing well?

A That it is -- well, that it's open.

Q Okay. And that goes to the patency of the IV?

A That's right.

Q I'm sorry. What time did we leave off?

A Let's see. All right. We got to 11:08.

Q Okay. What happened at 11:08 p.m.?

A 11:08, you brought the nurses narrative in here --

Q Yes, ma'am.

A -- but with that narrative, there's also -- when the nurse comes on at the beginning of the shift, there has to be an admission history physical. It's not a hospital rule, it is a national or a joint commission rule which so -- and I just want to say that her admission history and physical is incredible. I mean, it is -- it's awesome. She -- you can sometimes look at new nurses and they're just on it.

Q And you -- what are some of the information contained in her --

A Oh, my goodness.

Q initial history and physical?

A Skin color normal for ethnicity. Skin description, dry, warm. Heart and lungs are normal. Just relaxed, no crying. Breathing is relaxed. Arms and legs are relaxed. I mean, just -- it's a head to toe assessment. That's what we do when we go in. And this sets the pace for the rest of the shift.

Q Okay. So is that -- if you will, is that your baseline?

A This is your baseline. This is your baseline.

Q All right. And likewise when she documents if that entry at 19:30 at 7:30 that the peripheral IV in the right hand is flushing well --

A That's right.

Q -- is that a baseline?

A That's right.

Q All right. What else did you review of Nurse Downing's care and treatment of this patient?

A All right. So 11:08 she got the ampicillin. So that would have meant that at -- of course, we go back to 9:19, she had flushed it, okay? So about two hours later she starts -- she gives an another antibiotic ampicillin. So she would have gone in there with all of her little supplies like she showed you and -- well, no, she didn't do that part. And she would flush it again because she's giving an

antibiotic. You've got to flush it before and you've got to flush in after. So it got flushed again.

Q Okay. And so she'd given that antibiotic at that point in time?

A Yes.

Q And what was Nurse Downing's next interaction with the patient?

A At 11:23 she went in to check the IV again, which would have been another one of these checks.

Q And that would have been -- in military time, that would have been 23:23; is that correct?

A That's correct.

Q And that is listed right here on TRMC 181 and spills over into 182?

A Correct.

Q All right. And she would have again assessed for signs of infiltration; is that right?

A Correct.

Q And that is a zero?

A That's right.

Q And explain to the jury the significance of that score?

A That there's absolutely no problems with the IV. She did everything we've already talked about and it was still good.

Q And then it says phlebitis score, zero?

A No problems with the IV.

Q And, again, you've reviewed the policy and you heard her testimony. Is that what you're looking for since you're not infusing medicine continuously?

A Correct.

Q And so you always want to document the infiltration score and the phlebitis score?

A Correct.

Q And what was Nurse Downing's next interaction?

A Okay. So at 11:44 she went in again. Now, she's already given the ampicillin so she flushed before and she flushed after. Now a few minutes or several minutes later, twenty, thirty minutes later, she goes in to get another IV. So again, she flushes the IV, puts the medicine on a pump. And babies, little babies, you have to have them on a pump. And I believe this was a syringe pump. And then she would have flushed it afterwards. So that's two more flushes.

Q Okay. And what did she do after that point in time?

A Vital signs at 11:59 p.m.

Q Okay. And were those vital signs normal?

A Yes, they were.

Q And what did she do -- are we now close to midnight?

A We're at midnight.

Q We're at midnight. All right. And what did Nurse Downing do for R.J. at midnight?

A Well, on the MAR there was an order for the flush, which we know is the every four-hour flush that shows up on that medication record. Because as long as you have an IV, the policy said that IV has to be flushed at least every four hours. So with that, that feeds into the MAR, but she didn't do it.

Q Okay. What did she do?

A She didn't do it because she had just flushed it after she gave Claforan at quarter 'till 12.

Q Okay. And what time did she perform that flush?

A She performed that flush at 1:04 a.m., but that was after another IV check at 12:37.

Q 00:37?

A Yes, sir.

Q Let me see if we have that one. Yes, ma'am. Here we go. It's on TRMC 188. So again noted an infiltration score of zero?

A Yes.

Q Noted a phlebitis score of zero?

A Yes.

Q It says child was sleeping. Any signs and symptoms of any IV complications documented?

A No, sir.

Q What did Nurse Downing do after that assessment?

A The next time she did, I guess, a room check and she

noted that the baby was sleeping.

Q And is that part of your periodic nursing rounding?

A Yes, sir.

Q Now, each time -- there are things that nurses do that they don't -- is all, each and every ounce of care that a nurse provides, is that documented in the chart?

A No, sir. There isn't a way to do that.

Q Okay. All right. Go on. Thank you, Ms. Hurley.

A All right. So now we're at 2:41.

Q Yes, ma'am?

A And it's another IV check. She goes in and does another one of these right here.

Q Okay. And she did another one at 1:00, as well, I believe, correct?

A Yeah.

Q Okay.

A 1:04 a.m. That's the one that she didn't get at midnight because -- I think we talked about it. She'd just given the medicine.

Q All right. And what did she do after that point in time?

A Let's see. We talked about the IV check at 2:41. At 2:43 vital signs.

Q And how were those vital signs?

A They were okay too.

Q All right. And so that's another interaction between her and the baby?
A Well, probably with her and the baby, it would have been between 2:43 and 2:49 because at 2:43 the nursing assistant took the vital signs and then at 2:49 Ms. Downing confirmed them.
Q Okay. And so again at that 2:30 she made a note in nursing charts, correct?
A Right.
Q Patient asleep, no signs of distress. Will continue to monitor?
A That's right.
Q Okay. All right. And what was her next interaction?
A Let's see. 4:04 a.m. she did another IV check.
Q All right. And is that the IV assessment right there?
A Yes, sir.
Q Okay. And, again, would that be as a part of her monitoring and condition of the IV?
A Yes, sir.
Q And, again, that shows infiltration score of zero, phlebitis score of zero?
A Yes.
Q And that was at 4:04 a.m., correct?
A Correct.
Q All right. What was her next interaction with the

family?
A She went in to hang ampicillin.
Q All right. And that is --
A At 4:27.
Q And we've heard ampicillin is a vesicant, correct?
A Correct.
Q All right. And the difference between a vesicant and a non-vesicant, could you explain that to the jury?
A Well, a vesicant is something, in lay terms, that can just actually cause damage. There are like salt water like we're made out of and things like D5W. If you go in the hospital and you have surgery they hang stuff that isn't near as erosive as the medicines.
Q All right. And she would have assessed the IV at 4:04?
A She assessed the IV at 4:04.
Q And the ampicillin was administered at 4:27?
A That's right. So there she would have given -- of course, you would expect her to have given two flushes. But she hung the ampicillin at 4:27, so she flushed it before. But when she went back, of course, the IV had infiltrated. So there would have been no flush at all after that.
Q And that was the flush, I believe, Mr. Williams was asking about this time at 4:45; is that right?
A Right. But, again, that -- and that's the flush that would have been the every four-hour flush.

Q And again, that's where Nurse Downing documented not appropriate at this time?
A Right. And, of course, it wasn't.
Q And the reason why -- what was the reason why it wasn't appropriate at that time?
A Because there were signs of complications. There were signs that the IV was infiltrated. You're certainly not going to push anything else through there.
Q And, in fact, most likely the IV had been removed around that time as well?
A Her documentation -- I don't think it was removed until, let's see, 5:17. But in her deposition we know why. She saw it. She assessed it. She knew it wasn't right. She hadn't seen anything like it before. So she went and got her charge nurse, which is exactly what she was supposed to do.
Q Do you have an opinion to a reasonable degree of nursing certainty, more probable than not, that that was an appropriate course of action for her to take?
A Oh, it was. Certainly.
Q All right. And then you see in the record where Nurse Downing had a discussion with Ms. Middleton about the infiltration?
A I did.
Q And that was -- I think she timed that note at 4:50.

And you were here when she testified. You try to be exact but you can't exactly be exact, right?

A You can't.

Q Okay.

A The computer's not -- it has no mercy on you. You might have done something thirty minutes before but when you go to document it, it's going to document what time you're there.

Q So she's got it 4:50 IV antibiotics DC. Explain to the jury what that means?

A She stopped the -- She stopped the syringe pump from infusing any more ampicillin into the baby.

Q Okay. IV dressing removed. Hand puffy with bruising. And you heard Nurse Downing tell the jury about that, correct?

A Yes.

Q Mild swelling to the fingers. PIV removed. What does that mean?

A Peripheral IV removed.

Q So probably around 4:50 is when that would have been taken out, right?

A Right.

Q Catheter intact. Explain to the jury what that means?

A Well, when she showed you the little catheter you -- as soon as you pull the catheter or you see the catheter, you

always look at it to make sure all the pieces are there. It's only one piece but you want to make sure that there's been no damage to it, that it's all there.

Q And this is the catheter that Nurse Downing told us about, right?

A That's right.

Q You want to come down and show the jury what you mean?

THE COURT: Carefully.

THE WITNESS: I'll watch that.

A (Witness steps down) All right. Let's see. Yeah, she's got -- this is the little catheter that would have been in the baby. And you can see because it's so flimsy and so soft -- and the bigger IVs like for us, they're bigger and the holes are bigger. There was actually fluid given through that. I mean, you wouldn't -- it's not very big but it can go through there. But, yeah --

BY MR. TANNER:

Q So that the catheter tip when she says it's intact --

A Right.

Q -- it would look like it is now?

A Exactly. I mean, honestly sometimes you can pull out an IV and you will see where there's some damage to it. But, of course, there wasn't with that one.

Q But it's much more flexible and pliable than a catheter for an adult?

A Oh, yeah. Yeah. We're not allowed to put those in -- well, I've got to backtrack just a little bit. In the critical care setting, we don't even have those on the floor, 24 gauge, because in an emergency you couldn't get the drugs through it that you need to get through. So we're not even allowed to use them, just some children.

Q And so it was certainly proper to use a small catheter like that on a child?

A I don't think you'd use anything different unless it was a central line or something.

Q Okay. And when she explained to Ms. Hamilton infiltration, do you have an opinion on if that was appropriate nursing care?

A Oh, I think it was great. I mean nurses aren't -- nurses aren't just nurses, we're teachers and social workers and preachers.

Q And then after that 4:50 they called the physician as well?

A Yes, sir. And that was -- got that there.

Q And she's got -- entered that in the chart.

A And she did.

Q What was her next interaction with R.J. and his mom?

A Okay. Let's see. 5:16 -- well, of course, they took vital signs in between -- when this was going on.

Q Yes, ma'am.

A Also, there were two or three people in the room with that baby for about, oh, gosh, thirty, forty-five minutes at least. 5:16 she confirmed the vital signs. And then at 5:17 she removed the IV. And like she said in her nurses notes. It might -- these are a minute or two different. It could have been flip-flopped, but she removed the IV.

Q And then she would have reassessed R.J. around, I believe 6:00; is that right?

A She did. She went back in at 6:00 and he was asleep in his mama's arms, I think.

Q And then she subsequently later reported off to the on-coming nurse?

A Right. Did vital signs again at 6:22. 6:26 she confirmed them. And at 6:45 she gave shift report.

Q Okay. All right. And do you have an opinion to a reasonable degree of nursing certainty, most probably whether or not Nurse Downing's care and treatment of R.J. that night met the standard of care?

A It exceeded the standard of care.

Q And, again, you testified that you heard Nurse Stobbs -- you read her deposition, rather?

A Yes.

Q And on this catheter this is a 24 gauge needle right?

A Correct.

Q You saw where Nurse Stobbs testified numerous times in

a deposition for the jury about getting blood return on a 24 gauge needle. Are you familiar with that?

A Yes, sir.

Q Can you get blood return on a 24 gauge needle?

A We're taught not to even try. When --

Q I'm sorry. Why is that?

A Well, first of all, we see how flimsy it is. And if you hook a syringe to the end of it and there's any resistance at all, it's going to not only flatten the catheter, but it can also suck that tiny little vein down too and occlude it. So then nothing's going to go through and you do damage to the vein.

Q What does the literature say on whether or not a nurse can get blood return in a pediatric patient of a 24 gauge needle?

A When I started doing this case I used my education, my training, and my experience. But then when Ms. Stobbs kept saying about the blood return, I -- you know, you begin to second guess yourself. Everything I've read has indicated that you never -- you just don't do it. You just don't try to aspirate blood for two reasons. Number one, just what I just told you. You can damage the vein. You can damage the catheter. You can just damage. And it also -- even if you get the blood return, some of the literature says that it may not be from the vein. That it may be sucking that blood

from like around the catheter. So it's a false -- it's a false test. So they tell you not to do it.

Q Would another difference between adults and children be that on an adult patient a larger bore needle you can get blood return --

A Oh, yeah. In the critical care setting we like to put in nothing smaller than a 20. And we really like 18s. And it seems crazy but the lower the number, like 18, the bigger the catheter; 18 is huge, 24 is little. We like 18 in our patients that are on -- in ICU and post -- or progressive care because we can get that emergency medicine in quick and we can give blood. You can't give blood through a 24 catheter. If R.J. had needed blood, they would have had to have put in a central line or another kind of venous access.

Q Let me show you a part of Plaintiff's Exhibit 4. It's TRMC 006. And I'll direct you to that 16:07 flush of Nurse Craft. Again, do you have an opinion on whether or not that is a four-hour flush?

A You talking about the 16:07? Tell me again. I'm sorry. I was looking at mine.

Q I believe it's at 16:07?

A Yeah, 16:07.

Q Okay. What is your opinion of that flush?

A That was, I'm sure, a four-hour flush, but just happened to be at the same time that Nurse Craft was hanging

her Claforan. So instead of that -- that flush would have fit right into the schedule, but it's usually not that simple.

Q Okay. And then, again follow four-hour increments thereafter?

A Yeah, every four hours. She got a -- R.J. got a flush every four hours up until the time they deseated, plus all those in between.

Q Okay. Do you have an opinion to a reasonable degree of nursing certainty, more probable than not if the assessment that nurse downing did at 4:04, that last documented assessment before the ampicillin was administered, met the standard of care?

A It certainly met the standard of care.

Q Okay. And have you been qualified in this state before as an expert witness?

A Yes.

Q More than once?

A Yes.

Q Okay. Regarding your review of the literature -- and I think you've talked about some of the research you've done.

A Right.

Q Can you give the jury other -- explain to them how we're also different, peds and adults are different?

A I can. And their words are a lot better than mine

anyway. First of all, I think it's important, the very first page, very first paragraph, the potential for complications is always present in the patient receiving IV therapy.

Q And what are you referring from, Nurse Hurley?

A Infusion --

Q Infusion Nurses' Society, Infusion Therapy. Okay?

A Okay. So then, let's see. This is one that I was glad to see because it made me think I had not missed anything. Checking for a blood return or a back flow of blood is not a reliable method for determining the absence of an infiltration. A blood return may not present -- be present when small veins are used because they may not permit blood flow around the cannula.

Q All right. And I think as Nurse Stobbs testified, she said that those articles are older. Surely, those would have been in place well before 2014, correct?

A Right. And they've been teaching you about charting by exception. The reason these articles are old and there aren't any new ones, I would like to --

Q Do you have an opinion on that?

A I do.

Q Would you like to share it with the jury?

A Things haven't changed and you can't reinvent the wheel. I mean -- all the --

Q In IVs -- I'm sorry.
A Sorry. In every one of the articles that I looked at, they all say the same every one of them. And they range from 2001, I think to 1997, and -- yeah.
Q So certainly since Ms. Stobbs has been as a nurse. I think she's testified she's been a nurse over thirty years?
A It hasn't change.
Q Okay. All right. Do you have an opinion to a reasonable degree of nursing certainty whether or now Nurse Downing's flushing met the standard of care?
A It actually was above the standard. It only says that the IV has to be flushed every four hours. But that baby got seven -- I want to check it --
Q Yes, ma'am.
A -- well, seven flushes, I think in twelve hours. Seven flushes.
Q All right. And do you have an opinion to a reasonable degree of nursing certainty if Nurse Downing's actions met the policy expectation of The Regional Medical Center in regard to managing a patient?
A They actually exceeded them.
Q Okay.
A And let's see. (Reviews records) Sorry for the delay.
Q Take your time.
A Oh, okay. And this is why I say she exceeded it. Of

course, we've already talked about what policies and procedures are and how we're supposed to follow them. And let me just reiterate this too. These policies and procedures are going to be essentially the same as any hospital in South Carolina, North Carolina, all across the United States. And the reason is they're -- all the hospitals have to be accredited and they all have to meet the same standards. We actually expect the same care from anywhere we go, whether it's Orangeburg, Providence, the Mayo Clinic, that should be the quality of care. Okay. And this is how I say she exceeds it. Okay. This baby was getting -- of course, we already know, about seven flushes. She did it every four hours. But where she went through about every hour and did an IV check that we've gone through and talked about, she only had to do that -- let me read the policy. The phlebitis and infiltration scale is to be utilized to address IV site conditions a minimum of once per shift. That's all she had to do.

Q So wait a minute. Does that policy say she only needed it one time --

A Once a shift.

Q -- in twelve hours?

A Yes. Once a shift. That is the policy.

Q And how many times did she assess that IV.

A I'm going to have to count.

Q I'm sorry?
A That's all right. (Reviews document)
Q Well, I can show you. Is that easier for you? We did the 19:44, right?
A There you go.
Q We did 20:54?
A Yeah.
Q We did 22:05, 23:23, 00:37, 1:00 in the morning, 2:42, and 4:04, correct?
A That's correct.
Q And, again, according to policy she only needed to do one of those?
A One.
Q What does the literature say about IV complications?
A IV complications can be -- well, first of all, let's say local, like just right at the IV site. Sometimes they can cause problems all over the body, serious problems. On the hand, well, y'all know as much as I do now. We know swelling. We know leaking at the site. We know bruising or ecchymosis, phlebitis, those are the local things.
Q Okay. And are there other type of complications as well?
A There are serious complications. There's -- first of all pulmonary embolus, which is a blood clot that is throughout the body and goes into the lungs. An air

embolus, an air embolus is when somebody inadvertently gets air somehow into the venous system, serious, serious problems and those are catastrophic.

Q And I'm sure the other lawyers will show you these pictures when it's their turn. Do you have an opinion on whether or not the child's hand would have looked like that when Nurse Downing was caring and treating for this child?

A Oh, no. That's a healing wound there.

THE COURT: And that's Plaintiff's 3, I believe.

COURT REPORTER: You'll have to look at the little picture.

MR. TANNER: I'm sorry.

THE COURT: I'm pretty sure it's Plaintiff's 3. I have a fairly good memory for it. So we'll take -- unless y'all want to correct it we'll stay with 3, okay? I can call it up, okay? That's 1.

BY MR. TANNER:

Q What about Plaintiff's 1, would R.J.'s hand have looked like that before Nurse Downing -- I'm sorry. That's upside down.

A No, that's a healing wound.

Q I apologize.

A And what I would like, I'm not sure if anybody's interested or not. But actually, this picture would have been before the one you showed me first.

Q Okay.

A And the reason being, all that yellow stuff right there. He was getting mist therapy and that was to get all of that stuff off of it because that was preventing it to heal so that's why the mist therapy.

Q So this picture is actually after --

A That's correct.

Q -- and this would be more --

A Yes.

Q -- healing process?

A Yeah. See, it's already -- it's healing there. Yes.

Q All right. Any review of the documentation show that the phlebitis score prior to the infiltration on the night of October 27th was anything other than zero?

A No.

Q All right.

MR. TANNER: I beg the Court's indulgence.

THE COURT: Okay.

BY MR. TANNER:

Q Just a few more questions for you, Ms. Hurley, and then I'll let you go. Do you have an opinion to a reasonable degree of nursing certainty, most probably whether The Regional Medical Center acting through it's nurses, including Nurse Downing, complied with the standard of care in the care and treatment of [redacted]

A I do.
Q And what is that opinion?
A I think that Ms. Downing, who's a reflection of the hospital, did an outstanding job taking care of this baby.
Q Thank you very much for your time. Please answer any questions that Mr. Williams or Mr. Krell have for you.
A All right.

THE COURT: Mr. Krell, is she yours?

MR. KRELL: Yes, sir.

THE COURT: Okay. Mr. Krell, she's your witness.

MR. KRELL: Thank you.

THE COURT: Yes, sir.

CINDY HURLEY - CROSS-EXAMINATION

BY MR. KRELL:
Q Good afternoon?
A Good afternoon.
Q That baby is healing is your testimony, correct?
A Yes, sir.
Q Did that baby go into the hospital with any wounds to his hand?
A No.
Q When it left the hospital did it have any wounds to its hand?
A Yes, but we don't know what they looked like.
Q You don't know what what looked like?

A We don't know what his hand looked like when he left. I haven't seen any of those pictures. I'm can assure you --

Q You agree that's his hand. Is that normal?

A I do. It's a normal healing wound.

Q That's a normal hand?

A It's a normal healing wound. The wound is healing exactly like they expect it to.

Q What's the number one rule of nursing? Is it to do no harm?

A Certainly.

Q You talked about literature. When did you review some literature?

A After my deposition the other day.

Q That was about a month ago?

A I think it was a week ago, wasn't it to? Two weeks ago?

Q A week ago? And what did you review?

A I reviewed the article -- let's see. The Infusion Nurses' Society Infusion Therapy.

Q Okay.

A Intravenous Therapy in Children.

Q All right.

A Assessment of an Infant with a Peripheral IV, and Intravenous Extravasation Mechanisms Management and Prevention.

Q And the last one you mentioned is the article that you cited for blood return, correct? Checking for blood return?

A No, sir. That was the first one.

Q Okay. That's the - tell me which one it is.

A The Infusion Nurses' Society.

Q And what does that say?

A You want me to read it again?

Q Yeah. I'm a little confused.

A Checking for blood return or back-flow blood is not a reliable method for determining the absence of an infiltration. A blood return may not be present when small veins are used because they may not permit blood around -- they may permit blood around the cannula.

Q What's your opinion regarding how often the IV site should be checked?

A Every hour to hour and a half.

Q Is that what you testified to in your deposition?

A Well, I got confused there. You had me kind of nervous.

Q I did?

A Yeah. And I said the time was wrong. But when I looked at it, she was in there -- you had me thinking she wasn't -- I was wrong. But she was in there every hour to hour and a half.

MR. KRELL: Your Honor, may I --

THE COURT: You may.

MR. KRELL: May I explain to the jury what I'm doing now.

THE COURT: Yeah. And you can ask her what she said during the deposition. You might not need to even open it.

MR. KRELL: I'd like to.

THE COURT: Okay. Okay. Go ahead.

MR. TANNER: This is a transcript of the deposition I took of Ms. Hurley a couple weeks ago.

BY MR. KRELL:

Q Let me hand you this, Ms. Hurley. And I know you've got a lot of stuff. Would you like me to move any of this.

A This is my deposition? Oh, okay. I got you.

Q All right. I had you confused, right?

A You had me way confused.

Q Okay. Let's turn to page 72 in your deposition?

A Okay.

Q I think that's the right page. Excuse me. Page 71.

A Okay.

Q All right. And at line 20 I asked, So what's your opinion regarding how often a site should be checked? What was your answer?

A I said every hour to two hours and then I said an hour and a half.

Q Okay. What's the standard of the hospital for checking the site?

A Ever hour. I -- every hour. Every hour.

Q Every hour?

A Every hour, I think.

Q Okay. You think?

A Well, why don't we just make sure. I'd rather make sure. All right. If IV fluids are going and that would be -- we talked about in my deposition the buretrol, if the patient had a continuous IV, in adults it would be a bag and in a baby it would be a container with a smaller than that cup. Then you would check it every hour. And the reason you check it every hour is because you want to make sure it's not being infiltrated.

Q I'm looking at page six of nine, intravenous therapy, item thirteen. Is that what you're looking at?

A Yes.

Q This says, and correct me if I'm wrong, IV site is to be checked hourly and prn with appropriate documentation, correct?

A Correct. But that's because they're talking about IV fluids are going in that baby continuously. And this baby didn't have that. The only time he got medicine was every four to six hours, which would have been his ampicillin and his Claforan.

Q At the time of your deposition you had no idea about that, correct?

A I tried to explain that. We were -- we were not -- okay. Yes, we tried. I tried to explain that, that she was right. But then I got all confused.

Q I mean, you'd do anything to say this nurse was right; isn't that true?

MR. TANNER: Objection, Your Honor.

A You know --

THE COURT: Wait a minute.

A No, sir. That's not true.

THE COURT: Wait. Wait. You don't even need to respond. He doesn't need to ask it, okay? Thank you.

BY MR. KRELL:

Q You would -- in your deposition you actually said that these rules and these policies and procedures is the rule book of the hospital, correct?

A It's the rule book of health care, sir. I want to say something just so I can --

Q If you could just answer the question --

A I did answer the question.

Q I don't think you did.

THE COURT: Right now the only thing you can do is answer his question.

THE WITNESS: Is answer the question?

THE COURT: Yes, ma'am.

THE WITNESS: Okay.

THE COURT: I assure you that Mr. Tanner will follow-up. Okay.

THE WITNESS: Okay. Thank you.

THE COURT: Okay.

A Okay. I'm back.

MR. KRELL:

Q From where? Where are you back from?

MR. TANNER: Your Honor.

THE COURT: All right. Mr. Krell. That's okay. Just ask the questions. Just like she gets to answer them, you get to ask them.

BY MR. KRELL:

Q Is it appropriate to call the policies and procedures the rule book of the hospital?

A It certainly is. Yes, sir.

Q Is it appropriate for nurses to interpret these rules?

A Yes, sir.

Q They can interpret them in how they see fit?

A Well, they interpret them the correct way, I'm sure.

Q Okay. We've talked about this rule, and you can quote it. You've got the policies in front of you?

A Right.

Q Page five of nine?

A Right.
Q Flushing the INT with saline is to be documented on the MAR?
A Correct.
Q Was that done?
A Yes, sir, it was. Every four hours.
Q Was it done every time it was flushed?
A No, sir.
Q How do we know that?
A It's actually not protocol.
Q It's not protocol?
A No, sir, it's not.
Q Okay. Why does it say it on that document?
A It says on this document that it's to be documented every four hours and it was. And that's automatically -- like Nurse Downing was explaining to you, it goes automatically into the medication records so that they make sure that their IV gets flushed every four hours in case -- because a lot of times people don't have medicines.
Q Now, on the medical records it's done -- on the MAR, it's done every four hours?
A Yes, sir.
Q Now, when was the last flush prior to the administration of the ampicillin at 4:27 a.m.?
A (Witness pauses)

Q And I'm happy to provide you --

A I got it. All right. I'm looking for -- all right. 4:27?

Q Yes, ma'am.

A The patient got the ampicillin. She got one flush.

Q When?

A At 4:27.

Q Is it documented?

A No, sir. And it won't ever be documented. It's not protocol. When you give an IV medication it is part of the process. You get your supplies and you go in and you always flush it. You give your medicine and you always flush it again. That is just the way it is.

Q Prior to 4:27 when was the previous flush?

A The previous flush was at 1:04 a.m.

Q All right. Now, the way I read the record it looks to say at midnight. Does that say midnight on --

A Well, it didn't make much sense to give it at midnight because she had just had a flush at 11:44.

Q And so what time did she give it if it wasn't at midnight?

A At 1:04.

Q And how do you know that?

A Because she documented it.

Q Who did?

A Ms. Downing.
Q She documented it in this MAR that she gave a flush?
A At 1:04.
Q Okay. Have you read your deposition?
A Yes.
Q Do you have a copy of your deposition?
A I do.
Q Would you pull it out, please?
A Okay.
Q Would you look at line 17 and read 17 through 24, please?
A What page?
THE COURT: What page?
MR. KRELL: I'm sorry. Page 37. I apologize.
THE COURT: Page 37?
MR. KRELL: Page 37, Your Honor, lines 17 through 24 of Nurse Downing's deposition.
A Okay. 17 through 24. It's not a specific medication. It's the way MAR was set. So the IV had to be flushed at least every four hours with either saline or a medication. So it doesn't allow you to really document a flush. As a nurse you chart by exception, but to check an IV site you flush an IV, though it's not specifically in there, but that's how you assess an IV.
BY MR. KRELL:

Q You just read that it doesn't allow you to document a flush, correct?
A (Witness pauses)
Q Yes or no?
A I did.
Q You were here for Nurse Downing's testimony --
A I was.
Q -- this morning?
A Yes, sir.
Q Did you understand it?
A Yes, sir.
Q Okay. In regards to whether or not the jury's to believe your testimony based on the records or Ms. Downing's testimony based on being there, who would they be better off believing?

MR. TANNER: Objection, Your Honor. He's trying to pit the witnesses against each other.

THE COURT: Yeah. It does sound like pitting.

MR. KRELL: I'll withdraw the question.

A I will -- can I answer?
Q Sure.

THE COURT: No, ma'am.

MR. KRELL: Oh, excuse me. The Judge has to decide that.

THE COURT: No, ma'am. You cannot.

MR. KRELL:

Q Ms. Downing testified wasn't it, that that saline flush was given at midnight, didn't she? You heard her?

A I don't know. I don't know.

Q You don't know that she said it or you don't --

A No, sir. I don't know that she said it. I might have missed it if she did say it, but I'm not going to sit here and say that I heard it when I didn't hear it.

Q I show you a document that we've talked about throughout the year -- throughout the trial?

A She couldn't have. She couldn't have given it at 12:00.

THE COURT: You've already answered the question.

THE WITNESS: Okay.

BY MR. KRELL:

Q I just asked if that's what she testified to?

A And I said I didn't know. Okay.

Q All right. Tell us what that document is?

A Policies and procedures for infusion nursing of the pediatric patient.

Q All right. And who is it published by?

A (Witness pauses)

Q Is that the Nurses' Society --

A Yeah. Infusion Nurses' Society. Okay.

Q And that's the -- you quoted the Infusion Nurses'

Society document earlier. I don't think it's the same one, but the same publication, correct?

A Right.

Q Turn to page a hundred of the document I just handed you. It should be right --

A Okay.

Q All right. Do you see where it's highlighted --

A Correct.

Q -- at the bottom of the page?

A Correct.

Q All right. And it's under a section, correct, called flushing; is that correct?

A Correct.

Q Read that section for the jury from the pediatric -- it's a pediatric handbook, right? A pediatric --

A Correct.

Q It has to do with babies, right?

A Well, I don't know what I'm -- I mean, I'm not talking back or anything. I just don't know what I'm reading. This could be a twelve-year-old child or a fifteen-year-old child I'm fixing to read about, so --

Q Just go ahead --

A It says slowly aspirate until brisk blood return is obtained.

Q All right. Thanks.

A You're welcome.

Q One more question for you. How did the infiltration occur?

A There is very little way to know how that happened. There's a multitude of ways it could have happened.

Q Let's refer to your deposition when I asked you that question, okay?

A Right.

Q Let's look at page 77?

A Okay?

Q Lines 12 through 18.

THE COURT: 12 through 18?

MR. KRELL: Yes, sir.

BY MR. KRELL:

Q I ask, state, okay, how did the infiltration occur? And your answer?

A (Witness pauses)

THE COURT: That's where you read it.

A Oh, oh, I'm sorry.

BY MR. KRELL:

Q I'm sorry.

A You want me to read it.

Q I'm sorry Ms. Hurley, starting on line 13.

A Okay. Line 13.

Q I apologize?

A It's hard to say. There's a multitude of ways it can happen.

Q Okay. Do you have an opinion?

A And I said on how it was --

Q And I said how the injury happened?

A And I said, I have no idea.

Q Thank you.

MR. TANNER: Just briefly, Your Honor.

THE COURT: Are you through, Mr. Krell?

MR. KRELL: That's it.

THE COURT: Thank you.

MR. TANNER: Thank you, Judge.

THE COURT: All right. Redirect limited to his cross.

CINDY HURLEY - REDIRECT EXAMINATION

BY MR. TANNER:

Q Nurse Hurley, Mr. Krell had asked you something about the rule book, and I think you wanted to expound on that answer. Can you tell the jury what you wanted to tell them ???.

A These are rules, they're rules for all of us. But what you have to understand is that Ms. Downing did everything she was supposed to do. And I find offense because I know y'all are all well-read and you read the newspapers and as far as me doing anything to help a nurse -- the nursing

profession is the number one most honest and ethical profession there is and it has been for seventeen years. And there's not a nurse that would get up here and make up stories and tell stories. The only - and the second profession is military. So -- and I'm proud of that. So, no, I would never ever do that.

Q And just a few final questions. I'll show you what's been part of --

THE COURT: And, again, limited to his cross.

MR. TANNER: Yes, sir.

Q -- Plaintiff's Exhibit 4. He was asking you about the flush that's timed at 12:00?

A Right.

Q And I'll show you. This is page five?

A Right.

Q It says administration date and time, 10/28/2014, 0:00; is that right?

A Correct.

Q And then it says action details. Order Megan Bolton Shore 10/25/2014, 22:00. That would be the doctor's order, correct?

A That's right. From when the baby came in.

Q And then it says performed Jamie Downing R.N., Jamie D 10/28/2014 01:04, 1:04. What does -- explain to the jury what that means?

A Well, it just means that the reason she didn't give it at midnight was because the baby had an IV infusing at the time. It doesn't make much sense to go in there and --

Q And then it says verify Jamie Downing, Jamie D, 10/28/2014, 01:04?

A Right.

Q And so that's the computer time stamping when she gave that flush?

A That's right. It like I told you before. When you chart it's not like you can put things in there that didn't happen. When she wrote that she gave it. That time popped up because that's when she gave it.

Q So maybe she said she gave it at 12:00, but the record, the computer says she gave it at 1:04 a.m.

A She gave it at 1:04.

Q Thank you, Nurse Hurley.

A You're welcome.

THE COURT: Anything on recross limited to his redirect?

CINDY HURLEY - RECROSS-EXAMINATION

BY MR. KRELL:

Q Isn't it true you're getting paid two hundred dollars an hour?

A For today, yes, sir.

Q And how about before?

A A hundred dollars an hour.

MR. TANNER: Your Honor, I'd just object. This goes outside of my --

THE COURT: Well, it does. It does. But since you got to ask questions about that, I'm going to let him go even though --

MR. TANNER: Yes, sir.

THE COURT: -- but now everything else needs to be confined to his redirect.

Q So you just said that she entered it at midnight and it is at 1:04?

A No.

Q What did you say?

A It was on the MAR, the medication record to be given at 12:00.

Q Right.

A But she didn't give it until 1:04. She couldn't give it. The baby had an IV going at the time.

Q At what time? I'm sorry. I'm just confused.

A Well, let me explain.

THE WITNESS: What number was that, Mr. Tanner?

MR. TANNER: If I may, Your Honor.

THE COURT: You may?

MR. TANNER: TRMC 005.

THE WITNESS: Okay.

A I got it. This whole folder is the care that she gave that night. Everything in this --

Q Ms. Hurley.

THE COURT: Ms. Hurley. Ms. Hurley.

THE WITNESS: Sorry. I just want to --

THE COURT: I know.

THE WITNESS: I'm sorry.

THE COURT: And you have done a lot of --

THE WITNESS: I'm sorry.

THE COURT: You just need to answer his question, please, ma'am.

THE WITNESS: Okay. All right.

A So the IV -- the flush that we're talking about is the midnight flush. And the patient would have been receiving Claforan.

Q So at 12:00 when Ms. Downing testified she gave it, she just didn't know what she was doing or --

MR. TANNER: Objection, Your Honor. Mischaracterizing the testimony.

A Sir, I'm not going to answer why she said that. I don't know why she would say that.

Q But you agree she said it?

A No, I don't because I don't remember hearing it. And maybe they all did. Maybe everybody did but me.

Q All right.

A But it doesn't make -- it's not that - she couldn't give it. There's no way.

Q Thank you very much.

A You're welcome very much.

MR. TANNER: No further questions for Nurse Hurley, Your Honor.

THE COURT: All right. May she be excused?

MR. KRELL: Yes, sir.

THE WITNESS: Thank you, sir.

THE COURT: Okay. Thank you, ma'am.

THE WITNESS: Thank you, sir.

THE COURT: Is defense ready to call its next witness.

MR. TANNER: That is the defendant's -- we would rest our case at this time, Your Honor.

THE COURT: All right. Thank you. Appreciate it.

THE WITNESS: Thank you.

THE COURT: Thank you, ma'am. I know you've got a lot of stuff --

There's somebody's -- it's your deposition, the original deposition is right there. I just want to get it down.

COURT REPORTER: Yeah. All of our things are here.

THE COURT: Don't we need that, Mr. Krell. I'm

sorry. I think you need leave it with you if you don't mind. Thank you, sir.

(Off record discussion)

THE COURT: All right. Ladies and gentlemen, we've now heard --

Are y'all recalling anybody?

MR. KRELL: No, sir.

THE COURT: Okay. You have now heard all of the testimony in this case. There are some things I've got to take up with the attorneys. And let me tell you what my plans are, okay? It's going to take me a minute to do that. It's going to be kind of an extended break. And what my plan is is -- what we're going to do closing arguments, I'm going to charge you on the law and y'all will begin at least initially begin your deliberations late this afternoon, okay?

All right. Now, I'm going to let y'all go back in there. Remember, even though you heard all the testimony you cannot begin talking about this case until I tell you to start talking, okay? Thank y'all. Y'all doing real good. Thank you.

(Jury out at 2:52 p.m.)

THE COURT: Mr. Tanner?

MR. TANNER: Yes, sir?

THE COURT: Do you need to renew --

MR. TANNER: Actually, I need to proffer Nurse Hurley too.

THE COURT: Oh.

MR. TANNER: And I need to renew.

THE COURT: All right. Yeah, bring her back up here and we'll proffer that little bit of testimony.

(Court's Exhibit No. 3, deposition of Nurse Hurley, marked)

THE COURT: Nurse Hurley?

THE WITNESS: Yes, sir.

THE COURT: Be careful.

THE WITNESS: I'm going to be careful and I'm not going to tear anything up. I promise.

THE COURT: All right.

Ms. Hurley, go ahead and sit down.

THE WITNESS: Okay.

THE COURT: Okay. The purpose of this -- you were in here when we were talking about what you could testify and what you could not testify --

THE WITNESS: Yes, sir.

THE COURT: about? You were in here?

THE WITNESS: Yes, sir.

THE COURT: Okay. And you remember I told Mr. Tanner that since you weren't a lawyer you couldn't testify about negligence?

Q And what is that opinion?
A She absolutely was not.
Q And do you have an opinion to a reasonable degree of nursing certainty, more probable than not if TRMC as the employer of Nurse Downing was negligent?
A Absolutely not.
Q All right. And do you have an opinion to a reasonable degree of medical certainty -- nursing certainty more probable than not, if Nurse Downing was grossly negligent in her care and treatment of R.J.?
A Well, if she wasn't negligent she sure wasn't grossly negligent
Q And likewise then would you have an opinion if the hospital by and through Nurse Downing was grossly negligent in its care and treatment of [redacted]?
A My same answer, no.
Q So the hospital is not grossly negligent?
A No.

MR. TANNER: Nothing else from Ms. Hurley, Your Honor.

THE COURT: Mr. Krell, anything on cross.

THE WITNESS: Thank you.

THE COURT: Hold on. Whoa. Whoa. Whoa.

THE WITNESS: Oh, gosh.

THE COURT: Mr. Krell.

CINDY HURLEY - PROFFER CROSS-EXAMINATION

BY MR. KRELL:

Q Ms. Hurley, what's your definition of gross negligence?

A Actually causing a problem and knowing that you did it. Hurting someone intentionally.

Q Intentionally doing it?

A Uh-huh. (Affirmative response)

Q That's what gross negligence is?

A It is to me.

MR. KRELL: Thank you, Your Honor.

THE COURT: Okay.

MR. TANNER: Nothing further, Your Honor.

THE COURT: Okay. Thank you, ma'am.

(Off record discussion)

THE COURT: All right. Gentlemen, I appreciate you having your help in the back row, you know, Mr. Krell. Thank you for having Curley, Moe and Larry behind you, helping you. But unfortunately, you know, we're here, you know, to kind of work through this.

MR. KRELL: Yes, sir.

THE COURT: Okay. My question is -- okay, what I want to do is take a short break and then we meet back in the office and we'll talk a little bit about the charges and the verdict form, okay?

MR. KRELL: Yes, sir.

THE COURT: And you can bring one of them with you.

MR. TANNER: My renewed motion for directed verdict?

THE COURT: Oh, yeah. I'm sorry.

MR. TANNER: Do you want to hear it now?

THE COURT: Yes, sir.

MR. TANNER: Your Honor, now that we're closing the defendant's case, I'll renew my motion for directed verdict. The evidence as submitted by the plaintiff and all inferences thereof is not enough to go to the jury. Specifically, the issue of gross negligence. There's been no evidentiary proof. I would ask the Court to note my prior objection for the sake of the late hour and not having to reiterate that, but it would be the same argument that I made earlier now that we're at conclusion.

THE COURT: All right. And even though I've now heard the additional testimony from your expert, from the hospital's expert, there's still issues, factual issues that I believe that the jury needs to determine. And so I am going to deny your motion for a directed verdict. Okay.

MR. TANNER: Yes, sir.

THE COURT: All right. Y'all take a quick break and then y'all meet me back there and we can talk about the verdict form and the charge, okay? Thank you.

(Court in recess for short break at 3:05 p.m.)

(In chambers charge conference)

(Court in session after short break at 3:46 p.m.)

THE COURT: Okay. All right. Is the plaintiff ready?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: Okay. Is defense ready?

MR. TANNER: Yes, sir.

THE COURT: Okay. I'm going to put just a couple of things --

(Off record discussion)

THE COURT: All right. Mr. Williams?

MR. WILLIAMS: Yes, sir.

THE COURT: We had -- just to go back on the record. We had a conference in chambers about the charges; both the plaintiff and the defendant had -- took exception to my charges. What we have agreed to do is go ahead and do the closing arguments. I'll do my charge on the law and we'll turn the case over to the jury. And then we'll place those exceptions to the charge on the record so that it will be preserved. Is that correct, Mr. Williams?

MR. WILLIAMS: That's right, Your Honor.

THE COURT: Is that correct, Mr. Tanner?

THE WITNESS: Right.

THE COURT: But he's going to ask you about that anyway?

THE WITNESS: Okay.

THE COURT: Okay. But he's asking you that out of the presence of the jury.

THE WITNESS: Okay.

THE COURT: In case he wants to take my decision up to a higher authority, he wants to have it on the record so it'll be preserved, okay?

THE WITNESS: Yes, sir.

THE COURT: Okay. So, Mr. Tanner, she's all yours.

MR. TANNER: Thank you, Your Honor. May it please the Court?

THE COURT: Yes, sir.

CINDY HURLEY - PROFFER DIRECT EXAMINATION

BY MR. TANNER:

Q Nurse Hurley --

A Yes, sir.

Q -- based on your earlier testimony do you have an opinion to a reasonable degree of nursing certainty, more probable than not, if Nurse Downing was negligent in her care and treatment of [redacted]?

A And I do.

MR. TANNER: Yes, sir.

THE COURT: So are you ready?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: You want to say something else?

MR. WILLIAMS: No.

THE COURT: Okay. All right.

MR. WILLIAMS: Well, I do have something to ask Mike. We'll just make sure in closing I want to --

THE COURT: Okay. Well, you want to ask him now?

MR. WILLIAMS: Sure. Michael, is it going to be a problem with this event record that's been completed, highlighted if I'm just going to read this, site to be checked hourly and prn? Is that going to be a problem or do I need to block it out with a pen or something? I'm just going to read that to them.

MR. TANNER: Yeah, I know. That's fine.

MR. WILLIAMS: Okay. To make sure.

THE COURT: Okay. All right.

If the jury's ready --

MR. WILLIAMS: So we don't want her to wait and do the jury instruction stuff now or later?

THE COURT: No, we'll do it later.

MR. WILLIAMS: Okay.

THE COURT: I want y'all to go ahead and do the arguments and like that. Let them start deliberating

because, as I told you back there, I'm not going to change my mind

MR. WILLIAMS Got you.

THE COURT: But y'all are going to be able to get it on the record so that will be another thing that could go up and y'all can correct me on, okay?

(Off the record discussion)

THE COURT: All right. Bring the jury on in. Thank you.

THE BAILIFF: Yes, Your Honor.

(Off the record discussion)

(Jury in at 3:46 p.m.)

THE COURT: All right. Ladies and gentlemen, we are now getting down to the wire. Remember, I told you at the very first that after you hear all the testimony we'll do closing arguments, and then I'll charge you on the law? Right now we're getting ready -- what's going to happen is we're doing the closing arguments. Plaintiff will get up and make a closing argument. The defense will then get up and make a closing argument, and then the plaintiff will reply to that closing argument. After that, I will charge you on the law, okay? And then we will hopefully begin the deliberations but we won't really begin that because I've got to get some stuff on the record before we can start doing that. But, again, you cannot begin your deliberations

on this until I tell you you can start talking, okay? All right. You ready to go? All right. Mr. Williams.

MR. WILLIAMS: Yes, Your Honor. May it please the Court?

THE COURT: Yes, sir.

PLAINTIFF'S CLOSING ARGUMENT

BY MR. WILLIAMS:

Ladies and gentlemen of the jury, I thank y'all for your patience. Y'all have been a wonderful jury, patient with everybody in this case. Like he said, it's going to be a pretty short case. Then again it's a pretty simple issue.

Our issue is did the nurse at The Regional Medical Center fail to flush? That's the case, right? That is what we're here today about. That's what we've been talking about. That's what we hired an expert to do, okay? And, you know, you've heard this, this case, you know, a football game, right? Playing the football game and you're receiving on the fifty yard line. This has turned into a kind of Carolina Clemson game where the fans are throwing bottles at the players along the way. And, you know, but the fact remains, the evidence is pretty simple. You've got an opinion, what caused it. And on the other side, you've got no opinion. I don't know. That's what everybody's saying. I don't know, okay? So if that ball's on the fifty yard line and you've got a clear opinion of what caused this is

that they didn't flush the IV that lead to this young boy's hand ending up damaged. Now, whether this is what it looked like right then and there or whether it was later, we'll talk about that. But that's not the issue. And it's easy to get distracted from the issues, right? I mean, you want to do a good job as a jury so you want to hear all the facts and understand how to apply these things. But let's not get distracted. The issue that we're here today is to talk about rules. What were the rules? You heard what the rules were. You heard what the conclusion was, that there was a willful breaking of those rules. You've heard the nurse say I'm not allowed to interpret these rules, okay? And I wanted to be as polite to her as possible. You know, I feel sorry for the nurse. You know, it's a rough spot to begin, to become a professional and here you are, you know, three times a week -- she's probably been there two weeks according to her testimony, so ten weeks, you know, she'd been in training. Her first two weeks -- within her first six days roughly, you get put in a position to deal with something like this. And I feel sorry for her. I really do. But she's not who we're talking about. We're talking about The Regional Medical Center. We're talking about how they've got this young girl trained, but she's told -- I can't interpret these rules. These rules, no room for interpretation. But then right after that she say I

interpret the rule to say this. That's a problem. That's willful, wanton, disregard to what you're told to do by --

MR. TANNER: Your Honor, I object to any characterization, willful, wanton.

THE COURT: Well, I'll note your objection on the record. Go ahead.

MR. WILLIAMS: Sure.

THE COURT: Thank you, sir.

PLAINTIFF'S CLOSING ARGUMENT CONTINUED

BY MR. WILLIAMS:

Yeah, it's a very -- like I told you earlier, it's a wonderful thing that we have this jury system. It's what creates this democracy where we, we make allegations against the government, okay? We can make these allegations and we have a right to be heard. The court gives us that right and you get to make the decision where the government gets to bend the rule, where they get to say well, the rules are there, but we interpret them differently.

Well, you heard their expert who came up here and said well, I said this in the deposition but you tricked me, you know. I got paid. My attorney -- the attorney for the government came and gave me new material, told me what I needed to say because what I said in my deposition wasn't what I should have said. So I'm going to come in and say well, these rules fully apply if you giving, you know, an IV

thing, you know that IV you hang up. The first sentence of this rule, it isn't just for continuous medication, the rules, continuous or intermittent. What does intermittent mean? It means not continuous. It means the occasional administering of the medication. But I didn't like that I said these applied. I didn't like that I said well, they can be interpreted. But I can come in and be held accountable for not doing the things it says do. Not flushing properly, not inspecting the IV site every hour. Her testimony was she made seven inspections over twelve hours. The site needs to be checked hourly and as needed with appropriate documentation, okay? She testified seven, that's beyond the standard of care because, you know, you only -- is once. Because I'm going to reinterpret these rules because I'm the government. Well, you know what? They don't get to reinterpret this. They don't get to say that this doesn't apply. They have to abide by the flushing with the saline. It's to be documented in the MAR. You've got to. You don't have a choice. It's supposed to be documented. But you heard the nurse, the system won't let me document it. The system that I'm required to do, The Regional Medical Center doesn't even give me the tool to do what you say I've got to do. I'm not going to interpret this, but I'm going to interpret I don't have to do that. And, you know, I'm somewhat with her. When your boss tells

you you got to do something, but then doesn't give you the ability to do it. When they tell you these are the tools you use but here, I'm going to put this tool over here so use what you got left over, okay? What that is, is that is failure to provide this patient safety that she's sworn to do, that The Regional Medical Center's sworn to do, is to do no harm. Do no harm. Had she flushed -- you heard our expert -- we wouldn't be here today if she'd flushed properly and realized that this area was infiltrated. You heard her testimony, you know, she -- to me she said, you know, that it was a zero all through this, up until this injury occurred. No, the injury didn't look like this and like this at the time that she first noticed it. But this injury came from something at the highest it's ever been on a zero to five scale was a one, okay? Nobody attempted to do anything, other than put, you know, compress on this, okay? I have a hard time believing that if a five is worst case, a zero is best case, that this is a zero at the time this drug was administered. And at the end just a one, okay?

You heard my client explain the details of what she experienced. She was teary and you know, moved me to the -- how to explain that. And I think one thing, a poor mother's sitting there begging for help with a screaming baby. A screaming baby in her lap. She's pressing the call button.

I've got my baby being burnt. I don't know what's happening. I don't know that my baby's burning right now, but I've got my baby in my arms, screaming. What do you do with that? You know, you're at the hospital and you hit the call button and you can't get anybody. You would expect when you hit that call button you're not waiting -- you certainly expect when this happens they don't make you wait until the next morning to see the doctor. Why do they make you wait until the next morning to see the actual doctor? This issue is so clear in Exhibit 4.

You're going to get this. And I'll tell you I don't know how -- there's this big stack of documents. There's really only a couple of pages that are important. But sure they want to talk about the things early on that were done to distract you from the main issue. The main issue being that the record clearly says that it was administered, the flush, at midnight. You heard the witness say it. I made a point of it. It was the last point I made with that witness that it was administered at midnight, not before, not after. In fact, the witness went on unquestioned to explain why it read what it did. She said I have an hour to enter in the record and so I entered it later. I just want to reference you the exact document, TRMC 005. It's going to be the fifth page of. And you're going to see all of these things where it says administration date and time. It's going to

say administration, date and time. It's going to say zero all the way across. You're going to see charted date and time. That should mean when she got around to entering it in the system. Charted date, time, doesn't mean that's when you did it. Administration, the pumping of the saline into that tube is when you administered. There's nothing -- this is the MAR, the medication record, okay? This is the document though that she said, okay? She's the one that did it.

If there's anybody that's going to interpret this, it should be the one that did it, and why she did what she did, not an expert that's paid to tell you. Now, what I did, especially from my colleague here, it's our duty to try to keep our cool because we don't want this -- this isn't about us. This isn't about him. This isn't about me and as frustrated as we want to get, as mad as we want to get when somebody says something we don't agree with, it's not for us. It's for y'all and these witnesses. It's for y'all to determine between the defendant and plaintiff's, okay? But you heard this witness go over this colloquy about why you should believe her, because she's the most honest profession, etcetera. Why would she say that? That's like the guy that comes to you and says I'm not behind it, but let me tell you something, okay? When you start -- if you've got to start what you're saying with I'm not lying to

you or scouts honor or, you know, I've joked with another here but one attorney got up here and says officer of this court, Your Honor, and they go ahead and explain a total lie, which was all proved out --

MR. TANNER: Your Honor, I'd object. This is outside the scope of any evidence that's been permitted about some story about a lawyer standing up here, it's improper.

MR. WILLIAMS: It's just using it as an example. I don't think it's improper but I'm happy to move on.

THE COURT: If you'd just move on please, sir?

MR. WILLIAMS: Certainly.

THE COURT: Thank you.

PLAINTIFF'S CLOSING ARGUMENT CONTINUED

BY MR. WILLIAMS:

She went on to say that she's telling the truth. That the nurse is wrong, but I'm right because I know what this means, not the nurse who did it. And that's a problem. If the nurse didn't know, it's a big problem. But you know what y'all need to realize is we're giving the benefit of the doubt. We didn't create the record. We didn't get to offer anything in these documents. We didn't get to make up any of these policies or procedures. This is all The Regional Medica Center's documents. They entered this. This is even assuming that they're not lying in any of their

documents. This is assuming --

MR. TANNER: Your Honor, the characterization that Mr. Williams is making, there's been zero evidence that any document ha been altered, amended, fabricated. It's completely improper.

THE COURT: And I would caution you. These are the hospital records. I heard the word lying in there. And I didn't know what that was -- what you were getting at with that.

MR. WILLIAMS: Sure.

THE COURT: But those are the hospital records and there hasn't been anything about them being different, correct?

MR. WILLIAMS: That's what I'm saying.

THE COURT: Oh, okay.

MR. WILLIAMS: We are arguing that they are, in fact --

THE COURT: Those are the records of the hospital.

MR. WILLIAMS: -- the records that are accurate.

THE COURT: Okay.

PLAINTIFF'S CLOSING ARGUMENT CONTINUED

BY MR. WILLIAMS:

And the important thing about that is, is that record says that these policies and procedures were violated, okay? You, our safety judge, you're the one committee designed to

protect Orangeburg County by deciding whether or not the safety rules were broken. I would argue that you need to look at it and I hope you realize that not only was it broken but it was a known rule. It was a rule that everybody testified, until the last day witness, that we are required to abide by, but then we breached that rule and we know we breached it.

You heard from Peter DeVito. You heard about these continuing issues potentially that -- this is from the teacher. This is the one who taught Mr. Davis. This is the one who wrote the rule book. He talked about the pain and he talked about the tightness of that skin. He used that explanation where he describes -- I mean, there's just nothing there to work with and how that's going to affect this child, both physically and emotionally. And you heard from Mr. Davis in his direct he said certain things. In his cross he admits it's a permanent injury. This is something this kid's going to wear the rest of his life. It isn't getting any better. There's surgeries you can do. There's things we can do to try to mitigate it, but it isn't going away. It's always going to be there. You heard that he's emotionally traumatic -- this is emotionally traumatic. The idea of injecting more medication into those sites, that's emotionally traumatic to a child. We grow up with a mother, with a dad. We, you know, parents, we swaddle our kids.

You know, that touch, that caring, that love from day one. That's what you get as a child, hopefully, okay? Mama doesn't want to go to stick her child who's already had this experience with needles, cut him open, modify it. But that doesn't mean she doesn't have a right to recover for it to do it later. But she doesn't want to do it when her child's three years old. She doesn't want to do it when her child's one, two. This child was thirty days old. Their witness thought this child was, I think, nine days old, which is not right. The child was thirty days old at the time. The child was one month old.

You heard from Cynthia that the witness -- that the nurse hadn't seen anything like an infiltration like this before. I heard it. I hope you heard it. You heard that the computer keeps accurate time. Well, if it keeps accurate time, what populated 00:00 as the time of the flush, okay? That can't be manually entered. Why is that in the medication record? You heard her say that catheter was intact. And I don't know where that example is, but it wasn't damaged. You heard all this testimony about all of the things that can happen. The tube can be bent and the needle can be crimped that can cause this problem, but she said the catheter was intact. It's not that. She doesn't know what it was. The reason she doesn't want to know what it was because it's obvious what it was, a failure to flush.

We begin with a young child that for a lengthy period of time -- and this is from their expert's witness -- this wasn't right after. Why I know this wasn't right after, because all of that had to be scraped off, get off the dead tissue. That mother had to take her child to the doctor, to wound care center, while they scraped all this stuff that's this color off, okay? I don't think anybody has to be a rocket scientists to know how painful that probably was, but that's what her child went through. This is a healed -- and healing of what she used. Healing wound. That's progress. That baby because of that progress is going to live -- and I don't have that other exhibit. I'll go get it in a second. But this one is bigger and it's not much different. But that baby's going to live with something like that for the rest of his life. He's going to be like Paul.

MR. TANNER: Your Honor, I would object to Paul. Again, it's a matter not in evidence not involving this case not before the jury.

THE COURT: I note your objection.

PLAINTIFF'S CLOSING ARGUMENT CONTINUED

BY MR. WILLIAMS:

He will wear this scar for the rest of his life and he's going to deal with emotional as well as the physical consequences. The physical consequence is bad, but this is the most important thing, that emotional consequence. I'm

going to ask you for a big number. I'm going to -- the defendant gets to respond but you've heard that number where sure, will admit that it's more than a hundred thousand dollars in actual damages. It's much more than that. You're going to hear about that.

This isn't just a physical injury. This isn't a minor scar. It's the emotional part that we really care about. And, you know, some people don't realize. This case has got two different lines. There's a line you're going to fill out for mama and there's a separate line you're going to fill out for baby R.J. And that money for baby R.J. is protected by this Court. That's baby R.J.'s money. So understand that and when I tell you the difference between the two, I hope you'll give us your time.

You've been so patient. Just a little bit more. Just going to look at this and you got to come to a conclusion, but I think that football is in that end zone. It only has to be an inch past it, but I think it's in the end zone. I hope you see that too. Thank you.

THE COURT: Mr. Tanner.

MR. TANNER: Thank you, Judge Dickson.

THE COURT: Yes, sir.

DEFENSE'S CLOSING ARGUMENT

BY MR. TANNER:

Thank you ladies and gentlemen of the jury, obviously

going to ask you for a big number. I'm going to -- the defendant gets to respond but you've heard that number where sure, will admit that it's more than a hundred thousand dollars in actual damages. It's much more than that. You're going to hear about that.

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THE COURT: Mr. Tanner.

MR. TANNER: Thank you, Judge Dickson.

THE COURT: Yes, sir.

DEFENSE'S CLOSING ARGUMENT

BY MR. TANNER:

Thank you ladies and gentlemen of the jury, obviously

we've done a lot in two days. Thank you for your service.

Like I told you before, there's certain things that are going to be in contention. One of those things is that there was an IV infiltration. No one's disputing that. None of witnesses are disputing that. Again, what I did hear Mr. Williams in his argument was talk about the standard of care. And later on, Judge Dickson's going to charge you what the law is. You are the finders of the fact. He will give you the law to apply to those facts.

I can't predict the future, but what I think he's going to charge you on is the standard of care. And what is the standard of care? It is that care in which a nurse in the same or similarly related situation should have employed. And you heard from Nurse Jamie Downing, who came here of her own free will and testified and told you what happened. You've heard from our expert, Cindy Hurley. The plaintiff wants to characterize we have an expert and we pay our expert. Somehow that's bad or nefarious, but he did the same thing. They've got Nurse Stobbs who, again when you look at the two of them -- recall how they were qualified. Nurse Stobbs was qualified as an expert in general nursing. What does that mean? Well, I'll tell you what it doesn't mean. She's never practiced clinical pediatric nursing. She's never started an IV on a child. And more importantly, the issue in this case, she's never maintained, managed and

monitored an IV. She is not qualified.

Judge Dickson will probably give you a charge on when you have experts with competing opinions.

Think for yourself. You know the good thing about our jury system is you bring in your experiences. You bring in your background. You don't leave them at the door, your common sense. And, again, y'all have paid attention this whole time, and I'm counting on you to keep paying attention throughout this process. But think about it, you have one nurse who's never been an expert before, Ms. Stobbs, who's never practiced in this area. She can't tell you what pediatric nursing is. She can't tell you what the literature is. She wants to make kind of flippant comments during my examination and during the plaintiff's examination about the age of these articles and how oh, they had to go twenty years and fifteen. She'd been a nurse for over thirty-three years and guess how many pediatric IVs she started? The same amount as me, none. But what I have done that Nurse Stobbs didn't do? I've taken the time to read the articles. You'd think your expert would read the article so you'd know what the issues are. She didn't do that. She said over and over again you can get blood return on a 24 gauge needle. Yet you heard the people that are on the front lines that practice pediatric clinical nursing and what did they say? You cannot get blood return. More

importantly, not just what they said, what does the literature say that Ms. Stobbs agreed is authoritative in that field. You cannot get blood return on an IV that small. Period. End of story. She can say all she wants that a vein is a vein is a vein. Again, y'all have common sense. Y'all have experiences. I'm sure many of you have children. You can recall onto your children. We all have different anatomy. Yes, we all have arms and legs. We all have internal organs, but they are clearly different from a pediatric patient to an adult patient. Nurse Stobbs completely dismissed that. Yet, again, all the articles, all the literature, when confronted she has to say that is what they said. Okay, again, this is not Michael Tanner writing the text book. And Ms. Stobbs wanted to argue and say she disagrees. Well, where's her textbook? She hasn't written one because again, she has never done this the first shift in her life.

Plaintiff improperly characterized how long Nurse Downing worked. She wasn't here two weeks or a few days. She testified she had been here for about three months. She started orientation in August. She was off orientation when this happened in October. She had started hundreds -- I believe she said between fifty and a hundred IVs before this had happened, which, again, is a lot more than Nurse Stobbs who, again, has started zero.

The reality is, is an IV infiltration is unfortunate. I'm not here saying that it's not. I'm not here saying that this child wasn't injured. What I am saying is Nurse Downing and the hospital did not breach the standard of care, because an IV, as the literature said, which, again, Nurse Stobbs either chose to ignore or chose not to be informed in the first place and has a lack of experience. The unfortunate reality, the data compiled is twenty-three to seventy percent of IVs will have an infiltration. Now, I don't know how you have data -- have a report without any data. So she can say that you're not reporting but you have to have a report to have the data and that is what the data is. That's what the literature said. Again, that's not me getting up here and standing and saying, I think that it's twenty-three to seventy-eight percent. That is the literature recognized in this field. She doesn't like it because it's contrary to her position, but that's the reality.

I think Judge Dickson's going to charge you on gross negligence. And that's important because gross negligence in our state is the failure to only use slight care or the intentional doing of an act in which you should not do it. You heard Nurse Downing. You heard, you saw her -- you saw everything she talked -- came in and told you that she did on her assessment. She would check the site. She would

check for swelling. She would check for signs and symptoms of infiltration. She did that numerous times. She complied with the policy. Part of the issue in this case is the plaintiff frankly completely misreads this policy. And you heard from Nurse Downing and you heard from my expert -- again, they don't like what you heard because, again, they're expert didn't bother to do her homework and read. There is a different -- in this policy if you have continuous IV versus an INT. And that's what this child had. He had an INT. He was not getting continuous fluids. Again, think about your experiences in seeing IVs and seeing things on television, you have an IV machine that's hooked up to you. In this case, all this medication was administered through a syringe pump. You heard those witnesses say that. You heard the facts of what Ms. Downing did. And I tell you, I think when you look about that you'll certainly agree that's not just slight care, that's more than slight care.

And at the end of the case I'm going to ask you to return a verdict in the hospital's favor because the plaintiff has the burden of proof. And the plaintiff has to prove that the hospital was grossly negligent. And I do not believe the evidence shows that.

Again, we haven't heard them say anything about standard of care. They want to mischaracterize the

policies. Ms. Stubbs wants to be ignorant of the literature and you can't do that. This is just as important today for the hospital as it is for Ms. Hamilton, as it is for R.J.

Again, I haven't stood here at any point during this trial and said he did not suffer an infiltration. But an infiltration, unfortunately, is an inherent risk of the policy. No one wants him to have this injury. I don't want him to have this injury.

You heard from several doctors. You heard from Dr. DeVito who, again, that there was a huge gap between 2015 and then 2018 when he rendered any treatment. Ask yourself why is that? What happened in that time? Well, Dr. Davis saw the child after the court appointed him to do an independent medical exam and said thankfully, R.J. doesn't have any functional loss of his hand. He can do the things that a normal child can do. He'll be able to do the things that a normal adult can do. But then all of a sudden, there's another trip to Dr. DeVito, three weeks before trial. Yet, there's no trips for all these years. Dr. DeVito recommended back in 2015 that these injections be undertaken. And why did he recommended that the injections be undertaken, to try to lessen the scar, to try to help R.J. and his burn wound. Dr. Davis testified to the same thing. I know it was sort of an awkward way to deliver it, reading the deposition, but that was his testimony, sworn

testimony under oath, and it was his opinion that if he had had these injections back then, the scar would have been flatter and it would have been softer, just as Dr. DeVito said. You heard Dr. DeVito say if they had done this Derma Jet it would be an improved scar by now.

We're not saying that it wouldn't have happened. What we're saying is, it's not Nurse Downing's fault that this happened because Nurse Downing did not breach the standard of care. That's what you have to remember when you get that instruction. What does the standard of care say and can they prove by a preponderance that she breached the standard of care by acting in a grossly negligent manner, which I submit to you under the law, they don't have the evidence for that.

Nurse Downing monitored his IV. She assessed his IV. She charted his IV. You're going to see -- you're going to have the records. You're going to get them all. And, again, like Mr. Williams said there's really not a whole lot of pages in the chart you have to look. But one thing is, the computer is accurate. And when you look at that Exhibit 4 and you'll see TRMC page five like Mr. Williams wanted you to see. And what did the witnesses testify that took the time to read the policies. Not Ms. Stobbs who has a website that says I help you win. She wants you to win. She doesn't want to know the truth. The truth is these flushes

that are listed on the MAR are the every four-hour flushes. Nurse Downing testified numerous times whenever she gave that medicine she flushed it. There is no other flushes in here, other than the four-hour flushes. That's the reality. They may not like it, but that's the reality. And so when this flush pops up and says 0:00, what does the computer say? Performed, Jamie Downing 1:04. That's when she did it. She can't get in the computer and manipulate. Again, Nurse Stobbs doesn't understand that. She just sees it for what it is. It's right there in the document. That is a four-hour flush. You heard Nurse Hurley say the reason why it wasn't given is because this medicine was infusing and it had to over from 23:44. It's a twenty-minute infusion. There wouldn't have been enough time for her to do that, which is why it was done at 1:04 because she had already flushed that medicine before. The catheter was intact and that's important. Just because the catheter wasn't intact doesn't mean that this IV didn't infiltrate. And the reality is no one has an explanation for why it infiltrated. IVs go bad. It's unfortunate. All of the witnesses have testified to that. But, again, they have to show that there was a breach of the standard of care and that Nurse Downing was grossly negligent when she failed to use slight care. That young woman is not a woman that's going to fail to use slight care and come from Greensboro, North Carolina and

tell you what she did. I couldn't have made her come here if I wanted to. I don't have any subpoena power outside the state. She came here voluntarily to be with you to tell her what she did. To tell her how she cared. What did she say? She volunteered in high school. She wants to be a nurse because she cares. Again, think of all her certifications and think about their expert. My witness is more qualified to be an expert. My expert is certainly more qualified to be an expert.

They could have got a true expert. Ask yourself, why don't they have a pediatric expert? Why don't they have an expert that was qualified for monitoring and managing pediatric IVs? Is it because they couldn't get one? Again, use your common sense. Think about that.

You know, I don't know what Ms. Hamilton's plans are for her son. And I suspect they're going to -- this is the last you get to hear from me. Mr. Williams gets to come up and give you another argument, but I only have this one shot. You know, Ms. Hamilton testified, and I certainly empathize for her, knowing what's happened to her child. She doesn't have any plans to have the surgery. She doesn't want to do the steroid injections, even though the doctors say that they would work. Although she had other trips to Charleston with him, ask yourself why wasn't this all sort of done at the same time.

Again, Dr. Davis and Dr. DeVito said if it would have been done earlier maybe he wouldn't have ever known it. Maybe we wouldn't be here right now. We don't know because it wasn't done. But what we do know is that Nurse Downing has come in here and testified to what she did. And she's told you that she would not administer medication without first flushing. She has not denied that. That has been her story from day one, because it's the truth. And if it's the truth supported by Cindy Hurley based on the literature, based on the fact that pediatric patients are not just merely little adults. Based on that's the unfortunate we live in is that IVs go bad and then they infiltrate. Again, there is plenty of data that shows that. And all of that shows that The Regional Medical Center and Nurse Downing were not grossly negligent and certainly administer slight care. And you've heard Nurse Hurley say care that exceeded the standard of care.

So, again, you're not going to be able to hear from me again. But I want you to take your time. Review the evidence because it's not what the lawyers are up here say. Review what you heard from those witnesses and render a verdict in favor of the hospital.

THE COURT: Thank you, Mr. Tanner.

Mr. Williams.

MR. WILLIAMS: Yes, Your Honor, may it please the

Court?

THE COURT: Yes, sir.

PLAINTIFF'S REPLY CLOSING ARGUMENT

BY MR. WILLIAMS:

Opposing counsel argues that I haven't talked about the standard of care, that I haven't talked to you about the do no harm requirement, the nurses that are -- I haven't talked to you about the rules, which his expert says, not only are these the standards here, they're standards everywhere, whatever state you're in. These rules are the standards. So not to interpret these rules, and showed you this, which says this applies to IVs, not INTs. Protocols for INT flushes. If this applies only to IVs and not INTs, I mean, I don't know how to interpret that. If that's what the government wants you to do is reinterpret that, because these only apply. That's page five on nine, one of nine, continuous or intermittent. Continuous or intermittent. I don't know how you interpret that any way different but he wants to say oh, we haven't told you what the standard of care is in this case. And our expert's just -- you know, she's just a waste of time, waste of money, waste of effort because just doesn't know what she's talking about, because she hadn't read all these manuals. Our expert said I didn't read until last week, after my deposition and I was provided them last week. The nurse, I never read those. If they're

required to know what to do is to read those, then nobody knew what to do. Not a single person in this room knew what to do. But that isn't the case.

This case is about one standard of care, really. And the one standard care is the flush. Why is the flush standard of care? Because if you did the flush, it would show where that medication is about to go. If you did the flush, you would assess the site. I know their expert said you only got to do it one shift, but the flush, the idea of the flush is if it gets outside the vein, as well as that puffiness, she said cool touch, etcetera, etcetera, but you can see right there rather than in the vein it's all right there. So I don't need to give this burning medication that I know is corrosive and it's going to heat up in that hand if I give it. And that's why that's the standard of care. And then only person who says no one can explain why. There was an expert who's been at the number one hospital in the country, then at another top-ten hospital who says it's clear, you know. There's only one cause. You didn't flush it. Didn't abide by that standard of care. The gross negligence issue, the Judge is going to charge you. But that's when you say you can't interpret these, all these things. And it clearly says that it applies to intermittent fluid. It clearly says you're to not only flush it, but document when you flush it. Then it says you're supposed to

do it a minimum of four hours and the medical record says you didn't do it? That's gross negligence.

You've heard a lot of testimony in this case. At the initial outset of this case the Judge told you, short plain statement of facts. And then he went into evidentiary and he started talking about this twenty-three to seventy-eight percent of IVs infiltrate. Twenty-three to seventy -- just understand, twenty-three to seventy-eight percent of IVs infiltrate. That's saying that two to almost eight out of ten -- two to eight out of ten people that go to that government hospital that's supposed to be the same, according to his expert, as MUSC as the Mayo Clinic, as good as Duke, Harvard, it's supposed to be just as good. That's what we're supposed to have here in Orangeburg. That's the standard of care, she said. But his interpretation, the government -- The Regional Medical Center's interpretation is the standard is oh, two to almost eight people out of ten are going to have infiltration. That isn't what this document says. That is not what this document says. And it's scary if they think that's acceptable, that that's an acceptable potential risk, because this document says infiltration is the most commonly identified complication of PIV therapy, okay? Complication. Let's first understand that. You don't expect two to eight out of ten IVs to complicate. But if they did complicate -- what this is

saying is the reported incidence is between twenty-three percent to seventy-eight percent at different hospitals. So the hospitals that report the complications from PIV treatment, of those, some of them have twenty-three percent of infiltration, some have as high as seventy-eight percent. That doesn't mean that you've got a seventy-eight percent risk of going to the hospital if you get an IV and it infiltrated and burning a hole in your hand. That doesn't -- or it infiltrated period. That's not what that says. But that's how it has been interpreted. That's how the government wants to treat you. They want to tell you that this is going to be an IV, not -- this doesn't apply to INTs because it's got to be an IV for that to apply. They want to take that and reinterpret it for y'all.

And I know, yeah, you do need to use your common sense. You're from Orangeburg. You understand Orangeburg and you certainly understand some basic -- what the attorney says and the witness says, you can't really interpret that.

And I'm sorry for getting flustered but this case is clear. This case is about R.J. And this case is about Tekayah. And they've got significant damages. And I've got terrible handwriting and I apologize but I'm going to just run through the damages of this case so you can understand. So Tekayah, I'm going to just put T.K. TRMC bills that have been submitted, four thousand six hundred and ninety-nine

dollars. Dr. DeVito -- and I understand that's assuming the care after this incident happened, right? That's the care -- we've got this additional care, six hundred thirty-five dollars. The teacher, you know, that he wants to say well, -- he charged a whopping six hundred thirty-five dollars to try to provide this woman some help. Future surgery though, you heard him say twenty-five hundred dollars is what his bill is. But at the time, which he says goes up, and this is a minimal, twelve thousand dollars for the hospital charge. A thousand twenty dollars for the injection. Mama's cost, twenty thousand eight hundred and fifty four. That's what mama's cost is associated with this. It's not going to fix it, dealing with the trauma, he'll certainly deal with it the rest of his life. He's going to deal with this emotional injury, this emotional injury is going to be something that he's going to carry with him the rest of his life. When he rips a baseball bat at T-ball, and he's going to feel that skin tight. When he goes and decides to pick up a golf club, he's going to feel that get tight. If he decides to pick up a rake and rake a yard of leaves, he's going to feel that. When he goes to shake your hand, he's going to be sticking it out there in front of everybody, okay? What is that worth? You know, and another thing I told you, you've got to think about this emotional element. That's -- that's the worst part of this whole deal. I mean,

what's it's worth the past twelve hundred eighty-nine days, how long it's been since this incident? What do you get for those days? He's got seventy-three point seventy-six year life expectancy. The Judge is taking judicial notice of his life expectancy, and he's going to charge you how to calculate something or what you can do, the tools you can do, and he's going to tell you that it's up to y'all. But seventy-three point seventy-six years is twenty-six thousand nine hundred and forty days, okay? If you were to give him a hundred dollars a day for his loss of enjoyment of life, and a hundred dollars a day for his pain and suffering the first one thousand two hundred eighty-nine dollars, that's about two hundred and sixty thousand dollars. That's a hundred twenty-eight thousand dollars -- nine hundred dollars for pain and suffering and that's a hundred and twenty-eight thousand nine hundred dollars for loss of enjoyment of life. And it's hard to conceptualize this stuff, you know. But you're the judge of the facts. You're the judge to determine what's appropriate. If you would give him fifty dollars for the rest of his life for this permanent disfigurement, that number is one point three-four seven million dollars. That's one million six hundred and four thousand eight hundred dollars. If you were to give him twenty-five dollars a day, that's six hundred and seventy-three thousand five hundred dollars for a total of

nine hundred and fifty-two -- well, scratch that. I've got the wrong page there. Do you have that total for -- yeah. You can do the math. It would be, yeah, somewhere around nine hundred and fifty. Six hundred and seventy-three plus two sixty. It would be somewhere around nine hundred and fifty thousand dollars.

This is what you can do. This is what I think you should do is put a per day value on this, for the living with the physical, the pain, the issues that's going to effect him, the loss of enjoyment of life. When he grips a baseball bat and grabs a rake, and shakes the hand, and takes a picture, this is what you get. It's only the value it is to put something -- there's some value per day. I don't know if it's twenty-five dollars; I don't know if it's fifty dollars. Mama's easy, simple. Her cost associated with this. That's her's is. But R.J., it's a separate line. It's a line that's designed to go to this court, to handle appropriately for both this -- for all of. This, scraping that dead tissue off and wearing this for the rest of his life. I appreciate you. Thank you. You've been a wonderful jury. Thank you

THE COURT: Thank you, Mr. Williams.

COURT'S CHARGE

All right. Ladies and gentlemen, you've now heard the arguments of the attorneys. It is now my turn to charge you

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THE COURT: Thank you, Mr. Williams.

COURT'S CHARGE

All right. Ladies and gentlemen, you've now heard the arguments of the attorneys. It is now my turn to charge you

on the law of this case.

The plaintiff, as Guardian ad litem and parent of [redacted]., claims that her child has been injured by the actions of the defendant, Regional Medical Center. In bringing the lawsuit plaintiff claims that the defendant should compensate her for her minor child's injuries.

You and I have certain duties to perform. As the trial judge, it is my responsibility to preside over the trial of this case and to rule on the admissibility of the evidence offered during the trial. You are to consider only the evidence before you. The testimony that has been presented from the witness stand and any exhibits, which have been made a part of the record. I have the duty to charge you on the law that is applicable in this case. It is your duty as jurors to accept and apply this law as I state it to you. If you think you have any idea of what the law is or what the law ought to be and it does not agree with what I tell you the law is, you must forget your ideas because you are sworn to accept the law and apply the law exactly as I state it to you. In every case the jury is the sole and exclusive judge of the facts. A trial Judge cannot comment on or make any statement about the facts in a case. Since you're the sole judges of the facts, do not think by anything I've said during the trial that I have an opinion about the facts.

The law does not allow me to have an opinion about the facts.

The burden of proof in this case is by a preponderance of evidence. A preponderance of evidence simply means the greater weight of the evidence. It is evidence, which, as a whole, shows that the fact sought to be proved is more likely true than not true. This can be illustrated by imagining a set of scales. That's what we talked about yesterday. Y'all will probably remember. When the case begins, the scales are even. After all of the evidence has been presented, if the scales remain even or if they tip even slightly in favor of the defendant, then the plaintiff has failed to meet her burden of proof and would not be entitled to recovery in this case. On the other hand, if the scales tip even slightly in favor of the plaintiff, the plaintiff will have met her burden of proof and you should return a verdict for the plaintiff.

The preponderance of evidence is not determined by the number of witnesses. Instead, it is determined by the greater weight of all the evidence. There are two types of evidence generally presented during a trial, direct evidence and circumstantial evidence. Direct evidence is the testimony of a person who claims to have actual knowledge of a fact, such as an eyewitness. It is evidence which immediately establishes the main fact to be proved.

Circumstantial evidence is proof of a chain of facts and circumstances indicating the existence of a fact. It is evidence which immediately establishes collateral facts from which the main fact may be inferred. Circumstantial evidence is based on inference and not on personal knowledge or observation. It is proof that does not actually establish the fact in question but that asserts or describes something else from which you may either reasonably infer the truth of the fact or at least reasonably infer an increase in the probability that the fact is true. For circumstantial evidence to be sufficient to warrant the finding of a fact, the circumstances must lead to that fact with reasonable certainty. The facts and circumstances should be considered in light of ordinary experience and common sense. The existence of a fact cannot be based on speculation, surmise or conjecture. The law makes absolutely no distinction between the weight or value to be given to direct or circumstantial evidence, nor is a greater degree of certainty required of circumstantial evidence than of direct evidence.

Necessarily, you must determine the credibility of the witnesses who have testified. Credibility simply means believability. It is your duty as jurors to evaluate the evidence and determine which evidence convinces you it is true. In determining the believability of witnesses who

have testified, you may believe one witness over several witnesses or several witnesses over one witness. You may believe a part of the testimony of a witness and reject the remaining part of the testimony of the same witness. You may believe the testimony of a witness in its entirety or reject the testimony of a witness in its entirety. You may consider whether the witness has an interest in the result of the trial, whether the witness is prejudiced toward either the plaintiff or the defendant. The opportunity for the witness to have seen the matters and things about which the witness may testify, and the way the witness acts on the witness stand.

The rules of evidence ordinarily do not permit witnesses to testify to opinions or conclusions. An exception to this rule exists for witnesses we call experts. A witness who by education and experience has become expert in some art, science or profession, may give an opinion as to the subject the witness claims to be an expert in and may also give the reasons for that opinion. You should consider any expert opinion like any other evidence and give it the weight you think it deserves. If you decide that an expert witness's opinion is not based on sufficient education or experience or if you decide that the reasons given in support of the opinion are not sound, or that the opinion is outweighed by other evidence, you may disregard the opinion

entirely. An expert witness's testimony is to be given no greater weight than that of other witnesses simply because the witness is an expert. You do not have to accept an expert's opinion even though it is uncontradicted. The testimony of experts is to aid and assist you as jurors, not to dominate or control you in a decision of questions of facts. Their opinions and deductions from the evidence before you and their judgments and opinions do not preclude yours. You are required to decide disputed questions after comparison and consideration of all the evidence in this case. If the opinions of medical experts are relied on to establish proximate cause, the experts must state with reasonably certainty that in his or her opinion, professional opinion, the plaintiff's injuries most probably resulted from the negligence of the defendant. It is not necessary that the expert use the words most probably. It is enough for the expert to state that it is the expert's professional opinion that the defendant's negligence was most likely among the possible causes of the plaintiff's injuries. In this case there's been a conflict in the testimony of expert witnesses. To that end, you must weigh one expert's opinion against that of the other and you must consider the reasons given by one as compared with those of the other. You should consider the relative credibility and knowledge of the experts who have testified. Thereupon, you

should find in favor of that expert testimony, which, in your opinion, is entitled to the greater weight.

The plaintiff claims that the Defendant committed medical malpractice. Medical malpractice is a form of carelessness or negligence. In order to recover, the plaintiff must prove by a preponderance of evidence the standard of care, the breach of that standard of care, proximate cause and damages. The plaintiff must prove the standard of care the defendant owed in treating the plaintiff. When a nurse treats a plaintiff, the law does not require perfection or infallibility. The law does require that the nurse use that degree of knowledge, care and skill ordinarily possessed and used by nurses in good standing in the nurse's field of medicine under the same or similar circumstances and that the nurse followed the generally accepted practices and procedures in the profession. A nurse is not an insurer of health and is not required to guarantee results. A nurse undertakes only to meet the standard of skill possessed generally by others practicing in the field of nursing under the same or similar circumstances.

The plaintiff must prove that the defendant negligently departed from the standard of care in treating the plaintiff. Negligence is the failure to do what an ordinary careful nurse in the nurse's field of medicine would have

done under the same or similar circumstances or the doing of something that an ordinarily careful nurse would not have done under the same or similar circumstances. The mere fact that a treatment does not benefit the patient or that it even harms the patient is not in and of itself negligence. A bad result, injury, death or failure to cure is not enough alone to show that the defendant was negligent.

In considering whether the defendant made a reasonable decision, you must consider the decision in relation to the facts as they existed at the time, not in light of what hindsight may reveal.

The defendant in this case is a governmental entity as defined by State law. Therefore, they come under a special class of laws governing their liability called the torts claims act. The defendant cannot be held liable for any responsibility or duty, including but not limited to supervision, protection, control, confinement, or custody of any of their patients or clients, except when the responsibility or duty is exercised in a grossly negligent manner. Gross negligence is the intentional, conscious failure to do something which is incumbent upon one to do, or the doing of a thing intentionally that one ought not do. Negligence is the failure to exercise due care while gross negligence is the failure to exercise slight care.

To prove gross negligence the plaintiff must first

prove that the defendant owed a duty of care to the plaintiff, that they breached that duty by a negligent act or omission and that the breach was a proximate cause of damage to the plaintiff. Each of those elements must be proven by the plaintiff. To state a cause of action against the defendant, the law requires that the defendant was grossly negligent and that the gross negligence of the defendant was a proximate cause of [redacted], Jr.'s damages. The defendant's negligence must have proximately caused the plaintiff's injuries. Proximate cause is something that produces a natural chain of events, which in the end, brings about the injury. It is the direct cause of the injury.

To prove that the defendant's negligence proximately caused the plaintiff's injury, the plaintiff must first prove causation in fact. This is proven by showing that the injury would not have occurred but for the defendant's negligence. The plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the defendant's negligence. The plaintiff must prove that some injury from the defendant's negligence was foreseeable, but does not have to prove that the particular injury that occurred was foreseeable. However, the defendant cannot be held

responsible for things which could not be expected to happen. Proximate cause does not mean the only cause. The defendant's act can be a proximate cause of the plaintiff's injury if it was at least one of the direct concurring causes of that injury. The plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This means that the injury occurred as a natural and probable consequence of the defendant's negligence. The plaintiff must prove that some injury from the defendant's negligence was foreseeable but does not have to prove that the particular injury that occurred was foreseeable. However, the defendant cannot be held responsible for things which could not be expected to happen.

Proximate cause does not mean the only cause. The defendant's act can be a proximate cause of the plaintiff's injury if it was at least one of the direct concurring causes of that injury. Proximate cause need not be established with certainty. Probability is sufficient. A bare possibility is not sufficient. You are not permitted to guess, speculate or surmise as to the proximate cause. The plaintiff must prove to you by a greater weight of the evidence that gross negligence by the defendant was a proximate cause of the injury sustained by the minor plaintiff. In considering the plaintiff's damages and

losses, the law provides that you shall assess the amount that you find to be justified by a preponderance of evidence as full and just and reasonable compensation for all of the plaintiff's damages. No more and no less. This is what the law refers to as actual and compensatory damages. Compensatory damages are not restricted to the actual loss of money or time. These damages may include mental and physical aspects of the injury, tangible and intangible, financial and otherwise. By reimbursing or compensating the plaintiff in all aspects, you are to attempt to restore the plaintiff, that is to make the plaintiff whole or as the plaintiff existed immediately prior to his injuries. The plaintiff must prove that expenses caused by the injury were necessary and reasonable.

You should consider the following elements of damage to the extent you find they were proven by a preponderance of the evidence. You should place a value on each element of the damage in accord with the evidence presented and all these amounts together to determine the amount of your verdict. I instruct you that you shall evaluate each element of damage individually. The following are various elements of damage you may consider. Medical expenses, those incurred to date and any which may be incurred in the future. Value of bodily injury and permanent impairment. The reasonable value of any bodily injury sustained

including permanent injury, significant disfigurement or significant scaring, disability or impairment and the loss of capacity to perform bodily functions or to do daily activities, past and future. The reasonable value of the plaintiff's pain, suffering, mental anguish, inconvenience, discomfort and loss of capacity for the enjoyment of life. If you decide the plaintiff is entitled to a verdict, your next step would be to decide how much money the defendant should be required to pay.

Actual damages are to compensate the plaintiff for the plaintiff's injuries or loss and to put the plaintiff as near as possible in the same position that the plaintiff was in before the incident occurred. In other words, actual damages would be the actual losses and expenses, which the plaintiff has suffered. In this case, the plaintiff alleges significant scaring as a result of the defendant's actions. You may consider as factors in making this determination the appearance, coloration, existence, size and shape of the plaintiff's scar, along with the characteristics of the surrounding skin and the remnants of the healing process and other cosmetically important matters.

A plaintiff is never entitled to recover conjectural or speculative damages. But if you find the plaintiff is entitled to a verdict for actual damages, your verdict should include an amount to cover any past, present and

future damages, which were proximately caused by the defendant. Any future damages must be reasonably certain to occur in the future as a result of the defendant's acts. Actual damages need not be proven to a mathematical certainty or be based on evidence of the precise amount of damages the plaintiff has suffered. Instead, the evidence must allow you to determine what amount of damages is fair, just and reasonable. It is proper to include in the estimate of future damages compensation for future medical expenses and pain and suffering, which will, with reasonable certainty result. Any future damages must be reasonably calculated to have resulted form the alleged injury or damages sustained in the case. Future damages must be reduced to their present cash value. Pain and suffering compensates the plaintiff for physical discomfort and the emotional response to the sensation of pain caused by the injury itself. There's no definite standard by which to compensate the plaintiff for pain and suffering. You have the authority to determine the amount, if any, to be allowed for pain and suffering using calm and reasonable judgment to ensure that the damages are just and reasonable in light of the testimony and evidence presented in this case. Loss of enjoyment of life compensates the plaintiff for limitations on the plaintiff's ability to participate in and derive pleasure from the normal activities of daily life. Mental

suffering, apprehension, shock, fright, emotional upset, humiliation and anxiety, either present or expected in the future, can properly be considered as an element of damages. The amount of damages for mental suffering cannot be exactly measured.

If you find that the defendant was permanently injured as a result of the defendant's actions, you must then decide how, if at all, that injury will effect the rest of the plaintiff's life. A person's life expectancy is determined by a life expectancy table which is a part of the laws of this state. The life expectancy table is only an estimate of the probable average remaining life -- of the life of all person's in our state of a given age. The plaintiff is a three-year-old male with a life expectancy, according to the life expectancy table, of seventy-three point seven-six years. This fact is to be considered by you along with any other facts and circumstances in evidence bearing on the plaintiff's life expectancy, including occupation, habits and health at the time of injury in deciding the amount of damages to be awarded to the plaintiff.

I have declared the law to you through these instructions to help guide you to a just and lawful verdict. Whether some of these instructions apply will depend upon what you find to be the facts. The fact that I have instructed you on various subjects in this case, including

damages, must not be taken as indicating an opinion of this Court as to what you should find to be the facts or as to which party is entitled to your verdict. Your verdict must represent the considered judgment of each juror. In order to return a verdict, it is necessary that each one of you agree. You verdict must be unanimous. All twelve of you must agree on this verdict. Your verdict cannot be based on sympathy, passion, prejudice, emotion or any other consideration not in evidence in this case. Remember, at all times you're not partisans favoring one party over the other. You are the judges of the facts and your sole interest is to seek the truth from the evidence that has been presented to you in this case.

Now, Mr. Foreman, because I'm about as tired as y'all are of sitting, I get to come down. I'm going to go over this verdict form with you. This is the verdict form. You are charged with completing this based on y'all's decisions in the jury room. This just tells you where you are. This tells you what court we're in. We're in -- as I told you, we're in Common Pleas, First Judicial Circuit. This is the case number of the case and this just tells you the parties. You notice you've got Ms. Hamilton, individually and as the guardian for R.J. The defendant in this case is The Medical Center and this verdict form. You've got a number of questions. Each one of these questions as it says, we, the

jury, by unanimous consent, have responded to the following questions. And these are the questions. Question number one, do you find that the defendant was grossly negligent? And then you'll have to check either yes or no. If you check yes, you go to question two. If you check no, you stop your deliberation. Question two, was the defendant's gross negligence a proximate cause of the plaintiff's injuries? Again, you have two choices. Yes and no. If you answer yes, you go to question three. If you answer no, stop your deliberation. Question three, please state the amount of damages, if any, sustained by the minor plaintiff, [redacted]. You are to determine only the total amount of the plaintiff's damages and enter that amount below. This is the damages to the child, okay? The next part of that question is please state the amount of damages, if any, sustained by the plaintiff Tekayah --

Did I say that right? Tekayah?

MR. WILLIAMS: Tekayah.

THE COURT: Tekayah, I'm sorry. Tekayah Hamilton, individually and as the parent and Guardian ad litem for [redacted]. That's her son, as you know. You are to determine only the total amount of the plaintiff's damages and enter that below. Okay? Do you see the line for each one of those where you fill it out when you get to that, an actual damages amount. Then, Mr. Foreman, you are

charged with signing that and dating it, okay?

MR. FOREMAN: Yes, sir.

THE COURT: All right. Now, I'm not giving you this yet.

MR. FOREMAN: Okay.

THE COURT: Okay. The reason for that is y'all know how exciting that was to listen to, me read the law. I saw y'all were excited, you know. Every now and then when I do that I misstate something, but these attorneys were paying very close attention to what I said. And I could have misstated the law to you. And if I did, I've got to correct it. So what we're going to do now is I'm going to let you go back into the jury room. The attorneys are going to tell me if I stated the law correctly or if I need to correct something. If I don't need to correct something, the verdict form and all of the exhibits are going to come back into the jury room and you can begin your deliberations. Now, if I've got to correct something, we'll bring you back out here and we'll have a few more minutes of exciting reading, okay?

MR. FOREMAN: Yes, sir.

THE COURT: Okay. I'm going to let you go back in there. Again, you cannot begin deliberating yet. We'll be with y'all in just a second, I hope.

(Jury out at 4:57 p.m.)

THE COURT: All right. Now, we'll get into the charges that -- excuse me. We'll get into the charges in a minute that we talked about in chambers that I'm not going to charge. But as to what I did charge, any exceptions?

MR. WILLIAMS: Well, they kind of go hand in hand, so I'm subject to the objections that you've already heard and rationale that you've already heard the negligent standard, you know.

THE COURT: Right. Okay

And Mr. Tanner, any changes?

MR. TANNER: No, sir.

THE COURT: Other than the exceptions.

MR. TANNER: Other than the exceptions that we discussed.

THE COURT: That we're going to come back and put on the record after?

MR. TANNER: Yes, sir.

THE COURT: Okay. If y'all wouldn't mind, if y'all would go and let's make sure we've got all the exhibits straight. And then -- and you can -- when you take it back there you can tell the alternate she can leave.

(Reconciliation of exhibits with counsel)

THE COURT: All right. Delaine, they're ready to go. If you'd take the verdict form and those exhibits and

go on back.

THE BAILIFF: Yes, sir.

THE COURT: Okay.

(Alternate juror excused at 5:00 p.m.)

(Jury deliberating at 5:00 p.m.)

THE COURT: All right. Mr. Williams, are you ready right now. You want to go ahead and put that exception on the record?

MR. WILLIAMS: Yes, Your Honor.

THE COURT: Okay.

MR. WILLIAMS: So, my problem is compounded here. The jury charge you gave the jury gave them a medical malpractice standard, which is typically, as you said, based on a negligence standard. But then it instructed the jury they have to come back with a gross negligence determination based on one exception to the waiver of immunity in the tort claim act, which would require that they make the determination that the nurse was improperly supervised. I forget what all it says, but you know what I mean.

THE COURT: Right.

MR. WILLIAMS: Subsection 25, which that potentially limits a juror from contemplating, deciding that there was a deviation from the standard of care and that that is actionable in awarding. So in addition to the

confusing instruction, I think the law is clear. It's -- administration of medicine is not an exception to the waiver of immunity under the tort claim act. Therefore, it's a medical malpractice standard based solely on negligence. And negligence is the standard, and the jury is making determination solely whether or not there was gross negligence, supervision, etcetera based on subsection 25.

THE COURT: Okay.

All right. And the reason I did not charge that is I believe that the burden of proof in this case is gross negligence when you consider the actions of a nurse in this case. And I believe the case was Stewart. Isn't it Stewart?

MR. TANNER: Yes, sir. Stewart versus Richland Memorial Hospital.

THE COURT: Yeah. Stewart versus Richland Memorial Hospital is the controlling case in that. But I have -- I want to make sure on the record that we have you objection to my charge noted in case any further work on this case -- if it goes up, okay?

MR. WILLIAMS: Thank you, Judge.

THE COURT: And Mr. Tanner, likewise --

MR. TANNER: Yes, sir. May it please the Court?

THE COURT: -- you had, I believe two lines you wanted me to include?

MR. TANNER: Yes, sir. I had asked in our proposed charges, I had a charge that says the following. I instruct you practicing nursing is an art not a science and in providing nursing care, a nurse is not required to be all knowing and all wise. That is, again, from my proposed charge, which I believe was crafted in the '90's in Columbia, Richland County specifically the number of medical malpractice lawyers and judges there.

THE COURT: Wasn't there another line as well?

MR. TANNER: There was.

THE COURT: Yes, sir.

MR. TANNER: And while a nursing mistake or error in judgment alone would not support a verdict for the plaintiff's in a malpractice suit, if the nurse fails to comply with the recognized standard of care, of nursing care, which would be exercised by a similar nurse under the same or similar circumstances, that the liability would attach to the nurse for the state where error in judgment that proximately results in injury to a patient. That would be our exceptions.

THE COURT: Yeah. Yes, sir. And as I mentioned to you I believe that my -- I'm hopeful that my standard of care charge is the general charge that we give. And whereas I do take great deference in anything that's decided in Richland County, I think that took care of that. But out of

an abundance of caution, I wanted to preserve your objection to that ruling in case you have to take the steps further, okay?

MR. TANNER: Yes, sir.

MR. WILLIAMS: Judge, thank you for a wonderful trial. You've been a great trial Judge.

THE COURT: Thank you. I do want to thank y'all. Thank y'all for working with me to get this case done, okay?

MR. WILLIAMS: Yes, sir.

THE COURT: We'll see. You know one thing I tell people whenever I run into them, is I'm lucky to practice -- I mean to be a judge in South Carolina. Because the attorneys are much a pleasure to work with. Y'all are always prepared and willing to argue and do what you're supposed to do for your client, so I'm always --

(Court in recess awaiting the verdict of the jury at 5:03 p.m.)

(Court in session at 6:10 p.m.)

THE COURT: All right. I have -- I got a -- well, it's sort of -- it's more of a request than it is a question. It says we, the jury, ask to be released for today, asking to return 5/9/2018 at 9:00 a.m. for further deliberations to finalize our decision. So, I mean, I think if they want to be released, I don't think it's going to be to anyone's advantage for us to keep them, okay?

Any thoughts on that?

MR. TANNER: I don't know because, you know, it's the fear of the unknown.

THE COURT: Oh, yeah. It is.

MR. TANNER: I mean, you know, I always worry about late deliberations because people get hungry and -- I guess for the record, I'd move for a mistrial because we don't have a verdict and --

MR. WILLIAMS: I certainly don't think a mistrial is appropriate, Your Honor. But I'd defer to the Court whether they want to ask them to continue to deliberate or if they want to recess until tomorrow.

THE COURT: Well, you know, I don't know whether they've got issues about children or anything like that. But what I was going to do is I'll bring them back in here and just ask them some questions on the record about if they would -- if they think they could do it in a little while, I'd like for them to go ahead and do it. But I've got to make sure that they don't talk among themselves, talk to anybody else, you know, that kind of --

MR. TANNER: Any research.

THE COURT: Yeah. I've just got to caution them about that and make sure they realize that I'm going to ask them about tomorrow when it comes back, okay?

MR. TANNER: Yes, sir.

THE COURT: All right.

MR. TANNER: For the record, you're denying my motion.

THE COURT: Oh, I'm sorry. Yeah. You know, you know, they haven't said they couldn't -- they've given up on it so --

MR. TANNER: Yes, sir.

THE COURT: But I'll note your motion that you --

MR. TANNER: Thank you.

THE COURT: -- and note your objection to my ruling that I'm not granting a mistrial right now. But as always, I appreciate your asking.

Yeah, if you'd bring the jury back in here?

THE BAILIFF: Yes, Your Honor.

THE COURT: I just need to talk to them for a second.

THE BAILIFF: Yes, Your Honor.

(Off record discussion)

(Jury in at 6:15 p.m.)

THE COURT: All right. I just wanted to talk to y'all a little bit, okay, before we decide anything. If I let y'all go right now, y'all know y'all can't do any independent research. Y'all can't, you know -- one or two of y'all cannot contact each other and talk about it and do anything like that. I mean, y'all's deliberation is

absolutely shut down until tomorrow at 9:00. The only thing I was curious about and I don't know how close y'all are to a decision or anything like that and you don't need to tell me that. But, you know, right now it's 6:15. I don't know whether y'all have got other things that y'all might want to do tomorrow and like that. You realize you're going to have to come back here and do that or do you think another forty-five minutes or an hour y'all come to a decision? I mean, you don't know?

MR. FOREMAN: Your Honor, to speak on behalf of the jury, most of us are pretty well stressed right.

THE COURT: Oh, okay.

MR. FOREMAN: We have -- we have made a decision. There's some processes that we would like to discuss further --

THE COURT: Okay. All right.

MR. FOREMAN: Going through the evidence. And we all kind of came to a vote, a unanimous vote of twelve, that we would like to try to get some rest tonight and come back with a clear head --

THE COURT: Okay.

MR. FOREMAN: And we all understand and we've talked about that, that no one in this jury has spoken anything of this until you told us to deliberate.

THE COURT: Okay. All right.

MR. FOREMAN: And these people have been very trustworthy in that fact. And I feel like we will continue to tomorrow morning to be able to do so.

THE COURT: The way you explained it to me, I really appreciate it. That's exactly what I wanted to hear. I'm glad that y'all understand when things kind of get to a frustration level, y'all are willing to continue to talk about this. So what I will do is, per your request, if y'all will be back in the jury room at 9:00. Now, remember y'all need to be here at 9:00 and you cannot begin your deliberations until everybody's here. Okay?

MR. FOREMAN: Yes, sir.

THE COURT: Again, let me just remind you no independent investigation. I don't know if any of y'all know each other or anything like that, you know, where you can talk. You cannot do that, okay? And if anybody tries to talk to y'all, I need to know it, okay?

MR. FOREMAN: Yes, sir.

THE COURT: So y'all go home, relax and I'll see y'all at 9:00 in the morning. Thank y'all for what y'all doing.

JURORS: Thank you.

THE COURT: I appreciate it.

(Jury out at 6:20 p.m.)

(Court's Exhibit No. 4, jury note

was marked)

THE COURT: All right. Well, I've got to say the way the foreman explained it, I thought was pretty good. So I'm not going to -- you can renew your motion if you want to and I'll continue to deny it, just if we need to do that.

MR. TANNER: I think I made it and you denied it.

THE COURT: Okay. All right.

MR. TANNER: I mean, I know that it's protected on the record.

THE COURT: Well, it is in my view. But, you know, one thing I learned is whatever I think about a case is not necessarily --

MR. TANNER: Maybe with the Court's permission, in light of what he said, I would renew my motion for a mistrial for the record at this time.

THE COURT: Okay. Right. And I will again deny it. I think -- I was glad to hear that they, you know, had apparently reached some level of frustration and felt like a night to take off would help them. So we'll see. And so y'all be back -- we'll be back at 9:00 in the morning, y'all and we'll see what happens.

MR. WILLIAMS: Thank you, Judge.

THE COURT: All right. Thank y'all.

(Court in recess May 7, 2018 at 6:25 p.m.)

(Court in session May 9, 2018 at 9:00 a.m.)

(Jury in at 9:01 a.m.)

THE COURT: Good morning, ladies and gentlemen. I hope y'all had a good evening.

MR. FOREMAN: We did. And hope you did as well, sir.

THE COURT: Yeah, I did. I did. Thank you. And I got to get up this morning and eat breakfast and not hurry and all that kind of stuff. So it worked out really well good. I hope y'all did.

Okay. Now, this morning I've got to ask y'all some questions. I want to make sure nobody talked -- y'all did not talk among yourselves last night?

MR. FOREMAN: No, sir.

THE COURT: Nobody tried to contact y'all?

MR. FOREMAN: No, sir.

THE COURT: Okay. Now, I know y'all are going to get ready to go back in there and being your deliberations. We'll go back through the exhibits and make sure we've got them all. I think the court reporter has already gone through that. So we will send those back, along with the verdict form in there so y'all can finish your deliberations. And y'all can continue on. It's a beautiful day to be in a jury room making a decision, okay?

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MR. FOREMAN: Yes, sir.

THE COURT: So y'all have a good --

MR. FOREMAN: Could I ask a question? We would like to give you some questions to get you to answer on some certain items. And if we do so, we'll give you those in writing; is that correct?

THE COURT: Yes, sir. If y'all have a question -- now, I need for y'all just to understand. Sometimes, you know, when y'all have questions about a fact or something like that, most -- well, sometimes I just have to replay what the testimony was because I can't give you -- remember how I told you all along --

MR. FOREMAN: Yes, sir.

THE COURT: -- that I can't tell you anything about the facts or anything like that. So if y'all have a fact question it'll put us in a position to where y'all replay the tape or something like that. So just so y'all will be aware of that. If you have a question about the law, what I will do is I will read that portion of the charge that applies to that is normally what I do. But now it depends on what your question is.

MR. FOREMAN: Okay.

THE COURT: But if you'll write it out, we'll be glad to address it or try to address it, okay? All right, sir.

MR. FOREMAN: Thank you.

THE COURT: Y'all go on back in there and y'all begin your deliberations.

MR. FOREMAN: Thank you, sir.

THE COURT: Yes, sir.

(Jury out at 9:02 p.m.)

THE COURT: All right. Hilda's gone through the exhibits and ensured that we've got them all together. Do y'all want to review them before I take them back in there?

MR. TANNER: ???

MR. WILLIAMS: I'll take her word over our review.

THE COURT: Okay. All right. Thank you, ma'am.

THE BAILIFF: Thank you, sir.

THE COURT: You take them on.

THE BAILIFF: Yeah.

THE COURT: Yes, ma'am. Yes, ma'am. Thank you, ma'am.

THE BAILIFF: Thank you.

(Exhibits and verdict form delivered to the jury at 9:02 a.m.)

THE COURT: All right. So it's 9:02 or :03, something like that when they resume their deliberations.

(Jury resumes deliberations at 9:03 a.m.)

THE COURT: I'm anxiously awaiting questions.

(Court in recess at 9:05 a.m.)

(Court in session for verdict at 11:04 a.m.)

THE COURT: The jury's reached a verdict?

THE BAILIFF: Yes, Your Honor.

THE COURT: If you would, you know, bring them in, you know. You've told the Foreman he's going to give it to you and you're going to give it to me?

THE BAILIFF: Yes, Your Honor.

THE COURT: Okay. All right.

THE BAILIFF: Are you ready?

THE COURT: Yeah. Yeah. Is the plaintiff ready?

MR. WILLIAMS: Yes, sir.

THE COURT: Defendant ready?

MR. TANNER: Yes, sir.

THE COURT: Okay. All right.

(Off record discussion)

(Jury in at 11:05 a.m.)

THE COURT: All right. Mr. Foreman, has the jury reached their verdict?

MR. FOREMAN: Yes, we have, Your Honor.

THE COURT: Is that verdict unanimous?

MR. FOREMAN: Yes, sir.

THE COURT: If you wouldn't mind giving that to the bailiff, please sir?

MR. FOREMAN: Yes, sir.

THE BAILIFF: Your Honor, may I approach?

THE COURT: You may. Thank you, ma'am.

Y'all can sit down.

All right. Mr. Clerk if you wouldn't mind publishing the verdict please, sir?

THE CLERK: State of South Carolina, County of Orangeburg Tekayah Hamilton individually and as the parent Guardian ad litem for Robert Lee M., Jr., plaintiff versus The Regional Medical Center, defendant.

We, the jury, by unanimous consent have responded to the following questions:

Do you find that the defendant was grossly negligent? Yes.

Question number two, was the defendant's gross negligence the proximate cause of the plaintiff's injuries? Yes.

Please state the amount of damages, if any, sustained by the minor plaintiff, [redacted]? One million one hundred and twenty-seven thousand two hundred and eighty dollars actual damages.

Please state the amount of damages, if any, sustained by the plaintiff, Tekayah Hamilton, individually and as parent Guardian ad litem for [redacted]? One hundred thirty-five thousand four hundred seventy-seven

dollars actual damages.

THE COURT: All right. That was signed by the foreperson and dated today.

And, again, Mr. Foreman, this is the verdict?

MR. FOREMAN: Yes, sir.

THE COURT: Okay. Any issues from the plaintiff?

MR. WILLIAMS: No, sir.

THE COURT: Anything from the --

MR. TANNER: Just for the record if you could poll the jurors individually, Your Honor, and make sure it is a unanimous verdict for the record.

THE COURT: All right. Hold on one second.

All right. Ladies and gentlemen, they've requested that I poll the jury. So when I call your name I'll ask you to stand up and I've got two questions to ask you.

(Jurors individually polled and verdict stands)

THE COURT: All right. Anything further, Mr. Tanner?

MR. TANNER: Nothing further, Your Honor.

THE COURT: Okay. All right. Ladies and gentlemen, I appreciate the way y'all paid attention during the trial and like that and gave us and the attorneys your full attention. We do appreciate that. Y'all have done a good job as jurors and I appreciate the way y'all considered

everything, told me about it and how everything was going yesterday and like that. So thank you for your service. You know, in addition to the huge amount of money that you get paid, you know, for being on the jury, you know the other good reward you may remember is you don't have to serve on a jury now for three years, okay? But now you still can if you want to. I hope y'all had a good experience. I really hope you did. So if you get an opportunity, you know, I hope y'all will consider doing that. The other thing I need to tell you is, sometimes after the trials the attorneys will contact you and ask you if you want to talk about your jury service and like that. That's a way for them to learn, you know, different things, you know, about how did -- you know, maybe just ask you questions. And you can respond but it is up to you whether or not you want to respond. If they send you a questionnaire -- I know some attorneys send questionnaires sometime. You know, they might just run into you around town. They might want to ask you a question. If you want to talk to them, you can but you do not have to talk to them. But if you do want to have some feedback back and forth, feel free to do that. The prohibition against talking about it was when you were making your deliberations and like that, not after the trial. But if you just don't want to talk about it, you don't have to, okay? But, again,

thank y'all so much for your service. I hope y'all enjoy the rest of the week. I am glad y'all were willing to serve. I really am, okay? Thank y'all. Y'all have a good day.

MR. FOREMAN: Thank y'all.

THE COURT: Thank you.

(Jury out at 11:05 a.m.)

COURT REPORTER: May I see that verdict form when you get through?

THE COURT: It's one million one hundred twenty-seven two eighty.

MR. WILLIAMS: Your Honor

THE COURT: I'm going to run copies of this for y'all, okay?

Mr. Tanner, rather than do any motions or anything like that, you've got ten days, you know, unless --

THE COURT: Do you want to hear the motion to reduce it based on the tort claims act or do you want everything in ten days.

THE COURT: Well, I mean -- I'm aware of the -- I think everybody's aware of the tort claims act. I'm giving you ten days --

MR. TANNER: Ten days.

THE COURT: There are other things that you --

MR. TANNER: Yes, sir.

THE COURT: -- may want to address.

MR. TANNER: Yes, sir.

THE COURT: So, and I --

MR. TANNER: Everything will be taken up in ten days?

THE COURT: Yeah. Yeah. That'll give you time. I mean, if I were you, I'd want time.

MR. TANNER: I appreciate that. Yes, sir.

THE COURT: Okay. All right.

MR. TANNER: Thank you, sir.

THE COURT: We're going to run copies of this so everybody will have it, okay?

Okay. All right. Thank y'all very much.

MR. TANNER: Thank you.

MR. WILLIAMS: Thank you, Your Honor.

THE COURT: Appreciate it y'all.

(Court in recess May 9, 2018 at 11:20 a.m.)

C-E-R-T-I-F-I-C-A-T-E

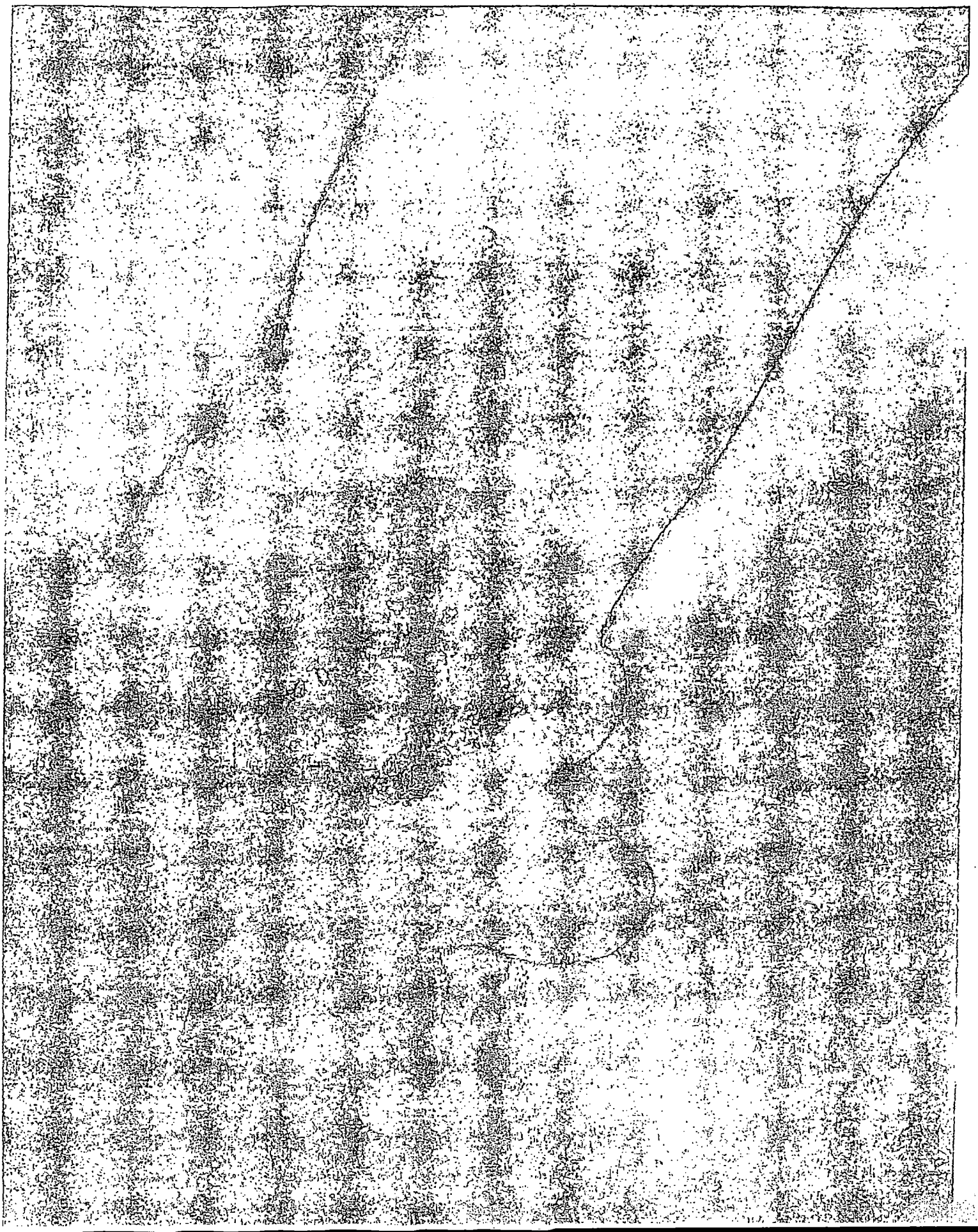
I, THE UNDERSIGNED HILDA M. JORDAN, CVR-M, OFFICIAL COURT REPORTER FOR THE FIRST JUDICIAL CIRCUIT OF THE STATE OF SOUTH CAROLINA, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE, ACCURATE AND COMPLETE TRANSCRIPT OF RECORD OF THE PROCEEDING IN THE CAPTIONED CAUSE, IN THE COURT OF COMMON PLEASE FOR ORANGEBURG COUNTY, SOUTH CAROLINA, ON THE 7 - 9 DAY OF MAY, 2018.

I DO FURTHER CERTIFY THAT I AM NEITHER OF KIN, COUNSEL, NOR INTEREST IN ANY PARTY HERETO.

Hilda M. Jordan, CVR-M

March 17, 2019

L97





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the Regional Medical Center

Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803)395 2200

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Bollin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Bollin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/29/2014 22:27
Medication Name: acetaminophen (acetaminophen oral liquid INFANT (0-2 years))
Charted Date/Time: 10/29/2014 22:28
Admin Details: Auth (Verified)
PRN Response Notes: Mom states PT no longer fussing. Pt breastfeeding well. Currently sleeping; PRN Medication Effectiveness: Yes; Patient Response to Medication: No Adverse Reaction to Medication; NIPS Pain Scale: Yes; Legs NIPS: Relaxed; Arms NIPS: Relaxed; State of Arousal NIPS: Sleeping; Breathing Pattern NIPS: Relaxed; NIPS Pain Assessment Score: 0; Cry NIPS: No cry; Facial Expression NIPS: Relaxed
Action Details: Order: Bollin,Megan Shuler 10/25/2014 22:00; Perform: Stocklin RN,Shannon M 10/29/2014 22:27; VERIFY: Stocklin RN,Shannon M 10/29/2014 22:27

Admin Date/Time: 10/29/2014 20:14
Medication Name: acetaminophen (acetaminophen oral liquid INFANT (0-2 years))
Charted Date/Time: 10/29/2014 20:15
Ingredients: acetaminophen oral liquid INFANT (0-2 years) 60 mg 0.6 mL
Admin Details: (Auth) Oral
Action Details: Order: Bollin,Megan Shuler 10/25/2014 22:00; Perform: Stocklin RN,Shannon M 10/29/2014 20:15; VERIFY: Stocklin RN,Shannon M 10/29/2014 20:15
Reason for Medication: Stocklin RN,Shannon M 10/29/2014 20:15
Fever

Admin Date/Time: 10/29/2014 00:00
Medication Name: cefotaxime (CLAFORAN PEDIATRIC SYRINGE)
Charted Date/Time: 10/29/2014 01:26
Admin Details: (Not Done) meds d/c verbal order
cefotaxime
Action Details: Perform: Stocklin RN,Shannon M 10/29/2014 00:00

Admin Date/Time: 10/29/2014 00:00
Medication Name: sodium chloride (*INT FLUSH)
Charted Date/Time: 10/29/2014 01:26
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/29/2014 00:00

PLAINTIFF'S EXHIBIT
[redacted]

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC002

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the Regional Medical Center

Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/28/2014 23:00
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
ampicillin
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 23:00

Admin Date/Time: 10/28/2014 20:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 20:00

Admin Date/Time: 10/28/2014 17:00
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
ampicillin
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 17:00

Admin Date/Time: 10/28/2014 16:00
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
cefotaxime
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 16:00

Admin Date/Time: 10/28/2014 16:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:26**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 16:00

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC003

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the Regional Medical Center

Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/28/2014 12:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:27**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 12:00

Admin Date/Time: 10/28/2014 11:00
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/29/2014 01:27**
Admin Details: (Not Done) meds d/c verbal order
ampicillin
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 11:00

Admin Date/Time: 10/28/2014 08:00
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/29/2014 01:27**
Admin Details: (Not Done) meds d/c verbal order
cefotaxime
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 08:00

Admin Date/Time: 10/28/2014 08:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/29/2014 01:27**
Admin Details: (Not Done) meds d/c verbal order
sodium chloride
Action Details: Perform: Stocklin RN,Shannon M 10/28/2014 08:00

Admin Date/Time: 10/28/2014 04:45
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/28/2014 05:22**
Admin Details: (Not Done) Not Appropriate at this Time
sodium chloride
Action Details: Perform: Downing RN,Jamie B 10/28/2014 04:45

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC004

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/28/2014 04:27
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/28/2014 04:27**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Downing RN,Jamie B 10/28/2014 04:27; VERIFY: Downing RN,Jamie B 10/28/2014 04:27

Admin Date/Time: 10/28/2014 00:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/28/2014 01:04**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Downing RN,Jamie B 10/28/2014 01:04; VERIFY: Downing RN,Jamie B 10/28/2014 01:04

Admin Date/Time: 10/27/2014 23:44
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/27/2014 23:44**
Ingredients: sterSol20 4.25 mL; cefo1REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:53; Perform: Downing RN,Jamie B 10/27/2014 23:44; VERIFY: Downing RN,Jamie B 10/27/2014 23:44

Admin Date/Time: 10/27/2014 23:08
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/27/2014 23:09**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Downing RN,Jamie B 10/27/2014 23:09; VERIFY: Downing RN,Jamie B 10/27/2014 23:09

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/27/2014 20:00
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 21:19**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Downing RN,Jamie B 10/27/2014 21:19; VERIFY: Downing RN,Jamie B 10/27/2014 21:19

Admin Date/Time: 10/27/2014 17:48
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/27/2014 17:48**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Craft RN,Susan M 10/27/2014 17:48; VERIFY: Craft RN,Susan M 10/27/2014 17:48

Admin Date/Time: 10/27/2014 16:08
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/27/2014 16:08**
Ingredients: cefo1REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:53; Perform: Craft RN,Susan M 10/27/2014 16:08; VERIFY: Craft RN,Susan M 10/27/2014 16:08

Admin Date/Time: 10/27/2014 16:07
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 16:08**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Craft RN,Susan M 10/27/2014 16:08; VERIFY: Craft RN,Susan M 10/27/2014 16:08

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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(803) 395-2200

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/27/2014 11:43
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 11:54**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Modified) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Craft RN,Susan M 10/27/2014 11:43; Modify: Craft RN,Susan M 10/27/2014 11:54; VERIFY: Craft RN,Susan M 10/27/2014 11:54

Admin Date/Time: 10/27/2014 11:40
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/27/2014 11:43**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Craft RN,Susan M 10/27/2014 11:43; VERIFY: Craft RN,Susan M 10/27/2014 11:43

Admin Date/Time: 10/27/2014 08:08
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/27/2014 08:09**
Ingredients: sterSol20 4.25 mL; cefo1REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:53; Perform: Craft RN,Susan M 10/27/2014 08:09; VERIFY: Craft RN,Susan M 10/27/2014 08:09

Admin Date/Time: 10/27/2014 08:08
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 08:09**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Craft RN,Susan M 10/27/2014 08:09; VERIFY: Craft RN,Susan M 10/27/2014 08:09

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/27/2014 06:28
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/27/2014 06:28**
Admin Details: Auth (Verified)
Patient Response to Medication: No Adverse Reaction to Medication, Temperature decreased; PRN Medication Effectiveness: Yes
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/27/2014 06:28; VERIFY: Reese RN,Angelia E 10/27/2014 06:28

Admin Date/Time: 10/27/2014 04:41
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/27/2014 04:42**
Ingredients: acetaminophen oral liquid INFANT (0-2 years) 60 mg 0.6 mL
Admin Details: (Auth) Oral
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/27/2014 04:42; VERIFY: Reese RN,Angelia E 10/27/2014 04:42
Reason for Medication: Reese RN,Angelia E 10/27/2014 04:42
Fever

Admin Date/Time: 10/27/2014 04:35
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 04:36**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/27/2014 04:35; VERIFY: Reese RN,Angelia E 10/27/2014 04:35
Early/Late Reason: Reese RN,Angelia E 10/27/2014 04:35
Other :

Request ID: 5707699

Print Date/Time 06/12/2016 06:36

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Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/27/2014 04:35
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/27/2014 04:36**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/27/2014 04:36; VERIFY: Reese RN,Angelia E 10/27/2014 04:36
Early/Late Reason: Reese RN,Angelia E 10/27/2014 04:35
Other :

Admin Date/Time: 10/27/2014 04:34
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/27/2014 04:36**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Reese RN,Angelia E 10/27/2014 04:36; VERIFY: Reese RN,Angelia E 10/27/2014 04:36

Admin Date/Time: 10/26/2014 22:56
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/26/2014 22:56**
Ingredients: cefo1REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:53; Perform: Reese RN,Angelia E 10/26/2014 22:56; VERIFY: Reese RN,Angelia E 10/26/2014 22:56
Early/Late Reason: Reese RN,Angelia E 10/26/2014 22:56
Other :

Admin Date/Time: 10/26/2014 22:56
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 22:56**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Subclavian
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Reese RN,Angelia E 10/26/2014 22:56; VERIFY: Reese RN,Angelia E 10/26/2014 22:56

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/26/2014 22:55
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/26/2014 22:56**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Reese RN,Angelia E 10/26/2014 22:56; VERIFY: Reese RN,Angelia E 10/26/2014 22:56

Admin Date/Time: 10/26/2014 18:18
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/26/2014 18:18**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Gray RN,Taylor C 10/26/2014 18:18; VERIFY: Gray RN,Taylor C 10/26/2014 18:18
Early/Late Reason: Gray RN,Taylor C 10/26/2014 18:18
Med Not Available

Admin Date/Time: 10/26/2014 18:18
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 18:18**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Gray RN,Taylor C 10/26/2014 18:18; VERIFY: Gray RN,Taylor C 10/26/2014 18:18

Admin Date/Time: 10/26/2014 15:52
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/26/2014 15:52**
Ingredients: cefo1REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Gray RN,Taylor C 10/26/2014 15:52; VERIFY: Gray RN,Taylor C 10/26/2014 15:52

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/26/2014 14:33
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 14:33**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Gray RN,Taylor C 10/26/2014 14:33; VERIFY: Gray RN,Taylor C 10/26/2014 14:33

Admin Date/Time: 10/26/2014 14:06
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/26/2014 14:06**
Admin Details: Auth (Verified)
PRN Medication Effectiveness: Yes; Temperature Rectal: 37.2; Temperature Method: Rectal
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Williams RN,Sarah B 10/26/2014 14:06; VERIFY: Williams RN,Sarah B 10/26/2014 14:06

Admin Date/Time: 10/26/2014 11:28
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/26/2014 11:28**
Ingredients: acetaminophen oral liquid INFANT (0-2 years) 60 mg 0.6 mL
Admin Details: (Auth) Oral
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Gray RN,Taylor C 10/26/2014 11:28; VERIFY: Gray RN,Taylor C 10/26/2014 11:28
Reason for Medication: Gray RN,Taylor C 10/26/2014 11:28
Fever

Admin Date/Time: 10/26/2014 11:22
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/26/2014 11:23**
Ingredients: amp500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Gray RN,Taylor C 10/26/2014 11:23; VERIFY: Gray RN,Taylor C 10/26/2014 11:23

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Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/26/2014 09:21
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 09:21**
Ingredients: *INT FLUSH 1 mL
Admin Details: **(Auth)** IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Gray RN,Taylor C 10/26/2014 09:21; VERIFY: Gray RN,Taylor C 10/26/2014 09:21

Admin Date/Time: 10/26/2014 07:17
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/26/2014 07:17**
Ingredients: sterSol20 4.25 mL; cefo1REC 425 mg
Admin Details: **(Auth)** IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Gray RN,Taylor C 10/26/2014 07:17; VERIFY: Gray RN,Taylor C 10/26/2014 07:17

Admin Date/Time: 10/26/2014 05:04
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/26/2014 05:07**
Ingredients: sterSol20 4.25 mL; ampi500REC 425 mg
Admin Details: **(Auth)** IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Morton RN,Teresa L 10/26/2014 05:07; VERIFY: Morton RN,Teresa L 10/26/2014 05:07

Admin Date/Time: 10/26/2014 05:04
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 05:07**
Ingredients: *INT FLUSH 1 mL
Admin Details: **(Auth)** IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/26/2014 05:05; VERIFY: Morton RN,Teresa L 10/26/2014 05:05

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

MAR

Medications

Admin Date/Time: 10/26/2014 04:25
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/26/2014 04:25**
Admin Details: Auth (Verified)
PRN Medication Effectiveness: Yes; Patient Response to Medication: Temperature decreased; Temperature Method: Rectal; Temperature Rectal: 37.5
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/26/2014 04:25; VERIFY: Morton RN,Teresa L 10/26/2014 04:25

Admin Date/Time: 10/26/2014 02:49
Medication Name: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Charted Date/Time: **10/26/2014 02:49**
Ingredients: acetaminophen oral liquid INFANT (0-2 years) 60 mg 1 mL
Admin Details: (Auth) Oral
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/26/2014 02:49; VERIFY: Morton RN,Teresa L 10/26/2014 02:49
Reason for Medication: Morton RN,Teresa L 10/26/2014 02:49
Fever

Admin Date/Time: 10/26/2014 02:49
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/26/2014 02:49**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/26/2014 02:49; VERIFY: Morton RN,Teresa L 10/26/2014 02:49

Admin Date/Time: 10/25/2014 23:31
Medication Name: **ampicillin (ampicillin injection PEDIATRIC)**
Charted Date/Time: **10/25/2014 23:32**
Ingredients: ampi500REC 425 mg; sterSol20 4.25 mL
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Morton RN,Teresa L 10/25/2014 23:32; VERIFY: Morton RN,Teresa L 10/25/2014 23:32

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

MAR

Medications

Admin Date/Time: 10/25/2014 23:31
Medication Name: **sodium chloride (*INT FLUSH)**
Charted Date/Time: **10/25/2014 23:32**
Ingredients: *INT FLUSH 1 mL
Admin Details: (Auth) IV Push, *Right Hand
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:00; Perform: Morton RN,Teresa L 10/25/2014 23:31; VERIFY: Morton RN,Teresa L 10/25/2014 23:31
Early/Late Reason: Morton RN,Teresa L 10/25/2014 23:31
Patient Not Available/Off Unit

Admin Date/Time: 10/25/2014 23:30
Medication Name: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Charted Date/Time: **10/25/2014 23:32**
Ingredients: sterSol20 4.25 mL; cefo1REC 425 mg
Admin Details: (Auth) IV Syringe
Action Details: Order: Boltin,Megan Shuler 10/25/2014 22:55; Perform: Morton RN,Teresa L 10/25/2014 23:32; VERIFY: Morton RN,Teresa L 10/25/2014 23:32

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/28/2014 05:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/28/2014 04:27 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/28/14 5:00:00 AM EDT, Stop date 10/28/14 4:27:11 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC0014

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/28/2014 00:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 23:44 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Reese RN,Angelia E on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/28/14 12:00:00 AM EDT, Stop date 10/27/14 11:44:47 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/28/2014 00:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/28/2014 01:04 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/28/14 12:00:00 AM EDT
Order Comment: As needed

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/27/2014 23:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 23:09 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 11:00:00 PM EDT, Stop date 10/27/14 11:09:03 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

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Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] 8 months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

Medication History

Medication History

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 20:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 21:19 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 8:00:00 PM EDT
Order Comment: As needed

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/27/2014 17:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 17:48 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 5:00:00 PM EDT, Stop date 10/27/14 5:48:59 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/27/2014 16:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 16:08 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Reese RN,Angelia E on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 4:00:00 PM EDT, Stop date 10/27/14 4:08:22 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Request ID: 5707699

Print Date/Time 06/12/2015 08:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC0016

Patient: [redacted]
MRN: [redacted]
Account Number: [redacted]
DOB/AGE/SEX: [redacted] months Male
Location: 2E; 2350; 01

Admit/Discharge 10/25/2014
Discharge Date: 10/30/2014
Admitting: Boltin MD,Megan Shuler
Attending: Boltin MD,Megan Shuler

Medication History

Medication History

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 16:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 16:08 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 4:00:00 PM EDT
Order Comment: As needed

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 12:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 11:43 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 12:00:00 PM EDT
Order Comment: As needed

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/27/2014 11:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 11:43 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 11:00:00 AM EDT, Stop date 10/27/14 11:43:45 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/26/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Request ID: 5707699

Print Date/Time 06/12/2015 06:36

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Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC0017

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months Male	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/27/2014 08:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 08:09 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Reese RN,Angelia E on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 8:00:00 AM EDT, Stop date 10/27/14 8:09:14 AM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 08:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 08:09 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Craft RN,Susan M on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 8:00:00 AM EDT
Order Comment: As needed

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 06:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 04:38 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/26/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 6:00:00 AM EDT
Order Comment: As needed

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Matthews Road, Orangeburg, SC, unless otherwise noted.
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Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC0018

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/27/2014 05:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 04:36 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 5:00:00 AM EDT, Stop date 10/27/14 4:36:09 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/27/2014 02:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/27/2014 04:36 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/27/14 2:00:00 AM EDT
Order Comment: As needed

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/27/2014 00:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 22:56 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Reese RN,Angelia E on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/27/14 12:00:00 AM EDT, Stop date 10/26/14 10:56:39 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

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Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/26/2014 23:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 22:56 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Klp on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 11:00:00 PM EDT, Stop date 10/26/14 10:56:38 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. : [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 22:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 22:56 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 10:00:00 PM EDT
Order Comment: As needed

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 18:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 18:18 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 6:00:00 PM EDT
Order Comment: As needed

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

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TRMC0020

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/26/2014 17:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 18:18 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 5:00:00 PM EDT, Stop date 10/26/14 6:18:44 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/26/2014 15:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 15:52 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 3:00:00 PM EDT, Stop date 10/26/14 3:52:21 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 14:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 14:33 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 2:00:00 PM EDT
Order Comment: As needed

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

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Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

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Regional Medical Center
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Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin Injection PEDIATRIC)**
Order Start Date/Time: 10/26/2014 11:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 11:23 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 11:00:00 AM EDT, Stop date 10/26/14 11:23:04 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin Injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 10:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 09:21 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 10:00:00 AM EDT
Order Comment: As needed

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/26/2014 07:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 07:17 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 7:00:00 AM EDT, Stop date 10/26/14 7:17:29 AM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

TRMC0022

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Regional Medical Center
3000 St Matthews Road
Orangeburg, SC 29118-
(803) 395-2200

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 06:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 05:07 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 6:00:00 AM EDT
Order Comment: As needed

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/26/2014 05:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 05:07 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/26/14 5:00:00 AM EDT, Stop date 10/26/14 5:07:37 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/26/2014 02:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/26/2014 02:49 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/26/14 2:00:00 AM EDT
Order Comment: As needed

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-395-2272 for additional information.

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/25/2014 23:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/25/2014 23:32 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/25/14 11:00:00 PM EDT, Stop date 10/25/14 11:32:07 PM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **ampicillin (ampicillin injection PEDIATRIC)**
Order Start Date/Time: 10/25/2014 23:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/29/2014 01:24 End-state Reason:
Ordering Physician: Clunis MD,Derrick Oliver Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:52
Order Details: neonatal sepsis, 425 mg, IV Syringe, q6hr Interval, Routine, Start date 10/25/14 11:00:00 PM EDT, 7 day, Physician Stop, Stop date 10/29/14 1:24:00 AM EDT, Infuse over 20 minute
Order Comment: 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration Target Dose: ampicillin injection PEDIATRIC 100 mg/kg 10/25/2014 22:53:05 100 mg/ml concentration ..... add 5 ml of sterile water to ampicillin 500 mg vial. [100 mg/1 ml] withdraw dose from vial as requested per order based on concentration

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/25/2014 23:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/25/2014 23:32 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Hagwood,Brian Kip on 10/25/2014 22:55
Order Details: neonatal sepsis, 425 mg, IV Syringe, Start date 10/25/14 11:00:00 PM EDT, Stop date 10/25/14 11:32:08 PM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] 8 months	Male	Attending: Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **cefotaxime (CLAFORAN PEDIATRIC SYRINGE)**
Order Start Date/Time: 10/25/2014 23:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/29/2014 01:24 End-state Reason:
Ordering Physician: Cluris MD,Derrick Oliver Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:53
Order Details: neonatal sepsis, 425 mg, IV Syringe, q8hr Interval, Routine, Start date 10/25/14 11:00:00 PM EDT, 7 day, Physician Stop, Stop date 10/29/14 1:24:00 AM EDT, Infuse over 30 minute
Order Comment: Target Dose: CLAFORAN PEDIATRIC SYRINGE 100 mg/kg 10/25/2014 22:53:18 see new preparation per package insert

Order: **acetaminophen (acetaminophen oral liquid INFANT (0-2 years))**
Order Start Date/Time: 10/25/2014 22:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/31/2014 00:05 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 60 mg = 0.6 mL, Liquid, Oral, q4hr Interval, PRN Fever, Routine, Start date 10/25/14 10:00:00 PM EDT, Administer for fever GREATER than 101 degF
Order Comment: Target Dose: acetaminophen oral liquid INFANT (0-2 years) 15 mg/kg 10/25/2014 22:00:02

Order: **sodium chloride (°INT FLUSH)**
Order Start Date/Time: 10/25/2014 22:00
Order Status: Completed Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/25/2014 23:32 End-state Reason:
Ordering Physician: Boltin,Megan Shuler Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, Start date 10/25/14 10:00:00 PM EDT
Order Comment: As needed

Patient:	[redacted]	Admit/Discharge	10/25/2014
MRN:	[redacted]	Discharge Date:	10/30/2014
Account Number:	[redacted]	Admitting:	Boltin MD,Megan Shuler
DOB/AGE/SEX:	[redacted] months	Attending:	Boltin MD,Megan Shuler
Location:	2E; 2350; 01		

Medication History

Medication History

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/25/2014 22:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/29/2014 01:25 End-state Reason:
Ordering Physician: Cluris MD,Derrick Oliver Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, As Directed, PRN, Other (see comment), Start date 10/25/14 10:00:00 PM EDT
Order Comment: Flush Protocol

Order: **sodium chloride (*INT FLUSH)**
Order Start Date/Time: 10/25/2014 22:00
Order Status: Discontinued Clinical Category: Medications Medication Type: Inpatient
End-state Date/Time: 10/29/2014 01:25 End-state Reason:
Ordering Physician: Cluris MD,Derrick Oliver Consulting Physician:
Entered By: Boltin,Megan Shuler on 10/25/2014 22:00
Order Details: 1 mL, Injection, IV Push, q4hr Interval, Start date 10/25/14 10:00:00 PM EDT
Order Comment: As needed

History and Physical Reports

Document Name	History and Physical
Document Status	Auth (Verified)
Performed By	Boltin,Megan Shuler (10/25/2014 22:20)
Signed By	Boltin,Megan Shuler (10/25/2014 22:57)
Authenticated By	Boltin,Megan Shuler (10/25/2014 22:57); Boltin,Megan Shuler (10/25/2014 22:57)

General Admission H&P

Patient: [redacted]
Age: 4 weeks Sex: Male DOB: [redacted]
Associated Diagnoses: None
Author: **Boltin, Megan Shuler**

Basic Information
Admit Information: 30 day old AA male infant admitted for neonatal fever .
Source of history: Mother.
Present at bedside: Mother.

Request ID: 5707699 Print Date/Time 06/12/2015 06:36

All tests performed at RMC Laboratory, 3000 St Mathews Road, Orangeburg, SC, unless otherwise noted.
Additional clinical information may be available for the patient via Horizon Patient Folder.
Please contact the Regional Medical Center Health Information Department at 803-396-2272 for additional information.

TRMC0026

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

Honorable Edgar W. Dickson, Circuit Court Judge

RECEIVED
SEP 29 2021
SC Court of Appeals

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of 18, Respondent,

v.

Regional Medical Center, Appellant.

AMENDED RECORD ON APPEAL

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+rmc
the Regional Medical Center

Subject:	Intravenous Therapy [Peripheral Access]	TJC Function:	PC
Page:	1 of 9	Manual:	Nursing

PURPOSE:

To effectively initiate, maintain, monitor and discontinue intravenous access for continuous or intermittent fluids and/or medications.

To control the rate of fluid administration.

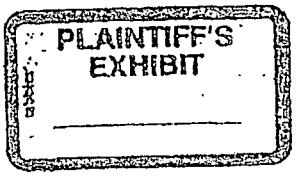
To prevent infection or other complications during intravenous access maintenance.

POLICY:

The Registered Nurse and the specifically trained Licensed Practical Nurse or Licensed Radiology technologist are to initiate, maintain, monitor and discontinue intravenous access/therapy as prescribed by a physician's order.
NOTE: **Qualified ED RNs may insert external jugular peripheral IVs in adult patients.**

SUPPLIES:

IV Start Kit
Saline flush kit
IV catheter or Butterfly [appropriate size]
Prescribed IV solution and tubing
Buretrol – if patient 12 years of age and under
Appropriate needleless devices
Infusion Control Device



PROCEDURE

1. Prior to initiating IV access:
   - Check physician's order;
   - Wash hands;
   - Assemble supplies;
   - Identify patient noting name and date of birth;
   - Explain the procedure to the patient;
   - Utilize standard precautions.

2. Considerations for site selection include:
   - Start distally and work up extremity;
   - Avoid areas of flexion and lower extremities to minimize complications;
   - Select vein and appropriately sized catheter on the basis of the intended purpose and duration of use, known complications [e.g., phlebitis and infiltration], and experience of individual catheter operators.
   - Apply a tourniquet 2-6 inches above the proposed site to impede venous flow without arterial occlusion. [A radial pulse should be felt.]

3. Tips to dilate vein include:
   - Apply digital pressure just above selected insertion site;
   - Ask the patient to open and close fist repeatedly;
   - Warm compresses may be used for difficult access;
   - Lower site below level of heart.

4. For children 2 months of age and under the site is to be prepared per protocol:
   - Cleanse with povidone iodine in a circular motion applying friction, starting friction from the center [insertion site] moving outward to the periphery until a 2" diameter has been cleansed.
   - Allow the povidone iodine to air dry.
   - Remove the povidone iodine with alcohol using the same circular motion applying friction.
   - Allow to air dry.

   NOTE: If the patient is allergic to iodine, prep with alcohol only using two alcohol preps or alternative method ordered by physician.

5. For patients over 2 months of age, the site is to be prepared per protocol:
   - Before skin prep, clip hair as needed [do not shave];
   - Cleanse with Chlorhexidine by pinching the wings on the applicator to break the ampule and release the antiseptic. Do not touch the sponge. Wet the sponge by repeatedly pressing and releasing the sponge against the treatment area until liquid is visible on the skin.
   - Use repeated back and forth strokes of the sponge for approximately 30 seconds. Completely wet the treatment area with antiseptic. Allow the area to air dry for approximately 30 seconds. Do not blot or wipe dry.

   NOTE: If the patient is allergic to Chlorhexidine or isopropyl alcohol, prep with Betadine or alternative method ordered by the physician.

6. The IV protective catheter is to be inserted using sterile technique:
   - Ensure catheter hub and primary push-off tab are fully seated to the needle housing assembly;
   - Hold catheter by ribbed needle housing with the thumb and fingers on opposite sides. The needle bevel and push-off tab should be in the up position;
   - Stabilize dilated vein by anchoring vein with thumb and gently stretching the skin downward;
   - Insert the needle into the skin and vein at an appropriate angle, usually 20-35 degrees;
   - Blood flashback may occur before the catheter tip is fully in the vein, since the catheter is shorter than the needle. Slight advancement of the catheter and needle together will assure full catheter entry into the vein.
   - Hold needle housing stable, thread the desired length of the catheter forward into vein by pushing tab forward. As the catheter is threaded, the needle guard will cover the needle.
   - Do not force if resistance is met.
   - Do not re-insert needle into the catheter at any time as needle could cut catheter causing a catheter embolus.
   - Stabilize device at push-off tab and withdraw needle into needle guard by retracting the ribbed needle housing until securely locked into place. The needle will "click" when locked.
   - Apply digital pressure to the vein just above the tip of the catheter and secure catheter hub.

- Remove needle guard by twisting slightly and pulling it out of the catheter hub.
- Collect blood sample, if applicable. [Withdraw blood prior to flushing catheter with normal saline.]
- Release tourniquet.
- Connect primed INT/IV set and luer lock in place, ensuring a secure connection.
- Dispose of secured needle in proper sharps container.

7. A butterfly needle is to be inserted utilizing sterile technique:
   - Pinch wings together maintaining sterility of needle.
   - Insert butterfly needle into the skin with bevel upward at a 45 degree angle. Decrease the angle of the needle until almost level with the skin surface, and direct it toward the vein.
   - Proceed carefully until the vein is punctured **indicated by the presence of "flash" directly behind or below the button.**
   - Continue to advance [exerting a gentle lifting pressure to avoid piercing the opposite wall of the vein] until the needle is well within the vein.
   - Release tourniquet;
   - Collect blood sample, if applicable. [Withdraw blood prior to flushing catheter with normal saline.]
   - Connect primed INT/IV set and luer lock in place, ensuring a secure connection.

8. Insertion attempts are to be documented:
   - All pertinent data to include date, time, site of insertion, catheter gauge, number of sticks, and staff member initiating IV access is to be documented.
   - If more than 2 attempts to start intravenous access are necessary, assistance is to be obtained from a nurse experienced in starting IV's.
   - After four attempts at initiating IV access, the physician may be notified for further instructions.

9. IV site dressing is to be applied over the IV insertion site to securely anchor the catheter/needle, avoid irritating motion and to avoid transport of cutaneous bacteria to the venipuncture site:
   - Skin prep may be used to secure dressing.
   - Tape is not to be applied under the transparent dressing.
   - Transparent dressing is to be applied over IV site to cover hub only, not junction of tubing and hub, to allow for easier tubing changes;
   - The date, catheter/needle gauge, and initials of staff member initiating access are to be noted and securely attached to the dressing;
   - Transparent dressing does not need to be changed unless integrity of the dressing is disturbed.

10. Protocol for collecting blood sample from IV site:
   - If blood is drawn when IV initiated, blood is to be collected prior to flushing of catheter with normal saline.
   - If blood is drawn from an established IV site, 3 mls of blood is to be discarded prior to collecting blood sample.

11. INT Protocol for Flushing:
   - Swab injection cap with Site Scrub.
   - Instill the saline flush via **endcap** to flush access: ~~maintaining positive pressure on plunger while infusing last ½ ml of saline flush as the clamp is closed.~~

12. Protocols for INT flushes to minimize clot formation: ***[See attached]***
   - Adolescents [13 - 18 years] and adults are to have INT flushed with 3 mls of saline on insertion, after administration of each medication, or a minimum of every 8 hours/PRN;
   - The pediatric [12 years of age and younger and younger] is to have INT flushed with 1 ml of saline [preservation free] on insertion, after administration of each medication, or a minimum of every 4 hours/PRN;
   - Flushing the INT with saline is to be documented on the eMAR.

13. IV Related Monitoring/Care:
    - A buretrol is to be utilized for all patients 12 years of age and under. Fluid volume of buretrol is to be limited to hourly infusion rate.
      [Exception : NBN – volume of buretrol is to equal IV rate for 4 hours]
    - IV site is to be checked hourly and PRN with appropriate documentation.
    - Phlebitis/Infiltration scale [attached] is to be utilized to address IV site condition a minimum of once per shift, unless complications warrant additional evaluations.
    - An Event Record is to be completed when IV complications are identified.
    - IV intake is to be recorded per policy or as ordered with appropriate documentation In CERNER **[right click on IVF on eMAR to enter volume or enter amount manually based on IV pump primary volume.**
    - IV site is to be changed every 3 days unless a physician order is obtained to use for a longer time frame.
    - IV access initiated outside RMC or with poor asepsis is to be restarted within 24 hours.
    - IV tubing is to be changed every 3 days. Exception :
      - EMS tubing – change on admission ;
      - Propofol tubing – change every 12 hours ;
      - TPN/PPN tubing/filter – change every 24 hours.
    - A change sticker is to be applied to the IV tubing to indicate the day tubing is to be changed.
    - With intermittent therapy, cap off end of IV tubing with Dual Luer Lock Cap [~~blue~~ dead end cap]. Use a new cap each time [do not leave tubing open to air].

    ~~Note : In an emergency, if EMS tubing has to be used prior to changing, a needle lock device is to be attached to the Y port for Clearlink access.~~

14. KVO Rate: [Keep Vein Open]
    - Utilize appropriate size bag to total 24 hours volume [i.e. 500 ml bag of IVF's for adults; 250 ml bag for all others].
    - The KVO rate for an adult patient is not to exceed 25 mls/hour unless specifically ordered otherwise by the physician.
    - The KVO rate for a renal patient is not to exceed 10 mls/hr unless specifically ordered otherwise by the physician.
    - The KVO rate for a pediatric patient is not to exceed 5 mls/hr unless specifically ordered otherwise by the physician.

15. Infusion Control Devices:
    - An infusion control device is to be utillzed for all IV infusions.
      Exceptions:
      - Infusion control device may not be warranted when transporting a patient between nursing units unless the IV solution is medicated.
      - Non-medicated IVF at KVO rate may be regulated by roller clamp.
      - When IVF bolus is required.

16. IV Access Removal:
    - Carefully remove the transparent dressing with alcohol, taking care not to disturb the catheter/needle.
    - A 2 x 2 sterile pad ~~or alcohol swab~~ is to be placed just above the IV site.
    - Without pressure, the device is to be quickly withdrawn pulling straight back to avoid tearing the vein.
    - If butterfly used:
      - **Place a gauze pad over the venipuncture site, covering the body of the device;**
      - **While needle still inside vein, grasp body of device with thumb and middle finger and activate button with tip of index finger [without impeding retraction of the needle at the end of the set].**
      - ~~withdraw by grasping the translucent yellow safety shield grip area with the thumb and index finger with opposite hand, grasp tubing between thumb and index finger, push yellow shield forward until safety shield is locked in place.~~
    - **Confirm that needle is shielded and dispose of device in approved sharps container.**
    - Immediately apply pressure and maintain the pressure to the site with the gauze until bleeding is stopped to prevent hematoma formation or/and blood oozing out of the vein.
    - A band-aid or pressure dressing is to be applied as indicated.
    - **For removal of external jugular [EJ] catheters:**
      - **Apply direct pressure with gauze for at least 5 minutes;**
      - **Apply pressure dressing;**
      - **Instruct patient to continue manual pressure to site for an additional ten minutes to minimize hematoma formation.**

- The venipuncture site is to be assessed for redness, swelling, or formation of a hematoma.
- The intravenous access device is to be assessed for integrity. The physician is to be notified if the integrity of the catheter has been compromised.
- Document the discontinuation of the IV access, site, and access device integrity.

17. Cultures:
    - Cultures of IV catheter and/or fluid may be required if either is the suspected cause of infection in a patient.
    - Each specimen is to be labeled with patient information, noting the type of specimen, date and time of collection, and the **CERNER logon** ~~name~~ of staff member collecting the specimen.
    - If IV fluids is the suspected source of infection:
        - Aseptically withdraw 20 mls of fluid into syringe and place in sterile specimen container.
        - The lot number of IV fluid container is to be recorded on the specimen container label and comment section of computer generated order.
        - Send to lab immediately.
    - If IV cannula is the suspected source of infection:
        - Prep insertion site.
        - Aseptically remove the cannula.
        - Clip cannula tip with sterile scissors and drop tip into a sterile container.
        - Label and send to lab immediately.

Vice President, Patient Care Services/Date

Chairman of Infection Control Comm./Date

References:	
N	• INS Guidelines • CDC Standards for Intravenous Therapy

Written: 1/00, 5/00, 2/03, 3/04, 3/06, 4/13
{IVAccess.Doc}

rmc
the Regional Medical Center

Subject:	Medication Management: Parenteral Medications	TJC Function: MM
Page:	1 of 4	Manual: Nursing & Pharmacy

PURPOSE: To define a process for parenteral administration of medications.

POLICY: The licensed nursing staff [after completion of appropriate education] is to administer parenteral medications as prescribed by the physician. The RN must administer IV push [bolus] medication and perform IV admixtures per the Nurse Practice Act when permitted per policy.

Only the pharmacy staff compounds or admixes sterile medications, including intravenous admixtures, except in emergencies, when the drug is to be used immediately, when not feasible [i.e. when the product is compounded, it has limited stability] or in ED, OR or other settings where a licensed independent practitioner controls the preparation of the medication.

PROCEDURE:

1. Refer to Medication Administration table [attached] for techniques for intradermal, subcutaneous, intramuscular and Z-track injections.

2. Injection site is to be documented using appropriate abbreviations:

RD	-	right deltoid
LD	-	left deltoid
RG	-	right gluteal
LG	-	left gluteal
RT	-	right lateral (lower) thigh
LT	-	left lateral (lower) thigh
LA	-	left arm
RA	-	right arm
ABD	-	abdomen

3. When allowed per policy, the licensed nurse is to prepare the parenteral [IM, subcutaneous, intradermal, etc.] medication immediately prior to administration.

4. The process for reconstituting of powdered medications when allowed per policy:
   - Inject the amount of diluent required per manufacturer into the vial of medication [preservative free sterile water, normal saline or other suitable preservative free diluent is to be utilized for newborns and pediatric patients up to 3 months of age];
   - Mix the solution by shaking gently;
   - Label multidose vial with:
     - time and date of reconstitution
     - amount and type of diluent added
     - equivalent dosage per ml
     - initials of staff reconstituting the medication.
   - Refrigerate when indicated.
   - Discard per policy.

5. To administer IV medications to pediatric patients/newborns:
   - Obtain prepared medication from Pharmacy;
     - Medications for pediatric patients [12 years of age or younger] are to be in a syringe rather than a minibag.
   - For IVF rates greater than 15 ml/hour, add medication to burette and fill with fluid volume to equal hourly infusion rate [medication volume plus fluid volume to equal hourly IV rate]; then infuse at prescribed rate.
   - When monitoring drug levels [i.e. Theophylline, Gentamicin, etc.], the medication is to be administered via a medfusion syringe pump.
   - For IVF rates less than 15 ml/hour and medication volumes less than 2 mls, use syringe pump. If not available:
     - close roller clamp;
     - pinch tubing below lower "y" port;
     - inject medication slowly into lower "y" port;
     - release tubing;
     - restart IV at prescribed rate.

6. To administer IV push medications, the RN is to:
   - Dilute appropriate medications with normal saline or sterile water to promote ease of calculation and accuracy of dosage or obtain premixed diluted medication, if available.
     Ex. [Morphine 10 mg/ml diluted with 9 mls NS = 1 mg/ml]
   - The syringe of diluted medication is to be labeled with dosage of medication, amount of diluent, resultant concentration, date/time and initials of person preparing medication.

- Check compatibility of IV medication and IV solution; if incompatibility noted, flush line with NS before and after medication administration.
- Close roller clamp or pinch IV tubing, wipe lower "y" port injection cap with an alcohol swipe, inject small amount of medication slowly. Open roller clamp and re-adjust flow rate or release IV tubing to flush line.
- If medication requires further dilution, medication may be administered via infusing IV fluids using upper "y" port to administer medication.
- Document medication and dosage administered, duration of administration and drug effect/adverse reactions.

7. When an IV additive is not available in a premixed solution and when permitted per policy, the RN is to compound the admixture:
   - Obtain the required medication dose and type/amount of diluent;
   - Wipe the injection port of the diluent container and add the prescribed dose of medication utilizing aseptic technique
   - Mix the solution thoroughly;
   - Label the solution using a red "medication added" sticker [refer to policy "Medication Management: Labeling"].
   - Refer to policy "Medication Management: Compounding" for additional information.

8. To administer a continuous IV medicated infusion:
   - Utilize the standardized premixed solution or pharmacy staff [or RN in emergency situation] is to prepare the medicated infusion according to the "Red Medication Booklet".
   - Utilize IV pump to deliver the prescribed dose via the specific drug dosing parameters.
   - Document the infusion admixture, to include the type and amount of medication and diluent and the prescribed dose with equivalent ml/hour rate. Also document when the infusion was initiated and ended.

9. Refer to the "Red Medication Booklet" for protocols to titrate or taper the medicated IV infusions.

MD 7/14/12
Chairperson P&T Committee/Date

7/14/12
Pharmacy Director/Date

13 Jul 12
VP – Patient Services/Date

References	
E	◦ RMC P&T Committee
N	◦ 2012 Hospital Accreditation Standards

Written: 5/78, 5/81, 11/83, 1/86, 9/86, 11/87, 10/89, 10/93, 2/97, 8/99, 10/02, 2/03, 8/05, 6/12

Techniques for administration of medication by injections:

Reminders for all injections:
- Cleanse site with alcohol prep, wiping from center out to the periphery;
- Express the air bubbles from the syringe leaving 0.1 ml at the tip so that all medication will be expelled;
- After medication is administered, activate safety device and discard in the sharps container.

Type injection:	Subcutaneous
Site of injection:	Upper lateral aspect of arm, anterior portion of thigh, abdomen
Needle:	25 – 26 gauge, 3/8 - 5/8 inch needle
Fluid Amount:	Usually 2 mls or less
Administration:	▪ Insert needle at a 45 or 90 degree angle depending on patient size; ▪ Inject medication slowly; ▪ Withdraw needle quickly and apply pressure unless contraindicated.

Type injection:	Intramuscular
Site of injection:	Larger muscle masses as deltoid muscle, gluteal muscles and vastus lateralis
Needle:	Appropriate size gauge and length for patient [gauges 22 or 23]
Fluid Amount:	Usually 2 mls or less
Administration:	▪ Insert needle at a 90 degree angle ▪ Pull back on plunger [if blood return noted, discard and prepare another dose of medication] ▪ Inject medication slowly; ▪ Withdraw needle at same angle as inserted; ▪ Apply pressure and/or massage injection site unless contraindicated.

Type injection:	Intradermal
Site of injection:	Medial forearm [back surfaces for allergy testing]
Needle:	26 gauge, 3/8 inch needle
Fluid Amount:	Usually 0.5 mls or less
Administration:	▪ Pull the patient's skin taut; ▪ Insert needle at 10 – 15 degree angle with bevel of needle facing up; ▪ Inject medication slowly, observing for wheals and blanching [normal]; ▪ Withdraw needle, wiping are gently if necessary

Type injection:	Z-track [for administration of irritating medications]
Site of injection:	IM site [preferably in a larger, deeper muscle]
Needle:	• Appropriate size gauge and length for patient • Apply new needle to syringe after preparing medication so no solution remains on outside of needle shaft
Fluid Amount:	Usually 2 mls or less
Administration:	• Pull overlying skin and subcutaneous tissue approximately 1 – 1 ½ inches laterally to the side • Insert needle at a 90 degree angle • Pull back on plunger [if blood return noted, discard and prepare another dose of medication] • Inject medication slowly; • Leave needle inserted for 10 seconds to allow the medication to disperse evenly; • Release the skin after withdrawing the needle [leaves zigzag path that seals the needle tract].

ITEMIZED BILL PAGE 1

DATE 06/09/2015
TIME 01:10:01 PM

REGIONAL MEDICAL CENTER
3000 ST. MATTHEWS ROAD
ORANGEBURG SC 291181442

PATIENT CONTROL NUMBER [redacted]

PATIENT NAME [redacted]

MEDICAL RECORD NUMBER [redacted]

BEGINNING DATE OF SERVICE 110314

ENDING DATE OF SERVICE 112814

REV CODE	PROCEDURE DESCRIPTION	HCPCS/ RATES	DATE	UNITS	CHARGE AMOUNT	NC CHARGE AMOUNT
0272	WND KLING GAUZE		110514	1	78.00	
0272	WND KLING GAUZE		110614	1	78.00	
0272	WND KLING GAUZE		111114	3	234.00	
0272	DRESSING, MEDIHONEY 2X2	A6196	111114	1	18.00	
0272	WND KLING GAUZE		111314	1	78.00	
0272	DRESSING, MEDIHONEY 2X2	A6196	111814	1	18.00	
0272	DRESSING, MEDIHONEY 2X2	A6196	112814	1	18.00	
0420	WND PT DEBRIDEMENT/SKIN	9759759GP	111914	1	199.00	
0940	WND LOW FREQUENCY ULTRAS	97610	110314	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	110514	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	110614	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	111114	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	111314	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	111414	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	111814	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	9761059	111914	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	112114	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	112414	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	112614	1	225.00	
0001	PAGE 1 OF 1			21	3196.00	
0001	TOTAL			21	3196.00	

PLAINTIFF'S EXHIBIT

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ITEMIZED BILL

PAGE 1

DATE 06/09/2015
TIME 10:19:59 AM

REGIONAL MEDICAL CENTER
3000 ST. MATTHEWS ROAD
ORANGEBURG SC 291181442

PATIENT CONTROL NUMBER
[redacted]

PATIENT NAME
[redacted]

MEDICAL RECORD NUMBER
[redacted]

BEGINNING DATE OF SERVICE
111114

ENDING DATE OF SERVICE
112814

REV CODE	PROCEDURE DESCRIPTION	HCPCS/ RATES	DATE	UNITS	CHARGE AMOUNT	NC CHARGE AMOUNT
0510	WND OP FACILITY FEE LEVE	99213	111114	1	237.00	
0510	WND OP FACILITY FEE LEVE	9921325	111914	1	237.00	
0510	WND OP FACILITY FEE LEVE	9921325	112114	1	237.00	
0510	WND OP FACILITY FEE LEVE	99213	112814	1	237.00	
0001	PAGE 1 OF 1			4	948.00	
0001	TOTAL			4	948.00	

518

Statement of Account Page 1

From 10/01/14 To 06/09/15

TRMC HOSPITALIST WOUND CENTER
3000 ST MATTHEWS RD
ORANGEBURG SC 29118-1442

Account [redacted]

Statement Date 06/09/15

Business Phone 803-395-4566
Registration Phone

Federal ID No. [redacted]

- - Patient Name - -

BC 10 TIKAYAH JEWEL HAMILTON
FC
NC [redacted]

[redacted]

- - Misc Remarks - -

[redacted]

Date	Patient	Code	PL	Mods	Description	Units	Doctor	Amount
11/19/14	ROBERT	99213		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	89.00
11/26/14	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	29.35-
11/26/14	ROBERT	99912			[redacted]		Gehling,Ma	59.65-
12/05/14	ROBERT	99212		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	65.00
01/09/15	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	14.93-
01/09/15	ROBERT	99912			[redacted]		Gehling,Ma	50.07-
10/31/14	ROBERT	99214		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	140.00
02/25/15	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	45.39-
02/25/15	ROBERT	99912			[redacted]		Gehling,Ma	94.61-
11/21/14	ROBERT	99213		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	89.00
03/18/15	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	58.70-
03/18/15	ROBERT	99912			[redacted]		Gehling,Ma	119.30-
11/28/14	ROBERT	99213		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	89.00
03/02/15	ROBERT	99212		22	VISIT EST OFFICE/OUTPATIE	1.000	Gehling,Ma	65.00
04/06/15	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	14.93-

04/06/15 ROBERT 99912 [redacted] Gebling,Ma
50.07-

Total Listed:	.00
Total Not Listed:	.00
Balance Due:	.00

520

Peter C. de Vito, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
1050 ST. ANDREWS BLVD.
CHARLESTON, SOUTH CAROLINA 29407

TELEPHONE (843) 571-2350

02/03/15

Jonathan Krell, Esquire
P O Box 399,
Charleston SC, 29401

RE: [redacted]

Dear Mr. Krell

This letter is regarding the future medical treatment required to assist Robert Middleton; these are a direct result of the accident which occurred on October 2014, when my patient sustained injuries. The following treatments and fees would be recommended:

Intralesional injections with cortico-steroids at a fee of $85.00 per injection. The patient will need these treatments at monthly intervals for an indefinite period, to obtain the desired softening.

The surgical fee for scar revision with possible skin grafs of the right hand would be-$2,500.00. The hospital, operating room, and anesthesia fees could range from $4,000.00 to $12,000.00 or more depending upon the length of stay, etc.

It should be understood, however, that while these procedures will improve the scarring, the patient will still be left with noticeable scars due to the nature of the injury.

If further information is needed to assist my patient, please do not hesitate to contact my office.

Very truly yours,

Peter C. de Vito, M.D.

Peter C. de Vito, M.D., F.A.C.S.
DBNR

PCD:pdv

PLAINTIFF'S EXHIBIT

Peter C. deVito, M.D.
1050 St. Andrews Boulevard
Charleston, SC 29407

(843)571-2350

4/23/18

DATE	PROCEDURE	PATIENT NAME	DOCTOR	CHARGES	CREDITS	BALANCE
1/26/15	Atty J Krell				500.00	-500.00
2/2/15	Consult, Exam & Evaluation		Peter C. deVito	500.00		0.00
3/2/15	Estab Patient follow up (15)		Peter C deVito	30.00		30.00
4/23/18	Estab Patient follow up (15)		Peter C. deVito	75.00		105.00

Current	75.00	30 Days	0.00	60 Days	0.00
90 Days	0.00	120 Days	0.00	150+Days	30.00

Please Pay This Amount 105.00

522

Peter C. deVito, M.D.
1050 St. Andrews Boulevard
Charleston, SC 29407

(843)571-2350

[redacted]

2/2/15

[redacted]

DATE	PROCEDURE	PATIENT NAME	DOCTOR	CHARGES	CREDITS	BALANCE
1/26/15	Ally J Krell[redacted]	[redacted]			500.00	-500.00
2/2/15	Consult, Exam & Evaluation	[redacted]	Peter C. deVito	500.00		0.00

Current	0.00	30 Days	0.00 60 Days	0.00	Please Pay This Amount → 0.00
90 Days	0.00	120 Days	0.00 150+Days	0.00	

STATE FO SOUTH CAROLINA
COUNTY OF ORANGEBURG

) IN THE COURT OF COMMON PLEAS
) FIRST JUDICIAL CIRCUIT
) CASE NUMBER: 2015-CP-38-01334

TEKAYAH HAMILTON, INDIVIVUALLY AND AS PARENT AND GUARDIAN AD LITEM FOR ROBERT LEE M., JR. A MINOR CHILD UNDER THE AGE OF EIGHTEEN,

Plaintiffs,

v.

REGIONAL MEDICAL CENTER AND JAMIE DOWNING, RN,

Defendants.

AFFIDAVIT OF MONICA STOBBS, RN, BSN

FILED FOR RECORD
ORANGEBURG COUNTY, SC
2015 OCT -7 P 4:29
CLERK OF COURT

PERSONALLY, appeared before me, the undersigned, who being duly sworn, under the penalties of perjury, says as follows:

1. I am a licensed registered nurse in the state of South Carolina.
2. My education, training and experience are set forth in the attached curriculum vitae (attached hereto as Exhibit 1).
3. My education, training and experience qualify me to render expert opinions regarding the care rendered to Robert Lee M., Jr.
4. I am familiar with the standard of care for what a reasonable, prudent nurse would do or not do in administering IV medication, including but not limited to the intravenous administration of antibiotics including similar situations to that of Robert Lee M., Jr.
5. I reviewed the medical records of Robert Lee M., Jr., which consist, in part, of records from Regional Medical Center located at 3000 St. Matthews Rd., Orangeburg, SC 29118. These are the types of records and documents which I normally consider in rendering an expert medical opinion.



6. After review of the afore mentioned medical records, it is my opinion to reasonable degree of medical certainty that Regional Medical Center and the nursing staff while in the course and scope of its employment at Regional Medical Center committed negligent acts or omissions in its care of Robert Lee M., Jr.

7. On October 25, 2014 Robert Lee M., Jr., was admitted to Regional Medical Center for the treatment of neo-natal fever. During the course of treatment at Regional Medical Center, the nursing staff administered intravenous antibiotic medication to Robert Lee M., Jr. Without intending to limit the scope of my opinions, below are some of the breaches of the standard of care for the administration of IV medication to Robert Lee M., Jr.:

   a. Failing and neglecting to properly inspect the IV site on October 28, 2014 at approximately 4:27 a.m. prior to the administration of antibiotic medication.

   b. Failing and neglecting to properly monitor the IV site after the administration of the antibiotic medication.

8. Further, it is my opinion, to a reasonable degree of medical certainty that the actions or inactions of the defendants most probably caused and/or contributed to the injuries and damages suffered by Robert Lee M., Jr.

9. This Affidavit is given in compliance with the South Carolina Code of Laws which do not require me to state all negligent acts or omissions by any defendant. Additionally, I reserve the right to supplement or amend this Affidavit or any testimony by me after receiving additional medical records, documents, depositions and/or information.

Signature Page to Follow

MONICA STOBBS, RN,BSN

SWORN TO AND SUBRSCRIBED BEFORE ME
This 12th day of March, 2015

SEAL

NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISION EXPIRES: 08/15/2024

Monica Stobbs, RN, BSN
164 Market Street, Suite 295
Charleston, SC 29401
TEL: (857) 334-5310 EMAIL: monicastobbs@gmail.com

PROFESSIONAL BACKGROUND

2012 – Present — MEDICAL UNIVERSITY OF SOUTH CAROLINA, Charleston, SC

Per Diem Nurse at this Level One Trauma Center
- Clinical areas of practice include Adult General Medicine & Surgery

1990 – 2012 — MASSACHUSETTS GENERAL HOSPITAL, Boston, MA

Per Diem Nurse at this Harvard affiliated hospital
- Clinical areas of expertise include Trauma Surgery, Orthopaedics, Neurosurgery, General Surgery, Acute Medical & Cardiac Units
- Interface daily with nationally recognized physicians in collaborative patient care
- Provide advanced in-patient care using state of the art equipment (including ventilator & cardiac monitoring)
- *Certified* IV Therapy Instructor; BCLS; EKG interpretation

1994 - 1996 — MA DEPARTMENT OF PUBLIC HEALTH, Boston, MA
Nurse Consultant

- Monitored seven (7) Long-Term Health Care facilities in MA for Quality Assurance, Regulatory Compliance and Standards of Clinical Practice
- Identified substandard areas of health care delivery
- Assisted facilities in developing plans of correction for substandard areas of practice
- Reported directly to MA's top three (3) Health Care officials
- One (1) of two (2) nurses in the country to perform this role

1986 - 1990 — NEW YORK HOSPITAL-CORNELL MEDICAL CENTER, New York, NY

1989 - 1990 — Acting Head Nurse on an Open Heart Surgery Critical Care Unit
1986 - 1989 — Senior Staff Nurse in this 1,000 Bed Metropolitan Hospital

1988 - 1989 — WASHINGTON UNIVERSITY MEDICAL CENTER, St. Louis, MO

Per Diem Nurse (General Medical/Surgical Units Organ Transplant & Critical Care Units)
- Performed basic & advanced nursing skills in a variety of settings including Critical Care & Organ Transplant Units

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1983 - 1985 ST. LOUIS UNIVERSITY HOSPITAL, St. Louis, MO

Charge Nurse/Staff Nurse (Cardiology & Head/Neck Surgical Unit)

- Provided direct patient care including EKG recognition, respiratory & intravenous therapy, advanced physical assessments

EDUCATION: BSN - May 1983, Creighton University School of Nursing
Current License in the State of SC

Presentations:

- Evaluating Spine Injury Claims; NCAJ & APITLA Medical Malpractice Seminar; Raleigh, NC; Nov 2011. CLE credited.
- Evaluating Spine Injury Claims; South Carolina Bar Association; Columbia, SC; October 2012. CLE credited.
- Evaluating Spine Injury Claims; United States Attorney Office, Southern District of Illinois; October 2013. CLE credited.
- Evaluating Spine Injury Claims; United States Attorney Office, Southern District of Florida; February 2014. CLE credited.

Publications:

- D.C. Trial Lawyers Association (DCTLA) Quarterly Journal; "Evaluating Spine Injury Claims". January 2012.
- The Nurse's Note
  - "Spine Arthritis & Back Injury Claims; Jan 2010
  - "Spine Surgery: Complications of Spinal Fusion Surgery"; Feb 2010
  - "Evaluating Breast Cancer Cases"; March 2010
  - "Orthopaedic Emergencies: Acute Compartment Syndrome"; April 2010
  - "Case Report: Plaintiff Wins 1.1 Million in ACS Case"; May 2010
  - "Medical Chronology A Critical Tool for Winning Your Case"; June 2010
  - "Evaluating Brain Injury Cases"; July 2010
  - "Sleep Deprivation"; August 2010
  - "Spinal Disc Replacement Surgery"; Sept 2010
  - "Evaluating Cancer Claims"; Oct 2010
  - "Emergency Room Practice: Imaging Protocols for Abdominal Pain"; Nov 2010.

Q. Was that certification thru the institution or to the state?
A. Through, through Massachusetts General Hospital.
Q. So that was a facility certification?
A. Yes.
Q. How long was that program?
A. It was so many years ago. Maybe it was, it was maybe over a week.
Q. And again, since you haven't had any clinical pediatric nursing experience I presume you've never started a pediatric IV?
A. No.
Q. Never cared for a pediatric patient with a peripheral IV?
A. Taking care of an IV is an IV whether it's a baby or an adult. It's the same principle in terms of management of the actual IV and giving administration of medication through it.
Q. All right. I appreciate the answer, but if you can say yes or no and then you're free to say whatever you want. So, my question was, I presume that you have not taken care of a patient with a peripheral IV that's pediatric?
A. I have not.
Q. Thank you. What is your hourly rate for your

Q. When we're talking about Ms. Hamilton and her child, the medication that was administered was what?
A. Ampicillin.
Q. All right. Is ampicillin a vesicant or non-vesicant?
A. It's a vesicant.
Q. Okay. So for the purposes of your deposition in, in, in the broad sense, when I ask you questions do you want me to use extravasation or infiltration to describe those events that occurred?
A. Either would work for this.
Q. Okay. So you think they are synonymous?
A. Yes.
Q. Have you done any literature research to come to any of your thoughts in this case?
A. No, this is basically Nursing 101. There are many articles that talk about policies and procedures for giving IV medication or managing an IV site, it's basic nursing 101 as well.
Q. So you are not relying on any literature in coming to any of your thoughts; is that fair?
A. That's fair. There will be literature that supports my opinions.
Q. But you haven't done a search, any sort of research

that there was any redness to the IV site?

A. No.

Q. Did you see at 4:04 that there was any documentation of any signs and symptoms of Phlebitis?

A. No.

Q. Did you see at 4:04 that there's any documentation of any signs and symptoms of swelling?

A. No. I didn't see the 4:27 either.

Q. All right. How many times have you given a peripheral IV to, with a 24 gauge needle to a pediatric patient?

A. I've administered no medications IV to a pediatric patient. I've administered thousands to adults.

Q. So the answer then would be none?

A. None to pediatric patients. Thousands to adult patients.

Q. So, as you sit here today you can't tell me that you could get blood return on an IV administered to a pediatric patient with a 24 gauge needle --

A. A vein is --

Q. Let me finish. Because you have no experience in doing that?

A. No. I'm not saying that period of vein is a vein. You should get blood return from a vein whether

it's a baby or whether it's an adult. A vein is a vein.

Q. Are you familiar with articles in the literature that say it is difficult to impossible to get blood return on the 24 gauge needle?

A. No. I have managed 24 gauge needles in adults and you can get a blood return.

Q. Well you would agree with me to the care, the management of an adult patient is different from a pediatric patient wouldn't you?

A. The management of a vein is the management of the vein whether it's an adult or whether it's a baby, it's the same. The management of a vein is a vein.

Q. What is your definition of a vesicant?

A. It would be a medication or fluid that can cause a burn like injury to the skin.

Q. Would you agree with me that signs and symptoms of infiltration or extravasation, however you want to, and for this question I'm using those terms synonymously, often do not occur and are not always obvious until a few hours after the patients IV device has failed?

A. I disagree.

Q. All right. Tell me why?

A. Because when theres an infiltration of the vein and

STATE OF SOUTH CAROLINA)	IN THE CIRCUIT COURT
)	FIRST JUDICIAL CIRCUIT
COUNTY OF ORANGEBURG)	
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen,)	C/A No.: 2015-CP-38-01234
Plaintiff,)	
-vs-)	**NOTICE OF MOTION AND MOTION IN LIMINE TO EXCLUDE MONICA STOBBS TESTIMONY**
Regional Medical Center)	
Defendant.)	

Defendant, The Regional Medical Center, (hereinafter TRMC), by and through the undersigned, hereby states the following for TRMC's Motion in Limine:

1. The Plaintiff commenced this action alleging Medical Malpractice against the Defendant, TRMC. The matter is scheduled for a date certain trial on May 7, 2018. Defendant TRMCis moving pursuant to this Motion in Limine to exclude Monica Stobbs, RN from testifying as a medical expert in administering/managing pediatric IV therapy.

2. Monica Stobbs is not qualified to testify as to IV Therapy for pediatric patients. There is a clear distinction between treatment of adults and pediatric patients, particularly neonates and infants. Monica Stobbs testified to the fact she never cared for and managed any pediatric patient with a peripheral IV and did not research any treatics or other journals regarding the treatment of pediatric peripheral IV treatment. Her contention that IV management for

pediatric patients is the same for adults is simply not accurate and contrary to modern medicine and the literature. Monica Stobbs has never started an IV on a pediatric patient.

3. In order to qualify an expert they must have the "knowledge, skill, experience, training or education" in order to testify. SCRE 702. "To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter.'" *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 253, 487 S.E.2d 596, 598 (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995); *see also Botehlo v. Bycura*, 282 S.C. 578, 587, 320 S.E.2d 59, 65 (1984) (orthopedic surgeon was not qualified to testify on the standard of care for podatrist where orthopedic surgeon had no training in podiatry, was not familiar with any journals or periodicals in podiatry, and was not familier with the surgical procedure performed).

4. Ms. Stobb's expert opinion is premised on her belief that the standard of care for IV management is the same for pediatric patients as it is for adults. Stobbs Depo. pg. 13 ll. 13-18 (Exhibit 1). There is a clear distinction between IV management in adults than pediatric patients.[1] Veins in infants are "*obviously* smaller" and they can be "threadlike".[2] In Ms. Stobb's deposition she testified to the fact she never treated a pediatric patient with IV therapy indicating

[1] The Infusion Nurses Society: In fusion Therapy in Clinical Practice, 2nd. eds Hankins J, Lonsway RA, Hedrick C and Perdue MB. Saunders, St. Louis, MO 2001, 561 "Children present a wide variety of physical characteristics different from those in adults. In addition, premature infants and newborns vary greatly from older children in their anatomy and physiology. These characteristics affect the ability of neonates and infants to cope with environmental stress and to manage the metabolism, absorption, distribution, and excretion of medications and solutions. Although body systems in infants and children are different from those in adults, for the purpose of this text, only those related to infusion therapy are addressed in detail." (Exhibit 5).

[2] *Id.* at 562 "The size of venous and arterial vessels in the infant and child are obviously smaller than those in the adult. Although the vessels are anatomically positioned in the same locations throughout life, their sometimes-threadlike characteristics and tendency to hide make them difficult to locate in the young patient." (Exhibit 6).

her lack of skill and experience in the subject matter. Stobbs Depo. pg. 13 ll. 9-24. She further testified she did not read any literature regarding the management of IV's in pediatric patients in preparing for this matter showing she lacks both knowledge and education. Stobbs Depo. pg. 26 ll. 15-24. (Exhibit 2). Her entire expert opinion is based on her speculative belief that pediatric patients are simply little adults. She stated "[t]aking care of an IV is an IV whether it's a baby or an adult." Stobbs Depo. pg. 13 ll. 15-16. And that the standard of care is the same, it is simply "nursing 101." Stobbs Depo. pg 26 ll. 17. She is under the belief that she "should get blood return from a vein whether it's a baby or whether it's an adult." Stobbs Depo. pg. 32 & 33 ll. 24-7 (Exhibits 3 & 4). This is directly contrary to the literature.[3] Because Ms. Stobbs lacks any experience, skill, training, knowledge, or education and her testimony is premised on her experience managing adult patients Ms. Stobbs is not qualified to give an expert opinion on IV therapy in pediatric patients, as she will not assist the jury as she is not qualified on the subject matter.

5. Similar to the facts in *Botehlo*, 282 S.C. 578, Ms. Stobbs, while a nurse, has not administered IV therapy or cared for a pediatric patient with IV therapy, similar to how the orthopedic surgeon was not familiar with the procedure performed by the podiatrist. Likewise, Ms. Stobbs has not reviewed any literature regarding IV therapy in pediatric patients, the same as the orthopedic surgeon not having reviewed any journals or periodicals for podiatry. *Id.* The only distinction is that here Ms. Stobbs is a nurse. Ms. Stobbs has not started or managed an IV on a pediatric patient. Using the requirements of the *Botehlo* case, Ms. Stobbs is not qualified to give an expert opinion on pediatric IV therapy. *Id.*

---

[3] *Id.* at 422 "Checking for a blood return, or backflow of blood, is not a reliable method for determining the absence of an infiltration. A blood return may not be present when small veins are used because they may not permit blood flow around the cannula; one may think the infusion has infiltrated when it has not." (Exhibit 7).

WHEREFORE, defendant the Regional Medical Center (TRMC) hereby prays this Court issue its Order granting its Motion in Limine excluding Monica Stobb's testimony as an expert.

MICHAEL C. TANNER, L.L.C.

Michael C. Tanner
PO Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Defendants

Bamberg, SC

May 1, 2018

536

Q. Was that certification thru the institution or to the state?
A. Through, through Massachusetts General Hospital.
Q. So that was a facility certification?
A. Yes.
Q. How long was that program?
A. It was so many years ago. Maybe it was, it was maybe over a week.
Q. And again, since you haven't had any clinical pediatric nursing experience I presume you've never started a pediatric IV?
A. No.
Q. Never cared for a pediatric patient with a peripheral IV?
A. Taking care of an IV is an IV whether it's a baby or an adult. It's the same principle in terms of management of the actual IV and giving administration of medication through it.
Q. All right. I appreciate the answer, but if you can say yes or no and then you're free to say whatever you want. So, my question was, I presume that you have not taken care of a patient with a peripheral IV that's pediatric?
A. I have not.
Q. Thank you. What is your hourly rate for your

Exhibit 1

Q. When we're talking about Ms. Hamilton and her child, the medication that was administered was what?
A. Ampicillin.
Q. All right. Is ampicillin a vesicant or non-vesicant?
A. It's a vesicant.
Q. Okay. So for the purposes of your deposition in, in, in the broad sense, when I ask you questions do you want me to use extravasation or infiltration to describe those events that occurred?
A. Either would work for this.
Q. Okay. So you think they are synonymous?
A. Yes.
Q. Have you done any literature research to come to any of your thoughts in this case?
A. No, this is basically Nursing 101. There are many articles that talk about policies and procedures for giving IV medication or managing an IV site, it's basic nursing 101 as well.
Q. So you are not relying on any literature in coming to any of your thoughts; is that fair?
A. That's fair. There will be literature that supports my opinions.
Q. But you haven't done a search, any sort of research

Exhibit 2

that there was any evidence in the IV site?
A. No.
Q. Did you see at 4:04 that there was any documentation of any signs and symptoms of Phlebitis?
A. No.
Q. Did you see at 4:04 that there's any documentation of any signs and symptoms of swelling?
A. No. I didn't see the 4:27 either.
Q. All right. How many times have you given a peripheral IV to, with a 24 gauge needle to a pediatric patient?
A. I've administered no medications IV to a pediatric patient. I've administered thousands to adults.
Q. So the answer then would be none?
A. None to pediatric patients. Thousands to adult patients.
Q. So, as you sit here today you can't tell me that you could get blood return on an IV administered to a pediatric patient with a 24 gauge needle --
A. A vein is --
Q. Let me finish. Because you have no experience in doing that?
A. No. I'm not saying that period of vein is a vein. You should get blood return from a vein whether

Exhibit 3

it's a baby or whether it's an adult. A vein is a vein.

Q. Are you familiar with articles in the literature that say it is difficult to impossible to get blood return on the 24 gauge needle?

A. No. I have managed 24 gauge needles in adults and you can get a blood return.

Q. Well you would agree with me to the care, the management of an adult patient is different from a pediatric patient wouldn't you?

A. The management of a vein is the management of the vein whether it's an adult or whether it's a baby, it's the same. The management of a vein is a vein.

Q. What is your definition of a vesicant?

A. It would be a medication or fluid that can cause a burn like injury to the skin.

Q. Would you agree with me that signs and symptoms of infiltration or extravasation, however you want to, and for this question I'm using those terms synonymously, often do not occur and are not always obvious until a few hours after the patients IV device has failed?

A. I disagree.

Q. All right. Tell me why?

A. Because when theres an infiltration of the vein and

Exhibit 4

Chapter 30

Intravenous Therapy in Children

Anne Marie Frey, BSN, CRNI*

ANATOMIC AND PHYSIOLOGIC DIFFERENCES IN CHILDREN
Physiologic system development in children
Body composition
PEDIATRIC DEVELOPMENTAL AND ASSESSMENT CONSIDERATIONS
History
Physical assessment
FLUID THERAPY
Maintenance fluid requirements
Replacement (deficit) therapy
FLUID VOLUME DEFICITS
Dysfunctions
Isotonic
Hypotonic
Hypertonic
OTHER INTRAVENOUS THERAPIES
Medications administration
Parenteral nutrition
Transfusion therapy
Exchange transfusion
PERIPHERAL ACCESS
Site selection
Peripheral sites
Peripheral access devices
Venipuncture
Heparin locks versus saline locks
Complications
CENTRAL ACCESS
Central venous catheters
OTHER INTRAVASCULAR ROUTES
Umbilical vein/vessel/artery
Intraosseous route
ADMINISTRATION EQUIPMENT
Containers
Administration sets
Electronic monitoring devices
ALTERNATIVE SITE INFUSION THERAPY
Outpatient care
Home infusion therapy
SUMMARY

Starting and maintaining intravenous (IV) therapies in children poses unique challenges to the clinicians responsible for their care. Children are not only very different from adults, but they also display variations among their different age groups. These differences include physical, physiologic, developmental, cognitive, and emotional variables. When any type of infusion therapy is used in a child, a great responsibility is placed on the nurse. Accordingly, the nurse performing IV techniques in children should be highly skilled in the basic IV therapy applications and knowledgeable of the child's developmental stage. Most of the basic principles of safe administration of IV solutions and medications are the same, regardless of the patient's age. However, special considerations are necessary to safeguard the child undergoing these procedures; these measures include the need to calculate small doses and low infusion rates, to choose appropriate venipuncture sites and equipment, and to develop creative measures to distract curious little minds and hands.

This chapter focuses on the needs of children as they relate to infusion therapy and on the unique aspects of caring for children and their families.

Anatomic and Physiologic Differences in Children

Children present a wide variety of physical characteristics different from those in adults. In addition, premature infants and newborns vary greatly from older children in their anatomy and physiology. These characteristics affect the ability of neonates and infants to cope with environmental stresses and to manage the metabolism, absorption, distribution, and excretion of medications and solutions. Although body systems in infants and children are different from those in adults, for the purpose of this text, only those related to infusion therapy are addressed in detail.

The newborn's adjustment to extrauterine life is a complex physiologic process. The first 24 hours of life are the most critical as the newborn makes the respiratory and circulatory transition to extrauterine life. During this period, there is a much higher incidence of death than in the remainder of the neonatal period. All of the body systems undergo change after

*The author and editors wish to acknowledge the contributions made by Corinne Wheeler, an author of this chapter in the first edition of *Intravenous Nursing: Clinical Principles and Practice*.

Exhibit 5

birth, and most of them remain immature for a while. During infancy (birth to 12 months of age), physical and developmental changes occur more rapidly than during any other period. The infant's head and body grow very rapidly during this period, and major body systems undergo a progressive maturation process. In healthy infants, the birth weight is usually doubled at 6 months and tripled at 1 year. During infancy, certain critical developmental tasks that affect nursing care are mastered. However, each child has his or her own pace of development; no two children of the same age are at the same exact stage of development and maturation.

Biologic development in the toddler period (12 to 36 months) is less dramatic than during infancy. Body systems continue to mature, resulting in many children reaching full maturation by the end of the toddler period. Growth slows during this time. Birth weight is quadrupled by 30 months, and the height at age 3 years is generally about half the adult height. Head circumference growth slows; and chest circumference exceeds the size of both the head and the abdomen. The toddler is able to participate in an increased number of activities as a result of gross and fine motor skill advancement. In toddlers, IV connections must be taped and secured and equipment kept outside of the child's reach.

Early childhood (36 months to 6 years), also referred to as the *preschool period,* is a time of growth stabilization. The average annual weight gain is about 5 pounds (2.5 kg); the increase in height ranges from 2.5 to 3 inches (6.4 to 7.6 cm). Most of the height growth occurs in the legs, leading to a more slender physical appearance. The preschooler's more mature body system enables him or her to tolerate moderate physiologic stress. Skills mastered during the toddler period are refined during this time and include a rapidly developing ability to understand and use language. Expected levels of growth and development must be attained for the child to refine these skills in preparation for the next stage of childhood, school age.

The school-age period (6 to 12 years of age) is a time of gradual growth and development until the end of the period, sometimes referred to as *prepubescence.* The school-age child will grow an average of 2 inches (5 cm) and gain 4.5 to 6.5 pounds (2 to 3 kg) annually. Until prepubescence, there is little difference in size between males and females; toward the end of this stage, however, a growth spurt occurs. Girls first surpass boys in both height and weight. Body proportions approach adult measurements by the end of the school-age period.

Adolescence is the period of transition from childhood to young adulthood. This period is divided into three substages: early adolescence (11 to 13 years), middle adolescence (13 to 15 years), and late adolescence (15 years and older). The changes occurring during adolescence are primarily puberty, growth, and personality. The central nervous system is inundated with hormonal activity, and dramatic and obvious growth changes are noted in both boys and girls. Both sexes develop secondary sexual characteristics and grow larger. Less obvious is the maturation of the reproductive system. This stage is often turbulent for adolescents because they are on a constant emotional roller coaster, attempting to master the developmental tasks for adulthood.

Thermoregulation. The large surface area in relation volume, thin layer of subcutaneous fat, and unique method producing heat predispose the neonate to excessive heat l Measures must be taken to protect the newborn from hypoth mia during all aspects of care, including obtaining vasc access and site care. Unlike the adult, the chilled neonate d not shiver but uses the mechanism of nonshivering therm genesis to increase heat production. In response to hyp thermia, norepinephrine is secreted by the sympathetic ne endings. This action stimulates the breakdown of brown to generate heat, allowing distribution of the heated blo through the body.

Increased metabolism as a response to hypothermia resu in higher oxygen and caloric requirements. A healthy inf can usually tolerate increased oxygen consumption; howev a sick infant is predisposed to cold stress and hypoglycem Cold stress begins as the infant requires an increase in oxyg and caloric consumption. The activation of norepinephr stimulates the metabolism, and anaerobic glycolysis resu The lactic acid produced by this process, combined with t acid end products of brown fat metabolism, can lead acidosis.[1]

This process of thermoregulation continues throughout t infant's first several months of life. During infancy, the chil ability to shiver increases. The older infant usually has acquir the benefit of insulation by the gradual growth of adipose tiss By early childhood, the skin is thicker, and the body has a high percentage of fat and a decreased surface area/volume rat these factors enable the preschooler to better cope with envire mental cold.

The nurse performing such procedures as venipuncture an infant must maintain a neutral thermal environment for t infant to prevent the possibility of cold stress. A neutral therm environment is one that permits the infant to maintain a norm core temperature with minimum oxygen consumption a caloric expenditure. The neutral thermal environment f smaller infants is 35.4° plus or minus 0.5° C (95.7° plus minus 1° F) and for larger infants is 32.5° plus or minus 1.4° (90.5° plus or minus 2.5° F).[2]

To help infants stay warm, nurses can use radiant warmi panels, incubators, cotton blankets, and head coverings (e.g. piece of stockinet knotted at one end) and ensure that only t extremity of the IV insertion site is exposed. Blankets can warmed in warming units or in clean, unoccupied incubators. warming lamp, placed at the recommended safe distance fro the infant, can be used to prevent hypothermia if an infant mu be removed from a neutral thermal environment.

Vessel size. The size of venous and arterial vessels in t infant and child are obviously smaller than those in the adu Although the vessels are anatomically positioned in the sam locations throughout life, their sometimes-threadlike characte istics and tendency to hide make them difficult to locate in th young patient. Applying heat to the extremity before performin venipuncture facilitates venous identification and cathet insertion.

Exhibit 6
Deposition No. 6110

Patient assessment. A complete assessment of the patient, the IV site, the involved extremity, and the infusion system may be necessary to determine the presence of an infiltration. The site around the tip of the cannula and the extremity should be inspected for swelling, blanching, stretched skin, firm tissues, and coolness. It may be helpful to compare the site with the same area on the opposite extremity. If both extremities appear edematous, the patient's medical status should be evaluated. Patients with hemodynamic problems, such as congestive heart failure, toxic conditions, compromised kidney function, hypothermia, and vascular insufficiency, are particularly prone to vascular edema. The immobilized patient or the patient with muscular weakness or paralysis of an extremity may experience edema of the extremity that is totally unrelated to a problem at the IV site.

If an assessment of the involved extremity and the patient's medical status are inconclusive, pressure should be applied to the vein with a finger or tourniquet about 2 inches above the insertion site (it must be above the tip of the cannula). If the cannula is in the vein, this pressure will slow or stop the infusion rate. If the infusion continues despite the venous obstruction, an infiltration has occurred.

Checking for a blood return, or backflow of blood, is not a reliable method for determining the absence of an infiltration. A blood return may not be present when small veins are used because they may not permit blood flow around the cannula; one may think the infusion has infiltrated when it has not. In addition, veins that have had previous punctures or that are very fragile may seep fluid at a site above or below the vein cannula entry point; a blood return may be present, yet an infiltration is occurring. The movement of a cannula, such as in-and-out motions, can also cause the skin and the vein entry site to enlarge, allowing fluid to seep at the vein entry site, causing an infiltration.

Nursing interventions. To prevent or minimize infiltration-associated problems (Box 24-3), it is imperative that the cannula be discontinued once an infiltration has been identified. The type of solution being infused should also be considered. If the solution is isotonic and has a normal pH, the patient may not feel much discomfort unless a large amount of fluid has infiltrated. In these cases, warm compresses, such as warm, moist towels or chemical packs, may help alleviate the discomfort and help absorb the infiltration by increasing circulation to the affected area. Sloughing can occur from the application of warm compresses to an area infiltrated with certain medications, such as potassium chloride. In these instances, the application of cold compresses is preferred.[5] Established policies and procedures should dictate the use of compresses. The involved extremity should be elevated to improve circulation and to help absorb infiltrated fluid.

If weeping of the tissues occurs because of an extensive infiltration or loose thin tissue, as is often present in the elderly, it may be necessary to apply a sterile dressing to the affected area. It is usually better to leave these areas open because the dressing necessitates the use of gauze and possibly tape, which can increase tissue damage. If a dressing is used, it should be applied loosely. Extreme care should be given to prevent infection. The physician should be notified and measures should be

Box 24-3 Effects of an Infiltration

Deprives the patient of the prescribed rate of medications and solutions essential for successful therapy
Limits mobility of an extremity
Limits availability of veins for therapy
Causes tissue damage
Causes unnecessary patient discomfort

carried out as ordered. If an infusion is needed, a cannula is placed in the opposite extremity or in a site above and away from the previous site.

Preventive measures. Not all infiltrations can be prevented, but adherence to certain measures can minimize their severity. Flexion areas should be avoided if possible. The cannula should be taped securely, and the site should be protected from excessive movement or pressure by use of an armboard and restraints. Restraints must be applied with extreme caution and within the guidelines established by JCAHO.[1] Restraints should be well padded and applied in a manner that will not cause nerve damage, constrict circulation, or cause pressure areas. They should be removed at frequent intervals and range-of-motion exercises performed. Inadequate or improper use of armboards or restraints can cause very serious complications; policies and procedures should be established to guide their use.

Patient education can be a key factor in the prevention and early recognition of the signs and symptoms of an infiltration. Patient knowledge about the care of the IV site and system can prevent activities that may cause an infiltration, such as manipulating the cannula, pulling on the tubing, picking at the dressing, and using the extremity excessively. A patient who knows what to look for can alert the nurse to the early signs of an infiltration, and immediate care can be rendered, thereby preventing the possibility of more-serious complications.

Extravasation. *Extravasation* is the inadvertent administration of a vesicant solution or medication into the surrounding tissues. A vesicant solution is a solution or medication that causes the formation of blisters, with subsequent sloughing of tissues occurring from tissue necrosis (Fig. 24-3).

Patient assessment. It is essential that an extravasation be noted early, before extensive fluid is allowed to infiltrate the interstitial tissues. A complete assessment of the patient, the IV site, the involved extremity, and the infusion system should be performed at regular intervals. The flow rate should never be increased to determine the infiltration of a vesicant, nor should a blood return be used as a reliable method to determine an infiltration. Fluid can seep into the tissues from a previous puncture site or around the vein insertion site and increase the potential for tissue necrosis (refer to Infiltration for the assessment process).

Initial indications that tissue sloughing may occur include pain or burning at the site with progression to erythema and edema. Tissue sloughing is usually apparent within 1 to 4 weeks because of tissue necrosis. Necrosis can involve a small or a large area, including underlying connective tissues, muscles, tendons, and bone, necessitating surgical intervention.

Exhibit 7

STATE OF SOUTH CAROLINA)) COUNTY OF ORANGEBURG)	IN THE CIRCUIT COURT FIRST JUDICIAL CIRCUIT
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen, Plaintiff, -vs- The Regional Medical Center Defendants.	C/A No.: 2015-CP-38-01234 **NOTICE OF MOTION AND MOTION IN LIMINE TO EXCLUDE PHOTOGRAPHS**

Defendants, The Regional Medical Center, (hereinafter TRMC), by and through the undersigned, hereby states the following for TRMC's Motion in Limine:

1. The Plaintiff commenced this action alleging Medical Negligence against the Defendant, TRMC. The matter is scheduled for a date certain trial on May 7, 2018. Defendants are moving pursuant to this Motion in Limine to exclude photographs of the Plaintiff's injuries;

2. Rule 403 of the SCRE states, "[a]lthough relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." "A trial court has particularly wide discretion in ruling on Rule 403 objections." *Busillo v. City of North Charleston*, 404 S.C. 604, 610, 745 S.E.2d 142 (2013). "To constitute unfair prejudice, the photographs must create 'an undue tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one.'"

State v. Holder, 382 S.C. 278, 290, 676 S.E.2d, 690, 697 (2012) (quoting *State v. Jackson*, 364 S.C. 329, 334, 613 S.E.2d 374 (2005).

3. At trial, Plaintiff intends to introduce photographs of injuries to the Right hand of Plaintiff that were sustained while the plaintiff was a one-month old infant. The images are grotesque, close-up images of the infant's open wounds. These close-up images will create an undue tendency to suggest a decision on an emotional basis and are highly prejudicial to the defendant.

4. There is no scale in the pictures to reflect the actual size of the wound, and the close-up nature of the photos makes the wounds appear substantially larger than they are in reality. The images do not reflect the minor's hand currently, as the plaintiff's hand has healed with some scarring. Further, Plaintiff, Tekayah Hamilton is able to testify to the nature of the wound and have an expert to testify to the injury giving the alternative forms of evidence that are less prejudicial to the defendant. The probative value of these photographs of an open flesh wound are substantially outweighed by the prejudice defendants will face in these are introduced to the jury.

WHEREFORE, defendant The Regional Medical Center (TRMC) hereby prays this Court issue its Order granting its Motion in Limine excluding photographs of the minor's injuries.

MICHAEL C. TANNER, L.L.C.

Michael C. Tanner
PO Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Defendants

Bamberg, SC
May 1, 2018

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG	)	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT
TEKAYAH HAMILTON, Individually and as Parent Guardian Ad Litem for [redacted]	)	CASE NO.: 2015-CP-38-01234
Plaintiff,	)	
vs.	)	VERDICT FORM
THE REGIONAL MEDICAL CENTER,	)	
Defendant.	)	

We, the jury, by unanimous consent, have responded to the following questions:

1. Do you find that the Defendant was grossly negligent?
   ✓ YES – Go to Question 2
   _____ NO – Stop deliberations

2. Was the defendant's gross negligence a proximate cause of the Plaintiff's injuries?
   ✓ YES – Go to Question 3
   _____ NO – Stop deliberations

3. Please state the amount of damages, if any, sustained by the minor plaintiff [redacted]. [You are to determine only the total amount of the plaintiff's damages and enter that amount below.]

   $ 1,127,280.00 Actual Damages

   Please state the amount of damages, if any, sustained by the Plaintiff Tekayah Hamilton, Individually and as Parent Guardian Ad Litem for Robert Lee Middleton Jr. [You are to determine only the total amount of the plaintiff's damages and enter that amount below.]

   $ [redacted] 135,477.00 Actual Damages

SIGNED: _____
JURY FOREPERSON

DATED: 5-9-2018, ORANGEBURG, SC.

PLEASE NOTIFY THE BAILIFF WHEN YOU HAVE COMPLETED THE VERDICT FORM.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF ORANGEBURG	)	FIRST JUDICIAL CIRCUIT
TEKAYAH HAMILTON, Individually and as Parent Guardian Ad Litem for ROBERT LEE M. JR.,	)	Case No.: 2015-CP-38-01234
Plaintiff,	)	NOTICE OF MOTION AND MOTION FOR JNOV OR IN THE ALTERNATIVE MOTION FOR NEW TRIAL
Vs.	)	
THE REGIONAL MEDICAL CENTER,	)	
Defendant.	)	

FILED FOR RECORD

TO: JONATHAN F. KRELL, ESQUIRE, AND DAVID WILLIAMS, ESQUIRE, ATTORNEYS FOR PLAINTIFF

YOU WILL PLEASE TAKE NOTICE, Defendant reserves its right to assert the statutory caps in its separate post-trial motion, that as soon as counsel may be heard, the defendant The Regional Medical Center (TRMC), by and through its undersigned attorney, pursuant to Rules 50 and 59 of the South Carolina Rules of Civil Procedure, move the court for (1) judgment notwithstanding the verdict ("JNOV"); (2) a new trial absolute; or (3) a new trial nisi remittitur.

LAW

Rule 50(b) of the South Carolina Rules of Civil Procedure allows that, "a party who has moved for a directed verdict may move to have the verdict and any judgment entered thereon set aside and to have judgment entered in accordance with his motion for a directed verdict." A motion for judgment notwithstanding the verdict and motion for a new trial may be made in the alternative. Rule 50, SCRCP.

ATTEST TRUE COPY
CLERK OF COURT
ORANGEBURG COUNTY, SC

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TRMC renews its motion for directed verdict made at the close of Plaintiff's case in chief and renewed at the close of all the evidence. There is no legally sufficient basis for a jury to find that TRMC is liable for damages in this case.

The trial judge may reverse a jury's verdict when a review of the record discloses no evidence which reasonably supports the factual finding necessary to sustain the verdict. *Horry County v. Laychur*, 315 S.C. 364, 434 S.E.2d 259 (1993). While the Court is concerned with the existence of evidence, not its weight, *Curcio v. caterpillar, Inc.*, 355 S.C. 316, 585 S.E.2d 272 (2003), and may not decide credibility issues or to resolve conflicts in the testimony or the evidence, *id.* At 320, 585 S.E.2d at 274, JNOV is warranted when there is no evidence to support the ruling or where the ruling is controlled by an error of law. *Hinkle v. National Cas. Ins. Co.*, 354 S.C. 92, 579 S.E.2d 616 (2003).

The thirteenth juror doctrine "entitles the trial judge to sit, in essence, as the thirteenth juror when he finds 'the evidence does not justify the verdict, and then to grant a new trial based solely 'upon the facts.'" *Norton v. Norfolk S. Ry. Co.*, 350 S.C. 473, 478, 567 S.E.2d 851, 854 (2002) (*quoting Folkens v. Hunt*, 300 S.C. 251, 254, 387 S.E.2d 265, 267 (1990)). As the thirteenth juror, the trial judge hands the jury by refusing to agree with the jury's unanimous verdict and casting his or her vote against it, resulting in a verdict which is no longer unanimous. *Id.*

The Court may grant a new trial, sitting as the thirteenth juror, when it is convinced that a new trial is necessary on the basis of the facts. *Vinson v. Hartley*, 324 S.C. 389, 404, 477 S.E.2d 715, 722 (Ct. App. 1996). Under the thirteenth juror doctrine, a new trial may be granted where the court merely finds that "the verdict is unsupported by

the evidence," that "the verdict is inconsistent and reflects the jury's confusion," or that "justice has not prevailed." *Id.* at 404, 477 S.E.2d at 722-23; *see also Trivelas v. S.C. Dep't of Transp.*, 357 S.C. 545, 552 593 S.E.2d 504, 508 (Ct. App. 2004) (granting new trial where "the evidence does not justify the verdict"); *Norton*, 350 S.C. at 480, 567 S.E.2d 855 (granting new trial when court "disapproves of the verdict on factual grounds"); *McEntire v. Mooregard Exterminating Servs., Inc.*, 353 S.C. 629, 631, 578 S.E.2d 746, 747 (Ct. App. 2003) (characterizing the use of doctrine as "granting a new trial upon the facts").

The Court's discretion in granting or denying a new trial under the thirteenth juror doctrine is "'funded upon the facts, the evidence, the witnesses, the trial circumstances, the verdict and the judge's view of them.'" *Vinson*, 324 S.C. at 404, 477 S.E.2d at 723 (*quoting Fallon v. Rucks*, 217 S.C. 180, 189, 60 S.E.2d 88, 92 (1950)). Consequently, the Court is entitled to "weigh the evidence and rely on his or her view of the circumstances." *Sorin Equip. Co. V. The Firm, Inc.*, 323 S.C. 359, 364, 474 S.E.2d 819, 822 (Ct. App. 1996).

Importantly, this Court need not provide any reasons for its exercise of this thirteenth juror power aside from a finding that the Court disapproves and rejects the verdict based on the facts and evidence. *Howard v. Roberson*, 376 S.C. 143, 654 S.E.2d 877 (Ct. App. 2007). Further, this Court's exercise of its thirteenth juror power will not be disturbed on appeal in the absence of a misuse of the power. *Trivelas*, 357 S.C. 545, 593 S.E.2d 504 (holding that a circuit court's order granting a new trial upon the facts will not be disturbed unless its decision is wholly unsupported by the evidence or the conclusion reached was controlled by an error of law).

As set forth below in the grounds asserted for judgment as a matter of law, the jury's verdict is unsupported by the evidence as set forth herein. First, Plaintiff's presented no evidence that defendant was grossly negligent. Defendant asserts that plaintiff's expert was not properly qualified and as such, no testimony she made should have been offered to the jury. There is no justification for a $1,127,280.00 award of damages in this case to the minor child and $135,477.00 to the mother. Therefore, the verdict should be set aside with a new trial ordered. *See, e.g., Folkens v. Hunt*, 300 S.C. 251, 387 S.E.2d 265 (1990) (upholding the grant of the excise of the trial court's thirteenth juror authority because the verdict was not in accordance with the facts.)

The Defendant asserts it is entitled to an order of JNOV or a new trial absolute on these separate grounds:

I. Monica Stobbs was not qualified to give an opinion on the standard of care of pediatric nursing and pediatric IV administration.

Monica Stobbs should not have been allowed to testify to the standard of care for pediatric nursing IV management. In order to qualify an expert, a witness must have the "knowledge, skill, experience, training or education" in order to testify. SCRE 702. "To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter.'" *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 253, 487 S.E.2d 596, 598 (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995); *see also Botehlo v. Bycura*, 282 S.C. 578, 587, 320 S.E.2d 59, 65 (1984) (orthopedic surgeon was not qualified to testify on the standard of care for podiatrist where orthopedic surgeon had no

training in podiatry, was not familiar with any journals or periodicals in podiatry and was not familiar with the surgical procedure performed).

Similar to the facts in *Botehlo*, 282 S.C. 578, Ms. Stobbs, while a nurse, has not administered IV therapy or cared for a pediatric patient with IV therapy, similar to how the orthopedic surgeon was not familiar with the procedure performed by the podiatrist. Likewise, Ms. Stobbs had not reviewed any literature regarding IV therapy in pediatric patients, the same as the orthopedic surgeon not having reviewed any journals or periodicals for podiatry. *Id.* The only distinction is that here Ms. Stobbs is a nurse. Ms. Stobbs has not started or managed an IV on a pediatric patient. Using the requirements of the *Botehlo* case, Ms. Stobbs was not qualified to give an expert opinion on pediatric IV therapy. *Id.* Therefore defendants are entitled to JNOV or in the alternative a new trial.

II. The Court should have directed a verdict in favor of TRMC as Plaintiff's did not establish Gross Negligence.

Plaintiff's failed to establish the elements of Gross Negligence. The Tort Claims Act "limits government liability regarding the supervision, protection, and control of a patient," and Plaintiffs were required to prove gross negligence. *See Stewart v. Richland Memorial Hosp.* 350 S.C. 589, 592, 567 S.E.2d 510, 511 (2002). "Gross negligence is the intentional conscious failure to do something which it is incumbent upon one to do or the doing of a thing intentionally that one ought not to do. [internal citations omitted] It is the failure to exercise slight care. "*Etheredge v. Richland School Dist. One*, 341 S.C. 307, 311 (2007). "While gross negligence ordinarily is a mixed question of law and fact, when the evidence supports but one reasonable inference, the question becomes a matter of law for the court." Id.

Plaintiff failed to establish Defendant was grossly negligent. Plaintiff's expert testified that she had no opinion as to whether or not Defendant intentionally harmed Plaintiff. Plaintiff's expert was not qualified to give an opinion on the standard of care of pediatric IV administration or monitoring. She also had no experience and did not research the treaties and was therefore not qualified to give an opinion. There was no evidence that TRMC employee Jamie Downing acted with any form of intent to cause harm. Plaintiffs failed to establish a material element of gross negligence, intent.

What the evidence did show was that Jamie Downing inspected the IV site 7 times in the twelve-hour shift, while she was only required to inspect it once a shift. Jamie Downing testified that she flushed the site prior to administering the antibiotics and Cynthia Hurly testified that Jamie Downing exceeded the standard of care. This is evidence that Defendant exercised greater than slight care, and as such, cannot be grossly negligent. *See Etheredge,* 341 S.C. 307.

The evidence presented shows that Defendant exercised greater than slight care and that Plaintiffs have failed to prove the element of intent. The only reasonable inference is that defendant exercised slight care and should have been granted a directed verdict. Therefore, defendants are entitled to JNOV, or to trial *de novo*.

III. Trial Judge erred by not excluding the prejudicial photographs of Robert Middleton, Jr.'s injuries to the Jury.

Rule 403 of the SCRE states, "[a]lthough relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." "To constitute unfair prejudice, the photographs must create 'an undue tendency to suggest a decision on an improper basis,

commonly, though not necessarily, an emotional one." *State v. Holder*, 382 S.C. 278, 290 (2012) (quoting *State v. Jackson*, 364 S.C. 329, 334 (2005)).

The photographs of [redacted]'s hand should have been excluded from the jury as the prejudicial effect substantially out-weighted the probative value. Due to the excessive jury award, defendant is left to conclude that the photographs substantially prejudiced the defendants. The photographs were grotesque, close-up images of the infants open wound. One of the photographs was quite blurry. There was no scale in the photographs. At no time did defendants argue that the infiltration was not the cause of the wound, and the fact that there was a wound was never disputed.

Due to the excessive jury award, defendant is left to conclude that the jury reached their decision on an emotional basis when they saw the enlarged picture of the infant's open flesh wound. Therefore, defendants are entitled to a new trial absolute.

IV. Cynthia Hurley should have been permitted to testify to whether or not Defendant was grossly negligent or negligent.

"Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." Rule 704, SCRE. "We have held, however that the trial judge has the discretion to permit expert testimony on the ultimate issue before the jury." *Redman v. Ford Motor Co.*, 253 S.C. 266, 278 (1969) (citing *O'Kelley v. Mutual Life Insurance Co.*, 197 S.C. 108 (1941)). "There is no invasion of the province of the jury, for the jury retains its power and duty to judge both the credibility of the witness and the weight to be given to his opinion." *Redman*, 253 S.C. at 278; *but see Dawkins v. Fields*, 354 S.C. 58 (2003) ("In general, expert testimony on issues of law is inadmissible.). "We have heretofore held that the trial judge may in his discretion permit a qualified expert to testify as to his

opinion on the ultimate issue before the jury." *Hughes v. Children's Clinic, P.A.*, 269 S.C. 389, 403 (1977).

Here, TRMC's expert, Ms. Hurley's, testimony was primarily on the standard of care and that Nurse Downing complied with the standard. Unlike the *Dawkins*, 354 S.C. 58, there was no affidavit in the present case, and the testimony was not legal argument. In that case the court was concerned with an expert affidavit that read like legal argument. Additionally, Ms. Hurley was not attempting to usurp the roll of the jury, the proffered testimony was whether or not defendants were grossly negligent. The evidence is not objectionable just because it embraces the ultimate issue. *See* Rule 704, SCRE. The trial court erred by not allowing Cynthia Hurley testify to the ultimate issue as her testimony would not usurp the roll of the jury as they still determined her credibility. Therefore, defendant is entitled to a new trial absolute.

V. The Request to Admit should not have been published to the Jury.

The Request to Admit should not have been published to the Jury and prejudiced the Defendant. "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE. Rule 36 (b) of the South Carolina Rules of Civil Procedure states,

> Any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission. Subject to the provisions of Rue 16 governing amendment of a pre-trial order, the Court may permit withdrawal or amendment when the presentation of the merits of the action will be sub-served thereby and the party who obtained the admission fails to satisfy the court that withdrawal or amendment will prejudice him in maintaining or defense on the merits Any admission made by a party under this rule is for the

purpose of pending action only and is not an admission by him for any other purpose.

RULE 36, SCRCP; *see also Commerce Center of Greenville, Inc. V. W. Powers McElveen*, 347 S.C. 545, 557, 556 S.E.2d 718, 724 (Ct. App. 2001) ("The trial court may allow a party to amend or withdraw its answers to a request to admit when: (1) the presentation of the merits is furthered by the amendment; and (2) the party who obtained the admission cannot demonstrate prejudice because of the amendment."). Defendant asserts that Plaintiff was not prejudiced by withdrawal of these Requests, which was denied by the Court.

Defendant concedes this is an unusual circumstance and the case law addresses issues for withdrawal by the admitting party. The Court should have permitted withdrawal of the RTA because the Plaintiffs could not show that withdrawal would prejudice them in maintaining the merits. Here the Request to Admit (RTA) was highly prejudicial to the defendant and did nothing but confuse the issues. At all times Defendant maintained that they were not negligent. By introducing the RTA to the jury, it had the effect as if Defendant admitted they were negligent. At no time did the Defendant admit negligence. The RTA had the opposite effect because Plaintiffs admitted the amount in controversy was more than $100,000. The RTA request number 1 stated, "Admit the value of the amount in controversy in this action is less than $100,000." The plaintiff denied this. This directly confuses the issues and is highly prejudicial to any probative value it may have.

The purpose of the request to admit was to obtain an Independent Medical Examination, not for Plaintiffs to represent that Defendant admitted the damages were in excess of $100,000.00.

Further, the Request to Admit was not mentioned in Plaintiff's pretrial brief. Plaintiffs intentionally failed to mention it to Defendant's counsel until they were about to publish the RTA to the Jury. This highly prejudiced the defendant, as they had no time to prepare argument and was unable to get rebuttal evidence. Therefore, defendants are entitled to a new trial.

VI. Jury Charges

Defendant contends they are entitled to a new trial as the requested jury charges were not charged to the jury.

> "Ordinarily a trial judge has a duty to give a requested instruction that correctly states the law applicable to the issues and evidence."*Ross v. Paddy*, 340 S.C. 428, 437, 532 S.E.2d 612, 617 (Ct.App.2000). "Where a request to charge is timely made and involves a controlling legal principle, a refusal by the trial judge to charge the request constitutes reversible error." *Id.* "Moreover, when general instructions to the jury are insufficient to enable the jury to understand fully the law of the case and issues involved, a refusal to give a requested charge is reversible error." *Id.*

Fairchild v. South Carolina Dept. Of Transp., 398 S.C. 90, 104, 727 S.E.2d 407, 414 (2012). To warrant reversal, the refusal must be both erroneous and prejudicial. *E..ison v. Parts, Distributors, Inc.*, 302 S.C. 299, 395 S.E.2d 740 (Ct. App. 1990). Defendants should have had the following jury charges.

"I instruct you that the practice of nursing is an art, not a science, and in providing nursing care a nurse is not required to be all knowing and all wise."

"While a Nurses mistake or error in judgment alone would not support a verdict for the plaintiffs in a malpractice lawsuit, if the nurse fails to comply with a recognized

standard of nursing care which would be exercised by a similar nurse under the same or similar circumstances, then liability would attach to the nurse's mistake or error in judgment if it proximately results in injury to the patient."

"I instruct you that the law does not require of a nurse absolute accuracy either in practice or in judgment. Nor does the law hold a nurse to the standard of infallibility. It does not even require of a nurse the utmost degree of care and skill of which the human mind is capable." *see generally Wall v. Suits*, 38 S.C. 377, 383-84 (1995) (discussing physician).

Therefore, defendants should be granted a new trial absolute.

VII. This Court should grant a new trial absolute because the jury verdict is shockingly disproportionate to the evidence admitted at trial.

Defendant is entitled to a new trial on the grounds that the Jury's verdict was grossly excessive and contrary to the evidence.

In addition, a trial judge is required to grant a new trial absolute when the amount of the verdict is "so grossly . . . excessive that it shocks the conscience of the court and clearly indicates the amount was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives." *Waring v. Johnson*, 341 S.C. 248, 257, 533 S.E.2d 906, 911 (Ct. App. 2000); *Vinson v. Hartley*, 324 S.C. 389, 404, 477 S.E.2d 715, 723 (Ct. App. 1996); *Duncan v. Hampton County School Dist. No. 2*, 235 S.C. 535, 517 S.E.2d 449, 455 (Ct. App. 1990) ("The trial court must grant a new trial absolute if the verdict is so grossly excessive that it shocks the conscience of the court and clearly indicates the amount of the verdict was the result of caprice, passion, prejudice, partiality, corruption, or other improper motive."). The term "passion and prejudice" does not "necessarily imply bad faith, wrongful purpose, or moral delinquency," but rather, results

when the award is "against the overwhelming weight of the evidence." *Beasley v. Ford Motor Co.*, 237 S.C. 506, 513, 117 S.E.2d 863, 867.

Importantly, it is an abuse of discretion not to grant a new trial absolute when the verdict is "shockingly disproportionate" to the evidence presented at trial. *Sullivan v. Porter*, 317 S.C. 462, 467, 454 S.E.2d 907, 912 (Ct. App. 1995). "Ordinarily the only means of discovering the existence of passion and prejudice as influencing the verdict is by comparing the amount of the verdict with the evidence before the trial court." *Id.* at 362, 98 S.E.2d at 802. However, in some instances, the "size of the verdict alone may show that it must have been the result of passion or prejudice." Id. (internal citation omitted); *see also Small v. Springs Indus., Inc.* 292 S.C. 481, 486, 357 S.E.2d 452, 455 (1987) ("The size of the jury's verdict alone establishes it is grossly excessive under the facts of this case.").

This case falls squarely within the holding in *Sullivan*. The size of the verdict alone is sufficient to show that the jury must have been moved by passion or prejudice. The evidence presented cannot support a $1,127,280.00 verdict for the claims asserted by the Plaintiffs. The verdict in this case is "without any rational support whatever in the evidence and is so grossly excessive as to show that the jury was actuated by considerations not founded on the evidence and/or the instructions of the court." *Joyner v. St. Mathews Builders*, 263 S.C. 136, 140-41, 208 S.E.2d 48, 50 (1974) (granting a new trial due to the "actual damages being so manifestly and grossly excessive").

Given the complete lack of any cognizable basis to support the damages award, the $1,127,280.00 actual damages award to the minor cannot stand. See *Zorn v. Crawford*, 252 S.C. 127, 138, 165 S.E.2d 640, 646 (1969) (granting a new trial in a

wrongful death action where "a verdict of $250,000.00 for the actual damages sustained by the beneficiaries . . . [was] not supported by the evidence and [could] only be explained upon the basis of sympathy, passion or prejudice on the part of the jury"). Therefore, this Court should vacate the award or order a new trial.

The only evidence of damages was $20,854 in medical bills, some pain and a scar while the jury returned a verdict for $1,127,280.00. The verdict is 54 times the amount of actual damages, this is grossly excessive and shocks the conscience. It is clear that the Jury did not pay attention to the jury instructions. The $135,477.00 jury verdict for Tekeyah Hamilton is further evidence of the jury failing to apply the law as charged. Plaintiff's mother testified she has no plans for the child to undergo any steroid injections or scar revision surgery. Defendant is left to conclude that the jury arrived at its award as a result of passion, caprice, or other improper motives, particularly in light of the excessive verdict compared to the evidence of actual damages. Where a jury renders a verdict in disregard of the charge, it is error for the trial judge not to grant a new trial upon motion. *See, Southeastern Mobile Homes Inc. v. Walicki*, 282 SC. 298, 317 S.E.2d 773 (Ct. App. 1984). Therefore, this Court should vacate the award and order a new trial *de novo*.

VIII. The Court should grant a new trial nisi remittitur because the jury rendered an excessive verdict compared to the evidence offered by plaintiffs.

If the Court denies the JNOV and new trial absolute motions it should next proceed to consider and grant a new trial nisi remittitur because the damages awarded by the jury are clearly excessive compared to the evidence presented at trial. This court "may grant a new trial nisi remittitur when it finds the verdict is merely inadequate or excessive." *Howard v. Roberson*, 376 S.C. 143 (2007). "The consideration of a motion

for a new trial nisi remittitur requires the court to consider the adequacy of the verdict in light of the evidence presented." *Waring v. Johnson*, 341 S.C. 248 (Ct. App. 2000).

"The trial court has wide discretionary power to reduce the amount of a verdict which in his or her judgment is excessive." *See. e.g., Rush v. Blanchard*, 310 S.C. 372 (1993)(affirming trial court's remittitur); *RRR, Inc v. Toggas*, 378 S.C. 174 (Ct. App. 2009 ("[T]he circuit court . . . has the power to grant a new trial nisi when it finds the amount of the verdict to be merely inadequate or excessive"); *Becker v. Walmart Stores, Inc.*, 339 S.C. 629 (Ct. App. 2000) (affirming trial court's granting of motion for remittitur on grounds that amount awarded by jury was "merely excessive").

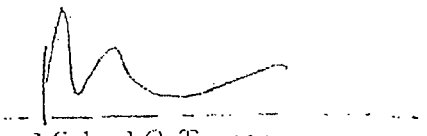
Here the jury's verdict was grossly excessive. The jury returned a verdict that was 54 times the actual damages. The jury returned a verdict for $1,127,280 for the child and another $135,477 for Tekayah Hamilton, when the actual damages were only $20,854. There is no evidence to support such a verdict [redacted] still has full use of his hand and he has a scar that will improve with surgery. There's no logical conclusion as to why the jury returned such a verdict and no evidence supports the excessiveness of the verdict. If Defendant's are not granted JNOV or a New Trial Absolute, defendants in the alternative ask for a new trial nisi remittitur.

CONCLUSION

WHEREFORE, defendant TRMC based on all of the foregoing reasons, respectfully request this Court reconsider its decisions and issue and order granting TRMC JNOV or in the alternative, grant Defendant's a new trial absolute, and grant such other and further relief as may be just and proper.

COUNSEL FOR DEFENDANT RESPECTFULLY REQUEST ORAL ARGUMENT.

MICHAEL C. TANNER, L.L.C.



Michael C. Tanner
PO Box 1061
Bamberg, SC 29003
(803)245-9153
Attorney for Defendants

Bamberg, SC

May 17, 2018

STATE OF SOUTH CAROLINA)
)
COUNTY OF BAMBERG)

I, Michael C. Tanner, attorney for defendant, The Regional Medical Center of Orangeburg and Calhoun Counties, in the case of Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen v. Regional Medical Center, case number 15-CP-38-1234 hereby certify that I have served the Notice Of Motion And Motion For JNOV Or In The Alternative Motion For New Trial by mailing a copy of same, with postage prepaid, by United States mail to the person(s) at the address(es) indicated as follows:

Honorable Edgar W. Dickson
Post Office Box 1949
Orangeburg, S.C. 29116

Jonathan F. Krell, Esquire
P.O. Box 399
Charleston, SC 29402

David Williams, Esquire
P.O. Box 1084
Orangeburg, SC 29116

MICHAEL C. TANNER, L.L.C.

By: _____

Michael C. Tanner
P.O. Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Defendant

Bamberg, S.C.

May 17, 2018

ATTEST: TRUE COPY
Winnie H. Clark
CLERK OF COURT
ORANGEBURG COUNTY, SC

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STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG	)	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT
TEKAYAH HAMILTON, Individually and as Parent Guardian Ad Litem for ROBERT LEE M. JR., Plaintiff, vs. THE REGIONAL MEDICAL CENTER, Defendant.	)	Case No.: 2015-CP-38-01234 POST TRIAL MOTION FOR REDUCTION TO STATUTORY CAP

FILED FOR RECORD
MINNIE D. CLARK

TO: JONATHAN F. KRELL, ATTORNEY FOR PLAINTIFF

YOU WILL PLEASE TAKE NOTICE, reserving its rights to be heard in the separate post-trial motions, that as soon as counsel may be heard, the defendant The Regional Medical Center (TRMC), by and through its undersigned attorney, will move before this Honorable Court for the following Post-Trial Relief:

1. Defendants are invoking the statutory cap on damages pursuant to the South Carolina Tort Claims Act (§15-78-10, et seq.). Section § 15-78-120(a) provides as follows:

> (a) For any action or claim for damages brought under the provisions of this chapter, the liability shall not exceed the following limits: (1) Except as provided in Section 15-78-120(a)(3), no person shall recover in any action or claim brought hereunder a sum exceeding three hundred thousand dollars because of loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved.

"Provisions establishing limitations upon and exemptions from liability of a governmental entity *must be liberally* construed in favor of limiting liability." *Plyler v. Burns*, 373 S.C. 637, 651 (2007) (citing *Steinke v. South Carolina Dep't of Labor*,

Licensing and Regulation, 336 S.C. 373 (1999)); *see also* S.C. Code Ann. §15-78-20(f) ("The provisions of this chapter establishing limitations on and exemptions to the liability of the State, its political subdivisions, and employees, while acting within the scope of official duty, *must be liberally construed* in favor of limiting the liability of the State.").

2. The Jury returned a verdict for the minor [redacted] for $1,127,280.00. This amount is excessively higher than the statutory cap and as a matter of law must be reduced to $300,000.00, pursuant to § 15-78-120 (a).

3. Defendant asserts Tekayah Hamilton's jury verdict must be reduced to $20,854.00.

4. A parent is the proper party in interest with respect to past medical expenses and future medical expenses while the child is a minor. *See, Patton v. Miller*, 420 S.C. 471 (2017). Under the Tort Claims Act, a parent may recover medical expenses separately from the parents claim. *See, Wright v. Colleton County School Dist.*, 301 S.C. 282 (1990).

5. The Jury returned a verdict for Tekayah Hamilton for $135,477.00. Pursuant to South Carolina law, Tekayah Hamilton's damages are limited to past and future medical expenses only as set forth above. The only evidence presented to the jury of medical expenses, past and future, were the amount of $20,854.00. Tekayah Hamilton's damages must be reduced to the amount of $20,854.00 for past and future medical expenses for the minor. She is not entitled to any pain and suffering.

WHEREFORE Defendants pray that this Honorable Court reduce the Jury Verdict to $300,000.00 for [redacted] and to $20,854.00 for Tekeyah Hamilton making

the verdict in Compliance with the South Carolina Tort Claims Act and grant such other relief as the Court deems just and proper.

MICHEL C. TANNER, L.L.C.



Michel C. Tanner
Joseph R. Shakibanasab
Post Office Box 1061
Bamberg, S.C., 29003
Attorneys for Defendant

Bamberg, S.C.

May 17, 2018

STATE OF SOUTH CAROLINA)
)
COUNTY OF BAMBERG)

I, Michael C. Tanner, attorney for defendant, The Regional Medical Center of Orangeburg and Calhoun Counties, in the case of Tekayah Hamilton, Individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen v. Regional Medical Center, case number 15-CP-38-1234 hereby certify that I have served the Post Trial Motion For Reduction To Statutory Cap by mailing a copy of same, with postage prepaid, by United States mail to the person(s) at the address(es) indicated as follows:

Honorable Edgar W. Dickson
Post Office Box 1949
Orangeburg, S.C. 29116

Jonathan F. Krell, Esquire
P.O. Box 399
Charleston, SC 29402

David Williams, Esquire
P.O. Box 1084
Orangeburg, SC 29116

FILED FOR RECORD

MICHAEL C. TANNER, L.L.C.

By: _____
Michael C. Tanner
P.O. Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Defendant

Bamberg, S.C.

May 17, 2018

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF ORANGEBURG	)	CIVIL ACTION NO. 2015-CP-38-01234
	)	
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18,	)	PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANT'S MOTION FOR JNOV OR IN THE ALTERNATIVE MOTION FOR NEW TRIAL/NEW TRIAL *NISI REMITTITUR* AND IN OPPOSITION TO DEFENDANT'S MOTION FOR REDUCTION TO STATUTORY CAP
Plaintiff,	)	
vs.	)	
Regional Medical Center	)	
Defendant.	)	

FILED IN THE COURT OF COMMON PLEAS
DEC 21 2015
WINNIE B. CLARK, CLERK
ORANGEBURG COUNTY, SC

Plaintiff submits this Memorandum in Opposition to Defendant's ("Defendant") motion for a new trial or, alternatively, for a new trial *nisi remittitur*.

Plaintiff's opposition to Defendant's motion is based on this memorandum of law and any exhibits filed along with this memorandum, the pleadings, and applicable law; all evidence and arguments presented during the trial of this case; as well as any other memorandum of law or arguments that Plaintiff may submit to the Court at or prior to a hearing on the motions. The Court should deny Defendant's motions and withstand the jury's award in the amount of $135,477.00 for Plaintiff Tekayah Hamilton ("Tekayah") and modifying the amount to Plaintiff Robert Lee M. Jr. ("RJ") to $1,065,000.00.

FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of Defendant's failure to implement policies, procedures, and equipment to allow Defendant to properly monitor an IV with ampicillin administered to RJ on or about October 28, 2014, while a patient at Defendant's facility in Orangeburg, South Carolina. Plaintiff's complaint alleges medical negligence, specifically the following:

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Winnie B Clark
CLERK OF COURT
ORANGEBURG COUNTY, SC

> The impression of the treating physician was high fever and admission to the hospital was necessary in order to work up CBC, LP, blood and urine cultures. It was decided to begin Ampicillin and Claforan. Pl.'s Complaint par.11

> Defendant Regional, by and through its agents and/or employees, and Defendant Downing[1], owed Plaintiff a duty of care to use that degree of care and skill which ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances. Pl.'s Complaint par.33.

> Defendants breached that duty of care and were negligent, grossly negligent, careless, willful, wanton, and reckless in the following particulars:
> a) In failing to use reasonable medical care in accordance with the recognized standards of acceptable professional practice in medicine during the care, diagnosis and treatment of Plaintiff;
> b) In failing to act with ordinary and reasonable care in accordance with the recognized standards of acceptable professional practice in medicine;
> c) In failing to follow the Infusion Nurse Society publication on *Policies and Procedures for infusion Nursing of the Pediatric Patient*;
> d) In failing to pursue such appropriate medical modalities and treatments which could have avoided this type of injury and permanent damage;
> e) In failing to act and behave in the same or similar manner that reasonably competent doctors and healthcare facilities and staff would have behaved or acted in the same or similar conditions;
> f) In failing and neglecting to properly inspect the IV site on October 28, 2014, at approximately 4:27 a.m. prior to the administration of antibiotic medication;
> g) In failing and neglecting to properly monitor the IV site after the administration of antibiotic medication;
> h) In failing to adequately train and supervise its medical staff;
> i) In failing to provide the safest care and treatment to Plaintiff; and
> j) For such other acts and omissions that may become more apparent through the discovery of this matter.

Pl.'s Complaint par. 34. Plaintiff attached an affidavit to her complaint by Monica Stobbs, RN, BSN, clarifying and reiterating the breaches in the standard of care by Defendant Regional, by and through its employees, causing harm to RJ and Tekayah. Specifically, Defendant Regional failed to properly monitor RJ's IV site prior to and after administering medication.

At trial Plaintiff offered Monica Stobbs, RN, BSN, as well as Dr. DeVito regarding RJ's future care and Plaintiff herself took the stand. Plaintiff also called nurse Jamie Downing, RN,

[1] Defendant Downing was dismissed as a party after the original summons and complaint was filed.

and published Plaintiff's answers to Defendant's First Set of Requests to Admit to the jury. RJ's medical records and bills were submitted as evidence along with several pictures of his injury and numerous policies and procedures of Defendant Regional.

Defendant called Dr. Davis to dispute RJ's future care, Nurse Jamie Downing, and Cynthia Hurley as their standard of care of expert. Defendant also submitted pictures of RJ's injuries, select medical records and select policies and procedures. Defendant moved for a directed verdict at the end of Plaintiff's case and its own. Defendant has now filed motions for a new trial, new trial nisi remittitur, and reduction to conform to the statutory cap.

STANDARD OF REVIEW

A motion for judgment notwithstanding the verdict may only be granted if no reasonable jury could have reached the challenged verdict. RFT Management Co., LLC v. Tinsley & Adams, LLP, 399 S.C. 322, 332, 732 S.E.2d 166, 171 (2012). A jury's verdict must be upheld unless no evidence reasonably supports the jury's findings. Curcio v. Caterpillar, Inc., 355 S.C.316, 320, 585 S.E.2d 272, 274 (2003). In ruling on a motion for judgment notwithstanding the verdict, the trial court must view the evidence and all inferences reasonably drawn therefrom in the light most favorable to the opposing party. Law v. S.C. Dep't of Corr., 368 S.C. 424, 434, 629 S.E.2d 642, 648 (2006).

The thirteenth juror doctrine is the method used by the trial court to grant a new trial upon a finding that the evidence presented at trial did not support the jury's verdict. Curtis v. Blake, 392 S.C. 494, 505, 709 S.E.2d 79, 85 (Ct. App. 2011). If the amount of the verdict is grossly inadequate or excessive so as to be the result of passion, impulse, prejudice, or some other influence outside the evidence, the trial court must grant anew trial absolute. Id. at 500, 709 S.E.2d at 82. Compelling reasons must be presented to support the trial judge's invasion of the jury's

province, merely highlighting that the verdict is greater than the amount of monetary damages is not enough as such other non-monetary factors must be considered as well. Id. at 501, 709 S.E.2d at 83.

I. **The jury's verdict reflects the evidence presented and should only be reduced to a total of $1.2 Million**

Ample evidence was presented to the jury to sustain Ms. Hamilton's recovery of $135,477.00, and to sustain RJ's recovery, only reducing it to $1,065,000.00, to bring the total recovery within the statutory cap of $1,200,000.00.

Under South Carolina common law, a parent may recover for her child's medical expenses, loss of services, and other economic losses as a result of incurred medical expenses. *See* Wright v. Colleton County School District, 391 S.E. 2d 564 (1990) and Doe v. Greenville County School District, 375 S.C. 63 (2007). At trial, Plaintiff presented past and potential future medical expenses of approximately $20,824.00. The future expenses include potential surgeries for RJ's scars. Ms. Hamilton also testified to the financial burden on her to take time off of work and travel expenses related to getting RJ to medical treatment appointments. Ms. Hamilton further testified that she has to keep an extra close eye on RJ to prevent reinjury of his hand and to protect his hand from over-exposure. Finally, there was testimony to support the psychological and social affect the scar will have on RJ, which will certainly affect RJ who is currently three years old. She will remain his guardian at least until he is eighteen, fifteen more years. There is evidence to support the award of $135,477.00 for Ms. Hamilton. It is not unreasonable for a jury to make this award in light of the evidence which exists to support it.

Defendant argues RJ's recovery should be reduced to $300,000.00 under section 15-78-120(a). However, Defendant ignores the entirety of the Torts Claims Act and the evidence to trigger the $1.2 Million cap.

The South Carolina Tort Claims Act allows for a maximum recovery out of a single occurrence of one million two hundred thousand dollars when the injury is caused by any licensed physician or dentist. S.C. Code Ann. §15-78-120(a)(4). Subsection (5) reads that subsection (a)(4)

> shall in no way limit or modify the liability of a licensed physician or dentist, acting within the scope of his profession, with respect to any action or claim brought hereunder which involved services for which the physician or dentist was paid, should have been paid, or expected to be paid at the time of the rendering of the services from any source other than the salary appropriated by the governmental entity or fees received from any practice plan.

Id. Defendant argued at trial, and the court agreed, that Plaintiff was required to prove gross negligence of Defendant pursuant to section 15-78-60(25) because the conduct at issue concerned Defendant's "responsibility or duty including but no limited to supervision, protection, control, confinement or custody of any...patient...of any governmental entity." S.C. Code Ann. §15-78-60(25). Indeed, the verdict form asked the jury to find if Defendant, The Regional Medical Center, was grossly negligent[2] in its supervision, protection, etcetera of RJ.

Additionally, under the Tort Claims Act, individual employees cannot be named. S.C. Code Ann. §15-78-70. *See also* S.C. Code Ann. §15-78-20(g) (indicating the inclusion of physicians under the Tort Claims Act and justification for the higher limits thereunder). Thus, the totality of Defendant's conduct is to be considered and is not limited to just the acts of Nurse Downing, but to the entirety of the conduct surrounding the alleged gross negligence and the resulting damages. This position is consistent with Defendant's consistent position that it is not subject to the South Carolina Medical Malpractice Act. *See* Exhibit A. This position is also echoed in the verdict form, which asked for a general verdict. Because there were multiple issues, including the conduct of Defendant's nurses and conduct of Defendant's physicians, the general

[2] Plaintiffs position at trial was that the medical malpractice standard of care applied, not a gross negligence standard as argued by Defendant at trial and charged by the judge. For purposes of Defendant's motions and the law of the case as it stands now, Plaintiffs present arguments based on the gross negligence standard.

verdict form encapsulates all of those issues, sustaining the $1.2 million cap applicable to physicians.

Section 15-78-20(g) explains the importance of including physicians and dentists under the Tort Claims Act stating that patients "deserve accountable and competent health care, regardless of the public or private character of the provider" and the need to "attract qualified physicians and dentists." S.C. Code Ann. §15-78-20(g). In this vain, limitations still exist on what can be recovered in lawsuits involving medical malpractice, but they are "higher limits [as] recognition by the General Assembly of significantly higher damages in cases of medical malpractice." Id. The Nurse Practice Act explains the hierarchy of physicians over advanced practice registered nurses, and then all nurses. S.C. Code Ann. 40-33-20 *et al.* This supervision is particularly emphasized when "administering and delivering medications and treatments as prescribed by an authorized licensed provider" and "providing for the maintenance of safe and effective nursing care rendered directly or indirectly." S.C. Code Ann. §40-33-20(47).

The allegations in Plaintiff's Complaint and expert affidavit certainly address Defendant's conduct in its entirety by and through its healthcare providers, including the conduct of physicians. *See* Factual and Procedural History *supra*. Likewise, the testimony at trial indicated the involvement of physicians. Ms. Stobbs testified proper administration of a saline flush prior to administration of the ampicillin at 4:27 a.m. on October 28, 2014, would have prevented the injury to RJ. She explained the administration of saline is administering medicine. The medical record, as well as Nurse Downing's testimony, indicated that Dr. Boltin, also an employee of Defendant, ordered the administration of the ampicillin, which would include the saline flush, for RJ. Nurse Downing could not have administered the ampicillin and saline flush without a doctor's order. She was subject to the supervision of Dr. Boltin. Through Dr. Boltin's orders Nurse Downing was

responsible for the supervision of RJ, again that conduct falling under section 15-78-60(25). Because of the medical care rendered and the causal connection between the orders from Dr. Boltin, being carried out by Nurse Downing, the $1.2 million cap applies to this case. Thus, after accounting for the $135,477.00 awarded to Ms. Hamilton, RJ's award should be reduced to $1,065,000.00.

Such an award to RJ is supported by the evidence. Testimony provided the basis for RJ's past, present, and future pain and suffering, mental and emotional anguish, anxiety, and loss of enjoyment of life. In its closing, Plaintiff's counsel asked the jury to award RJ a per diem amount for the remainder of his life to compensate him for those damages, suggesting $25.00 or $50.00 per day. RJ's life expectancy is approximately 73.76 years under section 19-1-150, or approximately 26,940 days. The jury's award of $1,127,280.00 divided by 26,940 is approximately $42.00 per day for the rest of his life. Given the severity of the permanent scar, the apparent suffering it has caused and will cause RJ, the jury's verdict is reasonably related to the evidence presented and does not shock the conscience.

Additionally, evidence was produced that the medical recording system did not allow the nurse to follow the policies and procedures. These policies and procedures were promulgated by the MEC, which is a solely physician entity. Therefore, the evidence is that the policies and procedures were implemented in a grossly negligent manner by the physicians. Naming The Regional Medical Center is naming physicians.

There was also evidence presented that Dr. Boltin was in the room close by RJ with the IV at the time the four-hour check was due and when the flush was due but did nothing to require the flush.

Finally, Defendant failed to raise an objection during the trial regarding Plaintiff counsel seeking to incite the jury's emotions, passion, or prejudice. The jury's verdict should be upheld and only modified to fit within the $1.2 million statutory cap.

II. Monica Stobbs, RN, BSN, was qualified to testify regarding the proximate cause of RJ'S injuries

"All expert testimony must satisfy the Rule 702 criteria, and that includes the trial court's gatekeeping function in ensuring the proposed expert testimony meets a reliability threshold for the jury's ultimate consideration." *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 37, 691 S.E.2d 135, 143 (2010) (internal quotation marks omitted). "[O]nly after the trial court has found that [1] expert testimony is necessary to assist the jury in resolving factual questions, [2] the expert is qualified in the particular area, and [3] the testimony is reliable, may the trial court admit the evidence and permit the jury to assign it such weight as it deems appropriate." *Watson v. Ford Motor Co.*, 389 S.C. 434, 446-47, 699 S.E.2d 169, 175 (2010)."

Plaintiff offered Monica Stobbs as an expert in nursing, particularly regarding the nursing standard of care in monitoring RJ's IV site. The trial judge allowed her to be admitted as a nurse, not a pediatric nurse, indicating Defendant would be able to question her credibility in comparison to Defendant's pediatric nurse expert, but that Ms. Stobbs was indeed qualified to testify regarding the nursing standard of care.

In her testimony, Ms. Stobbs recognized the IV had been placed and medication, including Ampicillin, was administered for over 48 hours without incident. However, leading into the third day, October 27th, Defendant Regional's medical record indicated below standard monitoring of the site, including untimely and incomplete assessments of the IV site, insufficient flushing, and other below the standard care in maintaining and monitoring the IV site which led to the RJ's injuries. She explained that assessment, flushing, and other procedures for monitoring and

inspecting an IV site prior to the administration of medicine and after the administration of medication are the same regardless of the patient's age.

Defendant submitted literature to Ms. Stobbs which conceded the similarities in monitoring an IV site whether the patient was a baby or an adult. Likewise, Defendant's expert agreed and only differentiated that placing the IV and identifying the IV site on an infant could be different from that with an adult. The placing and identification of RJ's site was not the proximate cause of his injuries. Defendant's expert also differed with Ms. Stobbs in that pulling back on the needle to verify proper location of the needle would not be done with a minor. Ms. Stobbs testified that is only one option in assessing an IV site, not the only tool and not the proximate cause of RJ's injuries. As such, any difference in qualifications that may exist between a pediatric nurse and an adult nurse were of no significance in determining the proximate cause of RJ's injuries.

III. There was ample evidence of gross negligence[3] to substantiate the jury's verdict

Plaintiff testified that she was in the room with RJ during the early morning hours of October 28, 2014, when the ampicillin was administered at about 4:27 a.m. by Nurse Downing. The order was to continuously infuse the antibiotic over 20 minutes. Shortly after the ampicillin was started, Plaintiff noticed a visible change in RJ's demeanor, his uncontrollable crying, and apparent discomfort. She repeatedly buzzed for assistance, but to no avail. No one from Defendant responded until approximately 4:50 a.m. when it was documented that RJ was fussy and that the hand was puffy with bruising. The jury could infer from this testimony, and rightly so, that Plaintiff was ignored for over 20 minutes by Defendant, leaving RJ in wretched pain and ultimately a permanent scar. The jury was charged that gross negligence "is the intentional, conscious failure

[3] Again, Plaintiffs position at trial was that the medical malpractice standard of care applied, not a gross negligence standard as argued by Defendant at trial and charged by the judge. For purposes of Defendant's motions and the law of the case as it stands now, Plaintiffs present arguments based on the gross negligence standard.

to do something which is incumbent upon one to do or the doing of a thing intentionally that one ought not to do...the failure to exercise slight care." Ignoring a patient's requests for help for such an extended period of time could certainly be interpreted by the jury as conscious failure to respond.

Additionally, the testimony and evidence revealed that there were multiple, repeated mistakes in the medical records. There were several failures to document the condition of the IV site and several failures to document flushing the site before administering the medication, despite the policies and procedures requiring the same. The jury could have interpreted this as repeated conscious or reckless disregard to do the task incumbent upon Defendant to do.

Finally, Defendant's physicians via the MEC implemented a system of policies and procedures which go with the standard of care, but the nurses, whom the physicians supervise and are responsible for, were not able to fulfill and meet those expectations due to the flawed electronic medical recording system. Furthermore, Dr. Boltin and the nurses ignored the electronic reminder to flush every four hours, intentionally overriding the prompt and not complying with the policies and procedures of the hospital. This conduct could certainly give rise to intentional conduct and/or failure to exercise slight care by the physicians and nurses.

IV. The photographs of RJ's injuries were not prejudicial

The trial judge properly exercised his discretion in allowing the photographs of RJ's injuries. The relevance, materiality, and admissibility of photographs are matters within the sound discretion of the trial court. The trial judge must balance the prejudicial effect of graphic photographs against their probative value. State v. Vang, 353 S.C. 78, 87, 577 S.E.2d *250 225, 229 (Ct.App. 2003). A trial judge's decision regarding the comparative probative value and prejudicial effect of relevant evidence should be reversed only in exceptional circumstances. State

v. Hamilton, 344 S.C. at 357, 543 S.E.2d at 593. Admitting photographs which serve to corroborate testimony is not an abuse of discretion. State v. Rosemond 335 S.C. 593 at 597, 518 S.E.2d 588 at 590; *see* State v. Tucker, 324 S.C. 155, 478 S.E.2d 260 (1996); State v. Jarrell, 350 S.C. 90, 564 S.E.2d 362 (Ct.App. 2002). However, photographs calculated to arouse the sympathy or prejudice of the jury should be excluded if they are irrelevant or not necessary to substantiate material facts or conditions. State v. Brazell, 325 S.C. 65, 78, 480 S.E.2d 64, 72 (1997). "To constitute unfair prejudice, the photographs must create a 'tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one.'" State v. Kelley, 460 S.E.2d 368 at 370-71 (quoting State v. Alexander, 303 S.C. 377, 382, 401 S.E.2d 146, 149 (1991)). A trial judge is not required to exclude relevant evidence merely because it is unpleasant or offensive. Davis v. Traylor, 340 S.C. 150, 530 S.E.2d 385, 387 (Ct.App.2000).

Plaintiff submitted three pictures of the wound and scar at various points in the healing process for the jurors to see from their seats in the jury panel. All three had an object to which the size of the wound and/or scar could be related to: (1) wound – adult thumb, (2) wound – RJ's head, more particularly his ear, and (3) scar – adult thumb. Then, RJ himself presented his hand to the jury for them to see the injury as it is today, giving further reference for the pictures as produced. Defendant also submitted a picture of the injury which was small in size. It was so small that it had to be passed around to the jury, held in each juror's hand, with the ability to analyze up close.

Defendant argues the pictures should have been excluded because they were "grotesque, up-close images of the infants open wound," "one was quite blurry", and "there was no scale in the photographs." Defendant also argues it never disputed the wound existed or that the infiltration caused the wound. However, Defendant did dispute the amount of damages that should be awarded to Plaintiff for that wound, necessitating Plaintiff fully presenting its evidence to that

regard. Also, it is an exercise in speculation and conjecture, at best, whether a more prejudicial effect results from being able to see a picture from a distance versus being able to hold it in your hands and examine it closely. Defendant had no scale to its picture. Plaintiff offered the most definitive scale possible, RJ himself. If one of the pictures was blurry – how does that create a prejudicial affect? The fact is it was a horrible injury which was ugly, unpleasant, and offensive in its nature. Plaintiff did nothing to enhance that reality, merely showed it to the jury. It would have been prejudicial to Plaintiff to NOT show those pictures and misrepresenting to the jury the exact nature of what RJ experienced. The trial judge properly exercised his discretion in permitting the pictures because they accurately reflected the facts of the case.

V. The trial judge properly exercised his discretion in not allowing Cynthia Hurley to testify as to whether or not Defendant was grossly negligent

Defendant properly recognizes the law that it is in the trial judge's discretion "to permit expert testimony on the ultimate issue before the jury." Redman v. Ford Motor Co., 253 S.C. 266, 278. The trial judge did just that in allowing Ms. Hurley to testify as to what could constitute gross negligence, but not the term "gross negligence" itself.

"In general, expert testimony on issues of law is inadmissible." Dawkins v. Fields, 354 S.C. 58 (2003). However, an expert's otherwise admissible opinion is not inadmissible simply because it embraces the ultimate issue to be decided. Id. The distinction between medical malpractice and negligence claims is subtle, with no rigid analytical line separating the two causes of action. Dawkins v. Union Hosp. Dist., 408 S.C. 171, 176, 758 S.E.2d 501, 503–04 (2014). "In medical malpractice actions, expert testimony is required to establish both the duty owed to the patient and the breach of that duty, unless the subject matter of the claim falls within a layman's common knowledge or experience." Id. The requisite expert testimony assists the jury in making a more accurate determination of fault regarding whether a negligence in rendering medical care

proximately caused the patient's injury. Id. Based on this law, the trial judge properly allowed Ms. Hurley to testify as to the appropriate standard of care, which she did. She testified that there was no intentional conduct, which can be gross negligence under South Carolina, and further testified that Nurse Downing met or exceeded the standard of care while caring for RJ. It was very clear for the jury that Ms. Hurley had no critique at all of Nurse Downing's or Defendant's care of RJ. Obviously, the jury chose not to believe her.

VI. The Requests to Admit were properly published to the Jury

The trial judge properly exercised his discretion in accordance with the rules in allowing Plaintiff to publish to the jury the requests to admit submitted by Defendant to Plaintiff. The South Carolina Rules of Civil Procedure plainly state "any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission...the Court *may* permit withdrawal...when the presentation of the merits of the action will be sub-served thereby and the party who obtained (Defendant in this instance) fails to satisfy the court that withdrawal or amendment will prejudice him in maintaining or defense of the merits." SCRCP Rule 36. Defendant argues publishing the requests to admit to the jury had the effect of Defendant admitting they were not negligent, confused the jury, and Plaintiff would not be prejudiced in withdrawing the requests.

If anything, the requests to admit suggested a potential value of the damages to the jury of greater than $100,000.00. The jury's award to Plaintiff individually exceeded that amount by thirty-five thousand dollars and the award to RJ exceeded that amount by more than one million dollars. To suggest the jury's decision hinged on the requests to admit thus seems absurd. Furthermore, for the jury to be confused by the admissions and think that Defendant was admitting negligence, they would have had to ignore Defendant's entire case as well as its attack on all of

Plaintiff's witnesses. There could be no doubt that Defendant disputed liability when its expert testified Nurse Downing exceeded the standard of care. There could be no doubt that Defendant disputed damages when it accused RJ's mother of denying her child car for his scar because he had rickets and because it was expensive to obtain.

Finally, the rule states "the party who obtained the admission" must who that it is not prejudiced in withdrawing the admission. SCRCP Rule 36. Plaintiff did not obtain the admission and thus has nothing to demonstrate. If the court would require Plaintiff to do so in this instance, then the prejudice is clear: although Defendant denies liability, it admits there is value to the damages. Defendant indeed admits in its own post-trial motion briefs that it never denied there was an injury that resulted from the infiltration at their hospital. Allowing the admissions is consistent with Defendant's position, absolutely confirming the merits, Defendant's merits, of the case.

VII. The jury charges sufficiently enabled the jury to understand fully the law of the case and issues involved

The trial judge properly charged the jury with the law applicable to the nursing standard of care even while omitting the exact language requested by Defendant. "The substance of the law is what must be instructed by the jury, not any particular verbiage." State v. Smith, 315 S.C. 547, 554, 446 S.E.2d 411, 415 (1994); *See also* Keaton v. Greenville Hospital System, 334 S.C. 448 (1999). "In reviewing jury charges for error, we must consider the court's jury charge as a whole in light of the evidence and issues presented at trial." Bragg v. Hi-Ranger, Inc., 319 S.C. 531, 462 S.E.2d 321, 330 (Ct. App. 1995) (*citing* Manning v. Dial, 271 S.C. 79, 245 S.E.2d 120 (1978).

In this case, the trial judge charged the jury on standard of care and breach of standard of care, which together echo, if not in the exact verbiage, the specific charge that Defendant requested.

> Standard of care
>
> The plaintiff must prove the standard of care the defendant owed in treating the plaintiff.
>
> When a nurse treats a patient, the law *does not require perfection or infallibility.* The law does require that the nurse use that degree of knowledge, care, and skill ordinarily possessed and used by nurses in good standing in the nurse's field of medicine, under the same or similar circumstances and that the nurse follow the generally accepted practices and procedures in the profession.[4]
>
> A nurse *is not an insurer of health and is not required to guarantee results.* A nurse undertakes only to meet the standard of skill possessed generally by others practicing in the field of nursing under same or similar circumstances.
>
> Breach of the standard of care
>
> The plaintiff must prove that the defendant negligently departed from the standard of care in treating the plaintiff.
>
> Negligence is the failure to do what an ordinary careful nurse in the nurse's field of medicine would have done under the same or similar circumstances, or the doing of something that an ordinary careful nurse would not have done under the same or similar circumstances.
>
> The mere fact that a treatment does not benefit the patient or that it even hams the patient, is not in and of itself, negligence. A bad result, injury, death, or failure to cure, is not enough, alone, to show that the defendant was negligent. In considering whether the defendant made a reasonable decision, you must

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[4] Durham v. Vinson, Op. No. 25872 (S.C. Sup. Ct. filed September 13, 2004); Bessinger v. Deloach, 230 S.C. 1, 94 S.E.2d 3 (1956); Iernigan v. King, 312 S.C. 331, 440 S.E.2d 379 (Ct. App. 1993).

consider the decision in relation to the facts as they existed at the time, and not in light of what hindsight may reveal.

Jury Charges (emphasis added). These charges in essence incorporate the ideas and principles in Defendant's requested charge including "a nurse is not required to be all knowing and all wise" and "the law does not require of a nurse absolute accuracy either in practice or in judgment." Furthermore, Defendant cannot point to any incorrect statement in the judge's charges, only wishes to add some exact verbiage. There is no reversible error. The trial judge accurately stated the substance of the law and there is absolutely no prejudice to Defendant in not including the exact verbiage. Indeed, to add that verbiage would only seem to overemphasize and exaggerate that law to the jury, prejudicing Plaintiff.

CONCLUSION

For the reasons stated above and based on any additional argument at a hearing on this motion, the Court should deny Defendant's motion for JNOV, a new trial or a new trial nisi remittitur, withstand the jury's award in the amount of $135,477.00 for Plaintiff Tekayah Hamilton and modify the amount to Plaintiff Robert Lee M. Jr. to $1,065,000.00.

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June 12, 2018

Orangeburg, South Carolina

ATTORNEYS FOR PLAINTIFF

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG	)	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT
TEKAYAH HAMILTON, Individually and as Parent Guardian Ad Litem for ROBERT LEE M. JR., Plaintiff, vs. THE REGIONAL MEDICAL CENTER, Defendant.	)	Case No.: 2015 CP-38-01234 Defendant's Response to Plaintiff's Memorandum in Opposition to Defendant's Motion For JNOV or In the Alternative Motion for New Trial *Nisi Remittur* and in Opposition to Defendant's Reduction to Statutory Cap

FILED FOR RECORD
WERNIFA B. CLARK
CLERK OF COURT
2017 SEP 27 PM 1:17

TO: JONATHAN F. KRELL, ESQUIRE AND DAVID WILLIAMS, ATTORNEYS FOR PLAINTIFF

NOW COMES DEFENDANT, and states the following in Response to Plaintiff's Memorandum in Opposition to Defendant's Motion For JNOV or in the alternative motion for new trial/new trial Nisi Remittitur and in Opposition to Defendants Motion For Reduction to statutory Cap:

Defendants reiterate and incorporate by reference herein, the arguments contained in Defendant's Post Trial Motion For Reduction To Statutory Cap and Defendant's Notice of Motion And Motion For JNOV or In The Alternative Motion For New Trial.

REPLY ARGUMENT

I: The Statutory Cap is $300,000.00 as this is a Nursing issue and there is no evidence of Physician malpractice and the Plaintiff's never alleged any malpractice by a Physician.

Plaintiffs argue for the first time in the memorandum the $1.2 million-dollar cap for physicians is applicable to this case. However, there were never any allegations in the

Complaint alleging physician malpractice. This case has always been about the pediatric nursing standard of care and whether that standard was breached in a grossly negligent manner. Because this is only a nursing issue, the statutory cap of $300,000.00 applies.

The statutory cap is $300,000.00 according to the S. C. Tort Claims Act. Section § 15-78-120(a) provides as follows:

> (a) For **any** action or claim for damages brought under the provisions of this chapter, the liability shall not exceed the following limits: (1) **Except as provided in Section 15-78-120(a)(3),** no person shall recover in any action or claim brought hereunder a sum exceeding three hundred thousand dollars because of loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved.

SC Code Ann. § 15-78-120(a) (1). Whereas § 15-78-120(a)(3), regarding physicians and dentists, states:

> (3) No person may recover in any action or claim brought hereunder against any **governmental entity** ***and caused by the tort of any licensed physician*** or dentist, employed by a governmental entity and acting within the scope of his profession, a sum exceeding one million two hundred thousand dollars because of loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved.

S.C. Code Ann. § 15-78-120 (a)(3). "Provisions establishing limitations upon and exemptions from liability of a governmental entity *must be liberally* construed in favor of limiting liability." *Plyler v. Burns*, 373 S.C. 637, 651 (2007) (citing *Steinke v. South*

Carolina Dep't of Labor, Licensing and Regulation, 336 S.C. 373 (1999)); *see also* S.C. Code Ann. §15-78-20(f) ("The provisions of this chapter establishing limitations on and exemptions to the liability of the State, its political subdivisions, and employees, while acting within the scope of official duty, *must be liberally construed* in favor of limiting the liability of the State.").

Plaintiff's Complaint does not allege any breaches of the standard of care by a TRMC employed physician. There was no testimony at trial that a TRMC employed physician allegedly violated the standard of practice in treating the child. Monica Stobbs is not a physician and therefore did not testify as to the standard of care for a physician. Further, as defendant asserts, Monica Stobbs was not qualified to testify about pediatric nursing standard of care, it only follows she is even more unqualified to testify to the standard of care for a pediatrician. Plaintiff offered no testimony on physician malpractice, which was also not plead. TRMC was not on notice of any alleged physician malpractice.

The words "and caused by the tort of any licensed physician" in section § 15-78-120 (a)(3) of the S. C. Code, means that the tort *must* have been caused by a licensed physician or dentist in order to trigger the statutory cap of $1.2 million dollars. As such, the words "any" and "except" in the section 15-78-120(a)(1) applies for all other actions not caused by a physician or dentist. The code states, "For *any* action or claim for damages brought under the provisions of this chapter, the liability shall not exceed the following limits: (1) *Except* as provided in Section 15-78-120(a)(3)," (Emphasis added)

A plain reading of the statute is clear. In order to trigger the $1.2 million-dollar cap, the tort must be caused by a licensed physician, if not the $300,000.00 cap applies.

As stated above, there has been no allegations or evidence or testimony that any TRMC physician breached the standard of care. It is abundantly clear the $300,000 cap applies.

In order to allege and prove physician negligence, specifically, plaintiff must present evidence of the generally recognized practice and procedures that would be exercised by competent practitioners in the defendant's field under the same or similar circumstances, and that the defendant departed from the recognized generally accepted standards, practices and procedures in the manner alleged by the plaintiff. Gooding v. Saint Francis Xavier Hospital, 326 S.C. 248, 487 S.E.2d 596 (1997). Plaintiff must use expert testimony to establish both the standard of care and the deviation thereof, and that the said deviation was the proximate cause of plaintiff's injury. Pederson v. Gould, 288 S.C. 141, 341 S.E.2d 633, (1986); Carver v. Medical Society of South Carolina, 286 S.C. 347, 334 S.E.2d 125 (S.C. App. 1985). Plaintiff must also establish the standard of care and deviation therefrom for a nurse. McMillan v. Durant, 312 S.C. 200, 439 S.E.2d 829 (1993). Plaintiff offered no such evidence.

The Plaintiff is also required to establish proximate cause as well as negligence and expert testimony is necessary to establish proximate cause. Bramlette v. Charter-Medical Columbia, 302 S.C. 68, 393 S.E.2d 914 (1990) and Botehlo v. Byeura, 282 S.C. 578, 320 S.E.2d 59 (S.C.Apps. 1984). Proximate cause requires proof of (1) causation in fact and (2) legal cause. Causation in fact is proved by establishing the injury would not have occurred "but for" the defendant's negligence. Legal cause is proved by establishing foreseeability. Bramlette, *supra*. Therefore, only the nursing liability cap of $300,000.00 applies.

II: Tekayah Hamilton's award must be reduced to $20,854.00.

The maximum jury award for Tekayah Hamilton was only to allow her to recover the past and future medical expenses of the minor child and therefore she can only recover $20,854.00.

A parent is the proper party in interest with respect to past medical expenses and future medical expenses while the child is a minor. *See, Patton v. Miller*, 420 S.C. 471 (2017). Under the Tort Claims Act, a parent may recover medical expenses and loss of services separately from the child's claim. *See, Wright v. Colleton County School Dist.*, 301 S.C. 282 (1990). A parent may not recover loss of filial consortium in South Carolina. *See, Doe v. Greenville Cnty. School Dist.*, 375 S.C. 63 (2007).

The jury returned a verdict for Tekayah Hamilton for $135,477.00. Pursuant to South Carolina law, Tekayah Hamilton's damages are limited to past and future medical expenses only as set forth above, as that was the only evidence presented. The only evidence presented to the jury of medical expenses, past and future, was the amount of $20,854.00. Tekayah Hamilton's damages must be reduced to the amount of $20,854.00 for past and future medical expenses for the minor. She is not entitled to any pain and suffering. Doe, supra.

Plaintiff's argued in the memorandum that the financial burden of taking time off work and travel expenses justify the award. There was no evidence presented at trial that Tekayah Hamilton was making or would have made six-figures in the few month period during the incident and recovery. It is even more unreasonable to suggest that travel expenses to and from the Regional Medical Center amounted to $114,623 dollars. Additionally, there was no evidence of travel cost or time off from work submitted to the jury.

There is no evidence of the loss of services presented at trial, and pursuant to South Carolina case law there is no loss for filial consortium, *Doe v. Greenville Cnty. School Dist.*, 375 S.C. 63 (2007). The law is clear Tekeyah's damages are limited to past and future medical expenses only until the child is 18. The only evidence presented to the jury is that of $20,854.00. Therefore, Tekayah Hamilton's verdict must be reduced to the amount of $20,854.00, if defendant's other relief is not granted.

III. The Court Should Grant a New trial absolute because the Jury verdict is shockingly disproportionate to the evidence admitted at trial.

There is no evidence to uphold a jury verdict of $1,127,280 for the child or $135,477 for the mother. The only evidence of damages was $20,854 in medical bills, some pain and a scar. The jury verdict is 54 times the amount of actual damages. Defendant reiterates and realleges herein its argument made in its Motion for JNOV/New Trial as if referenced herein.

A trial Judge is required to grant a new trial absolute when the amount of the verdict is "so grossly . . . excessive that it shocks the conscience of the court and clearly indicates the amount was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives." *Waring v. Johnson*, 341 S.C. 248 (Ct. App. 200). The term "passion and prejudice" does not necessarily imply bad faith, wrongful purpose, or moral delinquency," but rather, results when the award is "against the overwhelming weight of the evidence." *Beasley v. Ford Motor Co.* 237 S.C. 506. (1961).

Here the award is against the overwhelming weight of the evidence. The jury verdict is 54 times the actual damages. Plaintiff's closing argument is not evidence. It is obvious that the jury returned a verdict on the result of passion and prejudice when the

verdict is 54 times the actual damages. Therefore, defendants are entitled to a new trial absolute.

IV. The Court should have directed a verdict in favor of TRC as Plaintiff's did not establish Gross Negligence.

Plaintiffs were required to prove gross negligence. *See generally Stewart v. Richland Memorial Hosp.*, 350 S.C. 589 (2002). "Gross negligence is the intentional conscious failure to do something which it is incumbent upon one to do or the doing of a thing intentionally that one out not to do. [internal citations omitted]. It is the failure to exercise slight care." *Etheridge v. Richland School dist. One*, 341 S.C. 307, 311 (2000).

The evidence shows that the defendants exercised more than slight care. Jamie Downing inspected the IV site 7 times in a twelve-hour shift when the requirement was once every 12 hours. The only pediatric nurse expert, Cynthia Hurly, testified that Jamie Downing exceeded the standard of care. Plaintiff's expert, which defendant denies is an expert, testified that she had no opinion that Jamie Downing intended to harm the minor. There was no evidence of intent, which is required for gross negligence and the evidence shows that Jamie Downing exercised more than slight care.

Further, there were not multiple repeated mistakes in the medical records, plaintiff's expert misinterpreted the records and policies. At no time did plaintiff's present evidence that MEC medical recording system was flawed. Plaintiff's expert was not familiar with the medical recording system and had no experience in operating it. There was also no evidence offered at trial that Dr. Boltin ignored or intentionally override the reminder to flush every four hours. This allegation is raised for the first time in plaintiff's memorandum. Defendant asserts in Section I above this is improper.

There was no evidence of malpractice by Dr. Boltin. Plaintiff's expert testified that after the infiltration she had no criticism to the treatment the child received. She is again, not competent to render opinions as to physician treatment and standard of practice. There were no allegations pled against Dr. Boltin as set forth above and she did not testify to same. There was no evidence of any physician malpractice.

Plaintiffs cannot meet the elements of gross negligence. There was no evidence of intent, and the evidence presented reveals defendants exercised more than slight care. Therefore, defendants should have been granted a directed verdict, as more fully set forth in this Motion for JNOV/New Trial.

V. Monica Stobbs is not qualified to give an opinion as to pediatric IV management.

In order to qualify an expert, a witness must have the "knowledge, skill, experience, training or education" in order to testify. Rule 702, SCRE. "To be competent to testify as an expert, a 'witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter." *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 253 487 S.E.2d 596, 598 (1997) *(quoting O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995)).

Monica Stobbs was not qualified to give opinions on the standard of care that would have applied to Jamie Downing. She never managed, monitored, or started a pediatric IV. Ms. Stobbs did not do any research on the literature prior to forming any opinions.

This case is similar to the *Botehlo v. Bycura*, where an orthopedic surgeon was not qualified to testify on the standard of care for podiatrist where the orthopedic surgeon

had no training in podiatry, was not familiar with any journals or periodicals in podiatry and was not familiar with the surgical procedure performed, 282 S.C. 578, 320 S.E.2d 59 (1984).

Ms. Stobbs testified that medical record indicated insufficient monitoring of the site, incomplete assessments and insufficient flushing. Ms. Stobbs never used the Electronic System implemented by TRMC, and she misinterpreted the medical records. Ms. Stobbs was not qualified to testify about any of that, because she never used the system.

Ms. Stobbs testimony cannot be used to establish the standard of care for monitoring a pediatric IV site. She simply, stated Defendants broke the rules. She had no experience or knowledge to explain the rules that were allegedly broken. Her testimony was prejudicial as she had no experience monitoring pediatric IV sites or the medical records. She has never managed or maintained a pediatric IV site.

Monica Stobbs testimony should have been excluded and therefore defendants are entitled to a JNOV or in the alternative a new trial.

VI. The Request to Admit should have not be published to the Jury

Defendants concede that this is an unusual instance. However, the Request to Admit should not have been published to the Jury. Defendant asserts that the probative value of the Request to Admit was substantially outweighed by the prejudicial affect.

Here, Plaintiff's Counsel intentionally failed to even mention to Defendant's counsel that it intended to publish the request to the Jury. Plaintiff's pre-trial brief was silent on the issue. Defendants were unaware, until at the close of plaintiff's case, when plaintiff's counsel suddenly sprung it on defendant's counsel stating it was a stipulation.

There was never any discussion prior about the request to admit. Such tactics are highly prejudicial as defendants had not time to gather rebuttal evidence.

The Request to Admit did nothing but confuse the issues and was highly prejudicial to defendant. It had the effect of admitting negligence, there was no probative value to the Request to Admit. Plaintiff could show no prejudice by the exclusion of the evidence. There was no probative value to the request to admit. The purpose of the request was to obtain an independent medical examination.

The request to admit should not have been published to the Jury and therefore defendants are entitled to a new trial.

The Request to Admit should not have been published to the Jury and prejudiced the defendant. "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE. Rule 36 (b) of the South Carolina Rules of Civil Procedure states,

> Any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission. Subject to the provisions of Rue 16 governing amendment of a pre-trial order, the Court may permit withdrawal or amendment when the presentation of the merits of the action will be sub-served thereby and the party who obtained the admission fails to satisfy the court that withdrawal or amendment will prejudice him in maintaining or defense on the merits Any admission made by a party under this rule is for the purpose of pending action only and is not an admission by him for any other purpose.

RULE 36, SCRCP; *see also Commerce Center of Greenville, Inc. V. W. Powers McElveen*, 347 S.C. 545, 557, 556 S.E.2d 718, 724 (Ct. App. 2001) (" The trial court may allow a party to amend or withdraw its answers to a request to admit when: (1) the

presentation of the merits is furthered by the amendment; and (2) the party who obtained the admission cannot demonstrate prejudice because of the amendment."). Defendant asserts that plaintiff was not prejudiced by withdrawal of these Requests, which was denied by the Court.

South Carolina's case law addresses issues for withdrawal by the admitting party. The Court should have permitted withdrawal of the RTA because the plaintiffs could not show that withdrawal would prejudice them in maintaining the merits. Here the Request to Admit (RTA) was highly prejudicial to the defendant and did nothing but confuse the issues. At all times defendant maintained that they were not negligent. By introducing the RTA to the jury, it had the effect as if defendant admitted they were negligent. At no time did the defendant admit negligence. The RTA had the opposite effect because plaintiffs admitted the amount in controversy was more than $100,000. The RTA request number 1 stated, "Admit the value of the amount in controversy in this action is less than $100,000." The plaintiff denied this. This directly confuses the issues and is highly prejudicial to any probative value it may have.

The purpose of the request to admit was to obtain an Independent Medical Examination, not for plaintiffs to represent that defendant admitted the damages were in excess of $100,000.00. Therefore, defendants are entitled to a new trial.

VII: The probative value of the photographs was substantially outweighed by unfair prejudice.

Rule 403 of the SCRE states, "[a]lthough relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." "To constitute unfair prejudice, the

photographs must create 'an undue tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one." *State v. Holder*, 382 S.C. 278, 290(2012) (quoting state v. Jackson, 364 S.C. 329, 334 (2005)).

The Court should have excluded the photographs from the jury. In plaintiff's memorandum it states "the fact is it was a horrible injury which was ugly, unpleasant, and offensive in its nature." Pl. Memo. In Opposition pg 12. That is indicative of how prejudicial the photographs were to defendant. As shown at trial, there was ample evidence to prove an injury occurred. No witness disputed the injury had occurred. Plaintiff argues that the photograph that defendant introduced was small and had to be passed around and further that plaintiffs did nothing to enhance the photo. However, the plaintiff's photographs were enhanced, they were blown up, completely out of proportion to its relative size on top of the fact all of the photos were originally close-ups. As to the photograph that Defendant passed around, it was not the photograph of the open flesh wound, it was a photograph of the scar.

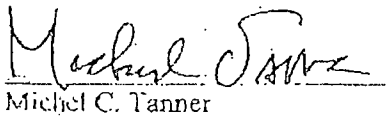
Given the excessive jury verdict it is evident that the jury returned a verdict on a result of passion and prejudice. Therefore, defendants should be granted a new trial absolute.

CONCLUSION

WHEREFORE, defendant TRMC asserts that based on all of the foregoing reasons contained in this Response, as well as those in the prior two filed Motions, the defendant respectfully requests this Court reconsider its decisions and issue and order granting TRMC JNOV or in the alternative, grant dDefendant's a new trial absolute, and

grant such other and further relief as contained herein and such other relief as may be just and proper.

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June 22, 2018

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY
Court of Common Pleas

Edgar W. Dickson, Circuit Court Judge

CASE NO.: 2015-CP-38-01234

Tekayah Hamilton, individually and as parent and guardian ad litem for [redacted] a minor child under the age of eighteen,

..... Respondent,

v.

The Regional Medical Center

.....Defendant.

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NOTICE OF APPEAL

Appellant, The Regional Medical Center appeals the attached Order of the Honorable Edgar W. Dickson dated October 25, 2019, and filed October 25, 2019. Appellant received written notice of entry of this Order on October 25, 2019.

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November 19, 2019

Orangeburg Common Pleas

Case Caption:	Tekayah Hamilton , plaintiff, et al VS Regional Medical Center , defendant, et al
Case Number:	2015CP3801234
Type:	Order/Other

So Ordered

s/ Edgar W. Dickson #2153

Electronically signed on 2019-10-25 11:31:39 page 10 of 10

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STATE OF SOUTH CAROLINA

COUNTY OF ORANGEBURG

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO. 2015-CP-38-01234

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18,

Plaintiff,

vs.

Regional Medical Center

Defendant.

ORDER GRANTING DEFENDANT'S MOTION FOR REDUCTION TO STATUTORY CAP AND DENYING DEFENDANT'S MOTION FOR JNOV OR IN THE ALTERNATIVE FOR A NEW TRIAL

FILED IN ORANGEBURG COMMON PLEAS CASE#2015CP3801234

This case was tried before a jury in this Court on or about May 9, 2018. The jury returned a verdict finding Defendant was grossly negligent and awarded $1,127,280.00 to the minor plaintiff Robert Lee M. Jr., and $135,477.00 to Plaintiff Tekayah Hamilton. Defendant filed two, separate post-trial motions, one to reduce the award to the statutory cap and a JNOV or in the alternative for a new trial. After review of the motions, memoranda of counsel and supporting documents, I grant in part Defendant's Motion for Reduction to Statutory Cap and deny Defendant's Motion for JNOV or in the Alternative for New Trial.

FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of Defendant's alleged failure to implement policies, procedures, and equipment to allow Defendant to properly monitor an IV with ampicillin administered to RJ on or about October 28, 2014, while a patient at Defendant's facility in Orangeburg, South Carolina. Plaintiff's complaint alleges medical negligence, specifically the following:

> The impression of the treating physician was high fever and admission to the hospital was necessary in order to work up CBC, LP, blood and urine cultures. It was decided to begin Ampicillin and Claforan. Pl.'s Complaint par. 11.

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> Defendant Regional by and through its agents and/or employees, and Defendant Downing[1] owed Plaintiff a duty of care to use that degree of care and skill which ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances. Pl.'s Complaint par. 33.
>
> Plaintiff asserts Defendants breached that duty of care and were negligent, grossly negligent, careless, willful, wanton, and reckless in the following particulars:
>
> a) In failing to use reasonable medical care in accordance with the recognized standards of acceptable professional practice in medicine during the care, diagnosis and treatment of Plaintiff;
> b) In failing to act with ordinary and reasonable care in accordance with the recognized standards of acceptable professional practice in medicine;
> c) In failing to follow the Infusion Nurse Society publication on *Policies and Procedures for infusion Nursing of the Pediatric Patient*;
> d) In failing to pursue such appropriate medical modalities and treatments which could have avoided this type of injury and permanent damage;
> e) In failing to act and behave in the same or similar manner that reasonably competent doctors and healthcare facilities and staff would have behaved or acted in the same or similar conditions;
> f) In failing and neglecting to properly inspect the IV site on October 28, 2014, at approximately 4:27 a.m. prior to the administration of antibiotic medication;
> g) In failing and neglecting to properly monitor the IV site after the administration of antibiotic medication;
> h) In failing to adequately train and supervise its medical staff;
> i) In failing to provide the safest care and treatment to Plaintiff; and
> j) For such other acts and omissions that may become more apparent through the discovery of this matter.

Pl.'s Complaint par. 34. Plaintiff attached an affidavit to her complaint by Monica Stobbs, RN, BSN, clarifying and reiterating the breaches in the standard of care by Defendant TRMC, by and through its employees, causing harm to RJ and Tekayah. Specifically, Plaintiff alleged Defendant Regional failed to properly monitor RJ's IV site prior to and after administering medication. Plaintiff did not offer any testimony at trial as to any alleged physician malpractice.

This matter was filed pursuant to South Carolina Tort Claims Act, S.C. Code Ann. §15-78-10, et Seq. I find that defendant TRMC is a governmental healthcare facility and is afforded the protections of the South Carolina Tort Claims Act, as defined by the Act.

[1] Defendant Downing, a registered nurse, was dismissed as a party after the original Summons and Complaint was filed.

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Trial Plaintiff offered Monica Stobbs RN BSN as well as Dr DeVito regarding RJ's future care and Plaintiff herself took the stand Plaintiff also called nurse Jamie Downing, RN, and published Plaintiff's answers to Defendant's First Set of Requests to Admit to the jury RJ's medical records and bills were submitted as evidence along with several pictures of his injury and numerous policies and procedures of Defendant Regional

Defendant called Dr. Davis to dispute RJ's future care. Nurse Jamie Downing, testified along with Cynthia Hurley as to standard of care and expert issues. Defendant also submitted pictures of RJ's injuries, select medical records and select policies and procedures. Defendant moved for a directed verdict at the end of Plaintiff's case and its own. The Court denied both motions for directed verdict.

Defendant TRMC filed two separate post trial motions The first post trial motion was a reduction of the damage caps to reduce the child's award to $300,000 00 and the second was to reduce the mother's jury award to $20,854 00 pursuant to the Tort Claims Act §15-78-120(a) (1) I find that Defendant TRMC's motion for JNOV/New Trial contained the following grounds: Defendant asserted plaintiff's witness, Monica Stobbs, was not qualified to render pediatric nursing opinions; Defendant TRMC asserted that Plaintiff did not establish gross negligence as required by the Tort Claims Act; Defendant TRMC asserts it was prejudiced by photographs submitted to the jury; Defendant TRMC asserts it was error to not allow its expert to testify to an opinion on gross negligence when Plaintiff's expert was allowed to render such opinion; Defendant TRMC asserts it was an error to publish its answers to Request to Admit to the jury; Defendant TRMC alleges it should be granted a new trial as certain jury charges were not given and finally Defendant's motion stated that the verdict was excessive In ruling on all of these motions, the court has reviewed the motions submitted by Defendant TRMC, the memoranda of

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both parties and a review of the applicable law. The Court incorporates all of Defendant's arguments raised in Defendant's motions and memoranda herein, as if restated verbatim.

STANDARD OF REVIEW

A motion for judgment notwithstanding the verdict may only be granted if no reasonable jury could have reached the challenged verdict. RFT Management Co., LLC v. Tinsley & Adams, LLP, 399 S.C. 322, 332, 732 S.E.2d 166, 171 (2012). A jury's verdict must be upheld unless no evidence reasonably supports the jury's findings. Cureton v. Caterpillar, Inc., 355 S.C.316, 320, 585 S.E.2d 272, 274 (2003). In ruling on a motion for judgment notwithstanding the verdict, the trial court must view the evidence and all inferences reasonably drawn therefrom in the light most favorable to the opposing party. Law v. S.C. Dep't of Corr., 368 S.C. 424, 434, 629 S.E.2d 642, 648 (2006).

The thirteenth juror doctrine is the method used by the trial court to grant a new trial upon a finding that the evidence presented at trial did not support the jury's verdict. Curtis v. Blake, 392 S.C. 494, 505, 709 S.E.2d 79, 85 (Ct. App. 2011). If the amount of the verdict is grossly inadequate or excessive so as to be the result of passion, impulse, prejudice, or some other influence outside the evidence, the trial court must grant a new trial absolute. Id. at 500, 709 S.E.2d at 82. Compelling reasons must be presented to support the trial judge's invasion of the jury's province, merely highlighting that the verdict is greater than the amount of monetary damages is not enough as such other non-monetary factors must be considered as well. Id. at 501, 709 S.E.2d at 83.

ANALYSIS

First, this Court finds that the statutory cap on damages pursuant to the South Carolina Tort Claims Act (§ 15-78-10, et seq.) is applicable to this case. This action against TRMC is

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subject to the Tort Claims Act, § 15-78-10, et seq. Specifically, the Act provides that no person shall recover a sum exceeding three hundred thousand dollars because of a loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved unless otherwise provided. S.C. Code Ann. § 15-78-120(a)(1).

In this case, the Jury returned a verdict for the minor [redacted] ("RJ"), in the amount of $1,127,280.00 and separately for his mother, Tekayah Hamilton, in the amount of $135,477.00. Defendant believes that the award to RJ should be reduced to the statutory cap of $300,000 and further argues that the award to Tekayah Hamilton should be reduced to $20,854. In response, Plaintiff's posits that since this single occurrence involved the totality of Defendant's conduct, which encompasses the alleged conduct of Defendant's physicians, then the applicable recovery cap of $1,200,000.00 contained in section 15-78-120(a)(3) applies.

Plaintiff's Complaint did not contain any allegations of physician malpractice and I do not find that Plaintiff offered any testimony that a physician breached the standard of care and alleged deviation of same. Plaintiff offered no expert testimony as to this issue at trial.

This Court agrees that the $1,127,280.00 award to RJ should be reduced to $300,000.00 pursuant to section 15-78-120(a)(1). As set forth above, the jury verdict for RJ must be reduced pursuant to the Tort Claims Act. Although a doctor ordered the medication and its administration, the crux of Plaintiff's case and the evidence presented at trial was that a nurse breached the applicable standard of care. I find that Plaintiff offered no evidence showing a physician was involved in any of the allegations in this matter. Furthermore, Defendant is correct that the evidence at trial showed RJ's mother incurred $20,854.00 in past medical expenses. However, the jury was presented evidence that Ms. Hamilton would be required to bear the financial burden to take time off of work and travel for any future expenses. Because she

ORANGEBURG - COMMON PLEAS CASE#2015CP3801234

will remain his guardian for at least fifteen more years, this court finds the award reasonable. Therefore, this Court finds that the award of $1,127,280.00 to RJ should be reduced to $300,000.00. Further, the award of $135,477.00 to Ms. Hamilton should remain without alteration. The Court denies Defendant's motion to reduce Ms. Hamilton's verdict to $20,854.00 pursuant to the Tort Claims Act.

Next, Defendant asserts that Monica Stobbs was not qualified to give an opinion on the standard of care of pediatric nursing and pediatric IV administration. Nurse Stobbs testified she never managed, maintained or started Pediatric IV's, nor did she review any literature on these issues. She did testify she did these tasks on adult patients. Once qualified, she testified that the assessment, flushing, and other procedures for monitoring and inspecting an IV site prior to the administration of medicine and after the administration of medication are the same regardless of the patient's age. Therefore, this Court sees no reason to depart from its earlier ruling that Monica Stobbs was properly qualified as an expert in nursing, but not as a pediatric nurse. The Court denies the Defendant's motion raised on this ground.

Similarly, Defendant argues that this Court should have directed a verdict in its' favor because Gross Negligence was not established. The determination of gross negligence is a mixed question of law and fact and should be presented to the jury when evidence supports it. Stauber v. City of Folly Beach, 331 S.C. 192, 205, 500 S.E.2d 160, 168 (Ct. App. 1998), aff'd, 339 S.C. 406, 529 S.E.2d 543 (2000). In this case, an inference that Ms. Downing failed to flush the child's IV is an inference that she failed to use slight care. Further, Plaintiff presented evidence that at least 20 minutes passed between RJ's reaction to the ampicillin and the time Defendant's employees responded to Ms. Hamilton's requests for assistance.

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Additionally, witnesses testified that in the medical field if isn't written down (documented), then it did not happen. Evidence of several failures to document the condition of the IV in question was presented at trial. Because the evidence presented could give rise to intentional conduct and/or a failure to exercise slight care, this Court finds that the evidence presented supported the Jury's finding of Gross Negligence. Defendant's Motion on this ground is denied.

Defendant next argues that the probative value of the photographs of RJ's injuries was substantially outweighed by unfair prejudice. Photographs may be admitted corroborating testimony, however, photographs calculated to arouse the sympathy or prejudice of the jury should be excluded if they are irrelevant or not necessary to substantiate material facts or conditions. State v. Jackson, 364 S.C. 329, 613 S.E.2d 374 (2005). This Court reviewed the photographs prior to their publication.

Although, given the nature of the injury and the child's age, they are hard to look at, there is little doubt the photographs are relevant to corroborate the injury. The photographs were admitted for the purpose of proving the injury and this Court sees no reason to depart from its earlier ruling permitting the pictures because they accurately reflected the facts of the case. Defendant's Motion is denied as to this ground.

Defendant also argues that Defendant's expert, Cynthia Hurley, should have been permitted to testify as to whether or not she believed its' employees were grossly negligent or negligent. Defendant asserts this evidence was proper under Rule 704, SCRE. In general, an expert's testimony on issues of law is inadmissible but not because it simply embraces the ultimate issue. Dawkins v. Fields, 354 S.C. 58 (2003). The Court declines to grant the Defendant's motion on this ground

ORANGEBURG COMMON PLEAS CASE#2015CP3801234

The Defendant raised in its motion for JNOV/New Trial the argument that it has been prejudiced by the publication of Request to Produce pursuant to Rule 36, SCRCP. The Court having considered this motion, declines to order a new trial on this ground.

Defendant moved for a new trial as to certain jury charges set forth in its motion of JNOV/New Trial, which are incorporated herein by reference, were not charged to the jury. The Court declines to grant Defendant's motion on this ground, which is denied.

The Defendant requested a new trial based upon the view that the jury verdict was grossly excessive and contrary to the evidence. Defendant asserts in its memoranda that the verdict was 54 times the amount of the actual damages and was a result of passion, caprice, or prejudice. The Court has considered the argument of the Defendant in its memoranda as set forth above, which is incorporated by reference. The Court denies Defendant's motion for a new trial based upon this ground.

Defendant additionally raised that if the Court denied its JNOV or new trial absolute motions it should grant a new trial nisi remittitur as it asserted the damages for excessive compared to the evidence presented at trial. After considering this argument, the court denies to grant the Motion on this ground.

The Court has considered all the issues raised by the Defendant in its post trial motions and denies the motion for JNOV/New Trial as set forth above and partially grants Defendant's motion to reduce the verdict to the Tort Claims Act liability cap. Accordingly, and for these reasons.

IT IS THERFORE ORDERED, that Defendant's Motion for post-trial relief of 1.) JNOV and 2.) a new trial absolute are DENIED. The Defendant's motion of reduction of damages to the

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[illegible] ORDERED that the Defendant's motion to reduce the mother's verdict is denied.

AND IT IS SO ORDERED

Resident Judge Edgar W. Dickson
The First Judicial Circuit

August _____, 2019
Orangeburg, South Carolina

FILED, 08:30:29 AM, 08/26/2019, COLLETON COUNTY, CLERK OF COURT, 2019CP1500129

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY
Court of Common Pleas

Edgar W. Dickson, Circuit Court Judge

CASE NO.: 2015-CP-38-01234

Tekayah Hamilton, individually and as parent and guardian ad litem for [redacted], a minor child under the age of eighteen, ... Respondent,

v.

The Regional Medical Center .....Defendant.

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I certify that I have served the Notice of Appeal on Tekayah Hamilton, by depositing a copy of it in the United States Mail, postage prepaid, on November 19, 2019, addressed to her attorneys of record, Jonathan F. Krell, Esquire, Post Office Box 299, Charleston, S.C., and David R. Williams, Esquire, Post Office Box 1084, Orangeburg, S.C., 29116

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November 19, 2019

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

Honorable Edgar W. Dickson, Circuit Court Judge

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of 18, Respondent,

v.

Regional Medical Center, Appellant.

CERTIFICATE OF COUNSEL

The undersigned certifies that this Record of Appeal complies with Rule 210(g), SCACR.

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April 30, 2021

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

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Honorable Edgar W. Dickson, Circuit Court Judge

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of 18,Respondent,

v.

Regional Medical Center, Appellant.

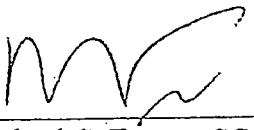
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I certify that I have served a copy of the Amended Record on Appeal by depositing a copy of same via e-mail on September 27, 2021, addressed to the Respondent's attorney as follows:

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September 27, 2021

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

Honorable Edgar W. Dickson, Circuit Court Judge

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee Middleton, Jr., a minor child under the age of eighteen,.. ..... Respondent

v.

The Regional Medical Center, ...Appellant

INITIAL BRIEF OF THE REGIONAL MEDICAL CENTER

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STATEMENT OF ISSUES ON APPEAL

1. Whether the Trial Court abused its discretion in qualifying Respondent's Expert Monica Stobbs as a general nurse and in permitting her to testify as to the standard of care for pediatric IV administration.

2. Whether Appellant is entitled to a reversal on the grounds that the lower court should have granted a directed verdict in favor of Appellant as Respondent did not establish gross negligence.

3. Whether the Trial Court abused its discretion by allowing, over objection, the admission of prejudicial photographs of the minor child to the jury.

4. Whether the Trial Court abused its discretion in prohibiting Appellant's expert Cynthia Hurley from testifying in front of the jury as to whether the Appellant was grossly negligent or negligent.

5. Whether the Trial Court abused its discretion in permitting the Request for Admission to be published to the jury.

6. Whether the Trial Court abused its discretion in not granting a new trial absolute or new trial *nisi remittitur* when the verdict was grossly excessive and shockingly disproportionate and contrary to the evidence admitted at trial, or, at the very minimum, was at least merely excessive given the evidence.

STATEMENT OF THE CASE

This matter arises out of an IV infiltration to a minor child which occurred during an admission at The Regional Medical Center from October 25 through October 30, 2014. On October 7, 2015, Plaintiff "Respondent" Tekayah Hamilton filed a Summons and Complaint alleging medical malpractice in the Orangeburg County Court of Common Pleas on behalf of herself individually, and as a parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen. The Defendant ("Appellant") The Regional Medical Center and Jamie Downing, RN, filed its Answer to the Complaint on November 30, 2015, denied liability and any wrongdoing, and asserted numerous affirmative defenses. Jamie Downing, RN, was dismissed from the action on June 29, 2016, pursuant to the Tort Claims Act.

The action came to a Jury Trial beginning May 7, 2018, in front of Judge Edgar W. Dickson in Orangeburg County, South Carolina. *See* Trial Tr. Mar. 19, 2019 & Trial Tr. Dec. 22, 2020. Appellant presented three pretrial motions *in limine*. *See* Def.'s Mot. in lim. to Exclude Photos., Def.'s Mot. in lim. to Exclude Monica Stobbs Testimony, Trial Tr. Dec. 22, 2020. In its first motion, Appellant moved that Respondent's expert, Monica Stobbs, should not be qualified as an expert witness in this matter and allowed testify to the standard of care for pediatric nursing on the ground that she lacked the required qualifications. In its second Motion, Appellant moved to exclude photographs of the minor child's hands on the ground that the probative value of the photographs was substantially outweighed by the danger of unfair prejudice. In its third and final motion, Appellant moved to exclude hearsay testimony of the Respondent. The Trial Court denied the Appellant's motions regarding Monica Stobbs and the photographs and granted the motion to exclude the hearsay testimony. On May 9, 2018, the Jury returned a verdict for the

Respondent Robert Lee Middleton Jr., in the amount of $1,127,280.00 and for Respondent Tekayah Hamilton in the amount of $135,477.00.

On May 17, 2018, Appellant filed two post trial motions. Appellant filed a Notice of Motion and Motion for JNOV or in the alternative Motion for New Trial and a Post Trial Motion For Reduction to Statutory Cap. Respondent filed a memorandum in opposition to Appellant's motions on June 13, 2018. On June 27, 2018, Appellant filed a response to the Respondent's Memorandum in Opposition. On October 25, 2019, the Trial Court issued its Order Granting Appellant's Motion for Reduction to Statutory Cap and Denying Appellant's Motion for JNOV or in the Alternative a New Trial.

Appellant timely filed a Notice of Appeal on November 19, 2019.

ARGUMENT

I. THE TRIAL COURT ABUSED ITS DISCRETION IN QUALIFYING RESPONDENT'S EXPERT MONICA STOBBS AS A GENERAL NURSE AND IN PERMITTING HER TO TESTIFY AS TO THE STANDARD OF CARE FOR PEDIATRIC IV ADMINISTRATION.

STANDARD OF REVIEW

"The qualification of an expert witness and the admissibility of the expert's testimony are matters within the trial court's discretion." *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 252, 487 S.E.2d 596 (1997) (citing *McGee v. Bruce Hosp. System*, 321 S.C. 340, 468 S.E.2d 633 (1996); *see, e.g., Fields v. The Reg'l Med. Ctr. of Orangeburg*, 363 S.C. 19, 25, 609 S.E.2d 506 (2005). "Similarly, the admission or exclusion of evidence in general is within the sound discretion of the trial court." *Fields*, 363 S.C. 19 at 25. "In both instances, the trial court's decision will not be disturbed on appeal absent an abuse of discretion." *Id.*; *see, e.g., Gooding v.*

St. Francis Xavier Hosp., 454 S.E.2d 328, 330 (Ct. App. 1995). "An abuse of discretion occurs when there is an error of law or a factual conclusion which is without evidentiary support." *Gooding*, 326 S.C. at 252 (citing *Lee v. Suess*, 318 S.C. 283, 457 S.E.2d 344 (1995)); *Fields*, 363 S.C. at 26. "A trial court's ruling on the admissibility of an expert's testimony constitutes an abuse of discretion when the ruling is manifestly arbitrary, unreasonable, or unfair." *Fields*, 363 S.C. at 26 (citing *Means v. Gates*, 348 S.C. 161, 166, 558 S.E.2d 921, 924 (2001). "To warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Fields*, 363 S.C. at 26 (citations omitted).

ARGUMENT

A. THE TRIAL COURT'S ERROR WAS AN ABUSE OF DISCRETION.

Appellant argues that the Trial Court erred in ruling that Monica Stobbs, R.N., was qualified as an expert in general nursing ("Nursing 101") (Trial Tr. 7-10, 10:4-6, Dec. 22, 2020 & Trial Tr. 78:1-19, Mar. 17, 2019) and in allowing her to testify to the standard of care for pediatric nursing IV management. Def's Mot. *in lim.* to Exclude Monica Stobbs Testimony, Def's Mot. for JNOV or in the alt. Motion for New Trial 4-5; Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 6. Appellant argues that this an error that amounted to an abuse of discretion because the case was about pediatric, not adult, nursing and IV medicine; Ms. Stobbs failed to meet the qualifications as set forth in the South Carolina Rules of Evidence 702 and *Gooding*; and the court allowed Ms. Stobbs to testify outside of the scope of her expert qualification in this matter.

1. THIS MATTER WAS ABOUT PEDIATRICS, NOT GENERAL NURSING.

Appellant first argues that the Trial Court's error in qualifying Ms. Stobbs amounts to an abuse of discretion because there was no basis or rationale for qualifying Ms. Stobbs as an expert in general nursing in this matter. Pediatric nursing, not general nursing or "Nursing 101" (Trial Tr. 8:4-11, Dec. 22, 2020), was the issue in this case. Medical literature indicates a clear distinction between IV administration and management for pediatrics and adults.[1] Veins in infants are "obviously smaller" and can be "threadlike."[2] Trial Tr. 105:3-13, Mar. 17 2019. "Vein fragility and the high acuity levels of young patients can increase the likelihood of infiltration and extravasation, resulting in significant morbidity."[3] *Id.* at 129:19-130:1. Furthermore, testimony from Appellant's expert and Nurse Downing, both of whom have extensive experience in pediatric nursing and IV administration (Trial Tr. 298:8-299:1, 323:10-324:21, 350:15-19, Mar. 17, 2019), revealed distinct differences between pediatrics and adult IV management (Trial Tr. 266:11-25, 331:11-332:24, Mar. 17, 2019). Pediatric patients and their veins are smaller, more fragile, and more mobile and therefore need to be more frequently assessed, whereas adults are more stable, have bigger veins, and thus, nurses are able to use larger catheters. *Id.* Because there is a clear distinction in pediatrics and adult IV care and the issue here was pediatrics, it was

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[1] [1]The Infusion Nurses Society: Infusion Therapy in Clinical Practice, 2nd. eds Hankins J, Lonsway RA, Hendrick C and Perdue MB. Saunders, St. Louis, MO 2001, 561 "Children present a wide variety of physical characteristics different from those in adults. In addition, premature infants and newborns vary greatly from older children in their anatomy and physiology. These characteristics affect the ability of neonates and infants to cope with environmental stress and to manage the metabolism, absorption, distribution, and excretion of medications and solutions. Although body systems in infants and children are different from those in adults, for the purpose of this text, only those related to infusion therapy are addressed in detail."

[2] *Id.* at 562 "The size of venous and arterial vessels in the infant and child are obviously smaller than those in the adult. Although the vessels are anatomically positioned in the same locations throughout life, their sometimes-threadlike characteristics and tendency to hide make them difficult to locate in the young patient."

[3] *Policies and Procedures from Fusion Nursing of the Pediatric Patient*, The Infusion Nurses Society, supra at 125.

manifestly arbitrary, unfair, and unreasonable, an thus, an abuse of discretion, to qualify and allow the testimony of a general nurse who never practiced pediatric nursing.

2. MONICA STOBBS FAILED TO MEET THE REQUIREMENTS OF RULE 702 OF THE SOUTH CAROLINA RULES OF EVIDENCE AND *GOODING.*

In order to be qualified as an expert witness, a person must have the "knowledge, skill, experience, training or education" in order to testify. Rule 702, SCRE. "To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter.'" *Gooding*, 326 S.C. at 253, 487 S.E.2d at 598 (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995); *see, e.g.*, *State v. Douglas*, 367 S.C. 498, 508-509, 626 S.E.2d 59 (Ct. App. 2006); *Botehlo v. Bycura*, 282 S.C. 578, 586, 320 S.E.2d 59, 65 (Ct. App. 1984) (holding that an orthopedic surgeon was not qualified to testify on the standard of care for podiatrist where the orthopedic surgeon had no training in podiatry, was not familiar with any journals or periodicals in podiatry, and was not familiar with the surgical procedure performed).

Appellant argues the Trial Court's error amounts of abuse of discretion because, as per the requirements of South Carolina Rules of Evidence 702 and *Botehlo,* Ms. Stobbs was not qualified to testify as to pediatric IV administration, as her experience has only been to general, adult IV administration. Trial Tr. 8:13-9:19, Dec. 22, 2020; Def's Mot. *in lim.* to Exclude Monica Stobbs Testimony. The issue is not over a *defect* in amount or quality of experience or knowledge but rather, much like *Botehlo*, is over whether she possessed *any* of the required knowledge or experience. Similar to the orthopedic surgeon in *Botehlo*, Ms. Stobbs has had no personal experience or training at all in pediatric nursing or IV administration. Trial Tr. 103:14-

104:8,108:22-110:21, Mar. 17, 2019. Ms. Stobbs has never cared for a pediatric patient and has never started or managed a pediatric IV. *Id.* at 79:24-25, 108:22-110:21; Stobbs Dep. 13:9-24. Additionally, Ms. Stobbs does not have any education or knowledge as to pediatric nursing or IV administration. Ms. Stobbs testified that she did not perform any research, independent study, or review any medical literature in preparation of formulating her opinions. Trial Tr. 111:14-23, Mar. 17, 2019; Stobbs Dep. 26:15-24.

Ms. Stobbs proved her lack of knowledge and expertise by making baseless and inaccurate claims and testifying directly contradictory to the literature. Ms. Stobbs' opinion is premised on her belief that the standard of care for IV management is the same for pediatric patients as it is for adults. Trial Tr. 111:22-23, Mar. 17, 2019. Mar. 17, 2019; Stobbs Dep. 13:13-18. Her opinions are based on the speculative belief that pediatric patients are simply little adults. She believes the standard of care for both pediatrics and adults is "simple nursing 101." *Id.* at 96:22-23; Stobbs Dep. 26:17. Although she acknowledged that the literature indicates children have a wide variety of physical characteristics that differ from adults, including smaller, "obviously threadlike" veins, it is her opinion that a "vein is a vein." Trial Tr. 104:20-105:23, 126:1-15, 128:1-5, Mar. 17, 2019. She also testified that she disagreed with literature provided by Respondent that stated "[l]arger amounts of subcutaneous fat in children can make the identification of an early infiltration difficult;"[4] however, she admitted she had no literature with her to support her opinion. *Id.* at 130:10-131:25.

Ms. Stobbs further proved her lack of knowledge concerning pediatric IV administration when she testified that she "should get blood return from a vein whether it's a baby or whether it's an adult." Stobbs Dep. 32:24–33:7. Trial Tr. 97:2-3, 110:22-24, 133:2-14, 133:20-134:13,

[4] The Infusion Nurses Society, *supra*

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Mar. 17, 2019. This is directly contrary to the literature.[5] Trial Tr. 104:16-106:2, 351:7-14, Mar. 17, 2019. Although Ms. Stobbs has obtained blood returns in adult patients, she has never attempted to obtain one in a pediatric patient, and therefore, she does not know what it could do to a pediatric vein. Trial Tr., 134:20-135:8, Mar. 17, 2019. On the contrary, Appellant's expert, Cindy Hurley, and Nurse Downing both testified that trying to obtain a blood return in a pediatric is inappropriate because it could cause the vein to collapse or result in a false reading. Trial Tr. 271:8-21, 347:20-25-349:14, Mar. 17, 2019.

Thus, Ms. Stobbs failed to meet the requirements of SCRE 702 and *Gooding*. The sole purpose of an expert is to educate a jury on the subject matter of his or her expertise, and that is impossible to do without prior experience or study. Without proper education, training, or experience regarding pediatric administration and management, Ms. Stobbs was not more qualified than the jury to form an opinion as to the same. Therefore, Appellant asserts it was arbitrary, unfair, and unreasonable, thus an abuse of discretion, to permit Ms. Stobbs to testify as an expert in the standard of care for pediatric IV administration and administration.

3. THE CONTENT OF MS. STOBBS' TESTIMONY EXCEEDED THE QUALIFICATION OF THE TRIAL COURT.

Lastly, Appellant argues that the Trial Court's error amounts to abuse of discretion because it allowed Ms. Stobbs to provide expert testimony beyond the scope for what she had been qualified in this matter. During the Motion *in limine* hearing, the Trial Court specifically indicated Ms. Stobbs would be qualified in general nursing and not pediatrics, as it

[5] "The Infusion Nurses Society, *supra at 422.*" "Checking for a blood return, or backflow of blood, is not a reliable method for determining the absence of an infiltration. A blood return may not be present when small veins are used because they may not permit blood flow around the cannula; one may think the infusion has infiltrated when it has not."

acknowledged she had no prior experience with regards to pediatrics. Trial Tr. 8:18-19, 9:20-10:6, Dec. 22, 2020. Despite this, during trial the Trial Court allowed Ms. Stobbs to testify as to the standard of care of pediatric nursing and IV administration. This was clearly beyond the scope of the Trial Court's qualification of her as an expert witness. Therefore, Appellant maintains that it was manifestly arbitrary, unfair, and unreasonable, and thus, an abuse of discretion, to allow Ms. Stobbs to testify regarding the standard of care for pediatric IV administration and management.

B. THE TRIAL COURT'S ABUSE OF DISCRETION WAS NOT HARMLESS

Appellant asserts this error was not harmless and was highly prejudicial to Appellant's case. "Whether an error is harmless depends on the circumstances of the particular case. No definite rule of law governs this finding. Rather, the materiality and prejudicial character of the error must be determined from its relationship to the entire case." *State v Douglas*, 367 S.C. at 519-520 (citations omitted). "Error is harmless where it could not reasonably have affected the result of the trial." *Id.* at 520 (citing *Arnold v. State,* 309 S.C. 157, 420 S.E.2d 834 (1992)). "The admission of improper evidence is harmless where the evidence is merely cumulative to other evidence." *Id.* at 520 (citations omitted); *see also*, *McGee,* 468 S.E.2d at 636 (allowing an expert to testify about the placement of catheters was harmless as it was cumulative to other evidence). "To show prejudice, there must be a reasonable probability that the jury's verdict was influenced by the challenged evidence or the lack thereof." *State v. Douglas*, 367 S.C. at 508 (citations omitted).

Given the arguably excessive verdict (Trial Tr. 446:18-447:1, Mar. 17, 2019) in light of no other testimony or evidence as to Appellant's negligence (*see infra* Argument II), Appellant asserts the error in allow Ms. Stobbs' qualification and testimony was not harmless. Appellant

asserts that had Ms. Stobbs not been qualified as an expert and allowed to testify as to the standard of care for pediatric IV management, then the Respondent could not meet its burden of proof which would have resulted in a directed verdict against Respondent. Ms. Stobbs' testimony was not cumulative to other testimony or evidence presented. She was the only witness offered by Plaintiff on two critical issues. Appellant further asserts that the excessive verdict demonstrates that there is reasonable probability that the jury was highly influenced by Ms. Stobbs' testimony. Thus, Appellant asserts this error not harmless, but rather was highly prejudicial to Appellant's defense of the matter. Therefore, because the Trial Court's error amounted to an abuse of discretion and this error was not harmless, the Trial Court's ruling is warranted a reversal on this ground.

II. APPELLANT IS ENTITLED TO A REVERSAL ON THE GROUNDS THAT THE LOWER COURT SHOULD HAVE GRANTED A DIRECTED VERDICT IN FAVOR OF APPELLANT AS RESPONDENT DID NOT ESTABLISH GROSS NEGLIGENCE.

STANDARD OF REVIEW

"When reviewing the denial of a motion for directed verdict or JNOV, this Court must employ the same standard as the trial court by viewing the evidence and all reasonable inferences in the light most favorable to the nonmoving party." *Welch v. Epstein*, 342 S.C. 279, 299-300, 536 S.E.2d 408 (2000) (citations omitted). "In ruling on a motion for directed verdict, it is the duty of the court to view the evidence and all inferences which may reasonably be drawn therefrom in the light most favorable to the non-moving party." *Hollins v. Richland Cnty. Sch. Dist. One*, 310 S.C. 486, 427 S.E.2d 654, 655 (1993) (citing *Horton v. Greyhound Corp.*, 241 S.C. 430, 128 S.E.2d 776 (1962)). "The trial court must deny the motions when the evidence yields more than one inference or its inference is in doubt." *Welch*, 342 S.C. at 300 (citing

Steinke v. S.C. Dept. of Labor, Licensing, & Reg, 336 S.C. 373, 520 S.E.2d 142(1999)). "Th[e] Court will reverse the trial court only when there is no evidence to support the ruling below." *Id.* (citations omitted)."When considering directed verdict and JNOV motions, neither the trial court nor the appellate court has authority to decide credibility issues or to resolve conflicts in the testimony or evidence." *Id.* (citations omitted). "A motion for JNOV may be granted only if no reasonable jury could have reached the challenged verdict." *Id.* (citing *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 415 S.E.2d 393 (1992)). "The jury's verdict will not be overturned if any evidence exists that sustains the factual findings implicit in its decision." *Id.* (citations omitted).

ARGUMENT

Gross negligence is the standard that applies in this matter. *See Stewart v. Richland Mem'l Hosp.*, 350 S.C. 589, 592, 567 S.E.2d 510, 511 (2002) (holding gross negligence was the standard, as per the South Carolina Torts Claim Act, that the plaintiff had to prove in a matter where a nurse in a hospital was involved in restraining and monitoring the plaintiff). Appellant is a government entity, as defined by the statute, S.C. Code Ann. § 15-78-30(j); and *Smith v TRMC*, 713 S.E.2d 656 (Ct. App. 2011) thus, this matter is restricted to the confines prescribed within the South Carolina Torts Claims Act, S.C. Code Ann. § 15-78-200. Per the South Carolina Torts Claims Act §15-78-60(25),

> The governmental entity *is not liable* for a loss resulting from . . . responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any student, patient, prisoner, inmate, or client of any governmental entity, *except when the responsibility or duty is exercised in a grossly negligent manner*

S.C. Code Ann. § 15-78-60(25) (Cum. Supp. 1991) (emphasis added). Moreover, the Torts Claims Act "must be liberally construed in favor of limiting the liability of the State." S.C. Code

Ann. § 15-78-20(f) and § 15-78-200. Therefore, gross negligence is the applicable standard, and the facts must be applied in such a way to limit the liability on the State.

This Court has defined gross negligence in a number of ways. "Gross negligence is the intentional failure to do something which it is incumbent upon one to do or the doing of a thing intentionally that one ought not to do." *Etheredge v. Richland Sch. Dist. One*, 341 S.C. 307, 310, 534 S.E.2d 275 (2007); *see, e.g., Clyburn v. Sumter Cnty. Dist. Seventeen*, 317 S.C. 50, 451 S.E.2d 885, 887 (1994); *Richardson v. Hambright*, 296 S.C. 504, 506, 374 S.E.2d 296, 298 (1988). It is the "failure to exercise slight care." *Id.* Gross negligence has also been defined as "a relative term, and means the absence of care that is necessary under the circumstances." *Hollins v. Richland Cnty. Sch. Dist. One*, 427 S.E.2d at 656 (quoting *Hicks v. McCandlish*, 221 S.C. 410, 415, 70 S.E.2d 629 (1952)). Furthermore, "[w]hile gross negligence ordinarily is a mixed question of law and fact, when the evidence supports but one reasonable inference, the question becomes a matter of law for the court." *Etheredge*, 341 S.C. at 310; *see, e.g., Clyburn*, 451 S.E.2d at 887-88.

Appellant maintains that the Trial Court erred in refusing to grant Appellant's motion for directed verdict (Trial Tr. 311:8-313:3, 315:2-23, 382:8-21, Mar. 17, 2019), or Appellant's motion for JNOV or a new trial as there was not more than one inference as to whether Appellant acted with gross negligence (Def. Mot. for JNOV or in the alt. Motion for New Trial 5-6; Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 6-7). This was not a case of credibility issue or conflict in evidence or testimony. Rather, Respondent failed to provide *any* evidence or testimony of gross negligence; and thus, no reasonable jury could have made any finding of such.

Respondent did not submit any question to its own expert about whether Nurse Stobbs or Appellant were grossly negligent. Moreover, when asked by counsel for Appellant, Respondent's expert had no opinion as to the intentional conduct of Nurse Downing. Trial Tr. 132:24-25, 133:17-19, Mar. 17, 2019. Respondent's expert further agreed that just because an IV infiltrated does not automatically warrant a conclusion that there was negligence. *Id.* at 139:7-16. In fact, she agreed that infiltration is a known risk. *Id.* at 112:2-24, 139:4-6. Respondent's expert herself testified that she has had IVs infiltrate without her having been negligent and has known other nurses who had IVs infiltrate without them being negligent. *Id.* at 138:10-139:3.

Nurse Downing testified that she acted in accordance with how she was trained with respect to pediatric IV administration. She testified regarding her knowledge on the differences between adult and pediatric IV administration and monitoring. *Id.* at 266:11-269:23, 271:8-21. She testified that she checked on the patient regularly and assessed the IV to make sure it was in properly and the medication was being administered as it should be. She testified that at no time during her assessment and monitoring of the minor Respondent did she see an infiltration score of anything other than zero. *Id.* at 303:25-305:19. She further testified that she followed the required protocol regarding flushing, always flushed the IV prior to administering medication, and documented her interactions with the patient into the hospital computer system as required. *Id.* at 272:9-274:19, 274:23-275:1, 275:19-276:9, 276:22-277:10, 280: 2-3, 280:6-10, 280: 13-18, 280:21-281:1, 299:13-303:22. This is evidence that Nurse Downing, at the very minimum exercised at least slight care.

Moreover, Cindy Hurley, Appellant's expert who has had extensive experience working in pediatric nursing (*Id.* at 323:10-324:21, 350:15-19), testified that Nurse Downing actually exceeded the standard and the hospital's policy and procedure requirements by checking on him

seven times during her twelve hour shift when she was only required to check on him once (*Id.* at 327:21-331:10, 333:2-347:25, 349:15-350:14, 352:8-354:13, 356:20-357:4). Certainly, if there was no evidence of negligence, but rather there was testimony that the standard was actually exceeded, there could not possibly have been any gross negligence or any inference of the same as a matter of law.

Even in the light most favorable to the non-moving party, there was no evidence or testimony presented establishing an inference or possibility of gross negligence on the part of Appellant. Respondent had the burden, and they failed to meet that burden. Respondent failed to demonstrate through evidence or testimony that Nurse Downing failed to exercise slight care or intentionally failed to do what she ought to have done in the care and treatment of the minor Respondent. Because Respondent failed to meet their burden of establishing any inference of gross negligence, and the courts favor limitations on liability on the State, the Trial Court erred by not granting a directed verdict in favor of Appellant. Thus, the decision must be reversed on this ground.

III. THE TRIAL COURT ABUSED ITS DISCRETION BY ALLOWING, OVER OBJECTION, THE ADMISSION OF PREJUDICIAL PHOTOGRAPHS OF THE MINOR CHILD TO THE JURY.

STANDARD OF REVIEW

"[T]he admission or exclusion of evidence in general is within the sound discretion of the trial court." *Fields*, 363 S.C. 19 at 25. "[T]he trial court's decision will not be disturbed on appeal absent an abuse of discretion." *Id.*; *Gooding*, 454 S.E.2d at 30. "An abuse of discretion occurs when there is an error of law or a factual conclusion which is without evidentiary support." *Gooding*, 326 S.C. at 487 (citing *Lee*, 318 S.C. 283, 457 S.E.2d 344); *Fields*, 363 S.C. at 26. "To

warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Fields*, 363 S.C. at 26 (citations omitted).

ARGUMENT

Rule 403 of the South Carolina Rules of Evidence states, "[a]lthough relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE. "To constitute unfair prejudice, the photographs must create 'an undue tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one.'" *State v. Holder*, 382 S.C. 278, 290, 676 S.E.2d 690 (2009) (quoting *State v. Jackson*, 364 S.C. 329, 334 (2005)). "Photographs calculated to arouse the sympathy or prejudice the jury should be excluded if they are irrelevant or not necessary to substantiate material facts or conditions." *State v. Torres*, 390 S.C. 618, 623, 703 S.E.2d 226 (2010).

In a Motion *in limine*, Appellant argued against the admission of photographs (Pltf.'s Exs. 1-3) of the minor Respondent's hand into evidence. Trial Tr. 10-15, Dec. 22, 2020; Def.'s Notice of Motion & Motion *in limine* to Exclude Photos. Appellant believes that the court erred in allowing the admission of the photographs (Trial Tr. 14:24-15:14, Dec. 22, 2020) and testimony during trial as to the same (Trial Tr. 151:7-152:15, 154:20-156:3, 228:1-230:15, 235:8-236:4, Mar. 17, 2019). Def.'s Motion for JNOV or in the alt. Mot. for New Trial 6-7; Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 7. First, these photographs were not necessary to substantiate the

Respondent's case. The fact that there was a wound was never disputed, and at no time did Appellant's argue that the infiltration did not occur or was not the cause of the wound. Trial Tr. 3:13-18, Dec. 22, 2020; Trial Tr. 399:3-5, Mar. 17, 2019. The Respondent had ample other evidence of the wound, such as the wound center records (Pltf.'s Ex. 6), testimony by the witnesses, and presentation of the minor child at trial (Trial Tr. 158:15-159:25, Mar. 17, 2019), that were less prejudicial than the photographs of the open flesh wound.

Second, these were grotesque, up-close images of the wound that made them appear substantially large than they were in reality. One of the photographs was actually quite blurry. Moreover, the photographs did not include a scale to indicate measurements and proportions. As such, Appellant argues that these images were graphic, inflammatory, and not an accurate reflection of the child's hand and injuries. Trial Tr. 12:23-14:1, Dec. 22, 2020; Def.'s Notice of Motion & Motion *in limine* to Exclude Photos; Def.'s Motion for JNOV or in the alt. Mot. for New Trial 6-7. The photos, by their very nature, had a prejudicial tendency to arouse the emotions of the jury. *Id.* Moreover, the photographs did not reflect the current state of the wound. The minor child appeared during trial and showed the jury his scar, which did not appear as it did in the photographs. Trial Tr. 158:15-159:25, Mar. 17, 2019. There was also testimony, including from Respondent's own expert, that the child's scar appeared healed since February 2015 and did not look like the photographs shown. *Id.* at 243:12-20, 245:2-3, 245:5-8. Thus, as the photographs were not necessary to determine the identity of the child or that the injury had occurred; were grotesque, up-close images not appropriately scaled; and were not representative of the nature of the child's scar, Appellant asserts the admission of the photographs and testimony of the same was in error.

Appellant further asserts this error amounted to prejudice based upon the excessive verdict in favor of Respondent. Due to the excessive jury award, the Appellant is left to conclude that the admission of the grotesque, up-close nature of the photographs were designed to and succeeded in arousing the sympathy of the jury. As stated above, the photographs were not necessary to establish identity or that the infiltration did occur and was the cause of the wound, the photographs were of little probative value. Appellant argues that any probative value they may have had was substantially outweighed by the fact that they were grotesque, up-close images of the open wound, not to scale, and not representative of the actual appearance of minor's scar. Despite hearing testimony that the minor child's scar has been healed since February 2015 (*Id.* at 245:2-8), is well-healed and stable (*Id.* at 191:17-192:3), does not appear as it did in the photographs, and, in fact, seeing this for themselves, the jury return a grossly excessive verdict in favor of Respondent. Thus, this leaves Appellant to conclude that, without any additional presentation from the Respondent of evidence of gross negligence on the part of Appellant, the jury must have been highly persuaded by these grotesque images. Thus, Appellant asserts the admission of these photographs were highly prejudicial to its defense.

Therefore, Appellant asserts the admission of the photographs was in error, was highly prejudicial to Appellant's defense, and their admission and the allowance testimony to the same an abuse of discretion by the Trial Court, thereby warranting a reversal of the Trial Court's decision.

IV. THE TRIAL COURT ABUSED ITS DISCRETION IN PROHIBITING APPELLANT'S EXPERT CYNTHIA HURLEY FROM TESTIFYING IN FRONT OF THE JURY AS TO WHETHER THE APPELLANT WAS GROSSLY NEGLIGENT OR NEGLIGENT.

STANDARD OF REVIEW

"The qualification of an expert witness and the admissibility of the expert's testimony are matters within the trial court's discretion." *Gooding*, 326 S.C. at 252 (citing *McGee v. Bruce Hospital System*, 321 S.C. 340, 468 S.E.2d 633 (1996); *see, e.g., Fields*, 363 S.C. at 25. "Similarly, the admission or exclusion of evidence in general is within the sound discretion of the trial court." *Fields*, 363 S.C. at 25. "In both instances, the trial court's decision will not be disturbed on appeal absent an abuse of discretion." *Id.*; *see, e.g., Gooding*, 454 S.E.2d at 330. "An abuse of discretion occurs when there is an error of law or a factual conclusion which is without evidentiary support." *Gooding*, 326 S.C. at 252 (citing *Lee*, 318 S.C. 283, 457 S.E.2d 344); *Fields*, 363 S.C. 19 at 26. "A trial court's ruling on the admissibility of an expert's testimony constitutes an abuse of discretion when the ruling is manifestly arbitrary, unreasonable, or unfair." *Fields*, 363 S.C. at 26 (citing *Means*, 348 S.C. at 166, 558 S.E.2d at 924). "To warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Fields*, 363 S.C. at 26 (citations omitted).

ARGUMENT

During trial, Respondent asked the court to prohibit Appellant's expert from testifying as to any legal conclusion. Trial Tr. 316:2-7, Mar. 17, 2019. Appellant argues that the court erred prohibiting counsel for Appellant from asking its expert in front of the jury whether she believed Appellant was negligent or grossly negligent and instead forcing counsel for Appellant to ask her outside the presence of the jury in a proffer. *Id.* at 316:2-320:1, 378:1-381:13; Def.'s Motion for JNOV or in the alt. Motion for New Trial 7-8; Court's Order Granting Def.'s Motion for

Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the alt. for a New Trial 7. It was her opinion via the proffer that Nurse Downing, and therefore TRMC, was not negligent and was not grossly neglect. (*Id.* at 380:3-18). Appellant argues that the Trial Court's error in not allowing this testimony has amounted to an abuse of discretion because it was allowed under the Rules of Evidence and case law, and it resulted in prejudice to the Appellant and the presentation of its defense on the matter.

Pursuant to the South Carolina Rules of Evidence, "[t]estimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." Rule 704, SCRE. "There is no invasion of the province of the jury, for the jury retains its power and duty to judge both the credibility of the witness and the weight to be given to his opinion." *Redman v. Ford Motor Co.*, 253 S.C. 266, 278, 170 S.E.2d 207 (1969). In *Dawkins*, the court held that "[i]n general, expert testimony on issues of law is inadmissible. *Dawkins v. Fields*, 354 S.C. 58, 66, 580 S.E.2d 433 (2003). However, the court has held "that the trial judge has the discretion to permit expert testimony on the ultimate issue before the jury." *Redman*, 253 S.C. at 278 (citing *O'Kelley v. Mut. Life Ins. Co.*, 197 S.C. 109, 14 S.E.2d 582 (1941)); *see, e.g., Hughes v. Children's Clinic, P.A.*, 269 S.C. 389, 403, 237 S.E.2d 753 (1977).

Appellant's expert, Cindy Hurley, testified as to the standard of care for pediatric nursing and her opinions as to whether Nurse Stobbs complied with that standard. Trial Tr. 327:21-24, 328-331:10, 333:2-347:25, 349:15-350:14, 352:8-354:13, 356:20-357:4, Mar. 17, 2019. For reasons previously discussed, the ultimate issue, the burden which Respondent had to establish, was gross negligence. Given her extensive experience and knowledge regarding pediatric nursing and IV administration (*Id.* at 323:10-324:21, 350:15-19), Appellant sought to ask Ms. Hurley

whether she believed Nurse Stobbs and Appellant hospital acted with negligence or gross negligence (*Id.* at 316:14-21, 318:1-5). Ms. Hurley could not be prohibited from testifying to this solely on the grounds that it was the ultimate issue in this matter. *See* Rule 704. Moreover, counsel for Appellant was not asking Ms. Hurley to give an opinion as to an issue of law, as this was not possible since Ms. Hurley was a nurse and not a legal expert. Asking Ms. Hurley this question should not have led to any confusion, as the jury was aware that Ms. Hurley was an expert in nursing, not law. Unlike in *Dawkins*, Ms. Hurley did not make, and was not asked to make, a legal argument nor she did offer these opinions in a written affidavit. Appellant wanted to simply asked its expert what her opinion was based on her experience and background as a pediatric nurse.

Earlier in the trial proceedings, counsel for Appellant had asked Respondent's expert the same questions regarding her opinions as to negligence and intentionality on the part of Appellant hospital and Nurse Stobbs, without any objection from counsel for Respondent. Trial Tr. 132:24-25, 133:17-19; 138:10-139:16, Mar. 17, 2019. Appellant thought that asking Ms. Hurley the same questioning would assist the jury in its decision and in weighing and comparing the testimony of both expert witnesses in this matter. Thus, because the jury did retain its power in judging the experts' credibility, allowing this part of Ms. Hurley's testimony would not have usurped its role. Therefore, Appellant argues that the Trial Court's ruling denying this portion of Ms. Hurley's testimony was arbitrary, unreasonable, and unfair to the presentations of Appellant's defense of this matter; thus, Defendants assert it was error for this to be kept from the jury for its consideration.

Appellant further assert that this error resulted in prejudice to Appellant's defense of this matter. The jury returned a grossly excessive verdict in favor of Respondent (Trial Tr. 446:18-

447:1, Mar. 17, 2019), despite not hearing any testimony or seeing any evidence of gross negligence. Therefore, the Appellant is left to conclude that not being allowed to ask its expert this important question did, in fact, affect the results of the trial. Appellant maintains that the purpose of the question was to ask its expert her opinion, based on her experience in pediatric nursing, and this would have helped educate and better inform the jury. Thus, not allowing the testimony in the presence of the jury was prejudicial to Appellant.

Therefore, the Trial Court abused its discretion in not allowing Ms. Hurley's testimony regarding gross negligence in front of the presence of the jury, and the decision must be reversed.

V. THE TRIAL COURT ABUSED ITS DISCRETION IN PERMITTING THE REQUEST FOR ADMISSION TO BE PUBLISHED TO THE JURY.

STANDARD OF REVIEW

"[T]he admission or exclusion of evidence in general is within the sound discretion of the trial court." *Fields*, 363 S.C. at 25 "[T]he trial court's decision will not be disturbed on appeal absent an abuse of discretion." *Id.*; *Gooding*, 454 S.E.2d at 330. "An abuse of discretion occurs when there is an error of law or a factual conclusion which is without evidentiary support." *Gooding*, 326 S.C. at 487 (citing *Lee*, 318 S.C. 283, 457 S.E.2d 344); *Fields*, 363 S.C. at 26. "To warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Fields*, 363 S.C. at 26 (citations omitted).

ARGUMENT

Appellant asserts that the publication of its Request to Admit was an error that prejudiced Appellant's defense of the matter and amounted to an abuse of discretion by the Trial Court. Trial

Tr. 250:21-258:25, Mar. 17, 2019; Def.'s Motion for JNOV or in the alt. Motion for New Trial 8-10; Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the alt. for a New Trial 8; Def. RTA. Appellant concedes this is an unusual circumstance and the case law seems to only address issues for withdrawal by the admitting party. As per Rule 36(b) of the South Carolina Rules of Civil Procedure, "[t]he Court may permit withdrawal or amendment when the presentation of the merits of the action will be subserved thereby and the party who obtained the admission fails to satisfy the court that withdrawal or amendment will prejudice him in maintaining or defense on the merits." Rule 36, SCRCP; *see, e.g., Commerce Ctr. of Greenville, Inc. v. W. Powers McElveen*, 347 S.C. 545, 557, 556 S.E.2d 718, 724 (Ct. App. 2001) ("The trial court may allow a party to amend or withdraw its answers to a request to admit when: (1) the presentation of the merits is furthered by the amendment; and (2) the party who obtained the admission cannot demonstrate prejudice because of the amendment."). However, Appellant asserts that, pursuant to Rule 403 of the South Carolina Rules of Evidence, publishing the Request to Admit was in error and was highly prejudicial to the Appellant, as it did nothing but confuse the issues for the jury. Trial Tr. 251:24-11, 253:9-18, 255:20-257:5. "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE.

In its Request to Admit, Appellant asked Respondent to admit or deny that the amount in controversy and amount of Respondent's actual damage exceeded one hundred thousand dollars. Trial Tr. 258:18-25, Mar. 17, 2019; Def.'s RTA. The Request to Admit were not a stipulation

under South Carolina Rules of Civil Procedure Rule 43(k)[6] but rather a discovery tool. Trial Tr. 253:9-18, Mar. 17, 2019. *See* The purpose of the request to admit was to obtain an Independent Medical Examination under Rule 35(a)[7] of the South Carolina Rules of Civil Procedure, not for Respondent to represent that Appellant admitted the damages were in excess of $100,000.00. *Id.* at 251:24-252:6. Although facts may be stipulated under the rule, these Request to Admit were subjective, as they went to damages. Because the purpose was for obtaining were to obtain Respondent's view of the case in order to obtain an Independent Medical Examination under South Carolina Civil Procedure Rule 35(a), these were subjective, not factual, and thus, could not be stipulated. *Id.* at 253:21-254:11.

Although the Trial Court stated that the modification of the Request to Admit would have to go to the merits, not damages, *Id.* at 254:12-255:17, Appellant argued that that publication to the jury would prejudice the merits of its defense, *Id.* at 255:20-257:5. Reading the Request to Admit to the jury had the effect of confusing them as to the issues in dispute and the purpose of the Request to Admit. Allowing the Request to Admit to be published to the jury made the effect that a verdict had to be awarded for Respondent in the amount of at least $100,000.00. *Id.* at 252:8-11, 255:20-257:5. This effectively directed a verdict of liability in the Respondent's favor, thereby impeding presentation of the merits of Appellant's case. Throughout the case, liability

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[6] Rule 43(k), SRCRP. "No agreement between counsel affecting the proceedings in an action shall be binding unless reduced to the form of a consent order or written stipulation signed by counsel and entered in the record, or unless made in open court and noted upon the record, or reduced to writing and signed by the parties and their counsel. Settlement agreements shall be handled in accordance with Rule 41.1, SCRCP."

[7] Rule 35(a), SRCP. "In any case in which the amount in controversy exceeds $100,000 actual damages, and the mental or physical condition . . . of a party, or of a person in the custody or under the legal control of a party, is in controversy, the court in which the action is pending may order the party to submit to a physical or mental examination by a physician or to produce for examination the person in his custody or legal control. . . ."

was contested, and Appellant maintained that it was not negligent. Therefore, publishing the Request to Admit to the jury subserved and impeded the presentation of the merits of the defense.

Appellant argued that the burden was on the Respondent to show that they would be prejudiced if the Request to Admit were not allowed to be published. *Id.* at 256:22-25. Appellant argued that they would not be able to meet that burden, as Respondent certainly had every right to argue for whatever verdict amount they wanted. *Id.* at 256:25-257:3. Appellant, on the other hand, would be and was in fact highly prejudiced by allowing the admission of the Request to Admit. Moreover, The Request to Admit was not mentioned in Respondent's pretrial brief. Pltf.'s Pretrial Br. Respondent intentionally failed to mention the Request to Admit to Appellant's counsel until they were about to publish it to the jury. This highly prejudiced Appellant, as it had no time to prepare argument or rebuttal evidence. Thus, when balancing the little, if any, probative value of the Request to Admit with the high amount of confusion and prejudicial effect publishing it would and did have, the admission of the Request to Admit was improper under Rule 403.

As such, the Trial Court should have not have allowed the admission into evidence of the Request for Admission because it was of little probative value and was highly prejudicial to Appellant as it directly confused the issues and impeded the merits of the Appellant's case. Thus, the decision of the Trial Court must be reversed.

VI. THE TRIAL COURT ABUSED ITS DISCRETION IN NOT GRANTING A NEW TRIAL ABSOLUTE OR NEW TRIAL *NISI REMITTITUR* WHEN THE VERDICT WAS GROSSLY EXCESSIVE AND SHOCKINGLY DISPROPORTIONATE AND

CONTRARY TO THE EVIDENCE ADMITTED AT TRIAL, OR, AT THE VERY MINIMUM, WAS AT LEAST MERELY EXCESSIVE GIVEN THE EVIDENCE.

STANDARD OF REVIEW

> The decision to grant or deny a new trial absolute based on the excessiveness of a verdict rests in the sound discretion of the trial court and ordinarily will not be disturbed on appeal. An abuse of discretion occurs if the trial court's findings are wholly unsupported by the evidence or the conclusions reached are controlled by an error of law.

Welch, 342 S.C. at 302 (citing *Krepps v. Ausen,* 324 S.C. 597, 479 S.E.2d 290 (Ct.App.1996)); *see, e.g., Stevens v. Allen*, 336 S.C. 439, 446, 520 S.E.2d 625 (Ct. App. 1999). "In deciding whether to assess error when a new trial motion is denied, this Court must consider the testimony and reasonable inferences therefrom in the light most favorable to the nonmoving party." *Welch*, 342 S.C. at 302-03 (citing *Vinson v. Hartley,* 324 S.C. 389, 477 S.E.2d 715 (Ct.App.1996)).

ARGUMENT

A. THE TRIAL COURT ERRED IN NOT GRANTING A NEW TRIAL ABSOLUTE BECAUSE THE VERDICT WAS GROSSLY EXCESSIVE AND SHOCKINGLY DISPROPORTIONATE AND CONTRARY TO THE EVIDENCE ADMITTED AT TRIAL.

> When a party moves for a new trial based on a challenge that the verdict is either excessive or inadequate, the trial judge must distinguish between awards that are merely unduly liberal or conservative and awards that are actuated by passion, caprice or prejudice. The trial court must set aside a verdict only when it is shockingly disproportionate to the injuries suffered and thus indicates that passion, caprice, prejudice, or other considerations not reflected by the evidence affected the amount awarded. In other words, to warrant a new trial absolute, the verdict reached must be so 'grossly excessive' as to clearly indicate the influence of an improper motive on the jury.

Welch, 342 S.C. at 302 (citations omitted); *see, e.g., Stevens*, 336 S.C. at 447 ("The trial judge must grant a new trial absolute if the amount of the verdict is grossly inadequate or excessive so

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as to shock the conscience of the court and clearly indicates the figure reached was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives."); *Duncan v. Hampton Cnt. Sch. Dist. No. 2*, 235 S.C. 535, 517 S.E.2d 449, 455 (Ct. App. 1990); *see also, Sullivan v. Davis*, 317 S.C. 462, 467, 454 S.E.2d 907, 912 (Ct. App. 1995) (holding that the Trial Court abused its discretion in not granting the new trial absolute motion when the verdict was "shockingly disproportionate" to the evidence presented); *Zorn v. Crawford*, 252 S.C. 127, 138, 165 S.E.2d 640, 646 (1969) (granting a new trial in a wrongful death action where "a verdict of $250,000.00 for the actual damages sustained by the beneficiaries . . . [was] not supported by the evidence and [could] only be explained upon the basis of sympathy, passion, or prejudice on the part of the jury").

The term "passion and prejudice" does not "necessarily imply bad faith, wrongful purpose, or moral delinquency," but rather, results when the award is "against the overwhelming weight of the evidence." *Beasley v. Ford Motor Co.*, 237 S.C. 506, 513, 117 S.E.2d 863, 867 (1961)."Ordinarily the only means of discovering the existence of passion and prejudice as influencing the verdict is by comparing the amount of the verdict with the evidence before the trial court." *Nelson v. Charleston W.C. Ry. Co.*, 231 S.C. 351, 362, 98 S.E.2d 798, 802 (S.C. 1957). However, in some instances,

> [t]he size of the verdict alone may show that it must have been the result of passion or prejudice, as for instance, when it is apparent that the award is obviously so disproportionate to the injury proved as to justify the conclusion that the verdict is not the result of the cool and dispassionate discretion of the jury.

Id. (quoting 15 Am. Jur., *Damages* § 205, p. 623); *see also, Smalls v. Springs Indus., Inc.* 292 S.C. 481, 486, 357 S.E.2d 452, 455 (1987) (stating that under the facts of the case, "the size of the jury's verdict alone establishes it is grossly excessive"). For further clarification,

> [a] close analysis of the results reached in the cases justifies the statement that the courts generally grant relief if convinced that the verdict substantially exceeds any rational appraisal or estimate of the damages even though the inference of passion, prejudice, partiality, or other improper motive on the part of the jury is no more natural or reasonable than the inference of mistake or misapprehension on their part.

Beasley, 237 S.C. at 512-513 (quoting 15 Am. Jur. *Damages* § 205, p. 623).

In this matter, the jury returned a verdict in the amount of $1,127,280 for the minor and $135,477.00 for Respondent Tekayah Hamilton. Trial Tr. 446:18-447:1, Mar. 17, 2019. Subsequently, Appellant filed a Motion for Judgment Notwithstanding the Verdict or in the alternative Motion for New Trial, in which one of the grounds for a new trial absolute was because the verdict was grossly excessive as compared to the evidence presented at trial. Def.'s Mot. for JNOV or in the alt. Mot. for New Trial 11-13. Appellant asserts the Trial Court's denial of its motion on this ground was an error in law, as the verdict was grossly excessive and shockingly disproportionate, wholly unsupported by and contradictory to the evidence presented a trial for the following reasons. Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 8.

First, there was little testimony regarding any pain and suffering. Dr. Devito testified that the minor seemed to be experiencing pain during his examination of him, although Dr. Davis testified that during his examination of the minor, the minor denied any pain, burning, or itching (*Id.* at 192:13-25). Dr. Davis testified that Respondent Tekayah Hamilton told him the minor would ask her if he could scratch it. (*Id.* at 192:25-193:2). The only testimony from Respondent Hamilton regarding pain was some itching and cramping that is alleviated with some exericses and crying during the infiltration and wound care follow up treatment.

Second, there was testimony establishing that very little has been done or is planned in regards to treatment. The minor treated at the wound care center at The Regional Medical Center immediately after the infiltration occurred and for a short period of time in 2015. *See* Plf.'s Ex. 6. He saw Respondent's expert Dr. Devito on February 2, 2015; March 5, 2015; and did not go back to him for three years until March 2018. *Id.* at 163:13-15, 163:23-25, 165:10-12. At the time of trial, the minor was not currently on any medications for this wound. *Id.* at 169:16-18. Nonsurgical options, such as steroidal injections and compression, have been recommended by both the physician referred by Respondent's lawyer and the court-appointed plastic surgeon; however, the minor has not gotten this treatment. *Id.* at 163:13-18, 163:23-164:13, 195:23-196:18, 198:20-199:15, 248:23-249:17. Surgery had also been recommended by both physicians as another method of treatment to improve the scar (*Id.* at 195: 23-196:18; 238:5), but Respondent Tekayah Hamilton testified she has no plans for surgery at this time, although she testified she may consider it when the minor is older (*Id.* at 170:3-4, 170:11-15, 171:10-13). Although surgery would improve the appearance of the scar, surgery is not needed for any functionality reasons. *Id.* at 210:2-12.

Third, although there is scar tissue (*Id.* at 191:5-14) and the scar is permanent (*Id.* at 210:23-211:5), his hand is fully functioning (*Id.* at 193:3-195:22), and the wound is "well-healed" and "stable" (*Id.* at 191:17-192:3) and will not get worse (*Id.* at 199:16-25). There are no functional deficits and "nothing inhibiting full functioning of the wrist": no diminished finger strength, no impairment of the tendons or wrist, and no issue with range of motion of the wrist. *Id.* at 192:6-12, 193:3-2-195:22. The child "should have normal functionality throughout the rest of his life." *Id.* at 194:14-15. The child will be able to do things a normal child would, such as a throwing a ball, playing a music instrument, holding a fishing pole, writing and drawing, and driving a car. *Id.* at 200:25-202:9.

As the evidence presented cannot support a $1,127,280 verdict for the minor and $135,477.00 for Respondent Tekayah Hamilton, the size of the verdict alone is sufficient to show that the jury must have been moved by passion or prejudice,. The verdict of $1,127,280 for minor Respondent is 54 times the amount of actual damages of $20,854. This is grossly excessive and shocks the conscience, as there was little testimony of pain and suffering; there is no ongoing treatment or plans for any in the future; the scar is well-healed and stable; and there are no functionality deficits. Additionally, the $135,477.00 verdict for Respondent Tekayah Hamilton is also grossly excessive, as past and future medical damages only amount to $20,854.00 (*Id.* at 412:24-413:12); she testified she has no plans for the child to undergo any steroidal injections or scar revision surgery (*Id.* at 170:3-4); and she is not entitled to any pain or suffering.

Thus, the verdict in this matter is "without any rational support whatever in the evidence and is so grossly excessive as to show that the jury was actuated by considerations not founded on the evidence and/or the instructions of the court." *Joyner v. St. Matthews Builders*, 263 S.C. 136, 140-41, 208 S.E.2d 48, 50 (1974) (granting a new trial due to the "actual damages" being so manifestly and grossly excessive"). Given the complete lack of any cognizable basis to support the damages award, it is clear that in awarding these amounts for both the minor and his mother, the jury did not pay attention to the jury instructions. "[I]t is fundamental that a jury must abide by the judge's charge, be it right or wrong. Where the jury renders a verdict in disregard of his charge, it is error for the judge not to grant a new trial upon motion." *Southeastern Mobile Homes Inc., v. Walicki*, 282 S.C. 298, 302, 317 S.E.2d 773 (Ct. App. 1984). Appellant is left to conclude that, in light of the excessive verdict as compared to the evidence of actual damages, the jury arrived as its award as a result of passion, caprice, or other improve motives. "If the

amount of the verdict is grossly excessive so as to be the result of passion, caprice, prejudice or some other influence outside the evidence, the trial judge must grant a new trial absolute, not a new trial *nisi remittitur." Welch*, 342 S.C. at 303 (citing *O'Neal v. Bowles*, 314 S.C. 525, 431 S.E.2d 555 (1993)). Therefore, it was an abuse of discretion for the Trial Court not to grant Appellant's motion for a new trial absolute based on the grossly excessive verdict, and thus, the decision must be reversed.

B. IN THE ALTERNATIVE, IF THE APPELLANT COURT DOES NOT BELIEVE THE TRIAL COURT ABUSED ITS DISCRETION IN DENYING THE MOTION FOR A NEW TRIAL ABSOLUTE, APPELLANT ASSERTS THAT THE TRIAL COURT ABUSED ITS DISCRETION BY NOT GRANTING ITS MOTION FOR NEW TRIAL *NISI REMITTITUR* BECAUSE THE VERDICT WAS, AT THE VERY LEAST, MERELY EXCESSIVE.

> The trial court has wide discretionary power to reduce the amount of a verdict which in his or her judgment is excessive. Indeed, when the verdict indicates the jury was unduly liberal in determining damages, the trial court alone has the power to reduce the verdict by the granting of a new trial *nisi remittitur.* A motion for new trial *nisi remittitur* asks the trial court in its discretion to reduce the verdict because it is merely excessive, although not motivated by considerations such as passion, caprice or prejudice.

Welch, 342 S.C. at 303 (citations omitted); *see, e.g., RRR, Inc v. Toggas*, 378 S.C. 174, 183, 662 S.E.2d 438 (Ct. App. 2008) ("[T]he circuit court alone has the power to grant a new trial nisi when it finds the amount of the verdict to be merely inadequate or excessive."); *Howard v. Roberson*, 376 S.C. 143, 154, 654 S.E.2d 877 (Ct. App. 2007) (stating that the court "may grant a new trial nisi additur or remittitur when it finds the verdict is merely inadequate or excessive."); *Becker v. Walmart Stores, Inc.*, 339 S.C. 629, 636, 529 S.E.2d 758 (Ct. App. 2000) (affirming trial court's granting of motion for remittitur on grounds that amount awarded by jury was

"merely excessive"). "In considering a motion for new trial *nisi*, the trial court must evaluate the adequacy of the verdict in light of the evidence presented." *Welch*, 342 S.C. at 303 (citing *Waring v. Johnson*, 341 S.C. 248, 533 S.E.2d 906 (Ct.App.2000)).

In its motion, Appellant asked the Trial Court that if did not agree with Appellant that the verdict is grossly excessive to the extent of shocking the conscience and did not appear to be motivated by considerations such as passion, caprice or prejudice, then to grant a new trial *nisi remittitur* because the verdict was, at the very least, merely excessive. Def.'s Mot. for JNOV or in the alt. Mot. for New Trial 11-14. The Trial Court denied Appellant's motion for a new trial *nisi remittitur*, although it did grant, in part, Appellant's motion to cap the damages as required by the South Carolina Torts Claims Act (§15-78-10, et seq.). Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 4-6, 8; Def.'s Post Trial Mot. for Reduction to Statutory Cap. The Trial Court capped the judgment for the minor at $300,000.00 because §15-78-120(a)(1) provides a maximum of $300,000.00 for a loss arising from a single occurrence.

Additionally, Appellant moved for a reduction in Respondent Tekayah Hamilton's verdict(, which was in the amount of $135,477.00, as she was only entitled to past and future medical costs, which totaled $20,854.00. Trial Tr. 412:24-413:12; Def.'s Post Trial Mot. for Reduction to Statutory Cap. *See, Patton v. Miller,* 420 S.C. 471, 804 S.E.2d 252 (2017) (a parent is the proper party in interest with respect to past and future medical expenses while the child is a minor); *Wright v. Colleton Cnty. Sch. Dist.*, 301 S.C. 282, 289-90, 391 S.E.2d 564 (1990) (finding that a parent may recover medical expenses separately from the child's claim). However, the Trial Court denied Appellant's motion to reduce the verdict for Respondent Tekayah Hamilton.

Even after capping the minor's judgment at $300.000.00 as required by §15-78-120(a)(1), the judgment is still, at the very minimum, merely excessive. As discussed above, there was no testimony of current, ongoing treatment or plans for any in the future, and there was little testimony of pain or suffering. The wound is well-healed (Trial Tr. 191:17-192:3, Mar. 17, 2019), and the hand fully functioning (*Id.* at 193:3-195:22). The jury saw this for themselves. Moreover, the verdict for Respondent Tekayah Hamilton in the amount of $135,477.00 was also, at the very minimum, merely excessive, as she testified she has no plans for steroidal injections or surgery (*Id.* at 170:3-4), and the only evidence of actual damages, past and future medical expenses, were in the amount of $20,854 (*Id.* at 412:24-413:12). She was not entitled to any damages for pain and suffering. Therefore, the verdict rendered by the jury, as well as the statutory cap placed on the minor's verdict, was at least merely excessive as compared to the evidence presented at trial. As such, the Trial Court abused its discretion in denying Appellant's alternative motion for new trial *nisi remittitur*.

Since the verdict was grossly excessive or at least merely excessive, the Trial Court's error in not granting either a new trial absolute or in the alternative a new trial *nisi remittitur* amounted to an abuse of discretion, and the decision must be reversed.

CONCLUSION

For the reasons stated, Appellant respectfully requests the Appellate Court to reverse the decision of the Trial Court and dismiss this action with prejudice or, in the alternative, reverse the decision of the Trial Court and grant Appellant a new trial.

Respectfully submitted,

January 21, 2021 /s/ Michael C. Tanner

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Jan 21 2021
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY
Court of Common Pleas

Edgar W. Dickson, Circuit Court Judge

Appeal No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee Middleton, Jr., a minor child under the age of eighteen, ... Respondent,

v.

The Regional Medical Center .....Appellant.

PROOF OF SERVICE

I certify that I have served the Initial Brief and Designation of Matter of The Regional Medical Center, by depositing a copy of it in the United States Mail, postage prepaid, and via e-mail, on January 21, 2021, addressed to the attorneys of record, Jonathan F. Krell, Esquire, Post Office Box 299, Charleston, S.C., 29402, and David R. Williams, Esquire, Post Office Box 1084, Orangeburg, S.C., 29116, and Kathleen Chewning Barnes, Esquire, Post Office Box 897, Hampton, S.C., 29924.

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Case No.: 2015-CP-38-01234
Appellate Case No.: 2019-001921

Dear Ms. Kitchings:

Enclosed for filing please find the Initial Brief of The Regional Medical Center and, Designation of Matter and Proof of Service in this matter.

Yours Truly,

Michael C. Tanner

MCT/ls
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Mar 24 2021
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THE STATE OF SOUTH CAROLINA
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APPEAL FROM ORANGEBURG COUNTY
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Edgar W. Dickson, Circuit Court Judge

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Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18, ...Respondent,

v.

Regional Medical Center,.....Appellant.

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STATEMENT OF ISSUES ON APPEAL

I. Whether the lower court properly exercised its discretion to qualify Nurse Stobbs as a nursing expert and allowed her to testify about the standard of care that applies to adults and children?

II. Whether the lower court correctly denied RMC's motions for a directed verdict and JNOV where there is evidence of gross negligence in the record?

III. Whether the lower court properly exercised its discretion to admit photographs of R.J.'s hand where the photographs corroborate Tekayah and Dr. DeVito's testimony and demonstrate the nature and severity of the injury?

IV. Whether the lower court properly exercised its discretion to exclude Ms. Hurley's opinion on gross negligence because expert testimony on issues of law is inadmissible?

V. Whether the lower court properly exercised its discretion to publish RMC's requests for admission to the jury for its consideration along with all other evidence?

VI. Whether the lower court properly exercised its discretion to deny RMC's motions for a new trial or, alternatively, a new trial *nisi remittitur*, where the verdicts are not excessive?

STATEMENT OF THE CASE

This is an appeal from a jury verdict for the Plaintiffs in a medical negligence trial arising out of an IV infiltration burn injury of a five-week-old boy. The lower court granted in part and denied in part the Defendant's post-trial motions.

On October 7, 2015, Respondent Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen, (collectively "Hamilton") filed this action against Appellant the Regional Medical Center ("RMC") for medical negligence. (Cmplt.) (R. pp. _). RMC filed an answer generally denying the allegations. (Ans.) (R. pp. _).

The parties tried the case from May 7-9, 2018, before the Honorable Edgar W. Dickson. (Order) (R. p. _). The jury returned a verdict finding RMC gross negligently and awarding Tekayah $135,477.00 and her child $1,127,280.00. (verdict form) (R. p. _).

On May 17, 2018, RMC filed two post-trial motions. It filed a post-trial motion for judgment notwithstanding the verdict or, alternatively, for a new trial or a new trial *nisi remittitur*. (Mot. for JNOV) (R. pp. _). RMC also filed a motion to reduce the child's damages to the $300,000.00 statutory cap pursuant to S.C. Code § 15-78-120(a) (2005) and to reduce Tekayah's damages to the amount of the medical expenses. (Mot. to Reduce) (R. pp. _). Hamilton filed a memorandum in opposition to the motions. (Memo. in Opp.) (R. pp. _).

On October 25, 2019, the lower court granted the motion to reduce the child's damages to $300,000.00 and denied all other motions. (Order) (R. pp. _). On November 19, 2019, RMC filed a notice of appeal. (Not.) (R. p. _).

FACTS

On October 25, 2014, Robert Lee M., Jr., ("R.J.") was admitted to RMC for a high fever. (Trial Tr. p. 82) (R. p. _). Five days later, R.J. left the hospital with a third-degree burn injury to his right hand because the IV antibiotics RMC administered infiltrated and burned his hand rather than entering his vein. (Trial Tr. pp. 102, 227) (R. pp. _). R.J. was five weeks old. (Trial Tr. p. 82) (R. p. _).

Jamie Downing is an RMC nurse who treated R.J. during his hospital admission. She had worked as a nurse for less than three months and been allowed to work on her own for about two weeks when she treated R.J. (Tr. pp. 263-64) (R. pp. _).

RMC did not initially know the cause of R.J.'s fever but started him on an IV antibiotic therapy in case he had an infection. (Trial Tr. p. 82) (R. p. _). RMC's policies state that, before putting medication into an IV, the nurse is required to flush the IV with normal saline. (Trial Tr. pp. 83-84, 293; Pl's Exh. 5) (R. pp. _). The saline flush is a way for the nurse to make sure the IV is properly in the vein so that the medicine will go into the vein and not the skin. (Trial Tr. pp. 95,

144) (R. pp. _). Infiltration occurs when medication inserted into an IV goes somewhere besides the vein and can cause injury. (Trial Tr. pp. 95, 129) (R. pp. _).

In the early morning of October 28, 2014, Downing administered the antibiotic ampicillin into R.J.'s IV. (Trial Tr. p. 86) (R. p. _). About twenty minutes later, R.J.'s hand was swollen with a dark spot and he was "really crying" so much that Tekayah buzzed the nurses' station. (Trial Tr. pp. 148-49, 291) (R. pp. _). Tekayah described R.J.'s hand as turning black with a lump full of fluid on it that burst the next day. (Trial Tr. pp. 150-51, 153) (R. pp. _). The antibiotic Downing gave R.J. through the IV caused a third-degree burn to his right hand because it infiltrated outside of his vein. (Trial Tr. pp. 97, 102, 281 lns. 2-5) (R. pp. _).

The parties disputed whether Downing flushed the IV with saline before she administered the ampicillin. R.J.'s medical records do not document a saline flush before the antibiotic. (Trial Tr. p. 86) (R. p. _). RMC's policies state: "Flushing the INT with saline is to be documented on the eMAR [electronic medical record]." (Pl.'s Exh. 5 p. 5 no. 12) (R. p. _ no. 12). Downing testified RMC's policies "are direct instructions" and there is "not room for interpretation" of them. (Trial Tr. p. 265) (R. p. _). Hamilton's expert witness testified: "If it's not documented, it wasn't done." (Trial Tr. p. 89 ln. 25, p. 96, p. 144) (R. pp. _). Downing does not remember administering a saline flush prior to ampicillin that morning but testified it is her practice to flush prior to giving medication. (Trial Tr. p. 280) (R. p. _).

R.J. left RMC on October 30, 2015, with a burn injury that required fifteen visits to a wound care center. (Trial Tr. p. 153) (R. p. _). Dr. Peter DeVito, an expert in plastic surgery, examined R.J. in February 2015, when he was four months old. (Trial Tr. pp. 225, 227) (R. p. _). He testified R.J.'s burn injury was "too contaminated for a skin graft" and took "a lot of wound care to heal." (Trial Tr. pp. 227, 229) (R. p. _). The burn resulted in keloid scar tissue. (Trial Tr. p. 227) (R. p.

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_). A keloid is a "tumor of scar tissue" that "invades" the skin surrounding it and causes painful burning and itching symptoms. (Trial Tr. p. 227) (R. p. _).

On October 7, 2015, Hamilton filed this action against RMC for medical negligence. (Cmplt.) (R. pp. _).

RMC filed two pre-trial motions relevant to this appeal. First, it moved to exclude Monica Stobbs, Hamilton's nursing expert, from testifying at trial. (Mot. in Limine to exclude Stobbs) (R. p. _). RMC argued Nurse Stobbs was not qualified to testify about IV therapy for pediatric patients because she had not administered IV therapy to a pediatric patient and did not review literature specifically about IV therapy for a pediatric patient. (Mot. in Limine; Pretrial Tr. pp. 8-9) (R. p. _). Hamilton argued that Nurse Stobbs testified the administration and monitoring of an IV is the same for a pediatric and adult patient, and RMC's argument goes to Nurse Stobbs' credibility rather than her qualifications. (Pretrial Tr. p. 7) (R. p. _). The lower court ruled it would qualify Nurse Stobbs as a nursing care expert and RMC could "make all the hay you want to" about her pediatric experience. (Pretrial Tr. pp. 9-10) (R. p. _).

Second, RMC argued three photographs of R.J.'s hand should be excluded because they are inflammatory. (Pretrial Tr. pp. 12-13) (R. pp. _). The lower court reviewed the photos and denied the motion. (Pretrial Tr. pp. 14-15) (R. pp. _).

On May 7-9, 2018, the parties tried the case before the Honorable Edgar W. Dickson. (Trial Tr. p. 1) (R. p. _). The parties' experts disagreed as to whether Downing performed a saline flush before administering the antibiotic to R.J. and whether the IV management standard of care is the same for adult and pediatric patients.

Nurse Stobbs testified the standard of care for IV management is the same for pediatric and adult patients. (Trial Tr. pp. 79-80, 99, 104-05, 111, 126-27) (R. pp. _). The nurse must flush the

IV with saline before administering medication to ensure that the IV is going into the vein. (Trial Tr. pp. 95, 97, 100-01) (R. pp. _). This is required by RMC's policies and procedures. (Pl.'s Exh. 5 p. 5 no. 12) (R. p. _). Nurse Stobbs testified that RMC breached the standard of care because Downing did not do a saline flush before administering the medication to R.J. on October 28 (Tr. pp. 101-02, 144).

After deliberating for three hours, the jury returned a verdict finding RMC's gross negligence caused R.J.'s injuries. (Tr. pp. 433, 436, 444-45; verdict form) (R. pp. _). The jury awarded Tekayah $135,477.00 and R.J. $1,127,280.00. (verdict form) (R. p. _).

RMC filed two post-trial motions. First, it moved for JNOV or, in the alternative, a new trial. Relevant to this appeal, RMC argued: (1) Nurse Stobbs was not qualified to testify about pediatric IV management, (2) Hamilton did not establish RMC's gross negligence, (3) the lower court should have excluded photographs of R.J.'s hand, (4) the lower court should have allowed RMC's expert, Cynthia Hurley, to testify that RMC was not grossly negligent, (5) the lower court should not have allowed Hamilton to publish to the jury her responses to RMC's requests to admit, and (6) the lower court should grant a new trial absolute or *nisi remittitur* because the verdict is disproportionate to the evidence. (Mot.) (R. pp. _).

Second, RMC moved to reduce R.J.'s damages to the $300,000.00 statutory cap in the South Carolina Tort Claims Act and to reduce Tekayah's damages to $20,854.00, the amount of the medical expenses. (Mot.) (R. pp. _).

Hamilton filed a memorandum in opposition to the motions. (Memo. in Opp.) (R. pp. _). On October 25, 2019, the lower court issued an Order granting RMC's motion to reduce R.J.'s damages to the statutory cap of $300,000.00 but denying the motion to reduce Tekayah's damages.

(Order pp. 4-6) (R. pp. _). The court denied the motion for JNOV and in the alternative a new trial absolute or *nisi remittitur* in its entirety. (Order pp. 6-9) (R. pp. _).

STANDARD OF REVIEW

Because there are multiple standards of review applicable to this appeal, the standard of review is addressed in the argument section for each issue.

ARGUMENT

The evidence in this case came down to a factual dispute about Downing's conduct and a battle of the experts. This is commonplace. The jury believed and accepted Hamilton's presentation of the facts. Over the course of the trial, based on the evidence admitted, the principal breach of the standard of care presented to the jury was that RMC, through Downing, failed to perform a saline flush before administering the IV medication. (Trial Tr. p. 386) (R. p. _). The issue Respondents presented to the jury was "did the nurse at The Regional Medical Center fail to flush?" (Trial Tr. p. 386 lns. 12-13) (R. p. _). This makes all of RMC's discussion about blood returns and other IV management irrelevant.

The majority of the issues on appeal are subject to an abuse of discretion standard, and the evidence in the record and the applicable law demonstrate that the lower court properly exercised its discretion. As to the remaining issue of RMC's motion for a JNOV, there is ample evidence that RMC breached the standard of care. RMC's disagreement with Hamilton's expert is nothing more than a jury issue. This Court should affirm.

I. THE LOWER COURT CORRECTLY QUALIFIED NURSE STOBBS AS AN EXPERT AND ALLOWED HER TO TESTIFY ABOUT THE STANDARD OF CARE.

The lower court properly exercised its discretion to qualify Nurse Stobbs as a nursing expert. (Trial Tr. p. 78) (R. p. _). "The qualification of an expert witness and the admissibility of the expert's testimony are each matters largely within the trial judge's discretion." *McMillan v.*

Durant, 312 S.C. 200, 204, 439 S.E.2d 829, 831 (1993). "[W]e will not reverse absent an abuse of that discretion." *Graves v. CAS Med. Sys.*, 401 S.C. 63, 74, 735 S.E.2d 650, 655 (2012). "An abuse of discretion occurs when the circuit court's rulings either lack evidentiary support or are controlled by an error of law." *Id.* at 74, 735 S.E.2d at 831 (internal quotation marks omitted).

RMC does not dispute Nurse Stobbs' qualifications as a nurse or ability to testify about IV management. Instead, it argues mainly that this case is about pediatric nursing such that pediatric nursing and not "general nursing" is the issue. (Br. of App. pp. 11-12). RMC then argues that Nurse Stobbs is not qualified to testify about pediatric nursing IV management and, in doing so at trial, she testified outside of the scope of her nursing qualifications. (Br. of App. p. 10). The lower court correctly rejected these arguments, and this Court should affirm.

A. The applicable standard of care is the same regardless of whether the patient is an adult or a child.

RMC's first argument is irrelevant because it does not affect the applicable standard of care. It is undisputed that in pediatric **and** adult IV management, the standard of care is to flush the IV with saline before administering a medication. (Trial Tr. pp. 268, 270, 336-37, 365) (R. pp.).

The difference between an adult and pediatric patient that RMC complains about is that a pediatric vein is smaller than an adult vein. (Br. of App. p. 11). That physiological difference does not change the standard of care to flush an IV site before administering medication or to follow RMC's policy to document a saline flush. Therefore, in response to all of RMC's arguments about Nurse Stobbs, its complaint does not make a difference for the evidence in this case. *McCall v. Finley*, 294 S.C. 1, 4, 362 S.E.2d 26, 28 (Ct. App. 1987) ("[W]hatever doesn't make any difference, doesn't matter."). The Court may affirm the qualification of Nurse Stobbs on this basis alone.

RMC is incorrect that this case is about pediatric nursing. (Br. of App. pp. 10-12). This case is about the IV management safety practice of doing and documenting a saline flush before administering medication. (Trial Tr. pp. 386, 410) (R. pp. _). Nurse Stobbs testified "the same safety practices" and "rules" are used for every patient "whether it's a baby or an adult."[1] (Trial Tr. pp. 79-80) (R. pp. _). Downing and Hurley testified that a saline flush is always required before administering medication. (Trial Tr. pp. 268, 270, 336-37, 365) (R. pp. _). Even if there existed a relevant difference in the IV management of pediatric and adult patients, it was for the jury to decide if and how that affected the applicable standard of care. *Madison v. Babcock Ctr., Inc.*, 371 S.C. 123, 140, 638 S.E.2d 650, 659 (2006) ("The factfinder may consider relevant standards of care from various sources in determining whether a defendant breached a duty owed to an injured person in a negligence case."). The lower court did not err in qualifying Nurse Stobbs as a nursing expert when nursing IV management principles apply to the facts of the case.

B. The lower court correctly held Nurse Stobbs' testimony satisfies Rule 702, SCRE.

RMC argues the lower court erred in qualifying Nurse Stobbs to testify about IV management in a case involving a pediatric patient because she did not treat pediatric patients and her testimony is, according to RMC, contrary to literature. (Br. of App. pp. 12-14). The lower court correctly exercised its discretion in ruling that RMC's arguments go to the weight and not the admissibility of her testimony. (Pretrial Tr. pp. 9-10) (R. p. _).

A person may be qualified as an expert based on "knowledge, skill, experience, training, or education." Rule 702, SCRE. "The test for qualification is a relative one that is dependent on

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[1] Nurse Stobbs maintained that the age of a patient does not alter IV management "in terms of the safety practices." (Trial Tr. p. 111) (R. p. _). She testified that a vein is the same in an adult and a child. (Trial Tr. pp. 104-05) (R. pp. _). Physiological differences in adults and children mean "their body size may be different" but "does not mean that their vein would be different." (Trial Tr. p. 126) (R. p. _). "[T]he management for IV therapy in terms of safety practices and what the rules are, it's exactly the same." (Trial Tr. p. 127 lns. 11-13) (R. p. _ lns. 11-13).

the particular witness's reference to the subject." *Lee v. Suess*, 318 S.C. 283, 285, 457 S.E.2d 344, 346 (1995). In deciding whether to admit expert testimony, the court makes three inquiries: whether (1) "the subject matter is beyond the ordinary knowledge of the jury, thus requiring an expert to explain the matter to the jury," (2) the expert has "acquired the requisite knowledge and skill to qualify as an expert in the particular subject matter, although he ***need not be a specialist in the particular branch of the field***," and (3) the substance of the testimony is reliable. *Graves v. CAS Med. Sys.*, 401 S.C. 63, 74, 735 S.E.2d 650, 655 (2012) (internal quotation marks omitted) (emphasis added). RMC disputes only the second inquiry.

An expert witness is not required to be a specialist in the particular branch of his or her profession involved in a case. On the contrary, "[a] physician is not incompetent to testify merely because he is not a specialist in the particular branch of his profession involved. The fact that he is not a specialist goes to the weight of his testimony, not its admissibility." *Creed v. Columbia*, 310 S.C. 342, 345, 426 S.E.2d 785, 786 (1993) (internal citation omitted). Our courts regularly apply this principle in the medical negligence context.

For example, in *Creed*, a "general practitioner" was qualified "to give an opinion on [the plaintiff's] mental and emotional injuries." *Id.* 344-45, 426 S.E.2d at 786.

A neurosurgeon was qualified to testify about the appropriate standard of nursing care. *McMillan v. Durant*, 312 S.C. 200, 204-05, 439 S.E.2d 829, 831-32 (1993); *see also Lee v. Suess*, 318 S.C. 283, 285, 457 S.E.2d 344, 345 (1995) (describing *McMillan* as holding "a medical practitioner's experience teaching in a particular specialty and his professional interaction with practitioners of that specialty are facts sufficient to support his qualification as an expert").

A plastic surgeon was qualified to testify as an expert in the field of family practice because the surgeon taught family practitioner residents. *Lee*, 318 S.C. at 285, 457 S.E.2d at 345-46. The

expert's "limited exposure to the field of family practice merely goes to the weight of his testimony and not its admissibility." *Id.* at 286, 457 S.E.2d at 346.

A neonatologist was qualified to testify about sudden infant death syndrome, even though she testified "that she would not consider herself a SIDS expert," because "an expert need not be a specialist in the particular branch of the field." *Graves v. CAS Med. Sys.*, 401 S.C. 63, 78, 735 S.E.2d 650, 657 (2012) (internal quotation marks omitted).

All of these cases support the lower court's decision to qualify Nurse Stobbs as an expert regardless of her lack of hands-on experience with pediatric IV patients because that criticism goes to the weight of her testimony and not its admissibility. Nurse Stobbs worked for over thirty years as a nurse. (Trial Tr. p. 77) (R. p. _). For twenty-one of those years, she worked at Massachusetts General Hospital, "which is Harvard's Hospital" and "the number one hospital in the country." (Trial Tr. p. 77 lns. 3-6) (R. p. _). She was certified in IV therapy, administered "thousands" of IVs in her career, and primarily provided IV therapy to her patients. (Trial Tr. p. 77) (R. p. _). She was amply qualified to testify about IV management in this case.

RMC relies on *Botehlo v. Bycura*, 282 S.C. 578, 320 S.E.2d 59 (Ct. App. 1984), for its assertion that Nurse Stobbs must have treated pediatric patients to be qualified to testify about IV management. (Br. of App. p. 12). In *Botehlo*, this Court ruled that an orthopedic surgeon was not an expert in podiatric standards of care, in part, because he "testified that he is not familiar with the standards of professional care generally observed by podiatrists" and "was not familiar with the surgical procedure [the defendant] performed on [the plaintiff]." *Id.* at 587, 320 S.E.2d at 65. In *McMillan v. Durant*, 312 S.C. 200, 439 S.E.2d 829 (1993), the Supreme Court described the orthopedist expert in *Botehlo* as "not versed at all in the practice of podiatry." *Id.* at 204, 439 S.E.2d at 832. This case is easily distinguishable.

Nurse Stobbs testified the standard of care for IV management is the same for a baby or an adult. (Trial Tr. p. 80 lns. 1-6) (R. p. _). Her thirty years of experience in administering thousands of IVs is evidence that supports the lower court's decision to find her familiar with the standards of professional care, unlike the expert in *Botehlo*.

RMC also relies on *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 487 S.E.2d 596 (1997). (Br. of App. pp. 12-14). However, *Gooding* supports Hamilton's position. In a medical malpractice action against an anesthesiologist regarding an intubation procedure, the Supreme Court held an EMT/paramedic who intubated over 100 patients and taught intubation procedures was qualified in the field of intubation. *Id.* at 251, 253, 487 S.E.2d at 597-98. It explained "[t]here was no requirement that [plaintiff]'s expert witness be an anesthesiologist in order to testify about intubation procedures." *Id.* at 253, 487 S.E.2d at 598. In this case, Nurse Stobbs is qualified in the field of IV management and she is not required to specifically practice in pediatric IV management to testify about IV management procedures.

RMC's disagreement with Nurse Stobbs' opinions (Br. of App. p. 13) are (and were in this case) subjects for cross-examination. The lower court properly exercised its discretion to qualify Nurse Stobbs as a nursing expert, and this Court should affirm.

C. RMC did not preserve an argument about the scope of Nurse Stobbs' testimony and, regardless, she testified according to her qualifications as a nursing expert.

RMC's argument that Nurse Stobbs' testimony exceeded the scope of her qualifications is unpreserved, abandoned, and legally incorrect.

"Our law is clear that a party must make a contemporaneous objection that is ruled upon by the trial judge to preserve an issue for appellate review." *State v. Sheppard*, 391 S.C. 415, 420-21, 706 S.E.2d 16, 19 (2011). RMC never objected during trial that any of Nurse Stobbs' testimony exceeded the scope of her qualifications. It cites to only two pages of the pre-trial motion *in limine*

hearing and does not specify what trial testimony is allegedly outside of the scope of her expertise. (Br. of App. p. 15). "Making a motion *in limine* to exclude evidence at the beginning of trial does not preserve an issue for review because a motion *in limine* is not a final determination. The moving party, therefore, must make a contemporaneous objection when the evidence is introduced." *State v. Moses*, 390 S.C. 502, 511, 702 S.E.2d 395, 400 (Ct. App. 2010) (internal quotation marks omitted). The issue is unpreserved.

The issue is also abandoned because RMC does not cite legal authority and makes only a conclusory, one-paragraph argument. (Br. of App. pp. 14-15). *See Bryson v. Bryson*, 378 S.C. 502, 510, 662 S.E.2d 611, 615 (Ct. App. 2008) ("An issue is deemed abandoned and will not be considered on appeal if the argument is raised in a brief but not supported by authority."); *Glasscock, Inc. v. United States Fid. & Guar. Co.*, 348 S.C. 76, 81, 557 S.E.2d 689, 691 (Ct. App. 2001) ("South Carolina law clearly states that short, conclusory statements made without supporting authority are deemed abandoned on appeal and therefore not presented for review.").

Finally, RMC's argument on the merits is incorrect. The lower court qualified Nurse Stobbs "as an expert in nursing." (Trial Tr. p. 78) (R. p. _). Nurse Stobbs repeatedly testified that her opinions on IV management applied to adults and children, making RMC's attempt to separate the two irrelevant. Her testimony was consistent with her qualifications and area of expertise.

D. Even if error, the admission of Nurse Stobbs' testimony was harmless.

Even if the Court finds the lower court erred in qualifying Nurse Stobbs or that her testimony exceeded the scope of her qualification, it should still affirm because any such error was harmless. "The key factor for determining whether a trial error constitutes reversible error is whether it appears beyond a reasonable doubt that the error complained of did not contribute to the verdict obtained." *State v. Tapp*, 398 S.C. 376, 389, 728 S.E.2d 468, 475 (2012) (internal

quotation marks omitted). The court does "not weigh the evidence when determining this." *In re Bilton*, 432 S.C. 157, __, 851 S.E.2d 442, 447 (Ct. App. 2020). "No definite rule of law governs this finding; rather, the materiality and prejudicial character of the error must be determined from its relationship to the entire case." *In re Care & Treatment of Gonzalez*, 409 S.C. 621, 636, 763 S.E.2d 210, 217 (2014) (internal quotation marks omitted).

Any alleged error did not contribute to the verdict because Nurse Stobbs' testimony on the standard of care was cumulative to other evidence. "The admission of improper evidence is harmless where the evidence is merely cumulative to other evidence." *Judy v. Judy*, 384 S.C. 634, 646, 682 S.E.2d 836, 842 (Ct. App. 2009).

Hamilton's theory of liability was RMC's failure to perform and document a saline flush before administering the medication to R.J. (Trial Tr. pp. 386, 389-90, 396, 410) (R. pp. _). RMC's policies and procedures admitted into evidence establish the standard of care to flush with saline and document it on the medical record. (Pl's Exh. 5) (R. p. _). RMC's expert, Cynthia Hurley, testified that the standard of care is to perform a saline flush prior to administering medication. (Trial Tr. pp. 336-37, 365). Nurse Stobbs testified R.J.'s medical records do not document a saline flush prior to Downing administering the medication, and RMC does not argue that she is unqualified to read medical records. Nurse Stobbs' standard of care testimony was cumulative to other evidence.

RMC attacked Nurse Stobbs' experience and credibility throughout the trial. (Trial Tr. pp. 72-73, 103-12, 124-27) (R. pp. _). It criticized Nurse Stobbs for saying something allegedly contrary to articles on IV management. However, Ms. Downing testified that she had never reviewed those articles prior to RMC's attorney giving them to her and that reviewing such articles

it not common practice for a nurse. (Tr. p. 283). RMC disputed Nurse Stobbs' qualifications in its closing argument:

> She's never practiced clinical pediatric nursing. She's never started an IV on a child. And more importantly, the issue in this case, she's never maintained, managed and monitored an IV. **She is not qualified.**
>
> . . .
>
> [Y]ou have one nurse who's never been an expert before, Ms. Stobbs, who's never practiced in this area. She can't tell you what pediatric nursing is. She can't tell you what the literature is. . . . She'd been a nurse for over thirty-three years and guess how many pediatric IVs she started? The same amount as me, none.
>
> . . .
>
> [S]he has never done this the first shift in her life.
>
> . . . [Downing started more pediatric IVs] a lot more than Nurse Stobbs who, again, has started zero.
>
> . . .
>
> My witness [Hurley] is more qualified to be an expert [than Stobbs]. My expert is certainly more qualified to be an expert. They could have got a true expert. Ask yourself, why don't they have a pediatric expert? Why don't they have an expert that was qualified for monitoring and managing pediatric IVs? It is because they couldn't get one? Again, use your common sense.

(Trial Tr. pp. 399-401, 407) (R. p. _) (emphasis added). The lower court charged the jury it could disregard an expert's opinion if it decided "an expert witness's opinion is not based on sufficient education or experience or if you decide that the reasons given in support of the opinion are not sound." (Trial Tr. p. 419) (R. p. _).

Given the cumulative nature of Nurse Stobbs' challenged testimony and RMC's blatant attack on her qualifications, any error in qualifying her and admitting her testimony was harmless and RMC suffered no prejudice.

II. THE LOWER COURT CORRECTLY DENIED RMC'S MOTIONS FOR DIRECTED VERDICT OR JNOV BECAUSE THERE IS EVIDENCE OF GROSS NEGLIGENCE.

The lower court correctly denied RMC's motions for directed verdict and JNOV because there is evidence that, viewed in a light most favorable to Hamilton, supports a reasonable inference of gross negligence.[2]

"When reviewing the trial court's ruling on a motion for a directed verdict or a JNOV, this Court must apply the same standard as the trial court by viewing the evidence and all reasonable inferences in the light most favorable to the nonmoving party." *RFT Mgmt. Co., L.L.C. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 331-32, 732 S.E.2d 166, 171 (2012). "In considering a JNOV, the trial judge is concerned with the existence of evidence, not its weight. When considering a JNOV, neither an appellate court, nor the trial court has authority to decide credibility issues or to resolve conflicts in the testimony or the evidence." *Curcio v. Caterpillar, Inc.*, 355 S.C. 316, 320, 585 S.E.2d 272, 274 (2003) (internal quotation and alteration marks omitted). "The trial court must deny a motion for a directed verdict or JNOV if the evidence yields more than one reasonable inference or its inference is in doubt." *RFT Mgmt. Co.*, 399 S.C. at 332, 732 S.E.2d at 171 (internal quotation marks and citation omitted).

RMC's assertion that Hamilton "failed to provide *any* evidence or testimony of gross negligence" is wholly without merit and seems based on an incorrect assumption that a witness must have used the words "gross negligence" for evidence of it to exist. (Br. of App. pp. 18-19).

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[2] A "governmental entity is not liable for a loss resulting from: . . . responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any . . . patient, . . . of any governmental entity, except when the responsibility or duty is exercised in a grossly negligent manner." S.C. Code Ann. § 15-78-60(25) (2005). Hamilton argued at trial that a medical malpractice, not a gross negligence, standard applies to this case because it concerns a nurse's administration of medication and not "supervision, protection, control, confinement, or custody" of a patient. (Trial Tr. pp. 52-53, 217-19, 314, 433-34) (R. pp. _). Given the jury's verdict and RMC's arguments, Hamilton argues based on the gross negligence standard. (Pl's Memo. in Opp. to Def. Mot. for JNOV p. 9 n.3). However, this case should not be construed as establishing that the gross negligence standard in S.C. Code Ann. § 15-78-60(25) applies to a nurse's administration of medication.

Our Courts define "gross negligence in a number of ways." *Hollins v. Richland Cnty. Sch. Dist. One*, 310 S.C. 486, 490, 427 S.E.2d 654, 656 (1993). "[I]t is the failure to exercise slight care." *Bass v. S.C. Dep't of Soc. Servs.*, 414 S.C. 558, 571, 780 S.E.2d 252, 259 (2015) (internal quotation marks omitted). "Gross negligence is the intentional, conscious failure to do something which is incumbent upon one to do or the doing of a thing intentionally that one ought not to do." *Faile v. S.C. Dep't of Juvenile Justice*, 350 S.C. 315, 331, 566 S.E.2d 536, 544 (2002) (internal quotation marks omitted). Gross negligence is "also defined [] as a relative term that means the absence of care that is necessary under the circumstances." *Id.* at 332, 566 S.E.2d at 544 (internal quotation marks omitted). While "[g]ross negligence is ordinarily a mixed question of law and fact," "[i]n most cases, [it] is a factually controlled concept whose determination best rests with the jury." *Id.* at 332, 566 S.E.2d at 545 (internal quotation marks omitted).

Under any definition of gross negligence, there is evidence of it in the record. There is evidence that RMC consciously failed to do or document a saline flush and that it was incumbent upon RMC to do those things. RMC's policies **require** a saline flush prior to administering medication and documentation of that flush. (Pl.'s Exh. 5; Trial Tr. pp. 88-89, 144) (R. pp. _). Nurse Stobbs testified that Downing failed to do or document a flush before administering the medication to R.J. (Trial Tr. pp. 102, 144) (R. pp. _). If RMC (and nursing standards of care) required a saline flush prior to administering medication, then the inference in a light most favorable to Hamilton is that the failure to do it shows an absence of care that is necessary under the circumstances. *See Jinks v. Richland Cnty.*, 355 S.C. 341, 348, 585 S.E.2d 281, 285 (2003) (citing to evidence that the defendant failed to follow its policies as evidence of gross negligence).

Downing testified that a saline flush prior to administering medicine is "ingrained in you in nursing school" and "it makes no sense not to" flush. (Trial Tr. pp. 280-81, 293) (R. pp. _).

Downing testified there is "no way to really tell if the site is open and flowing without flushing it." (Trial Tr. pp. 302-03) (R. p. _). If it makes no sense not to do a flush, then the failure to do it is the failure to exercise slight care.

Evidence that, once the IV infiltrated and began to harm R.J., RMC failed to respond to Tekayah's call for help for at least twenty minutes is also evidence that it failed to exercise slight care and consciously failed to care for a patient. (Trial Tr. pp. 148-50, 285) (R. pp. _).

RMC's evidentiary arguments merely show differing inferences to be drawn from the evidence. However, competing evidence is not a permissible basis to reverse the denial of a motion for JNOV. The Court must "examin[e] the record to discern whether there was any evidence put forward at trial to support the jury verdict." *Bass v. S.C. Dep't of Soc. Servs.*, 414 S.C. 558, 574, 780 S.E.2d 252, 260 (2015). Evidence that a defendant "acted with slight care" along with "evidence in the record that [the defendant] acted with gross negligence" is sufficient to support a jury's verdict of gross negligence. *Id.* at 574, 780 S.E.2d at 260.

Finally, to the extent RMC is arguing that a witness must have testified using the words "gross negligence" (Br. of App. p. 19), there is no legal support for the proposition that an expert must use magic words. *See, e.g.*, *Stallings v. Ratliff*, 292 S.C. 349, 353, 356 S.E.2d 414, 417 (Ct. App. 1987) ("The issue of breach of duty does not turn on a ritual incantation of certain magic words by an expert witness."). The substance of the testimony and the jury's consideration of it are what matter. Further, as discussed below in Argument section IV, expert testimony on a legal conclusion is improper.

Hamilton presented evidence that Downing did not remember doing a saline flush before she administered the medicine that burned R.J., there is no documentation of a saline flush, and if something is not documented, then it was not done. (Trial Tr. pp. 89, 96, 144, 280) (R. pp. _).

Viewing that evidence in a light most favorable to Hamilton, a jury could have (and did) find that RMC's conduct amounted to gross negligence. The evidence "support[s] the jury's verdict," and this Court should affirm. *Bass*, 414 S.C. at 573, 780 S.E.2d at 259.

III. THE LOWER COURT PROPERLY EXERCISED ITS DISCRETION IN ADMITTING THE PHOTOGRAPHS OF R.J.'S HAND.

Hamilton submitted into evidence three photographs of R.J.'s hand. (Pl's Exhs. 1-3; Trial Tr. pp. 54-56). Two photographs show R.J.'s hand shortly after the burn injury occurred and the lump full of fluid on his hand burst. (Trial Tr. pp. 150-53; Pl's Exhs. 1, 3) (R. pp. _). One photograph shows R.J.'s hand with a scar on the last day of his treatment at the wound center. (Pl's Exh. 2; Trial Tr. p. 155) (R. p. _).

RMC argues that the alleged prejudicial effect of the photographs outweighed their probative value under Rule 403, SCRE ("Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice . . . .").

"A trial court has particularly wide discretion in ruling on Rule 403 objections." *State v. Gray*, 408 S.C. 601, 608, 759 S.E.2d 160, 164 (Ct. App. 2014) (internal quotation marks omitted). "The relevance, materiality and admissibility of photographs are matters within the sound discretion of the trial court and a ruling will be disturbed only upon a showing of an abuse of discretion." *State v. Rosemond*, 335 S.C. 593, 596, 518 S.E.2d 588, 589-90 (1999). The lower court properly exercised its discretion by balancing the probative value of the photos against any unfair prejudice and admitting them into evidence. (Pre-Trial Tr. pp. 10-15; Order p. 7) (R. pp. _).

Probative Value

The photos had probative value in establishing and proving damages, especially the condition of R.J.'s hand at the time of the burn because he was too young to testify. The photos

had probative value in showing the healing process and, importantly, in helping Dr. DeVito to explain and corroborate his testimony.

Photographs are admissible when they "clearly demonstrate the extent and nature of the injuries in a way that would not be as easily understood based on the testimony alone." *State v. Holder*, 382 S.C. 278, 290, 676 S.E.2d 690, 697 (2009) (affirming the admission of autopsy photos of a two-year-old child). Tekayah used the photographs to explain the nature of R.J.'s injury at the time of the burn. (Trial Tr. pp. 151-55) (R. pp. _). Dr. DeVito used the photos to describe the layers of skin and tissue injured by the infiltration, explain some of the healing process, explain the type of scar and his proposed treatment for it, and support his opinion as to the level of pain R.J. would have felt from this type of burn at the time of the injury and throughout the healing process. (Trial Tr. pp. 228-30, 235). R.J. could not tell the jury what he felt, and the photographs aided in explaining that to the jury.

"A test to determine whether the trial judge abused his discretion is whether the photographic evidence serves to corroborate the testimony of witnesses offered at trial." *State v. Vang*, 353 S.C. 78, 88, 577 S.E.2d 225, 230 (Ct. App. 2003). "If the offered photograph serves to corroborate testimony, it is not an abuse of discretion to admit it." *State v. Nance*, 320 S.C. 501, 508, 466 S.E.2d 349, 353 (1996) (affirming the admission of photographs of the victim's stab wounds in his hospital bed). Hamilton used the photographs to corroborate Tekayah's testimony about the appearance and state of the injury at the time it occurred and to corroborate Dr. DeVito's testimony describing the injury, the healing process, and that R.J. suffered pain. (Trial Tr. pp. 151-11, 228-30, 235) (R. pp. _). RMC challenged Hamilton's damages and tried to focus the jury on the fact that R.J.'s hand healed to a scar rather than the condition of his hand right after the burn occurred. (Trial Tr. pp. 74-75) (R. pp. _). This makes the corroborating probative value of the

photographs very high. *See State v. Gray*, 408 S.C. 601, 613, 759 S.E.2d 160, 166-67 (Ct. App. 2014) ("Photos that corroborate important testimony on issues significant to the case may have very high probative value . . . .").

Unfair Prejudice

RMC argues three reasons why the lower court should have excluded the photos: they were (1) not necessary to substantiate Hamilton's case because RMC did not dispute that R.J. suffered an injury, (2) "grotesque, up-close images" that make the wound look bigger than it was, and (3) not representative of the state of R.J.'s hand at the time of trial. (Br. of App. pp. 21-22). These arguments show only that the evidence is prejudicial, as "[a]ll evidence is meant to be," and do not rise to the level unfair prejudice. *State v. Gray*, 408 S.C. 601, 616, 759 S.E.2d 160, 168 (Ct. App. 2014). "Unfair prejudice does not mean the damage to a defendant's case that results from the legitimate probative force of the evidence; rather it refers to evidence which tends to suggest decision on an improper basis." *Id.* at 616, 759 S.E.2d at 168.

As to RMC's first argument, its acknowledgment that R.J. suffered an injury does not eliminate the need for Hamilton to establish for the jury the nature and severity of the injury. RMC essentially wants the Court to hold that, when a defendant admits an injury occurred and the injury heals some by the time of trial, the condition of the injury when it occurred is unfairly prejudicial evidence. That is not the law, and RMC cites no case with that ruling.

As to RMC's second argument, that the injury is, as the lower court stated, "hard to look at," does not make photographs of it unfairly prejudicial. (Order p. 7) (R. p. _). "Numerous jurisdictions have found that photos are not inadmissible merely because they are gruesome,

especially where, as here, the photos simply mirror the unfortunate reality of the case."[3] *State v. Collins*, 409 S.C. 524, 535-36, 763 S.E.2d 22, 28 (2014). Because the photos in this case merely show the reality of the injury to the jury, they are not unfairly prejudicial.

RMC incorrectly argues that the photos make the injury look bigger than its actual size. Each photograph has a scale of reference. Two of them include adult fingers holding R.J.'s hand, and one includes R.J.'s head. (Pl's Exhs. 1-3) (R. pp. _). There is no basis to assume the photos enlarged the injury.

As to RMC's third argument, that R.J.'s burn wound healed by the time of trial does not make an image of it at the time of the burn unfairly prejudicial. Hamilton asked the jury to award damages for the injury from the time it occurred. Evidence showing the injury, particularly in light of R.J.'s inability to testify, does not suggest a "decision on an improper basis" but, rather, a decision based on the reality of the injury. *State v. Gray*, 408 S.C. 601, 616, 759 S.E.2d 160, 168 (Ct. App. 2014).

The photos are not *unfairly* prejudicial.

Balance

"The trial judge must balance the prejudicial effect of graphic photographs against their probative value." *State v. Vang*, 353 S.C. 78, 87, 577 S.E.2d 225, 229 (Ct. App. 2003). The lower court ruled that, although the photographs "are hard to look at, there is little doubt the photographs

[3] Our courts regularly allow the admission of photographs that are arguably "grotesque." *See Gray*, 408 S.C. at 609, 617, 759 S.E.2d at 164, 169 (affirming the admission of eleven "graphic" before-and-after autopsy photos, including the victim's "exposed skull and brain"); *State v. Holder*, 382 S.C. 278, 291, 676 S.E.2d 690, 697 (2009) (affirming the admission of autopsy photos of a two-year-old victim of child abuse "[a]lthough the photographs were graphic"); *State v. Jarrell*, 350 S.C. 90, 106-07, 564 S.E.2d 362, 371 (Ct. App. 2002) (affirming the admission of autopsy photos of a ten-month-old sexual abuse victim because they corroborated and helped the jury understand testimony).

are relevant to corroborate the injury." (Order p. 7) (R. p. _). The evidence and law support the lower court's conclusion that any danger of unfair prejudice does not substantially outweigh the probative value of the photos. This Court should affirm.

IV. THE LOWER COURT PROPERLY EXERCISED ITS DISCRETION TO EXCLUDE MS. HURLEY'S TESTIMONY ON GROSS NEGLIGENCE.

The lower court properly exercised its discretion to prohibit RMC from asking its nursing expert, Cynthia Hurley, whether RMC committed "negligence" or "gross negligence." The admissibility of expert testimony is a matter "largely within the trial judge's discretion." *McMillan v. Durant*, 312 S.C. 200, 204, 439 S.E.2d 829, 831 (1993). The Court "will not reverse absent an abuse of that discretion." *Graves v. CAS Med. Sys.*, 401 S.C. 63, 74, 735 S.E.2d 650, 655 (2012).

RMC made a directed verdict motion arguing that, because Nurse Stobbs did not use the words "gross negligence" in her testimony, Hamilton failed to introduce evidence of gross negligence. (Trial Tr. pp. 311, 312 lns. 23-25, 313) (R. pp. _). After the court denied the motion, Hamilton moved to exclude RMC from asking its expert, Ms. Hurley, whether RMC committed gross negligence. (Trial Tr. pp. 316-20) (R. pp. _). The lower court granted the motion because Hurley is not qualified to testify about the legal concepts of negligence and gross negligence, and RMC could elicit testimony about those topics without using the exact legal terminology. (Trial Tr. pp. 318-19) (R. pp. _). The lower court properly exercised its discretion.

While RMC characterizes the testimony as an opinion on "an ultimate issue" under Rule 704, SCRE, the lower court correctly analyzed the testimony as a legal conclusion (Trial Tr. pp. 318-19; Order p. 7) (R. pp. _), and correctly ruled it inadmissible because, "[i]n general, expert testimony **on issues of law** is inadmissible." *Dawkins v. Fields*, 354 S.C. 58, 66, 580 S.E.2d 433,

437 (2003) (emphasis in original).[4] This Court recently reiterated that "expert testimony on issues of law is rarely admissible. The common law and the federal rules of evidence forbid opinions on issues of law, except foreign law." *Carter v. Bryant*, 429 S.C. 298, 313, 838 S.E.2d 523, 531 (Ct. App. 2020) (internal citations omitted).

In *Carter*, which RMC does not address in its brief, an appellant proffered expert testimony that a warrant lacked probable cause. 429 S.C. at 312, 838 S.E.2d at 531. This Court affirmed the lower court's decision to exclude the testimony because "the expert's proffered testimony on probable cause was a legal conclusion." *Id.* at 313, 838 S.E.2d at 531. Looking to the advisory committee note to Federal Rule of Evidence 704, the Court explained:

> an opinion on the ultimate issue has to be "otherwise admissible," meaning in the context here that it must be helpful to the jury as required by Rule 702, SCRE, and satisfy the strictures of Rule 403, SCRE. The opinion here was not helpful to the jury because it stated a legal conclusion and essentially told the jury what result to reach on the probable cause question.

Id. at 313, 838 S.E.2d at 531. The same reasoning applies to this case.

Hurley's opinion was not helpful because it would have confused and misled the jury as to the meaning of gross negligence. During the proffer, Hurley testified RMC's conduct was not negligent or grossly negligent. (Trial Tr. pp. 379-80) (R. pp. _). On cross-examination, she defined "gross negligence" as "[a]ctually causing a problem and knowing that you did it. Hurting someone intentionally." (Trial Tr. p. 381) (R. p. _). That is not the correct legal definition of gross negligence. The lower court charged the jury that "[g]ross negligence is the intentional, conscious failure to do something which is incumbent upon one to do, or the doing of a thing intentionally that one ought not do. . . . gross negligence is the failure to exercise slight care." (Trial Tr. p. 422)

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[4] RMC's attempt to distinguish this case from *Dawkins* is unconvincing. (Br. of App. p. 26). RMC did ask Hurley to make a legal conclusion on gross negligence. As RMC acknowledged in its closing argument, "Judge Dickson's going to charge you on gross negligence." (Trial Tr. p. 402) (R. p. _).

(R. p. _). Because Hurley's definition of gross negligence is contrary to the legal definition of gross negligence, it would have confused and misled the jury, Rule 403, SCRE, and "also risked treading on the trial judge's role as the sole source of the law in the trial," *Carter*, 429 S.C. at 314, 838 S.E.2d at 532.

Hurley's opinion also "essentially told the jury what result to reach on" the gross negligence question. *Id.* at 313, 838 S.E.2d at 531. RMC asked Hurley her opinion as to whether it "was grossly negligent in its care and treatment of" R.J. (Trial Tr. p. 380) (R. p. _). The verdict form asked the jury "Do you find the Defendant was grossly negligent?" (Verdict Form) (R. p. _). The admission of Hurley's testimony would have impermissibly allowed an "expert to define [gross negligence] to the jury and apply [her] view of the facts to [her] definition of law," which "ran the risk of misleading the jury and telling them what their verdict should be." *Carter*, 429 S.C. at 314, 838 S.E.2d at 532. The proffered question was undoubtedly an "attempt[] to usurp" the jury's role in determining whether RMC was grossly negligent. *Dawkins v. Fields*, 354 S.C. 58, 65, 580 S.E.2d 433, 437 (2003).

The decision of the United States District Court for the District of South Carolina in *Hermitage Industries v. Schwerman Trucking Co.*, 814 F. Supp. 484 (D.S.C. 1993), is instructive on this issue and, for brevity, Hamilton incorporates the reasoning of the decision into this brief. The Court excluded expert testimony on the legal conclusion of negligence because "the proffered testimony of defendant's expert witness that plaintiff was 'negligent' constitutes a legal conclusion and is therefore inadmissible." *Id.* at 487.

Alternatively, even if the Court finds error in the lower court's ruling, it is harmless and RMC suffered no prejudice from the exclusion because Hurley made it apparent to the jury that she believed Downing satisfied the standard of care and RMC did nothing wrong. Hurley testified

four times to her opinion that Downing's treatment met the standard of care. (Tr. p. 347 lns. 15-18; 350 lns. 9-13; 352 lns. 8-10; 356 lns. 21-25) (R. pp. _). She testified that Downing's treatment met RMC's policy expectations, "exceeded the standard of care," and was "an outstanding job." (Tr. p. 347, 352-53, 357) (R. pp. _). The jury understood that Hurley did not think RMC was grossly negligent.

The lower court properly exercised its discretion to exclude Hurley's testimony on the legal conclusion of RMC's gross negligence, and this Court should affirm.

V. THE LOWER COURT PROPERLY EXERCISED ITS DISCRETION TO PUBLISH THE REQUESTS FOR ADMISSION TO THE JURY.

The court properly exercised its discretion to publish the requests to admit to the jury so it could consider them along with all of the other evidence. "A trial court has particularly wide discretion in ruling on Rule 403 objections." *State v. Gray*, 408 S.C. 601, 608, 759 S.E.2d 160, 164 (Ct. App. 2014) (internal quotation marks omitted).

Hamilton moved to admit the requests to admit as a stipulation (Trial Tr. p. 252) (R. p. _) and asked to explain to the jury "what a request to admit is" (Trial Tr. p. 247) (R. p. _), but the lower court denied those requests and only allowed Hamilton to read the exact language of the requests and answers to the jury (Trial Tr. pp. 257-58) (R. p. _). The jury was free to accept or reject the requests to admit just like any other evidence.

Under Rule 43(g), SCRCP, "[c]ounsel for any party may read his pleadings to the jury." Even when a pleading, including a request for admission, is later amended, both the original and the amended answer may be published to the jury for it to consider along with all of the other evidence.[5]

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[5] "Once an answer to a Request for Admissions is amended under Rule 36, both the initial answer and the amended answer may be published to the jury. The jury may consider the initial answers as evidence, while the party who made such answers is free to explain why it was made and

RMC made two objections to the evidence. It argued (1) the purpose of the requests was to obtain an independent medical examination, and (2) the prejudicial effect of the requests outweighed the probative value under Rule 403, SCRE, because the requests would confuse the jury by telling them "a verdict had to be awarded" and "effectively" directing a verdict of liability for Hamilton. (Trial Tr. pp. 251-57) (Br. of App. pp. 28-30). The lower court properly acted within its discretion to rule these arguments did not require exclusion of the evidence.

As to the first argument, the reason RMC sent the requests to admit does not dictate their admissibility, especially when RMC did not limit the requests to a specific purpose. That RMC intended to use the requests to admit to get an independent medical examination under Rule 35(a), SCRCP, does not remove them from Rule 43(g), SCRCP.

Regardless, even if the Court considers RMC's argument, the language of the requests shows they were not limited solely to Rule 35(a). Rule 35(a), SCRCP, provides for an independent medical examination when "the ***amount in controversy*** exceeds $100,000 actual damages." (emphasis added). RMC requested that Hamilton:

> Admit the value of the amount in controversy in this action is less than $100,000.00.
>
> Admit the ***value and amount in controversy*** in this action is greater than $100,000.00.
>
> Admit the ***value*** of Plaintiff's actual damages exceeds $100,000.00.

(Req. to Admit) (R. p. _) (emphasis added). The requests to admit went beyond the amount in controversy by asking Hamilton to admit the "value" of her actual damages. This supports the lower court's discretionary decision to publish the requests to admit to the jury.

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amended. . . . It was for the jury to weigh the evidence along with [other evidence]." *Tuomey Reg'l Medical Ctr. v. McIntosh*, 315 S.C. 189, 191, 432 S.E.2d 485, 487 (1993) (internal citation, quotation marks, and alterations omitted).

As to RMC's Rule 403, SCRE, argument, the record supports the lower court's determination that the probative value of the evidence is not substantially outweighed by the danger of any unfair prejudice or confusion. The evidence had probative value in proving the amount of damages. In its post-trial motions and on appeal, RMC argues that the actual damages are only $20,854.00—the amount of the medical bills. (Br. of App. pp. 37-38). RMC cannot assert that the "value of Plaintiff's actual damages exceeds $100,000.00" so it can get an independent medical examination and then deny the possibility of that damages value in front of the jury.

RMC's argument that it suffered unfair prejudice because the jury would believe it had to find RMC liable and award damages is incorrect. Both parties argued about liability and damages in their closing arguments. (Trial Tr. pp. 387-415) (R. pp. _). The court charged the jury on its duty "to evaluate the evidence and determine which evidence convinces you it is true." (Trial Tr. p. 418 lns. 23-25). It charged the jury to determine if RMC acted with gross negligence and, if applicable, to choose an amount of damages. (Trial Tr. pp. 421-428) (R. pp. _). It instructed the jury to "assess the amount that ***you*** find to be justified by a preponderance of the evidence" and to "place a value on each element of the damage in accord with the evidence presented." (Trial Tr. p. 425) (R. p. _) (emphasis added). There is "a sound presumption of appellate practice, that jurors are reasonable and generally follow the instructions they are given." *Arnold v. State*, 309 S.C. 157, 166, 420 S.E.2d 834, 838 (1992). The verdict form asked the jury to decide whether "the Defendant was grossly negligent" and, if so, to "state the amount of damages, ***if any***," sustained by R.J. and Tekayah. (Verdict Form) (R. p. _) (emphasis added). The jury knew that it must decide liability and damages.

The responses to the requests for admission were merely one piece of evidence. RMC was free to produce other, contradictory evidence, which it did. Just like any other evidence, the jury

was free to accept or reject the requests for admission. The evidence and law support the lower court's decision, and this Court should affirm.

Finally, any error in publishing the admissions to the jury was harmless because, as explained below, there was ample other evidence that Hamilton's damages exceeded $100,000.00.

VI. THE LOWER COURT DID NOT ABUSE ITS DISCRETION IN DENYING THE MOTION FOR A NEW TRIAL OR *NISI REMITTITUR*.

The lower court did not abuse its discretion in denying RMC's new trial motions based on the alleged excessiveness of the verdicts and the thirteenth juror doctrine. "The jury's determination of damages is entitled to substantial deference. The denial of a new trial motion is within the discretion of the trial court and, absent an abuse of discretion, it will not be reversed on appeal." *Clark v. S.C. Dep't of Pub. Safety*, 353 S.C. 291, 309-10, 578 S.E.2d 16, 25 (Ct. App. 2002).

The lower court maintained R.J.'s $1,127,280.00 verdict but reduced it to the $300,000.00 cap in the Tort Claims Act, and maintained Tekayah's verdict of $135,477.00. (Order) (R. p. _). This Court "must accord the trial court's decision great deference, and respect its superior position to gauge credibility and the field of evidence." *Nestler v. Fields*, 426 S.C. 34, 41, 824 S.E.2d 461, 465 (Ct. App. 2019) (internal quotation marks omitted).

"A verdict which may be supported by ***any*** rational view of the evidence and bears a reasonable relationship to the character and extent of the injury and damage sustained is not excessive." *King v. Daniel Int'l Corp.*, 278 S.C. 350, 355, 296 S.E.2d 335, 338 (1982) (emphasis added). RMC moved for a new trial on three grounds—thirteenth juror doctrine, new trial absolute when a verdict is grossly excessive or inadequate, or a new trial *nisi remittitur* or *additur* when the verdict is merely excessive or inadequate. *See Burke v. AnMed Health*, 393 S.C. 48, 55-57, 710 S.E.2d 84, 88-89 (Ct. App. 2011) (listing the three general grounds for a new trial). "Compelling

reasons [] must be given to justify invading the jury's province in this manner." *Bailey v. Peacock*, 318 S.C. 13, 14, 455 S.E.2d 690, 691 (1995). The lower court correctly found the verdicts were not excessive in the first place—a basis to affirm as to all three alleged grounds for a new trial in this case.

If the court first finds the verdict excessive, it must determine whether it is merely excessive or grossly excessive. A merely excessive verdict is one that the court views as "not in accord with accepted judicial standards for measuring damages under the facts of the particular case." *Bowers v. Charleston & W. Carolina R.R. Co.*, 210 S.C. 367, 375, 42 S.E.2d 705, 708 (1947). A grossly excessive verdict is one "deemed to be the result of a disregard of the facts and of the instructions of the Court, and to be due to passion and prejudice rather than reason." *Id.* at 375, 42 S.E.2d at 708. "[T]o warrant a new trial absolute, the verdict reached must be so grossly excessive as to clearly indicate the influence of an improper motive on the jury." *Holroyd v. Requa*, 361 S.C. 43, 66, 603 S.E.2d 417, 429 (Ct. App. 2004).

In determining whether a verdict amount is excessive, "the facts must be viewed in the light most favorable to the plaintiff and, where the amount of a verdict bears a reasonable relationship to the character and extent of the injury sustained, it is not excessive." *Watson v. Wilkinson Trucking Co.*, 244 S.C. 217, 224, 136 S.E.2d 286, 289 (1964). RMC presents no compelling reason for the Court to invade the jury's province. Viewing the evidence in a light most favorable to Hamilton, it bears a reasonable relationship to the character and extent of the injuries sustained and supports the lower court's finding that neither verdict was excessive.

A. The evidence supports the jury's verdict for R.J.

Hamilton presented ample evidence of R.J.'s damages to support the jury's verdict. There is evidence R.J. suffered a permanent injury. There is evidence R.J. suffered past, present, and future pain and suffering, mental and emotional anguish, anxiety, and loss of enjoyment of life.

"An award for pain and suffering compensates the injured person for the physical discomfort and the emotional response to the sensation of pain caused by the injury itself." *Boan v. Blackwell*, 343 S.C. 498, 501-02, 541 S.E.2d 242, 244 (2001). "Separate damages are given for mental anguish where the evidence shows, for example, that the injured person suffered shock, fright, emotional upset, and/or humiliation as the result of the defendant's negligence." *Id.* at 502, 541 S.E.2d at 244. "One cannot easily or with any mathematical certainty place a value on the amount of a person's pain and suffering." *Smalls v. S.C. Dep't of Educ.*, 339 S.C. 208, 218, 528 S.E.2d 682, 687 (Ct. App. 2000).

RMC argues "there was little testimony regarding pain and suffering." (Br. of App. p. 33). This is false. There is evidence R.J. experienced pain at the time of the infiltration, during the healing process, and after the scar formed. When the nurses finally called a doctor to look at R.J.'s hand, it was swollen with "a big black scar and it was a bubble" on top of his hand full of fluid. (Trial Tr. pp. 150-51) (R. pp. _). R.J. cried during every one of the fifteen visits to the wound care center. (Trial Tr. pp. 153-54) (R. pp. _). Dr. DeVito testified the "whole nature of the wound is painful." (Trial Tr. p. 230) (R. p. _). R.J. could not crawl with his hand out and Hamilton "constantly" watched him to make sure he did not hit it on something or make it bleed. (Trial Tr. p. 157) (R. p. _).

The infiltration resulted in keloid scar tissue that "invades" the skin surrounding it and causes painful burning and itching symptoms. (Trial Tr. p. 227) (R. p. _). Dr. DeVito testified some patients describe the pain "as if someone were putting hot needles to the skin." *Id.* Dr.

DeVito saw R.J. weeks before trial but testified he "couldn't even examine the child" because R.J. pulled his hand back and withdrew, it is still "a source of pain for him," and the examination "was really an ordeal." (Trial Tr. pp. 236-37) (R. pp. _).

R.J. was three-years-old at the time of trial, and Hamilton testified he suffered complications from his scar. (Trial Tr. pp. 156-57) (R. pp. _). His hand cramps up and he complains about itching and cannot sit still when it hurts. (Trial Tr. p. 156) (R. p. _). Hamilton massages his hand and does hand exercises with him using a ball. (Trial Tr. p. 156) (R. p. _).

Dr. Davis and Dr. DeVito agreed that R.J. will have a permanent scar regardless of any future treatment. (Trial Tr. pp. 210-11, 236) (R. pp. _). R.J.'s skin will never be normal again. (Trial Tr. p. 237) (R. p. _). He does not have sweat glands or hair follicles on his right hand. (Trial Tr. p. 237) (R. p. _). Even slightly bumping R.J.'s hand could cause a blister or ulcer. (Trial Tr. p. 238) (R. p. _). The court charged the jury that R.J.'s life expectancy was 73.76 years. (Trial Tr. p. 428) (R. p _).

RMC argues that the functionality of R.J.'s hand is a basis to find the damages excessive. (Br. of App. p. 34). This misstates the testimony and fails to view it in a light most favorable to Hamilton. During all of the functionality tests that Dr. Davis performed, R.J. complained that his hand felt tight. (Trial Tr. p. 205) (R. p. _). Dr. Davis testified that scars have a negative psychological impact on a person regardless of functional abilities. (Trial Tr. pp. 202-03) (R. pp. _). Almost four years after the infiltration, R.J. still complained of itching on the scar site. (Trial Tr. pp. 203-04) (R. pp. _). Dr. DeVito testified R.J. "has some limitation" compared to a child with no scar because R.J. would not even let Dr. DeVito touch the hand during the examination. (Trial Tr. p. 249) (R. p. _). Tekayah testified that she limits R.J.'s activities for fear that he will

injure his hand. (Trial Tr. p. 158) (R. p. _). That R.J. has functionality in his hand does not decrease the significance, frequency, or intensity of his regular emotional and physical pain from the scar.

"[A] verdict which may be supported by any rational view of the evidence, or as to which reasonable and disinterested men might draw different inferences, is not of this class" of excessive verdicts. *Mickle v. Blackmon*, 252 S.C. 202, 248, 166 S.E.2d 173, 194 (1969) (affirming the denial of a new trial absolute of "probably the highest verdict in a personal injury case in the history of this State"). That RMC disagrees with the jury's damages determination does not make it excessive. Further, that R.J.'s verdict of $1,127,280.00 is "54 times" the medical expenses (Br. of App. p. 35), is not a basis for finding it excessive. RMC does not cite any law requiring that a verdict amount must be within a certain multiplier of alleged actual damages. On the contrary, the law is that there is no yardstick or measure for determining non-economic damages. *See Knoke v. S.C. Dep't of Parks, Rec. & Tourism*, 324 S.C. 136, 142, 478 S.E.2d 256, 258-59 (1996) (stating "intangible damages" "cannot be determined by any fixed measure"); *Lucht v. Youngblood*, 266 S.C. 127, 137, 221 S.E.2d 854, 859 (1976) (stating non-economic damages "are intangibles, the value of which cannot be determined by any fixed yardstick"). Further, R.J.'s medical expenses are Tekayah's damages and, therefore, cannot be used as the "yardstick" for his measure of damages.

An award of $1,127,280.00 for a child who will have to endure a scar and the daily physical and emotional pain and limitations associated with it for his ***entire life*** is neither merely nor grossly excessive.

B. The evidence supports the jury's verdict for Tekayah.

Hamilton presented ample evidence of Tekayah's damages to support the jury's verdict. A parent can recover medical expenses, loss of services, and other pecuniary losses arising out of the

injuries of a minor child. *Doe v. Greenville Cnty. Sch. Dist.*, 375 S.C. 63, 68, 651 S.E.2d 305, 307-08 (2007).

The medical bills totaled $20,854.00. (Trial Tr. p. 413; Pl.'s Exh. 7) (R. pp. _). Dr. DeVito's recommended surgical treatment for R.J.'s scar will cost approximately $2,500.00 for the surgical fee and in excess of $12,000.00 for other associated costs such as the anesthesia, hospitalization, the operating room, and testing. (Tr. pp. 240-41) (R. pp. _). Dr. DeVito testified that R.J. would need steroid injections "indefinitely" and each injection costs $85.00. (Tr. p. 234; Pl.'s Exh. 8) (R. pp. _).

RMC argues Hamilton did not establish the scar treatment. (Br. of App. p. 34). This is incorrect. Tekayah testified that she did not want to have surgery on R.J.'s hand at the time of trial because he was so young and had already been through a lot. (Tr. pp. 170-71). Dr. Davis testified that giving the steroid treatment to a three-year-old is "not easy" and "not successful at that age" because it is traumatic for the child and requires a sedative. (Tr. pp. 207-08). Dr. DeVito testified that Keloid scars are difficult to treat with steroids because penetrating "a hard scar with a needle and syringe is . . . like trying to inject the paint on [a] wall." (Tr. pp. 231-32). Even an alternative vaccination gun that uses high pressure is "painful." (Tr. pp. 232-33). Dr. DeVito found it "very understandable" that Tekayah may not want to put R.J. through that pain at three-years-old and agreed it is a "painful dilemma" for a child. (Tr. pp. 234-35). Based on that testimony, the jury could have accepted Hamilton, Dr. DeVito, and Dr. Davis's testimony that it is best to wait to pursue scar treatment until R.J. is older. That Tekayah is choosing to wait does not mean she cannot recover for the future treatment.

The lower court considered that Tekayah missed work for a year because she could not trust any one to properly watch out for R.J.'s hand. (Trial Tr. p. 157; Order p. 5) (R. pp. _). The

lower court considered that Tekayah would remain R.J.'s guardian for an additional fifteen years from the date of trial. (Order p. 6) (R. p. _).

RMC incorrectly argues that Tekayah's damages are limited to only the medical expenses. (Br. of App. p. 37). A parent may recover for loss of a child's services and earning capacity (which are not at issue here), as well as "***other*** pecuniary losses, ***including*** medical expenses incurred as a result of the injury." *Doe v. Greenville County Sch. Dist.*, 375 S.C. 63, 68, 651 S.E.2d 305, 308 (2007). That the court listed medical expenses as included within the category of "pecuniary losses" necessarily means that a parent's recovery is not limited to medical expenses.

An award of $135,477.00 for R.J.'s past and future medical expenses, as well as Tekayah's pecuniary loss for missed work, travel expenses, and constant daily watching over and caring for R.J. is neither merely nor grossly excessive.

CONCLUSION

For these reasons, the Court should affirm the lower court.

Respectfully submitted,

March 24, 2021

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

Honorable Edgar W. Dickson, Circuit Court Judge

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee Middleton, Jr., a minor child under the age of eighteen,.. ..... Respondent

v.

The Regional Medical Center, ...Appellant

REPLY BRIEF OF THE REGIONAL MEDICAL CENTER

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I. THIS CASE IS ABOUT PEDIATRIC NURSING AND IV ADMINISTRATION AND MONITORING AND RESPONDENT'S EXPERT MONICA STOBBS FAILED TO MEET THE REQUIREMENTS OF RULE 702, SCRE, AND GOODING AS IT PERTAINED TO PEDIATRICS

In its brief, Respondent falsely states that Appellant is incorrect about this case being about pediatric nursing, and instead, characterizing it as "IV management safety practice of doing and documenting a saline flush before administering medication." (Br. of Resp. 8) Respondent falsely characterizes Appellant's discussion of blood return and IV management irrelevant on the basis that this case is about whether a flush was done, (Br. of Resp. 6), and that Appellant's arguments regarding Nurse Downing's qualifications are mute or "does not make a difference." (Br. of Resp. 7.) on the basis that the standard of care is the same for pediatrics and adults.

This case *is* about pediatric nursing, and there *are* differences between pediatrics and adults and the care provided to each during IV administration and monitoring. App. Br. 11. There are various physiological differences that vary greatly among infants, children, and adults. App. Br. 11 fn 1, 2, 3. Veins in infants are "obviously smaller" and can be "threadlike." App. Br. 11 fn 2. "Vein fragility and the high acuity levels of young patients can increase the likelihood of infiltration and extravasation, resulting in significant morbidity." App. Br. 11-12, fn 3. Since infants, children, and adults are all different, there are different procedures in place, different equipment used, and different techniques utilized in the IV administration. Trial Tr. 331:4-17, 332:7-12, 15-20, Mar. 17, 2019. It requires a certain skill. *Id.* at 332:7-9.

As this matter was about pediatric nursing, not general nursing, to testify as to the standard of care regarding *pediatric* standard of care for IV administration and monitoring, Nurse

Stobbs was required, by Rule 702 of the South Carolina Rules of Evidence, to possess the "knowledge, skill, experience, training or education" as it pertained to *pediatrics*. Rule 702, SCRE. "To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter.'" *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 253, 487 S.E.2d 596, 598 (1997) (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995); *see, e.g.*, *State v. Douglas*, 367 S.C. 498, 508-509, 626 S.E.2d 59 (Ct. App. 2006); *Botehlo v. Bycura*, 282 S.C. 578, 586, 320 S.E.2d 59, 65 (Ct. App. 1984). Nurse Stobbs fails to meet the requirements of both Rule 702 and Gooding as to *pediatric* nursing and IV administration. App. Br. 12-15. Nurse Stobbs has never cared for a pediatric patient; has never started or managed a pediatric IV; does not have any education or knowledge as to pediatric nursing or IV administration; and did not perform any research, independent study, or review any medical literature in preparation of formulating her opinions. App. Br. 13. Moreover, Nurse Stobbs actually testified in direct contradiction with the medical literature regarding obtaining blood return, as well as testimony from Nurse Downing and Cynthia Hurley, both of whom actually practice in pediatrics. App. Br. 13-14. This argument is not irrelevant, as it is further proof of Nurse Stobb's lack of experience or knowledge regarding *pediatric* nursing and IV administration.

Respondent incorrectly states in its brief that Nurse Stobbs "is qualified in the field of IV management." Resp. Br. 11. Nurse Stobbs was qualified as to *general nursing*, not the field of IV management. Trial Tr. 10:4-6, Dec. 22, 2020; Trial Tr. 78:1-9, Mar. 17, 2019. Moreover, Respondent argues that she was "not required to specifically practice in pediatric IV

management." Resp. Br. 11. However, the argument is not that Nurse Stobbs has to specifically practice in pediatrics. The issue is not over a *defect* in amount or quality of experience or knowledge. App. Br. 13. Rather, the issue is whether Nurse Stobbs possessed *any* of the required "knowledge, skill, experience, training or education" "acquired by reason of study or experience or both" such that she is "better qualified than the jury to form an opinion on" *pediatric* nursing and *pediatric* IV administration and monitoring. Rule 702, SCRE; *Gooding*, 326 S.C. at 253, 487 S.E.2d at 598; App. Br. 12-13. Nurse Stobbs must have gained knowledge or experience in *pediatric* nursing and IV administration by some means to be qualified to testified as to the standard of care of the same. She has no such knowledge or experience in *pediatric* nursing and IV administration, and therefore was not qualified to testified as to the standard of care for *pediatric* nursing and IV administration. App. Br. 12-15.

Respondent is incorrect that Appellant's arguments against the qualification of Nurse Stobbs goes to the weight and not admissibility of her testimony. Br. of Resp. 8. Similar to the orthopedic surgeon in *Botehlo*, Ms. Stobbs has had no personal experience or training at all in pediatric nursing or IV administration. App. Br. 13. Respondent is incorrect in that *Botehlo* is not easily distinguishable from the facts of this matter. Resp. Br. 10. In *Botehlo*, the court held that an orthopedic surgeon was not qualified to testify on the standard of care for podiatrist where the orthopedic surgeon 1) had no training in podiatry, 2) was not familiar with any journals or periodicals in podiatry, and 3) was not familiar with the surgical procedure performed. *Botehlo v. Bycura*, 282 S.C. 578, 586, 320 S.E.2d 59, 65 (Ct. App. 1984). Similar to *Botehlo*, Nurse Stobbs 1) has had no training, education, or any experience at all in *pediatric* nursing or IV administration; 2) was not familiar with any medical literature regarding *pediatric* nursing or IV

administration and had not performed any research, independent study, or review any medical literature as to *pediatric* nursing and IV administration in preparation of formulating her opinions; and 3) has never cared for a *pediatric* patient and has never started or managed a *pediatric* IV. App. Br. 13; Trial Tr. 79:24-25, 108:22-110:21, 103:14-104:8,108:22-110:21, 111:14-23, Mar. 17, 2019; Stobbs Dep. 13:9-24, 26:15-24. Thus, similar as to how the orthopedist in *Botehlo* "not versed at all in the practice of podiatry," *McMillan v. Durant*, 312 S.C. 200, 204, 439 S.E.2d 829, 832 (1993) (referring to *Botehlo*), Nurse Stobbs is not versed at all in the practice of *pediatric* nursing and IV administration.

Respondent relies on *McMillian, Lee, Graves,* and *Creed* for its argument that Nurse Stobbs lack of experience in pediatrics is not sufficient in prohibiting her from testifying as to the standard of care for pediatric nursing and IV administration. Resp. Br. 8-10; *McMillan v. Durant*, 312 S.C. 200, 439 S.E.2d 829 (1993); *Lee v. Suess*, 318 S.C. 283, 457 S.E.2d 344 (1995); *Graves v. CAS Med. Sys.*, 401 S.C. 63, 735 S.E.2d 650 (2012); *Creed v. Columbia*, 310 S.C. 342, 426 S.E.2d 785 (1993). However, these cases are easily distinguishable.

Unlike *McMillian*, where a neurosurgeon was qualified to testify as to the appropriate standard of care of nursing on the basis that he taught nursing courses at a university, *McMillian*, 439 S.E.2d at 833, and *Lee*, where a plastic surgeon who was qualified to testify as to where he was a professor who taught family practitioner residents how to identify skin cancers and perform biopsies, *Lee*, 457 S.E.2d at 346, Nurse Stobbs has not had any experience teaching any courses regarding pediatric nursing or pediatric IV administration. In fact, she has no experience —knowledge or skill, training or education—whatsoever in pediatric IV administration. App. Br. 12-13.

Unlike in *Graves,* where the doctor stayed current on sudden infant death syndrome (SIDS) literature and routinely encountered SIDS in her practice, *Graves*, 401 S.C. at 78, Nurse Stobbs was unfamiliar with the medical literature regarding pediatric IV administration and management and had not done any research during her time spent prepping for this trial. App. Br. 13. Further, not only does she not "routinely encounter" pediatrics in her practice, she has *never* treated a single pediatric patient during her *entire* career. App. Br. 12-13. She has never started or monitored an IV in a single pediatric patient in her nursing career. App. Br. 12-13.

This case is also not similar to *Creed.* In *Creed*, the general practitioner who was qualified to give an opinion on the plaintiff's mental and emotional injuries had personally examined the plaintiff and referred him to a neuro-psychologist as a part of his course of treatment. *Creed*, 426 S.E.2d at 786. In the present matter, Nurse Stobbs did not personally treat, examine, or care for the minor Respondent and did not refer him to an outside specialist as a part of his course of treatment. In fact, she has not personally treated or care for *any* pediatric patient. App. Br. 12-13.

Additionally, in its brief, Respondent maintains that Appellant relies on *Gooding* but that *Gooding* supports Respondent's position. Resp. Br. 10. However, the present matter is also distinguishable from *Gooding*. In *Gooding*, the EMT who was qualified to testify as to intubation procedure had personal, hands-on experience with intubation and had intubated over 100 patients. *Gooding*, 326 S.C. at 251. This case is about *pediatric* IV management, and Nurse Stobbs has had *no experience whatsoever* in pediatric IV management or pediatric nursing. App. Br. 12-13.

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Respondent's expert Nurse Stobbs was the only witness it produced as it pertained to two critical issues. The jury returned a verdict that was excessive in light of the testimony and evidence presented at trial. Thus, the issue concerning her qualification or lack of *does* matter and *does* make a difference. App. Br. 15-16.

In its brief, Respondent incorrectly argues that Appellant's argument regarding Nurse Stobbs' testimony on the pediatric standard of care for IV administration and monitoring was not preserved for appeal. Resp. Br. 11-12. In its Motion in limine, counsel for Appellant made it known to the court that he felt like this was a situation in which Respondent was attempting to have her qualified in pediatric nursing. Trial Tr. 8:13-17, 8:20-9:19, Dec. 22, 2020. The Trial Court specifically indicated Ms. Stobbs would be qualified in general nursing and not pediatrics, as it acknowledged she had no prior experience with regards to pediatrics. Trial Tr. 8:18-19, 9:20-10:6, Dec. 22, 2020. In its decision, the Trial Court stated that it would qualify her for nursing care but not neonatal. Trial Tr. 10:5-6, Dec. 22, 2020. Respondent incorrectly maintains the position that Appellant's argument was not preserved but it was never objected to during trial. Br. of Resp. 11. However, during the qualification of Nurse Stobbs at trial, counsel for Appellant contemporaneously objected and stated on the record that Nurse Stobb's qualification was "subject to my prior objection." Trial Tr. 78:5-6, Mar. 17, 2019.

Nurse Stobbs was qualified as an expert in nursing, *general* nursing, not pediatrics or neonatal and not in the "field of IV management" as stated in Respondent's brief (Resp. Br. 11). Trial Tr. 10:4-6, Dec. 22, 2020; Trial Tr. 78:1-9, Mar. 17, 2019. As suspected, Nurse Stobbs did in fact testify during trial regarding the standard of care for *pediatric* nursing and IV

administration and care. All supporting arguments and authority as it pertains to Nurse Stobb's testimony regarding pediatric nursing and IV administration and monitoring have already been discussed in this brief, as well as Appellant's Initial Brief. *See* Rule 702, SCRE; *Gooding,* 326 S.C. 248, 487 S.E.2d 596; *Botehlo*, 282 S.C. 578, 320 S.E.2d 59; App. Br. 9-16.

II. GROSS NEGLIGENCE IS THE STANDARD THAT APPLIES IN THIS MATTER AND RESPONDENT FAILED TO MEET THEIR BURDEN

Gross negligence is the standard that applies in this case. App. Br. 17; Trial Tr , 214:12-215:16, 434:10-17, Mar. 17, 2019. *Stewart* is the governing law in this matter. *See Stewart v. Richland Mem'l Hosp.,* 350 S.C. 589, 592, 567 S.E.2d 510, 511 (Ct. App. 2002). As defined by S.C. Code Ann. § 15-78-30(j) and *Smith v. TRMC,* Appellant is a governmental entity, and therefore this matter is strictly governed by the confines of the South Carolina Torts Claims Act. App. Br. 17; *see Smith v TRMC*, 713 S.E.2d 656 (Ct. App. 2011); S.C. Code Ann. §15-78-200. The South Carolina Torts Claims Act limits liability of a governmental entity unless there is gross negligence. S.C. Code Ann. § 15-78-60(25); App. Br. 17. Respondent argues that gross negligence is the applicable standard because "because it concerns a nurse's administration of medication and not 'supervision, protection, control, confinement, or custody' of a patient." Br. of Resp. 15, fn 2. However, although Stewart involved the custody of an inmate, it also involved the monitoring of him as a patient. *Stewart,* 350 S.C. 589, 591-592; Trial Tr. 213:14-22, Mar. 17, 2019. Therefore, the gross negligence standard is applicable in cases involving the monitoring of patients, and thus, as the Trial Court agreed, is applicable in this case.

Respondent is incorrect in its presumption that Appellant is arguing that the words "gross negligence" must have been used for the evidence of the same to exist. Resp. Br. 15. Appellant's

position is that Respondent failed to establish *any* evidence of gross negligence, and thus, they failed to meet their burden and a directed verdict should have been returned in favor of Appellant. App. Br. 18.

Respondent believes the issue in this matter is whether the IV was flushed before administering ampicillin, and Respondent's theory is based on "if it wasn't documented, it wasn't done." Resp. Br. 3. However, this theory is directly contradictory to the testimony as to the policies and procedures of pediatric nursing and IV administration at The Regional Medical Center (RMC) and is based on a complete misread of the policy itself. In its brief, Respondent maintains that there was evidence that RMC "consciously failed to do or document a saline flush." Resp. Br. 16. Respondent bases assertion by stating "RMC's policies require a saline flush prior to administering medication and documentation of that flush." Resp. Br. 16. However, this is factually incorrect and blatantly mischaracterizing the testimony as to what the policy requires.

Both Nurse Downing and Cynthia Hurley testified numerous times that flushing a site is part of the assessment with administering a medication, and there is no way to give the medication without flushing the IV first. Trial Tr. 272 25-273:8, 273:18-274:1, 276:22-25, 277:5-10, 280:2-281:1, 364:2-19, 365:9-13, Mar. 17, 2019. It is considered a part of the process and therefore it is not to be documented separately. *Id.* at 284:19-21. Even Respondent acknowledged in its brief that Nurse Downing testified it is her practice to flush prior to administering medication (Resp. Br. 3); that Downing testified flushing prior to administration of medication is "ingrained in you in nursing school" and "it makes no sense not to" flush (Resp. Br. 16); and that Downing testified there is "no way to really tell if the site is open and flowing without flushing it" (Resp. Br. 17).

The issue comes down to the fact that there are two types of flushes and different policies and procedures for each: 1) flushes done when administering medication, and 2) four-hour flushes that are automatically populated in the MAR computer system. The flushes that are given prior to and after administering medication are considered a part of the process for administering medication, and they are not to be documented separately in the MAR system. Trial Tr. 284:19-21, 336:19 -337:2, Mar. 17, 2019. In fact, there is not a flow sheet or space in which to document it. *Id.* at 284:19-21. In contrast, the flushes that task automatically in four-hour increments in the computer MAR program automatically populate when the ordering physicians puts in the order for the IV. *Id.* at 285:18-23. Although the timing of these flushes could align with the administration of medication, these flushes are not associated with medication administration. *Id.* at 275:23. These four-hour flushes are a part of an intermittent, not continuous, IV schedule, as was the case here, and are to be documented pursuant to RMC policy. *Id.* at 274:6-19, 274:23-275:1, 275:19-276:9, 364:14-19. Per RMC policy, infants are to be flushed in four-hour increments, which is a different in adult IV administration. *Id.* at 331:4-8. Nurse Downing and Cynthia Hurley both testified several times that although these four hour flushes automatically populate in the system to be tasked at a certain time, it is not always appropriate to do those flushes at that time. It would not be appropriate when a nurse has already flushed the IV prior to that time as part of the process of administering a medication. *Id.* at 331:1-3, 365:18-19. If a medication is already being administered when the four-hour flush tasks, it would not be appropriate to flush at that time and would instead be appropriate once that medication has finished being administered. *Id.* at 285:2-7. It would also not be appropriate to flush if it has infiltrated. *Id.* at 285:7-9, 343:4-8.

The very notable and important distinctions between these two flushes that were discussed at length during trial. Respondent is basing its position on that Downing did not remember doing a flush prior to administering the ampicillin and "if something is not documented, then it was not done." Resp. Br. 17. Respondent is misreading the RMC policy, mischaracterizing the testimony, and attempting to make it seem like Nurse Downing did not follow the correct policy, when in fact, she and Appellant's expert Cynthia Hurley, testified that she did, in fact, follow RMC policy and procedure. Although Nurse Stobbs could not recall specifically flushing at that particular time due the length of time that has transpired, she testified that flushing prior to administering medication is a part of the process, is "ingrained in you in nursing school,"and "it makes no sense not to" flush. *Id.* at 280:21-281:1. Moreover, she testified it was not documented because it was not supposed to be, as it was considered a part of the process for administering medication, and there was not a place in the computer system to document it separately. *Id.* at 272:25-273:8, 273:12-14.

Not only did Nurse Downing testify that she complied with the policy and that at no time she did see an infiltratin score of 5, Trial Tr. 303:25-305:21, Mar. 17, 2019, Cynthia Hurley, in her testimony, gave a detailed description and timeline of the flushes that Nurse Downing performed in her treatment and care of the minor. Nurse Downing began working at 6:45 pm and got a report saying the patient's hand was flushing well. Trial Tr. 327:12, Mar. 17, 2019. At 7:30 pm, Nurse Downing wrote her nurse's note and documents indicate the patient was resting in his mother's arms and the IV flushing properly. *Id.* at 328:6, 333:25-334:3, 336:11-16. The first IV check was at 7:44. *Id.* at 328:7, 21-24. A four-hour flush was tasked at 8 pm, but a previous nurse had already flushed when administering an antibiotic, so it did not make sense to do it at the time

and was instead done at 9:19 p.m. *Id.* at 330:9-331:10. At 10:05 pm Nurse Downing performed an IV check and flush. *Id.* at 333:4-10. At 11:08 p.m. Nurse Downing administered ampicillin, which would have included a flush before and after administration of medication. *Id.* at 336:19-337:2. At 11:23 p.m. she checked the IV; it was documented that the IV infiltration score was 0, phlebitis score was 0, and there were no problems. *Id.* at 337:8-338:8. Nurse Downing went in again at 11:44 p.m. for another IV administration and flush. *Id.* at 338:10-17. Vitals were taken at 11:59 p.m. and were normal. *Id.* at 338:19-21.

A four-hour flush was tasked at midnight; however, it tasked after Claraforan, an antibiotic, was given at 11:44 p.m. *Id.* at 339:1-9. Since it had just been flushed during that process of administering that medication, the IV was flushed after the completion of the administration of Claraforan. *Id.* at 339:1-12. It would have made no sense to give it at midnight. *Id.* at 365:18-19 . Nurse Downing checked the IV at 12:37 a.m. and performed the flush at 1:04 a.m. *Id.* at 339:11-12. The minor had a phlebitis score of zero, infiltration zero, no signs of complication, and was sleeping. *Id.* at 307:4-9, 339:15-23.

Nurse Downing then checked on the minor as a part of her periodic nursing rounds. *Id.* at 339:24-340:3. At 2:30 a.m. a note was made in the nursing charts that the patient was asleep, no signs of distress, and will continue to monitor. *Id.* at 341:7-12. At 2:41 a.m. Nurse Downing performed another IV check. *Id.* at 340:9-12. At 2:43 vitals were assessed by a nursing assistant and were confirmed to be okay by Nurse Downing at 2:49 a.m. *Id.* at 340:22-341:6. At 4:04 Nurse Downing performed another IV assessment that showed an infiltration score of zero and phlebitis score of zero. *Id.* at 341:14-24. Cynthia Hurley testified that this 4:04 a.m. assessment "certainly met the standard of care." *Id.* at 350:9-14.

Ampicillin medication was administered at 4:27 a.m.. *Id.* at 341:25-342:4. Nurse Downing testified that when she gave the medication, she assessed the site and it was 0 and flushing well. *Id.* at 292:12-14. A four-hour flush tasked at 4:45 a.m., but Nurse Downing and Cynthia Hurley both testified that it was not appropriate to flush at that time because medication was already infusing and was not appropriate to flush after the medication was finished being administered because the IV had infiltrated. *Id.* at 285:4-5, 342:22 -343:8. The medical records indicate at 4:50 a.m. Nurse Downing had a discussion with the Respondent Tekeyah Hamilton about the infiltration, discharged the IV antibiotics, stopped the pump from administering anymore ampicillin, removed dressing, removed peripheral IV removed, noted catheter intact, and called the physician. *Id.* at 343:21-345:3, 346:17-21. Nurse Downing testified that she went in as soon as the alarm sounded, and "you do the best you can" with regards to charting real time because "[o]obviously, at the moment the more pressing circumstance would be to assess the patent and follow proper procedures for removing an IV." *Id.* at 286: 22-287:5. Cynthia Hurley testified that Nurse Downing took the appropriate course of action. *Id.* at 343:14-20.

At 5:16 and 5:17 a.m., vitals were confirmed and the IV was removed. *Id.* at 347:3-4. At 6 am the patient was assessed and was asleep. *Id.* at 347:7-10. At 6:22 and 6:26 a.m. vitals were confirmed, and at 6:45 a.m., Nurse Downing gave a shift report to another nurse as her shift was ending. *Id.* at 347:13-14.

Cynthia Hurley testified that not only did Nurse Downing abide by the standard of care and do everything she was supposed to do, but she actually exceeded the standard of care. *Id.* at 347:19, 352:8 - 354:13, 356:20-357:4, 371:22-23. Ms. Hurley testified that according to RMC's policy, "The phlebitis and infiltration scale is to be utilized to address IV site conditions a

minimum of once per shift. That's all she had to do." *Id.* at 353:11-18. However, Nurse Downing checked on the minor and the IV about every hour and gave seven flushes during her twelve hour shift when the policy required one flush every four hours. *Id.* at 353:11-14. Nurse Downing assessed the IV 19:44, 20:54, 22:05, 23:23, 0:37, 1:00, 2:42 and 4:04. *Id.* at 354:3-10. She only had to do one of these assessment per RMC policy. *Id.* at 331:6-8; 354:11-13. This is evidence that Nurse Downing not only followed protocol, but she *exceeded* it and exceeded the standard of care required.

Contrary to Respondent's brief, Respondent did not put forth any evidence of conscious failure to act or intentionality. In fact, Nurse Stobbs had no opinion as to the intentional conduct of Nurse Downing. Br. of App. 19. Respondent failed to put forth evidence that Nurse Stobbs failed to abide by RMC policy, and in fact, there was much testimony to the contrary. Furthermore, Nurse Stobbs agreed that just because there is an IV infiltration does not mean there is negligence and that it is a known risk and admitted to having had IVs infiltrate without having been negligent herself. Br. of App. 19. This is not a situation of "competing evidence" such that "evidence yields more than one reasonable inference or its inference is in doubt" as suggested in Respondent's brief. *See* Resp. Br. 15 & 17. Respondent did not put forth "any evidence. . .to support the jury verdict." *See* Resp. Br. 17. Respondent did not put forth any evidence establishing gross negligence, and therefore did not meet their burden and the jury's verdict is not supported by the evidence. A directed verdict or JNOV should have been granted.

III. RESPONDENT TEKAYAH HAMILTON'S VERDICT AWARD WAS EXCESSIVE AS SHE WAS LIMITED TO PAST AND FUTURE MEDICAL DAMAGES

As discussed previously, this case is subject to the limitations of the South Carolina Torts Claims Act. In *Wright*, the court in finding that a parent may recover medical expenses separately from the child's claim, provided that parent's claim for loss of services and medical expenses resulting from the injury of a minor child is within the tort claims act statutory definition of "loss." *Wright v. Colleton Cnty. Sch. Dist.*, 301 S.C. 282, 289-90, 391 S.E.2d 564 (1990).

Respondent relies on *Doe v. Greenville County School District.* Resp. Br. 32-34. *Doe v. Greenville Cnty. Sch. Dist.*, 375 S.C. 63, 651 S.E.2d 305 (2007). In *Doe*, the parents argued that the trial court erred in dismissing their claim for loss of consortium as it pertained to their child. The Supreme Court disagreed. What Respondent is relying on in the case is a text pertaining to a description of what was allowed at common law.

> At common law, a father possessed the right to maintain an action for the injuries of his minor child. This right was based upon the concept that a father was entitled to compensation for the loss of services and earning capacity of his minor child. Additionally, the father could recover for other pecuniary losses, including medical expenses incurred as a result of the injury.

Id. at 68 (internal citations omitted). The Court went on to explain that in *Taylor*, the Court, in declining to recognize a cause of action for loss of parental consortium, "held that the determination of which relationships may give rise to a loss of consortium claim in South Carolina is one best left to the discretion of the legislature."*Id.* at 69 (quoting *Taylor v. Medenica,* 324 S.C. 200, 222, 479 S.E.2d 35, 47 (1996)). The Court further explained that in *Kirkland*, the South Carolina District Court adopted the *Taylor* analysis and found "that South Carolina law did not provide a cause of action for loss of consortium of a child or for filial consortium." *Id.* (quoting *Kirkland v. Sam's East, Inc.*, 411 F.Supp.2d 639, 641 (D.S.C.2005)). The Court in *Doe*

extended *Taylor* and held "that South Carolina law does not recognize claims for loss of filial consortium" as "[s]uch rights did not exist under the common law, and the legislature has not provided such a right by statute." *Id.*

> ...our common law only allowed a parent to maintain an action for the loss of a child's services and earning capacity. These common law claims did not include the intangible losses of aid, companionship, and society which have traditionally defined loss of consortium claims. Accordingly, in absence of some action from the legislature, this Court has no authority upon which it could rely in finding that South Carolina law recognizes claims for loss of filial consortium.

Id. 69-70.

In 2017 the Court was presented with the issue of whether a minor may bring an action for her own medical expenses. *Patton v. Miller,* 420 S.C. 471, 804 S.E.2d 252 (2017). The Court stated that this invoked the"real party in interest" requirement of Rule 17(a) of the South Carolina Rules of Civil Procedure (at 479-80) and found that a parent is the proper party in interest with respect to past and future medical expenses while the child is a minor. *Id.* at 479-80.

Based on previous argument regarding Respondent's failure to establish evidence of gross negligence, Appellant maintains its position that a directed verdict, JNOV, or in the alternative, a new trial, should have been granted, as the verdict rendered was shockingly disproportionate. wholly unsupported by and contradictory to the evidence presented. However, in the event the court disagrees, Appellant believes its motion for a new trial *nisi remittitur* should have been granted, as the verdict was, at the very least, merely excessive in light of the evidence presented, and the damages are subject to the above limitations.

Loss of services is not at issue in this case. Therefore, Respondent Tekeyah Hamilton is limited to past and future medical damages only. Respondent presented past and future medical

costs in the amount $20,854.00. Trial Tr. 412:24 - 413:12, Mar. 17, 2019. This included $4,699 TRMC bills; $635 for Dr. Devito; future surgery $2500; $12,000 future hospital charge; and $1,020 for steroidal injection. *Id.* As loss of service is not at issue in this matter, these past and future medical bills, which total $20,854.00, is all Respondent Tekayah Hamilton is entitled to recover. Therefore, the jury verdict for Respondent Tekayah Hamilton in the amount of $135,477.00 must be reduced to $20,854.00.

IV. OTHER ARGUMENTS: PHOTOGRAPHS, REQUEST TO ADMIT, TESTIMONY OF CYNTHIA HURLEY. EXCESSIVE DAMAGES REGARDING MINOR

For sake of brevity, as a response to Respondent's arguments as to photographs of minor's hand, Request to Admit, testimony of Cynthia Hurley regarding gross negligence, and excessive verdict rendered to minor, please see Appellant's Initial Brief.

CONCLUSION

For the reasons stated, Appellant respectfully requests the Appellate Court to reverse the decision of the Trial Court and dismiss this action with prejudice or, in the alternative, reverse the decision of the Trial Court and grant Appellant a new trial.

Respectfully submitted,

April 2, 2021

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

RECEIVED
May 20 2021
SC Court of Appeals

APPEAL FROM ORANGEBURG COUNTY
Court of Common Pleas

Edgar W. Dickson, Circuit Court Judge

Appellate Case No. 2019-001921

Tr[illegible] Hamilton, individually and as parent and guardian ad litem for Robert Lee M[illegible], a minor [illegible] under the age of 18, Respondent,

Reg[illegible] Medical Center, Appellant.

FINAL BRIEF OF RESPONDENT

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STATEMENT OF ISSUES ON APPEAL

I. Whether the lower court properly exercised its discretion to qualify Nurse Stobbs as a nursing expert and allowed her to testify about the standard of care that applies to adults and children?

II. Whether the lower court correctly denied RMC's motions for a directed verdict and JNOV where there is evidence of gross negligence in the record?

III. Whether the lower court properly exercised its discretion to admit photographs of R.J.'s hand where the photographs corroborate Tekayah and Dr. DeVito's testimony and demonstrate the nature and severity of the injury?

IV. Whether the lower court properly exercised its discretion to exclude Ms. Hurley's opinion on gross negligence because expert testimony on issues of law is inadmissible?

V. Whether the lower court properly exercised its discretion to publish RMC's requests for admission to the jury for its consideration along with all other evidence?

VI. Whether the lower court properly exercised its discretion to deny RMC's motions for a new trial or, alternatively, a new trial *nisi remittitur*, where the verdicts are not excessive?

STATEMENT OF THE CASE

This is an appeal from a jury verdict for the Plaintiffs in a medical negligence trial arising out of an IV infiltration burn injury of a five-week-old boy. The lower court granted in part and denied in part the Defendant's post-trial motions.

On October 7, 2015, Respondent Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen, (collectively "Hamilton") filed this action against Appellant the Regional Medical Center ("RMC") for medical negligence. (R. pp. 17-23). RMC filed an answer generally denying the allegations. (R. pp. 29-33).

The parties tried the case from May 7-9, 2018, before the Honorable Edgar W. Dickson. (R. p. 60). The jury returned a verdict finding RMC gross negligently and awarding Tekayah $135,477.00 and her child $1,127,280.00. (R. p. 535).

On May 17, 2018, RMC filed two post-trial motions. It filed a post-trial motion for judgment notwithstanding the verdict or, alternatively, for a new trial or a new trial *nisi remittitur*. (R. pp. 536-49). RMC also filed a motion to reduce the child's damages to the $300,000.00 statutory cap pursuant to S.C. Code § 15-78-120(a) (2005) and to reduce Tekayah's damages to the amount of the medical expenses. (R. pp. 552-54). Hamilton filed a memorandum in opposition to the motions. (R. pp. 556-71).

On October 25, 2019, the lower court granted the motion to reduce the child's damages to $300,000.00 and denied all other motions. (R. pp. 2-10). On November 19, 2019, RMC filed a notice of appeal. (R. p. 585).

FACTS

On October 25, 2014, Robert Lee M., Jr., ("R.J.") was admitted to RMC for a high fever. (R. p. 97). Five days later, R.J. left the hospital with a third-degree burn injury to his right hand because the IV antibiotics RMC administered infiltrated and burned his hand rather than entering his vein. (R. pp. 117, 233). R.J. was five weeks old. (R. p. 97).

Jamie Downing is an RMC nurse who treated R.J. during his hospital admission. She had worked as a nurse for less than three months and been allowed to work on her own for about two weeks when she treated R.J. (R. pp. 271-72).

RMC did not initially know the cause of R.J.'s fever but started him on an IV antibiotic therapy in case he had an infection. (R. p. 97). RMC's policies state that, before putting medication into an IV, the nurse is required to flush the IV with normal saline. (R. pp. 98-99, 301, 495). The saline flush is a way for the nurse to make sure the IV is properly in the vein so that the medicine will go into the vein and not the skin. (R. pp. 110, 159). Infiltration occurs when medication inserted into an IV goes somewhere besides the vein and can cause injury. (R. pp. 110, 144).

In the early morning of October 28, 2014, Downing administered the antibiotic ampicillin into R.J.'s IV. (R. p. 101). About twenty minutes later, R.J.'s hand was swollen with a dark spot and he was "really crying" so much that Tekayah buzzed the nurses' station. (R. pp. 163-64, 299). Tekayah described R.J.'s hand as turning black with a lump full of fluid on it that burst the next day. (R. pp. 165-66, 168). The antibiotic Downing gave R.J. through the IV caused a third-degree burn to his right hand because it infiltrated outside of his vein. (R. pp. 112, 117, 289 lns. 2-5).

The parties disputed whether Downing flushed the IV with saline before she administered the ampicillin. R.J.'s medical records do not document a saline flush before the antibiotic. (R. p. 101). RMC's policies state: "Flushing the INT with saline is to be documented on the eMAR [electronic medical record]." (R. p. 495 no. 12). Downing testified RMC's policies "are direct instructions" and there is "not room for interpretation" of them. (R. p. 273). Hamilton's expert witness testified: "If it's not documented, it wasn't done." (R. pp. 104 ln. 25, 111, 159). Downing does not remember administering a saline flush prior to ampicillin that morning but testified it is her practice to flush prior to giving medication. (R. p. 288).

R.J. left RMC on October 30, 2015, with a burn injury that required fifteen visits to a wound care center. (R. p. 168). Dr. Peter DeVito, an expert in plastic surgery, examined R.J. in February 2015, when he was four months old. (R. p. 231, 233). He testified R.J.'s burn injury was "too contaminated for a skin graft" and took "a lot of wound care to heal." (R. p. 233, 235). The burn resulted in keloid scar tissue. (R. p. 233). A keloid is a "tumor of scar tissue" that "invades" the skin surrounding it and causes painful burning and itching symptoms. (R. p. 233).

On October 7, 2015, Hamilton filed this action against RMC for medical negligence. (R. pp. 17-23).

RMC filed two pre-trial motions relevant to this appeal. First, it moved to exclude Monica Stobbs, Hamilton's nursing expert, from testifying at trial. (R. pp. 522-25). RMC argued Nurse Stobbs was not qualified to testify about IV therapy for pediatric patients because she had not administered IV therapy to a pediatric patient and did not review literature specifically about IV therapy for a pediatric patient. (R. pp. 522-25, 44-45). Hamilton argued that Nurse Stobbs testified the administration and monitoring of an IV is the same for a pediatric and adult patient, and RMC's argument goes to Nurse Stobbs' credibility rather than her qualifications. (R. p. 43). The lower court ruled it would qualify Nurse Stobbs as a nursing care expert and RMC could "make all the hay you want to" about her pediatric experience. (R. pp. 45-46).

Second, RMC argued three photographs of R.J.'s hand should be excluded because they are inflammatory. (R. pp. 48-49). The lower court reviewed the photos and denied the motion. (R. pp. 50-51).

On May 7-9, 2018, the parties tried the case before the Honorable Edgar W. Dickson. (R. p. 60). The parties' experts disagreed as to whether Downing performed a saline flush before administering the antibiotic to R.J. and whether the IV management standard of care is the same for adult and pediatric patients.

Nurse Stobbs testified the standard of care for IV management is the same for pediatric and adult patients. (R. pp. 94-95, 114, 119-20, 126, 141-42). The nurse must flush the IV with saline before administering medication to ensure that the IV is going into the vein. (R. pp. 110, 112, 115-16). This is required by RMC's policies and procedures. (R. p. 495). Nurse Stobbs testified that RMC breached the standard of care because Downing did not do a saline flush before administering the medication to R.J. on October 28. (R. pp. 116-17, 159).

After deliberating for three hours, the jury returned a verdict finding RMC's gross negligence caused R.J.'s injuries. (R. pp. 444, 447, 455-56, 535). The jury awarded Tekayah $135,477.00 and R.J. $1,127,280.00. (R. p. 535).

RMC filed two post-trial motions. First, it moved for JNOV or, in the alternative, a new trial. Relevant to this appeal, RMC argued: (1) Nurse Stobbs was not qualified to testify about pediatric IV management, (2) Hamilton did not establish RMC's gross negligence, (3) the lower court should have excluded photographs of R.J.'s hand, (4) the lower court should have allowed RMC's expert, Cynthia Hurley, to testify that RMC was not grossly negligent, (5) the lower court should not have allowed Hamilton to publish to the jury her responses to RMC's requests to admit, and (6) the lower court should grant a new trial absolute or *nisi remittitur* because the verdict is disproportionate to the evidence. (R. pp. 536-49).

Second, RMC moved to reduce R.J.'s damages to the $300,000.00 statutory cap in the South Carolina Tort Claims Act and to reduce Tekayah's damages to $20,854.00, the amount of the medical expenses. (R. pp. 552-54).

Hamilton filed a memorandum in opposition to the motions. (R. pp. 556-71). On October 25, 2019, the lower court issued an Order granting RMC's motion to reduce R.J.'s damages to the statutory cap of $300,000.00 but denying the motion to reduce Tekayah's damages. (R. pp. 5-7). The court denied the motion for JNOV and in the alternative a new trial absolute or *nisi remittitur* in its entirety. (R. pp. 7-10).

STANDARD OF REVIEW

Because there are multiple standards of review applicable to this appeal, the standard of review is addressed in the argument section for each issue.

ARGUMENT

The evidence in this case came down to a factual dispute about Downing's conduct and a battle of the experts. This is commonplace. The jury believed and accepted Hamilton's presentation of the facts. Over the course of the trial, based on the evidence admitted, the principal breach of the standard of care presented to the jury was that RMC, through Downing, failed to perform a saline flush before administering the IV medication. (R. p. 395). The issue Respondents presented to the jury was "did the nurse at The Regional Medical Center fail to flush?" (R. p. 395 lns. 12-13). This makes all of RMC's discussion about blood returns and other IV management irrelevant.

The majority of the issues on appeal are subject to an abuse of discretion standard, and the evidence in the record and the applicable law demonstrate that the lower court properly exercised its discretion. As to the remaining issue of RMC's motion for a JNOV, there is ample evidence that RMC breached the standard of care. RMC's disagreement with Hamilton's expert is nothing more than a jury issue. This Court should affirm.

I. THE LOWER COURT CORRECTLY QUALIFIED NURSE STOBBS AS AN EXPERT AND ALLOWED HER TO TESTIFY ABOUT THE STANDARD OF CARE.

The lower court properly exercised its discretion to qualify Nurse Stobbs as a nursing expert. (R. p. 93). "The qualification of an expert witness and the admissibility of the expert's testimony are each matters largely within the trial judge's discretion." *McMillan v. Durant*, 312 S.C. 200, 204, 439 S.E.2d 829, 831 (1993). "[W]e will not reverse absent an abuse of that discretion." *Graves v. CAS Med. Sys.*, 401 S.C. 63, 74, 735 S.E.2d 650, 655 (2012). "An abuse of discretion occurs when the circuit court's rulings either lack evidentiary support or are controlled by an error of law." *Id.* at 74, 735 S.E.2d at 831 (internal quotation marks omitted).

RMC does not dispute Nurse Stobbs' qualifications as a nurse or ability to testify about IV management. Instead, it argues mainly that this case is about pediatric nursing such that pediatric nursing and not "general nursing" is the issue. (Br. of App. pp. 11-12). RMC then argues that Nurse Stobbs is not qualified to testify about pediatric nursing IV management and, in doing so at trial, she testified outside of the scope of her nursing qualifications. (Br. of App. p. 10). The lower court correctly rejected these arguments, and this Court should affirm.

A. The applicable standard of care is the same regardless of whether the patient is an adult or a child.

RMC's first argument is irrelevant because it does not affect the applicable standard of care. It is undisputed that in pediatric **and** adult IV management, the standard of care is to flush the IV with saline before administering a medication. (R. pp. 276, 278, 345-46, 374).

The difference between an adult and pediatric patient that RMC complains about is that a pediatric vein is smaller than an adult vein. (Br. of App. p. 11). That physiological difference does not change the standard of care to flush an IV site before administering medication or to follow RMC's policy to document a saline flush. Therefore, in response to all of RMC's arguments about Nurse Stobbs, its complaint does not make a difference for the evidence in this case. *McCall v. Finley*, 294 S.C. 1, 4, 362 S.E.2d 26, 28 (Ct. App. 1987) ("[W]hatever doesn't make any difference, doesn't matter."). The Court may affirm the qualification of Nurse Stobbs on this basis alone.

RMC is incorrect that this case is about pediatric nursing. (Br. of App. pp. 10-12). This case is about the IV management safety practice of doing and documenting a saline flush before administering medication. (R. pp. 395, 420). Nurse Stobbs testified "the same safety practices" and "rules" are used for every patient "whether it's a baby or an adult."[1] (R. pp. 94-95). Downing

[1] Nurse Stobbs maintained that the age of a patient does not alter IV management "in terms of the safety practices." (R. p. 126). She testified that a vein is the same in an adult and a child. (R. pp. 119-20). Physiological differences in adults and children mean "their body size may be different"

and Hurley testified that a saline flush is always required before administering medication. (R. pp. 276, 278, 345-46, 374). Even if there existed a relevant difference in the IV management of pediatric and adult patients, it was for the jury to decide if and how that affected the applicable standard of care. *Madison v. Babcock Ctr., Inc.*, 371 S.C. 123, 140, 638 S.E.2d 650, 659 (2006) ("The factfinder may consider relevant standards of care from various sources in determining whether a defendant breached a duty owed to an injured person in a negligence case."). The lower court did not err in qualifying Nurse Stobbs as a nursing expert when nursing IV management principles apply to the facts of the case.

B. The lower court correctly held Nurse Stobbs' testimony satisfies Rule 702, SCRE.

RMC argues the lower court erred in qualifying Nurse Stobbs to testify about IV management in a case involving a pediatric patient because she did not treat pediatric patients and her testimony is, according to RMC, contrary to literature. (Br. of App. pp. 12-14). The lower court correctly exercised its discretion in ruling that RMC's arguments go to the weight and not the admissibility of her testimony. (R. pp. 45-46).

A person may be qualified as an expert based on "knowledge, skill, experience, training, or education." Rule 702, SCRE. "The test for qualification is a relative one that is dependent on the particular witness's reference to the subject." *Lee v. Suess*, 318 S.C. 283, 285, 457 S.E.2d 344, 346 (1995). In deciding whether to admit expert testimony, the court makes three inquiries: whether (1) "the subject matter is beyond the ordinary knowledge of the jury, thus requiring an expert to explain the matter to the jury," (2) the expert has "acquired the requisite knowledge and skill to qualify as an expert in the particular subject matter, although he ***need not be a specialist in***

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but "does not mean that their vein would be different." (R. p. 141). "[T]he management for IV therapy in terms of safety practices and what the rules are, it's exactly the same." (R. p. 142 lns. 11-13).

the particular branch of the field," and (3) the substance of the testimony is reliable. *Graves v. CAS Med. Sys.*, 401 S.C. 63, 74, 735 S.E.2d 650, 655 (2012) (internal quotation marks omitted) (emphasis added). RMC disputes only the second inquiry.

An expert witness is not required to be a specialist in the particular branch of his or her profession involved in a case. On the contrary, "[a] physician is not incompetent to testify merely because he is not a specialist in the particular branch of his profession involved. The fact that he is not a specialist goes to the weight of his testimony, not its admissibility." *Creed v. Columbia*, 310 S.C. 342, 345, 426 S.E.2d 785, 786 (1993) (internal citation omitted). Our courts regularly apply this principle in the medical negligence context.

For example, in *Creed*, a "general practitioner" was qualified "to give an opinion on [the plaintiff's] mental and emotional injuries." *Id.* 344-45, 426 S.E.2d at 786.

A neurosurgeon was qualified to testify about the appropriate standard of nursing care. *McMillan v. Durant*, 312 S.C. 200, 204-05, 439 S.E.2d 829, 831-32 (1993); *see also Lee v. Suess*, 318 S.C. 283, 285, 457 S.E.2d 344, 345 (1995) (describing *McMillan* as holding "a medical practitioner's experience teaching in a particular specialty and his professional interaction with practitioners of that specialty are facts sufficient to support his qualification as an expert").

A plastic surgeon was qualified to testify as an expert in the field of family practice because the surgeon taught family practitioner residents. *Lee*, 318 S.C. at 285, 457 S.E.2d at 345-46. The expert's "limited exposure to the field of family practice merely goes to the weight of his testimony and not its admissibility." *Id.* at 286, 457 S.E.2d at 346.

A neonatologist was qualified to testify about sudden infant death syndrome, even though she testified "that she would not consider herself a SIDS expert," because "an expert need not be

a specialist in the particular branch of the field." *Graves v. CAS Med. Sys.*, 401 S.C. 63, 78, 735 S.E.2d 650, 657 (2012) (internal quotation marks omitted).

All of these cases support the lower court's decision to qualify Nurse Stobbs as an expert regardless of her lack of hands-on experience with pediatric IV patients because that criticism goes to the weight of her testimony and not its admissibility. Nurse Stobbs worked for over thirty years as a nurse. (R. p. 92). For twenty-one of those years, she worked at Massachusetts General Hospital, "which is Harvard's Hospital" and "the number one hospital in the country." (R. p. 92 lns. 3-6). She was certified in IV therapy, administered "thousands" of IVs in her career, and primarily provided IV therapy to her patients. (R. p. 92). She was amply qualified to testify about IV management in this case.

RMC relies on *Botehlo v. Bycura*, 282 S.C. 578, 320 S.E.2d 59 (Ct. App. 1984), for its assertion that Nurse Stobbs must have treated pediatric patients to be qualified to testify about IV management. (Br. of App. p. 12). In *Botehlo*, this Court ruled that an orthopedic surgeon was not an expert in podiatric standards of care, in part, because he "testified that he is not familiar with the standards of professional care generally observed by podiatrists" and "was not familiar with the surgical procedure [the defendant] performed on [the plaintiff]." *Id.* at 587, 320 S.E.2d at 65. In *McMillan v. Durant*, 312 S.C. 200, 439 S.E.2d 829 (1993), the Supreme Court described the orthopedist expert in *Botehlo* as "not versed at all in the practice of podiatry." *Id.* at 204, 439 S.E.2d at 832. This case is easily distinguishable.

Nurse Stobbs testified the standard of care for IV management is the same for a baby or an adult. (R. p. 95 lns. 1-6). Her thirty years of experience in administering thousands of IVs is evidence that supports the lower court's decision to find her familiar with the standards of professional care, unlike the expert in *Botehlo*.

RMC also relies on *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 487 S.E.2d 596 (1997). (Br. of App. pp. 12-14). However, *Gooding* supports Hamilton's position. In a medical malpractice action against an anesthesiologist regarding an intubation procedure, the Supreme Court held an EMT/paramedic who intubated over 100 patients and taught intubation procedures was qualified in the field of intubation. *Id.* at 251, 253, 487 S.E.2d at 597-98. It explained "[t]here was no requirement that [plaintiff]'s expert witness be an anesthesiologist in order to testify about intubation procedures." *Id.* at 253, 487 S.E.2d at 598. In this case, Nurse Stobbs is qualified in the field of IV management and she is not required to specifically practice in pediatric IV management to testify about IV management procedures.

RMC's disagreement with Nurse Stobbs' opinions (Br. of App. p. 13) are (and were in this case) subjects for cross-examination. The lower court properly exercised its discretion to qualify Nurse Stobbs as a nursing expert, and this Court should affirm.

C. RMC did not preserve an argument about the scope of Nurse Stobbs' testimony and, regardless, she testified according to her qualifications as a nursing expert.

RMC's argument that Nurse Stobbs' testimony exceeded the scope of her qualifications is unpreserved, abandoned, and legally incorrect.

"Our law is clear that a party must make a contemporaneous objection that is ruled upon by the trial judge to preserve an issue for appellate review." *State v. Sheppard*, 391 S.C. 415, 420-21, 706 S.E.2d 16, 19 (2011). RMC never objected during trial that any of Nurse Stobbs' testimony exceeded the scope of her qualifications. It cites to only two pages of the pre-trial motion *in limine* hearing and does not specify what trial testimony is allegedly outside of the scope of her expertise. (Br. of App. p. 15). "Making a motion *in limine* to exclude evidence at the beginning of trial does not preserve an issue for review because a motion *in limine* is not a final determination. The moving party, therefore, must make a contemporaneous objection when the evidence is

introduced." *State v. Moses*, 390 S.C. 502, 511, 702 S.E.2d 395, 400 (Ct. App. 2010) (internal quotation marks omitted). The issue is unpreserved.

The issue is also abandoned because RMC does not cite legal authority and makes only a conclusory, one-paragraph argument. (Br. of App. pp. 14-15). *See Bryson v. Bryson*, 378 S.C. 502, 510, 662 S.E.2d 611, 615 (Ct. App. 2008) ("An issue is deemed abandoned and will not be considered on appeal if the argument is raised in a brief but not supported by authority."); *Glasscock, Inc. v. United States Fid. & Guar. Co.*, 348 S.C. 76, 81, 557 S.E.2d 689, 691 (Ct. App. 2001) ("South Carolina law clearly states that short, conclusory statements made without supporting authority are deemed abandoned on appeal and therefore not presented for review.").

Finally, RMC's argument on the merits is incorrect. The lower court qualified Nurse Stobbs "as an expert in nursing." (R. p. 93). Nurse Stobbs repeatedly testified that her opinions on IV management applied to adults and children, making RMC's attempt to separate the two irrelevant. Her testimony was consistent with her qualifications and area of expertise.

D. Even if error, the admission of Nurse Stobbs' testimony was harmless.

Even if the Court finds the lower court erred in qualifying Nurse Stobbs or that her testimony exceeded the scope of her qualification, it should still affirm because any such error was harmless. "The key factor for determining whether a trial error constitutes reversible error is whether it appears beyond a reasonable doubt that the error complained of did not contribute to the verdict obtained." *State v. Tapp*, 398 S.C. 376, 389, 728 S.E.2d 468, 475 (2012) (internal quotation marks omitted). The court does "not weigh the evidence when determining this." *In re Bilton*, 432 S.C. 157, 167, 851 S.E.2d 442, 447 (Ct. App. 2020). "No definite rule of law governs this finding; rather, the materiality and prejudicial character of the error must be determined from

its relationship to the entire case." *In re Care & Treatment of Gonzalez*, 409 S.C. 621, 636, 763 S.E.2d 210, 217 (2014) (internal quotation marks omitted).

Any alleged error did not contribute to the verdict because Nurse Stobbs' testimony on the standard of care was cumulative to other evidence. "The admission of improper evidence is harmless where the evidence is merely cumulative to other evidence." *Judy v. Judy*, 384 S.C. 634, 646, 682 S.E.2d 836, 842 (Ct. App. 2009).

Hamilton's theory of liability was RMC's failure to perform and document a saline flush before administering the medication to R.J. (R. pp. 395, 398-99, 405, 420). RMC's policies and procedures admitted into evidence establish the standard of care to flush with saline and document it on the medical record. (R. pp. 491-98). RMC's expert, Cynthia Hurley, testified that the standard of care is to perform a saline flush prior to administering medication. (R. pp. 345-46, 374). Nurse Stobbs testified R.J.'s medical records do not document a saline flush prior to Downing administering the medication, and RMC does not argue that she is unqualified to read medical records. Nurse Stobbs' standard of care testimony was cumulative to other evidence.

RMC attacked Nurse Stobbs' experience and credibility throughout the trial. (R. pp. 87-88, 118-27, 139-42). It criticized Nurse Stobbs for saying something allegedly contrary to articles on IV management. However, Ms. Downing testified that she had never reviewed those articles prior to RMC's attorney giving them to her and that reviewing such articles it not common practice for a nurse. (R. p. 291). RMC disputed Nurse Stobbs' qualifications in its closing argument:

> She's never practiced clinical pediatric nursing. She's never started an IV on a child. And more importantly, the issue in this case, she's never maintained, managed and monitored an IV. **She is not qualified**.
>
> . . .
>
> [Y]ou have one nurse who's never been an expert before, Ms. Stobbs, who's never practiced in this area. She can't tell you what pediatric nursing is. She can't tell

> you what the literature is. . . . She'd been a nurse for over thirty-three years and guess how many pediatric IVs she started? The same amount as me, none.
>
> . . .
>
> [S]he has never done this the first shift in her life.
>
> . . . [Downing started more pediatric IVs] a lot more than Nurse Stobbs who, again, has started zero.
>
> . . .
>
> My witness [Hurley] is more qualified to be an expert [than Stobbs]. My expert is certainly more qualified to be an expert. They could have got a true expert. Ask yourself, why don't they have a pediatric expert? Why don't they have an expert that was qualified for monitoring and managing pediatric IVs? It is because they couldn't get one? Again, use your common sense.

(R. pp. 409-11, 417) (emphasis added). The lower court charged the jury it could disregard an expert's opinion if it decided "an expert witness's opinion is not based on sufficient education or experience or if you decide that the reasons given in support of the opinion are not sound." (R. p. 430).

Given the cumulative nature of Nurse Stobbs' challenged testimony and RMC's blatant attack on her qualifications, any error in qualifying her and admitting her testimony was harmless and RMC suffered no prejudice.

II. THE LOWER COURT CORRECTLY DENIED RMC'S MOTIONS FOR DIRECTED VERDICT OR JNOV BECAUSE THERE IS EVIDENCE OF GROSS NEGLIGENCE.

The lower court correctly denied RMC's motions for directed verdict and JNOV because there is evidence that, viewed in a light most favorable to Hamilton, supports a reasonable inference of gross negligence.[2]

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[2] A "governmental entity is not liable for a loss resulting from: . . . responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any . . . patient, . . . of any governmental entity, except when the responsibility or duty is exercised in a grossly negligent manner." S.C. Code Ann. § 15-78-60(25) (2005). Hamilton argued at trial that a medical

"When reviewing the trial court's ruling on a motion for a directed verdict or a JNOV, this Court must apply the same standard as the trial court by viewing the evidence and all reasonable inferences in the light most favorable to the nonmoving party." *RFT Mgmt. Co., L.L.C. v. Tinsley & Adams L.L.P.*, 399 S.C. 322, 331-32, 732 S.E.2d 166, 171 (2012). "In considering a JNOV, the trial judge is concerned with the existence of evidence, not its weight. When considering a JNOV, neither an appellate court, nor the trial court has authority to decide credibility issues or to resolve conflicts in the testimony or the evidence." *Curcio v. Caterpillar, Inc.*, 355 S.C. 316, 320, 585 S.E.2d 272, 274 (2003) (internal quotation and alteration marks omitted). "The trial court must deny a motion for a directed verdict or JNOV if the evidence yields more than one reasonable inference or its inference is in doubt." *RFT Mgmt. Co.*, 399 S.C. at 332, 732 S.E.2d at 171 (internal quotation marks and citation omitted).

RMC's assertion that Hamilton "failed to provide *any* evidence or testimony of gross negligence" is wholly without merit and seems based on an incorrect assumption that a witness must have used the words "gross negligence" for evidence of it to exist. (Br. of App. pp. 18-19).

Our Courts define "gross negligence in a number of ways." *Hollins v. Richland Cnty. Sch. Dist. One*, 310 S.C. 486, 490, 427 S.E.2d 654, 656 (1993). "[I]t is the failure to exercise slight care." *Bass v. S.C. Dep't of Soc. Servs.*, 414 S.C. 558, 571, 780 S.E.2d 252, 259 (2015) (internal quotation marks omitted). "Gross negligence is the intentional, conscious failure to do something which is incumbent upon one to do or the doing of a thing intentionally that one ought not to do."

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malpractice, not a gross negligence, standard applies to this case because it concerns a nurse's administration of medication and not "supervision, protection, control, confinement, or custody" of a patient. (R. pp. 66-67, 323, 444-45). Given the jury's verdict and RMC's arguments, Hamilton argues based on the gross negligence standard. (R. p. 564 n.3). However, this case should not be construed as establishing that the gross negligence standard in S.C. Code Ann. § 15-78-60(25) applies to a nurse's administration of medication.

Faile v. S.C. Dep't of Juvenile Justice, 350 S.C. 315, 331, 566 S.E.2d 536, 544 (2002) (internal quotation marks omitted). Gross negligence is "also defined [] as a relative term that means the absence of care that is necessary under the circumstances." *Id.* at 332, 566 S.E.2d at 544 (internal quotation marks omitted). While "[g]ross negligence is ordinarily a mixed question of law and fact," "[i]n most cases, [it] is a factually controlled concept whose determination best rests with the jury." *Id.* at 332, 566 S.E.2d at 545 (internal quotation marks omitted).

Under any definition of gross negligence, there is evidence of it in the record. There is evidence that RMC consciously failed to do or document a saline flush and that it was incumbent upon RMC to do those things. RMC's policies **require** a saline flush prior to administering medication and documentation of that flush. (R. pp. 491-98, 103-04, 159). Nurse Stobbs testified that Downing failed to do or document a flush before administering the medication to R.J. (R. pp. 117, 159). If RMC (and nursing standards of care) required a saline flush prior to administering medication, then the inference in a light most favorable to Hamilton is that the failure to do it shows an absence of care that is necessary under the circumstances. *See Jinks v. Richland Cnty.*, 355 S.C. 341, 348, 585 S.E.2d 281, 285 (2003) (citing to evidence that the defendant failed to follow its policies as evidence of gross negligence).

Downing testified that a saline flush prior to administering medicine is "ingrained in you in nursing school" and "it makes no sense not to" flush. (R. pp. 288-89, 301). Downing testified there is "no way to really tell if the site is open and flowing without flushing it." (R. pp. 310-11). If it makes no sense not to do a flush, then the failure to do it is the failure to exercise slight care.

Evidence that, once the IV infiltrated and began to harm R.J., RMC failed to respond to Tekayah's call for help for at least twenty minutes is also evidence that it failed to exercise slight care and consciously failed to care for a patient. (R. pp. 163-64, 293).

RMC's evidentiary arguments merely show differing inferences to be drawn from the evidence. However, competing evidence is not a permissible basis to reverse the denial of a motion for JNOV. The Court must "examin[e] the record to discern whether there was any evidence put forward at trial to support the jury verdict." *Bass v. S.C. Dep't of Soc. Servs.*, 414 S.C. 558, 574, 780 S.E.2d 252, 260 (2015). Evidence that a defendant "acted with slight care" along with "evidence in the record that [the defendant] acted with gross negligence" is sufficient to support a jury's verdict of gross negligence. *Id.* at 574, 780 S.E.2d at 260.

Finally, to the extent RMC is arguing that a witness must have testified using the words "gross negligence" (Br. of App. p. 19), there is no legal support for the proposition that an expert must use magic words. *See, e.g.*, *Stallings v. Ratliff*, 292 S.C. 349, 353, 356 S.E.2d 414, 417 (Ct. App. 1987) ("The issue of breach of duty does not turn on a ritual incantation of certain magic words by an expert witness."). The substance of the testimony and the jury's consideration of it are what matter. Further, as discussed below in Argument section IV, expert testimony on a legal conclusion is improper.

Hamilton presented evidence that Downing did not remember doing a saline flush before she administered the medicine that burned R.J., there is no documentation of a saline flush, and if something is not documented, then it was not done. (R. pp. 104, 111, 159, 288). Viewing that evidence in a light most favorable to Hamilton, a jury could have (and did) find that RMC's conduct amounted to gross negligence. The evidence "support[s] the jury's verdict," and this Court should affirm. *Bass*, 414 S.C. at 573, 780 S.E.2d at 259.

III. THE LOWER COURT PROPERLY EXERCISED ITS DISCRETION IN ADMITTING THE PHOTOGRAPHS OF R.J.'S HAND.

Hamilton submitted into evidence three photographs of R.J.'s hand. (R. pp. 463-65, 68-70). Two photographs show R.J.'s hand shortly after the burn injury occurred and the lump full

of fluid on his hand burst. (R. pp. 165-68, 463, 465). One photograph shows R.J.'s hand with a scar on the last day of his treatment at the wound center. (R. pp. 464, 170).

RMC argues that the alleged prejudicial effect of the photographs outweighed their probative value under Rule 403, SCRE ("Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice . . . .").

"A trial court has particularly wide discretion in ruling on Rule 403 objections." *State v. Gray*, 408 S.C. 601, 608, 759 S.E.2d 160, 164 (Ct. App. 2014) (internal quotation marks omitted). "The relevance, materiality and admissibility of photographs are matters within the sound discretion of the trial court and a ruling will be disturbed only upon a showing of an abuse of discretion." *State v. Rosemond*, 335 S.C. 593, 596, 518 S.E.2d 588, 589-90 (1999). The lower court properly exercised its discretion by balancing the probative value of the photos against any unfair prejudice and admitting them into evidence. (R. pp. 46-51, 8).

Probative Value

The photos had probative value in establishing and proving damages, especially the condition of R.J.'s hand at the time of the burn because he was too young to testify. The photos had probative value in showing the healing process and, importantly, in helping Dr. DeVito to explain and corroborate his testimony.

Photographs are admissible when they "clearly demonstrate the extent and nature of the injuries in a way that would not be as easily understood based on the testimony alone." *State v. Holder*, 382 S.C. 278, 290, 676 S.E.2d 690, 697 (2009) (affirming the admission of autopsy photos of a two-year-old child). Tekayah used the photographs to explain the nature of R.J.'s injury at the time of the burn. (R. pp. 166-70). Dr. DeVito used the photos to describe the layers of skin and tissue injured by the infiltration, explain some of the healing process, explain the type of scar

and his proposed treatment for it, and support his opinion as to the level of pain R.J. would have felt from this type of burn at the time of the injury and throughout the healing process. (R. pp. 234-36, 241). R.J. could not tell the jury what he felt, and the photographs aided in explaining that to the jury.

"A test to determine whether the trial judge abused his discretion is whether the photographic evidence serves to corroborate the testimony of witnesses offered at trial." *State v. Vang*, 353 S.C. 78, 88, 577 S.E.2d 225, 230 (Ct. App. 2003). "If the offered photograph serves to corroborate testimony, it is not an abuse of discretion to admit it." *State v. Nance*, 320 S.C. 501, 508, 466 S.E.2d 349, 353 (1996) (affirming the admission of photographs of the victim's stab wounds in his hospital bed). Hamilton used the photographs to corroborate Tekayah's testimony about the appearance and state of the injury at the time it occurred and to corroborate Dr. DeVito's testimony describing the injury, the healing process, and that R.J. suffered pain. (R. pp. 166-71, 234-36, 241). RMC challenged Hamilton's damages and tried to focus the jury on the fact that R.J.'s hand healed to a scar rather than the condition of his hand right after the burn occurred. (R. pp. 89-90). This makes the corroborating probative value of the photographs very high. *See State v. Gray*, 408 S.C. 601, 613, 759 S.E.2d 160, 166-67 (Ct. App. 2014) ("Photos that corroborate important testimony on issues significant to the case may have very high probative value . . . .").

Unfair Prejudice

RMC argues three reasons why the lower court should have excluded the photos: they were (1) not necessary to substantiate Hamilton's case because RMC did not dispute that R.J. suffered an injury, (2) "grotesque, up-close images" that make the wound look bigger than it was, and (3) not representative of the state of R.J.'s hand at the time of trial. (Br. of App. pp. 21-22). These arguments show only that the evidence is prejudicial, as "[a]ll evidence is meant to be," and do not

rise to the level unfair prejudice. *State v. Gray*, 408 S.C. 601, 616, 759 S.E.2d 160, 168 (Ct. App. 2014). "Unfair prejudice does not mean the damage to a defendant's case that results from the legitimate probative force of the evidence; rather it refers to evidence which tends to suggest decision on an improper basis." *Id.* at 616, 759 S.E.2d at 168.

As to RMC's first argument, its acknowledgment that R.J. suffered an injury does not eliminate the need for Hamilton to establish for the jury the nature and severity of the injury. RMC essentially wants the Court to hold that, when a defendant admits an injury occurred and the injury heals some by the time of trial, the condition of the injury when it occurred is unfairly prejudicial evidence. That is not the law, and RMC cites no case with that ruling.

As to RMC's second argument, that the injury is, as the lower court stated, "hard to look at," does not make photographs of it unfairly prejudicial. (R. p. 8). "Numerous jurisdictions have found that photos are not inadmissible merely because they are gruesome, especially where, as here, the photos simply mirror the unfortunate reality of the case."[3] *State v. Collins*, 409 S.C. 524, 535-36, 763 S.E.2d 22, 28 (2014). Because the photos in this case merely show the reality of the injury to the jury, they are not unfairly prejudicial.

RMC incorrectly argues that the photos make the injury look bigger than its actual size. Each photograph has a scale of reference. Two of them include adult fingers holding R.J.'s hand,

[3] Our courts regularly allow the admission of photographs that are arguably "grotesque." *See Gray*, 408 S.C. at 609, 617, 759 S.E.2d at 164, 169 (affirming the admission of eleven "graphic" before-and-after autopsy photos, including the victim's "exposed skull and brain"); *State v. Holder*, 382 S.C. 278, 291, 676 S.E.2d 690, 697 (2009) (affirming the admission of autopsy photos of a two-year-old victim of child abuse "[a]lthough the photographs were graphic"); *State v. Jarrell*, 350 S.C. 90, 106-07, 564 S.E.2d 362, 371 (Ct. App. 2002) (affirming the admission of autopsy photos of a ten-month-old sexual abuse victim because they corroborated and helped the jury understand testimony).

and one includes R.J.'s head. (R. pp. 463-65). There is no basis to assume the photos enlarged the injury.

As to RMC's third argument, that R.J.'s burn wound healed by the time of trial does not make an image of it at the time of the burn unfairly prejudicial. Hamilton asked the jury to award damages for the injury from the time it occurred. Evidence showing the injury, particularly in light of R.J.'s inability to testify, does not suggest a "decision on an improper basis" but, rather, a decision based on the reality of the injury. *State v. Gray*, 408 S.C. 601, 616, 759 S.E.2d 160, 168 (Ct. App. 2014).

The photos are not *unfairly* prejudicial.

Balance

"The trial judge must balance the prejudicial effect of graphic photographs against their probative value." *State v. Vang*, 353 S.C. 78, 87, 577 S.E.2d 225, 229 (Ct. App. 2003). The lower court ruled that, although the photographs "are hard to look at, there is little doubt the photographs are relevant to corroborate the injury." (R. p. 8). The evidence and law support the lower court's conclusion that any danger of unfair prejudice does not substantially outweigh the probative value of the photos. This Court should affirm.

IV. THE LOWER COURT PROPERLY EXERCISED ITS DISCRETION TO EXCLUDE MS. HURLEY'S TESTIMONY ON GROSS NEGLIGENCE.

The lower court properly exercised its discretion to prohibit RMC from asking its nursing expert, Cynthia Hurley, whether RMC committed "negligence" or "gross negligence." The admissibility of expert testimony is a matter "largely within the trial judge's discretion." *McMillan v. Durant*, 312 S.C. 200, 204, 439 S.E.2d 829, 831 (1993). The Court "will not reverse absent an abuse of that discretion." *Graves v. CAS Med. Sys.*, 401 S.C. 63, 74, 735 S.E.2d 650, 655 (2012).

RMC made a directed verdict motion arguing that, because Nurse Stobbs did not use the words "gross negligence" in her testimony, Hamilton failed to introduce evidence of gross negligence. (R. pp. 320, 321 lns. 23-25, 322). After the court denied the motion, Hamilton moved to exclude RMC from asking its expert, Ms. Hurley, whether RMC committed gross negligence. (R. pp. 325-29). The lower court granted the motion because Hurley is not qualified to testify about the legal concepts of negligence and gross negligence, and RMC could elicit testimony about those topics without using the exact legal terminology. (R. pp. 327-28). The lower court properly exercised its discretion.

While RMC characterizes the testimony as an opinion on "an ultimate issue" under Rule 704, SCRE, the lower court correctly analyzed the testimony as a legal conclusion (R. pp. 327-28, 8), and correctly ruled it inadmissible because, "[i]n general, expert testimony **on issues of law** is inadmissible." *Dawkins v. Fields*, 354 S.C. 58, 66, 580 S.E.2d 433, 437 (2003) (emphasis in original).[4] This Court recently reiterated that "expert testimony on issues of law is rarely admissible. The common law and the federal rules of evidence forbid opinions on issues of law, except foreign law." *Carter v. Bryant*, 429 S.C. 298, 313, 838 S.E.2d 523, 531 (Ct. App. 2020) (internal citations omitted).

In *Carter*, which RMC does not address in its brief, an appellant proffered expert testimony that a warrant lacked probable cause. 429 S.C. at 312, 838 S.E.2d at 531. This Court affirmed the lower court's decision to exclude the testimony because "the expert's proffered testimony on probable cause was a legal conclusion." *Id.* at 313, 838 S.E.2d at 531. Looking to the advisory committee note to Federal Rule of Evidence 704, the Court explained:

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[4] RMC's attempt to distinguish this case from *Dawkins* is unconvincing. (Br. of App. p. 26). RMC did ask Hurley to make a legal conclusion on gross negligence. As RMC acknowledged in its closing argument, "Judge Dickson's going to charge you on gross negligence." (R. p. 412).

> an opinion on the ultimate issue has to be "otherwise admissible," meaning in the context here that it must be helpful to the jury as required by Rule 702, SCRE, and satisfy the strictures of Rule 403, SCRE. The opinion here was not helpful to the jury because it stated a legal conclusion and essentially told the jury what result to reach on the probable cause question.

Id. at 313, 838 S.E.2d at 531. The same reasoning applies to this case.

Hurley's opinion was not helpful because it would have confused and misled the jury as to the meaning of gross negligence. During the proffer, Hurley testified RMC's conduct was not negligent or grossly negligent. (R. pp. 388-89). On cross-examination, she defined "gross negligence" as "[a]ctually causing a problem and knowing that you did it. Hurting someone intentionally." (R. p. 390). That is not the correct legal definition of gross negligence. The lower court charged the jury that "[g]ross negligence is the intentional, conscious failure to do something which is incumbent upon one to do, or the doing of a thing intentionally that one ought not do. . . . gross negligence is the failure to exercise slight care." (R. p. 433). Because Hurley's definition of gross negligence is contrary to the legal definition of gross negligence, it would have confused and misled the jury, Rule 403, SCRE, and "also risked treading on the trial judge's role as the sole source of the law in the trial," *Carter*, 429 S.C. at 314, 838 S.E.2d at 532.

Hurley's opinion also "essentially told the jury what result to reach on" the gross negligence question. *Id.* at 313, 838 S.E.2d at 531. RMC asked Hurley her opinion as to whether it "was grossly negligent in its care and treatment of" R.J. (R. p. 389). The verdict form asked the jury "Do you find the Defendant was grossly negligent?" (R. p. 535). The admission of Hurley's testimony would have impermissibly allowed an "expert to define [gross negligence] to the jury and apply [her] view of the facts to [her] definition of law," which "ran the risk of misleading the jury and telling them what their verdict should be." *Carter*, 429 S.C. at 314, 838 S.E.2d at 532. The proffered question was undoubtedly an "attempt[] to usurp" the jury's role in determining

whether RMC was grossly negligent. *Dawkins v. Fields*, 354 S.C. 58, 65, 580 S.E.2d 433, 437 (2003).

The decision of the United States District Court for the District of South Carolina in *Hermitage Industries v. Schwerman Trucking Co.*, 814 F. Supp. 484 (D.S.C. 1993), is instructive on this issue and, for brevity, Hamilton incorporates the reasoning of the decision into this brief. The Court excluded expert testimony on the legal conclusion of negligence because "the proffered testimony of defendant's expert witness that plaintiff was 'negligent' constitutes a legal conclusion and is therefore inadmissible." *Id.* at 487.

Alternatively, even if the Court finds error in the lower court's ruling, it is harmless and RMC suffered no prejudice from the exclusion because Hurley made it apparent to the jury that she believed Downing satisfied the standard of care and RMC did nothing wrong. Hurley testified four times to her opinion that Downing's treatment met the standard of care. (R. pp. 356 lns. 15-18 ; 359 lns. 9-13; 361 lns. 8-10; 365 lns. 21-25). She testified that Downing's treatment met RMC's policy expectations, "exceeded the standard of care," and was "an outstanding job." (R. pp. 356, 361-62, 366). The jury understood that Hurley did not think RMC was grossly negligent.

The lower court properly exercised its discretion to exclude Hurley's testimony on the legal conclusion of RMC's gross negligence, and this Court should affirm.

V. THE LOWER COURT PROPERLY EXERCISED ITS DISCRETION TO PUBLISH THE REQUESTS FOR ADMISSION TO THE JURY.

The court properly exercised its discretion to publish the requests to admit to the jury so it could consider them along with all of the other evidence. "A trial court has particularly wide discretion in ruling on Rule 403 objections." *State v. Gray*, 408 S.C. 601, 608, 759 S.E.2d 160, 164 (Ct. App. 2014) (internal quotation marks omitted).

Hamilton moved to admit the requests to admit as a stipulation (R. p. 259) and asked to explain to the jury "what a request to admit is" (R. p. 264), but the lower court denied those requests and only allowed Hamilton to read the exact language of the requests and answers to the jury (R. pp. 264-65). The jury was free to accept or reject the requests to admit just like any other evidence.

Under Rule 43(g), SCRCP, "[c]ounsel for any party may read his pleadings to the jury." Even when a pleading, including a request for admission, is later amended, both the original and the amended answer may be published to the jury for it to consider along with all of the other evidence.[5]

RMC made two objections to the evidence. It argued (1) the purpose of the requests was to obtain an independent medical examination, and (2) the prejudicial effect of the requests outweighed the probative value under Rule 403, SCRE, because the requests would confuse the jury by telling them "a verdict had to be awarded" and "effectively" directing a verdict of liability for Hamilton. (R. pp. 258-64) (Br. of App. pp. 28-30). The lower court properly acted within its discretion to rule these arguments did not require exclusion of the evidence.

As to the first argument, the reason RMC sent the requests to admit does not dictate their admissibility, especially when RMC did not limit the requests to a specific purpose. That RMC intended to use the requests to admit to get an independent medical examination under Rule 35(a), SCRCP, does not remove them from Rule 43(g), SCRCP.

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[5] "Once an answer to a Request for Admissions is amended under Rule 36, both the initial answer and the amended answer may be published to the jury. The jury may consider the initial answers as evidence, while the party who made such answers is free to explain why it was made and amended. . . . It was for the jury to weigh the evidence along with [other evidence]." *Tuomey Reg'l Medical Ctr. v. McIntosh*, 315 S.C. 189, 191, 432 S.E.2d 485, 487 (1993) (internal citation, quotation marks, and alterations omitted).

Regardless, even if the Court considers RMC's argument, the language of the requests shows they were not limited solely to Rule 35(a). Rule 35(a), SCRCP, provides for an independent medical examination when "the ***amount in controversy*** exceeds $100,000 actual damages." (emphasis added). RMC requested that Hamilton:

> Admit the value of the amount in controversy in this action is less than $100,000.00.
>
> Admit the ***value and amount in controversy*** in this action is greater than $100,000.00.
>
> Admit the ***value*** of Plaintiff's actual damages exceeds $100,000.00.

(R. p. 35) (emphasis added). The requests to admit went beyond the amount in controversy by asking Hamilton to admit the "value" of her actual damages. This supports the lower court's discretionary decision to publish the requests to admit to the jury.

As to RMC's Rule 403, SCRE, argument, the record supports the lower court's determination that the probative value of the evidence is not substantially outweighed by the danger of any unfair prejudice or confusion. The evidence had probative value in proving the amount of damages. In its post-trial motions and on appeal, RMC argues that the actual damages are only $20,854.00—the amount of the medical bills. (Br. of App. pp. 37-38). RMC cannot assert that the "value of Plaintiff's actual damages exceeds $100,000.00" so it can get an independent medical examination and then deny the possibility of that damages value in front of the jury.

RMC's argument that it suffered unfair prejudice because the jury would believe it had to find RMC liable and award damages is incorrect. Both parties argued about liability and damages in their closing arguments. (R. pp. 396-425). The court charged the jury on its duty "to evaluate the evidence and determine which evidence convinces you it is true." (R. p. 429 lns. 23-25). It charged the jury to determine if RMC acted with gross negligence and, if applicable, to choose an amount of damages. (R. pp. 432-39). It instructed the jury to "assess the amount that ***you*** find to

be justified by a preponderance of the evidence" and to "place a value on each element of the damage in accord with the evidence presented." (R. p. 436) (emphasis added). There is "a sound presumption of appellate practice, that jurors are reasonable and generally follow the instructions they are given." *Arnold v. State*, 309 S.C. 157, 166, 420 S.E.2d 834, 838 (1992). The verdict form asked the jury to decide whether "the Defendant was grossly negligent" and, if so, to "state the amount of damages, ***if any***," sustained by R.J. and Tekayah. (R. p. 535) (emphasis added). The jury knew that it must decide liability and damages.

The responses to the requests for admission were merely one piece of evidence. RMC was free to produce other, contradictory evidence, which it did. Just like any other evidence, the jury was free to accept or reject the requests for admission. The evidence and law support the lower court's decision, and this Court should affirm.

Finally, any error in publishing the admissions to the jury was harmless because, as explained below, there was ample other evidence that Hamilton's damages exceeded $100,000.00.

VI. THE LOWER COURT DID NOT ABUSE ITS DISCRETION IN DENYING THE MOTION FOR A NEW TRIAL OR *NISI REMITTITUR*.

The lower court did not abuse its discretion in denying RMC's new trial motions based on the alleged excessiveness of the verdicts and the thirteenth juror doctrine. "The jury's determination of damages is entitled to substantial deference. The denial of a new trial motion is within the discretion of the trial court and, absent an abuse of discretion, it will not be reversed on appeal." *Clark v. S.C. Dep't of Pub. Safety*, 353 S.C. 291, 309-10, 578 S.E.2d 16, 25 (Ct. App. 2002).

The lower court maintained R.J.'s $1,127,280.00 verdict but reduced it to the $300,000.00 cap in the Tort Claims Act, and maintained Tekayah's verdict of $135,477.00. (R. pp. 9-10). This Court "must accord the trial court's decision great deference, and respect its superior position to

gauge credibility and the field of evidence." *Nestler v. Fields*, 426 S.C. 34, 41, 824 S.E.2d 461, 465 (Ct. App. 2019) (internal quotation marks omitted).

"A verdict which may be supported by ***any*** rational view of the evidence and bears a reasonable relationship to the character and extent of the injury and damage sustained is not excessive." *King v. Daniel Int'l Corp.*, 278 S.C. 350, 355, 296 S.E.2d 335, 338 (1982) (emphasis added). RMC moved for a new trial on three grounds—thirteenth juror doctrine, new trial absolute when a verdict is grossly excessive or inadequate, or a new trial *nisi remittitur* or *additur* when the verdict is merely excessive or inadequate. *See Burke v. AnMed Health*, 393 S.C. 48, 55-57, 710 S.E.2d 84, 88-89 (Ct. App. 2011) (listing the three general grounds for a new trial). "Compelling reasons [] must be given to justify invading the jury's province in this manner." *Bailey v. Peacock*, 318 S.C. 13, 14, 455 S.E.2d 690, 691 (1995). The lower court correctly found the verdicts were not excessive in the first place—a basis to affirm as to all three alleged grounds for a new trial in this case.

If the court first finds the verdict excessive, it must determine whether it is merely excessive or grossly excessive. A merely excessive verdict is one that the court views as "not in accord with accepted judicial standards for measuring damages under the facts of the particular case." *Bowers v. Charleston & W. Carolina R.R. Co.*, 210 S.C. 367, 375, 42 S.E.2d 705, 708 (1947). A grossly excessive verdict is one "deemed to be the result of a disregard of the facts and of the instructions of the Court, and to be due to passion and prejudice rather than reason." *Id.* at 375, 42 S.E.2d at 708. "[T]o warrant a new trial absolute, the verdict reached must be so grossly excessive as to clearly indicate the influence of an improper motive on the jury." *Holroyd v. Requa*, 361 S.C. 43, 66, 603 S.E.2d 417, 429 (Ct. App. 2004).

In determining whether a verdict amount is excessive, "the facts must be viewed in the light most favorable to the plaintiff and, where the amount of a verdict bears a reasonable relationship to the character and extent of the injury sustained, it is not excessive." *Watson v. Wilkinson Trucking Co.*, 244 S.C. 217, 224, 136 S.E.2d 286, 289 (1964). RMC presents no compelling reason for the Court to invade the jury's province. Viewing the evidence in a light most favorable to Hamilton, it bears a reasonable relationship to the character and extent of the injuries sustained and supports the lower court's finding that neither verdict was excessive.

A. The evidence supports the jury's verdict for R.J.

Hamilton presented ample evidence of R.J.'s damages to support the jury's verdict. There is evidence R.J. suffered a permanent injury. There is evidence R.J. suffered past, present, and future pain and suffering, mental and emotional anguish, anxiety, and loss of enjoyment of life.

"An award for pain and suffering compensates the injured person for the physical discomfort and the emotional response to the sensation of pain caused by the injury itself." *Boan v. Blackwell*, 343 S.C. 498, 501-02, 541 S.E.2d 242, 244 (2001). "Separate damages are given for mental anguish where the evidence shows, for example, that the injured person suffered shock, fright, emotional upset, and/or humiliation as the result of the defendant's negligence." *Id.* at 502, 541 S.E.2d at 244. "One cannot easily or with any mathematical certainty place a value on the amount of a person's pain and suffering." *Smalls v. S.C. Dep't of Educ.*, 339 S.C. 208, 218, 528 S.E.2d 682, 687 (Ct. App. 2000).

RMC argues "there was little testimony regarding pain and suffering." (Br. of App. p. 33). This is false. There is evidence R.J. experienced pain at the time of the infiltration, during the healing process, and after the scar formed. When the nurses finally called a doctor to look at R.J.'s hand, it was swollen with "a big black scar and it was a bubble" on top of his hand full of fluid.

(R. pp. 165-66). R.J. cried during every one of the fifteen visits to the wound care center. (R. pp. 168-69). Dr. DeVito testified the "whole nature of the wound is painful." (R. p. 236). R.J. could not crawl with his hand out and Hamilton "constantly" watched him to make sure he did not hit it on something or make it bleed. (R. p. 172).

The infiltration resulted in keloid scar tissue that "invades" the skin surrounding it and causes painful burning and itching symptoms. (R. p. 233). Dr. DeVito testified some patients describe the pain "as if someone were putting hot needles to the skin." (R. p. 233). Dr. DeVito saw R.J. weeks before trial but testified he "couldn't even examine the child" because R.J. pulled his hand back and withdrew, it is still "a source of pain for him," and the examination "was really an ordeal." (R. pp. 242-43).

R.J. was three-years-old at the time of trial, and Hamilton testified he suffered complications from his scar. (R. pp. 171-72). His hand cramps up and he complains about itching and cannot sit still when it hurts. (R. p. 171). Hamilton massages his hand and does hand exercises with him using a ball. (R. p. 171).

Dr. Davis and Dr. DeVito agreed that R.J. will have a permanent scar regardless of any future treatment. (R. pp. 225-26, 242). R.J.'s skin will never be normal again. (R. p. 243). He does not have sweat glands or hair follicles on his right hand. (R. p. 243). Even slightly bumping R.J.'s hand could cause a blister or ulcer. (R. p. 244). The court charged the jury that R.J.'s life expectancy was 73.76 years. (R. p 439).

RMC argues that the functionality of R.J.'s hand is a basis to find the damages excessive. (Br. of App. p. 34). This misstates the testimony and fails to view it in a light most favorable to Hamilton. During all of the functionality tests that Dr. Davis performed, R.J. complained that his hand felt tight. (R. p. 220). Dr. Davis testified that scars have a negative psychological impact on

a person regardless of functional abilities. (R. pp. 217-18). Almost four years after the infiltration, R.J. still complained of itching on the scar site. (R. pp. 218-19). Dr. DeVito testified R.J. "has some limitation" compared to a child with no scar because R.J. would not even let Dr. DeVito touch the hand during the examination. (R. p. 255). Tekayah testified that she limits R.J.'s activities for fear that he will injure his hand. (R. p. 173). That R.J. has functionality in his hand does not decrease the significance, frequency, or intensity of his regular emotional and physical pain from the scar.

"[A] verdict which may be supported by any rational view of the evidence, or as to which reasonable and disinterested men might draw different inferences, is not of this class" of excessive verdicts. *Mickle v. Blackmon*, 252 S.C. 202, 248, 166 S.E.2d 173, 194 (1969) (affirming the denial of a new trial absolute of "probably the highest verdict in a personal injury case in the history of this State"). That RMC disagrees with the jury's damages determination does not make it excessive. Further, that R.J.'s verdict of $1,127,280.00 is "54 times" the medical expenses (Br. of App. p. 35), is not a basis for finding it excessive. RMC does not cite any law requiring that a verdict amount must be within a certain multiplier of alleged actual damages. On the contrary, the law is that there is no yardstick or measure for determining non-economic damages. *See Knoke v. S.C. Dep't of Parks, Rec. & Tourism*, 324 S.C. 136, 142, 478 S.E.2d 256, 258-59 (1996) (stating "intangible damages" "cannot be determined by any fixed measure"); *Lucht v. Youngblood*, 266 S.C. 127, 137, 221 S.E.2d 854, 859 (1976) (stating non-economic damages "are intangibles, the value of which cannot be determined by any fixed yardstick"). Further, R.J.'s medical expenses are Tekayah's damages and, therefore, cannot be used as the "yardstick" for his measure of damages.

An award of $1,127,280.00 for a child who will have to endure a scar and the daily physical and emotional pain and limitations associated with it for his ***entire life*** is neither merely nor grossly excessive.

B. The evidence supports the jury's verdict for Tekayah.

Hamilton presented ample evidence of Tekayah's damages to support the jury's verdict. A parent can recover medical expenses, loss of services, and other pecuniary losses arising out of the injuries of a minor child. *Doe v. Greenville Cnty. Sch. Dist.*, 375 S.C. 63, 68, 651 S.E.2d 305, 307-08 (2007).

The medical bills totaled $20,854.00. (R. pp. 423, 506-09). Dr. DeVito's recommended surgical treatment for R.J.'s scar will cost approximately $2,500.00 for the surgical fee and in excess of $12,000.00 for other associated costs such as the anesthesia, hospitalization, the operating room, and testing. (R. pp. 246-47). Dr. DeVito testified that R.J. would need steroid injections "indefinitely" and each injection costs $85.00. (R. pp. 240, 510-12).

RMC argues Hamilton did not establish the scar treatment. (Br. of App. p. 34). This is incorrect. Tekayah testified that she did not want to have surgery on R.J.'s hand at the time of trial because he was so young and had already been through a lot. (R. pp. 185-86). Dr. Davis testified that giving the steroid treatment to a three-year-old is "not easy" and "not successful at that age" because it is traumatic for the child and requires a sedative. (R. pp. 222-23). Dr. DeVito testified that Keloid scars are difficult to treat with steroids because penetrating "a hard scar with a needle and syringe is . . . like trying to inject the paint on [a] wall." (R. pp. 237-38). Even an alternative vaccination gun that uses high pressure is "painful." (R. pp. 238-39). Dr. DeVito found it "very understandable" that Tekayah may not want to put R.J. through that pain at three-years-old and agreed it is a "painful dilemma" for a child. (R. pp. 240-41). Based on that testimony, the jury

could have accepted Hamilton, Dr. DeVito, and Dr. Davis's testimony that it is best to wait to pursue scar treatment until R.J. is older. That Tekayah is choosing to wait does not mean she cannot recover for the future treatment.

The lower court considered that Tekayah missed work for a year because she could not trust anyone to properly watch out for R.J.'s hand. (R. pp. 172, 6). The lower court considered that Tekayah would remain R.J.'s guardian for an additional fifteen years from the date of trial. (R. p. 7).

RMC incorrectly argues that Tekayah's damages are limited to only the medical expenses. (Br. of App. p. 37). A parent may recover for loss of a child's services and earning capacity (which are not at issue here), as well as "***other*** pecuniary losses, ***including*** medical expenses incurred as a result of the injury." *Doe v. Greenville County Sch. Dist.*, 375 S.C. 63, 68, 651 S.E.2d 305, 308 (2007). That the court listed medical expenses as included within the category of "pecuniary losses" necessarily means that a parent's recovery is not limited to medical expenses.

An award of $135,477.00 for R.J.'s past and future medical expenses, as well as Tekayah's pecuniary loss for missed work, travel expenses, and constant daily watching over and caring for R.J. is neither merely nor grossly excessive.

CONCLUSION

For these reasons, the Court should affirm the lower court.

Respectfully submitted,

May 20, 2021

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IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM ORANGEBURG COUNTY
Court of Common Pleas

The Honorable Edgar W. Dickson

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18,.....Respondent,

v.

Regional Medical Center,.....Appellant.

PROOF OF SERVICE

The undersigned certifies that a copy of the Final Brief of Respondent and Certificate of Compliance have been served upon counsel for Appellant via electronic mail at the email address stated in the Attorney Information System as set forth below on May 20, 2021.

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CERTIFICATE OF COMPLIANCE

The undersigned counsel certifies that the Final Brief of Respondent complies with Rule 211(b), SCACR.

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STATEMENT OF ISSUES ON APPEAL

1. Whether the Trial Court abused its discretion in qualifying Respondent's Expert Monica Stobbs as a general nurse and in permitting her to testify as to the standard of care for pediatric IV administration.

2. Whether Appellant is entitled to a reversal on the grounds that the lower court should have granted a directed verdict in favor of Appellant as Respondent did not establish gross negligence.

3. Whether the Trial Court abused its discretion by allowing, over objection, the admission of prejudicial photographs of the minor child to the jury.

4. Whether the Trial Court abused its discretion in prohibiting Appellant's expert Cynthia Hurley from testifying in front of the jury as to whether the Appellant was grossly negligent or negligent.

5. Whether the Trial Court abused its discretion in permitting the Request for Admission to be published to the jury.

6. Whether the Trial Court abused its discretion in not granting a new trial absolute or new trial *nisi remittitur* when the verdict was grossly excessive and shockingly disproportionate and contrary to the evidence admitted at trial, or, at the very minimum, was at least merely excessive given the evidence.

STATEMENT OF THE CASE

This matter arises out of an IV infiltration to a minor child which occurred during an admission at The Regional Medical Center from October 25 through October 30, 2014. On October 7, 2015, Plaintiff "Respondent" Tekayah Hamilton filed a Summons and Complaint (R. pp. 12 - 28) alleging medical malpractice in the Orangeburg County Court of Common Pleas on behalf of herself individually, and as a parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen. The Defendant ("Appellant") The Regional Medical Center and Jamie Downing, RN, filed its Answer to the Complaint (R. pp. 29-33) on November 30, 2015, denied liability and any wrongdoing, and asserted numerous affirmative defenses. Jamie Downing, RN, was dismissed from the action on June 29, 2016, pursuant to the Tort Claims Act.

The action came to a Jury Trial beginning May 7, 2018, in front of Judge Edgar W. Dickson in Orangeburg County, South Carolina. *See* Trial Tr. Mar. 19, 2019 (R. pp. 60 - 462) & Trial Tr. Dec. 22, 2020 (R. pp. 37-59). Appellant presented three pretrial motions *in limine*. *See* Def.'s Mot. in lim. to Exclude Photos (R. pp. 533-534), Def.'s Mot. in lim. to Exclude Monica Stobbs Testimony (R. pp. 522-532), Trial Tr. Dec. 22, 2020 (R. pp. 37-59). In its first motion,

Appellant moved that Respondent's expert, Monica Stobbs, should not be qualified as an expert witness in this matter and allowed testify to the standard of care for pediatric nursing on the ground that she lacked the required qualifications. In its second Motion, Appellant moved to exclude photographs of the minor child's hands on the ground that the probative value of the photographs was substantially outweighed by the danger of unfair prejudice. In its third and final motion, Appellant moved to exclude hearsay testimony of the Respondent. The Trial Court denied the Appellant's motions regarding Monica Stobbs and the photographs and granted the motion to exclude the hearsay testimony. On May 9, 2018, the Jury returned a verdict for the Respondent Robert Lee Middleton Jr., in the amount of $1,127,280.00 and for Respondent Tekayah Hamilton in the amount of $135,477.00 (R. p. 535).

On May 17, 2018, Appellant filed two post trial motions. Appellant filed a Notice of Motion and Motion for JNOV or in the alternative Motion for New Trial (R. pp. 536-550) and a Post Trial Motion For Reduction to Statutory Cap (R. p. 552-554). Respondent filed a memorandum in opposition to Appellant's motions on June 13, 2018 (R. p. 556-571). On June 27, 2018, Appellant filed a response to the Respondent's Memorandum in Opposition (R. pp. 572-584). On October 25, 2019, the Trial Court issued its Order Granting Appellant's Motion for Reduction to Statutory Cap and Denying Appellant's Motion for JNOV or in the Alternative a New Trial (R. pp. 1-10).

Appellant timely filed a Notice of Appeal on November 19, 2019 (R. p. 585-597).

ARGUMENT

I. THE TRIAL COURT ABUSED ITS DISCRETION IN QUALIFYING RESPONDENT'S EXPERT MONICA STOBBS AS A GENERAL NURSE AND IN

PERMITTING HER TO TESTIFY AS TO THE STANDARD OF CARE FOR PEDIATRIC IV ADMINISTRATION.

STANDARD OF REVIEW

"The qualification of an expert witness and the admissibility of the expert's testimony are matters within the trial court's discretion." *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 252, 487 S.E.2d 596 (1997) (citing *McGee v. Bruce Hosp. System*, 321 S.C. 340, 468 S.E.2d 633 (1996); *see, e.g., Fields v. The Reg'l Med. Ctr. of Orangeburg*, 363 S.C. 19, 25, 609 S.E.2d 506 (2005). "Similarly, the admission or exclusion of evidence in general is within the sound discretion of the trial court." *Fields*, 363 S.C. 19 at 25. "In both instances, the trial court's decision will not be disturbed on appeal absent an abuse of discretion." *Id.*; *see, e.g., Gooding v. St. Francis Xavier Hosp.*, 454 S.E.2d 328, 330 (Ct. App. 1995). "An abuse of discretion occurs when there is an error of law or a factual conclusion which is without evidentiary support." *Gooding*, 326 S.C. at 252 (citing *Lee v. Suess*, 318 S.C. 283, 457 S.E.2d 344 (1995)); *Fields*, 363 S.C. at 26. "A trial court's ruling on the admissibility of an expert's testimony constitutes an abuse of discretion when the ruling is manifestly arbitrary, unreasonable, or unfair." *Fields*, 363 S.C. at 26 (citing *Means v. Gates*, 348 S.C. 161, 166, 558 S.E.2d 921, 924 (2001). "To warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Fields*, 363 S.C. at 26 (citations omitted).

ARGUMENT

A. THE TRIAL COURT'S ERROR WAS AN ABUSE OF DISCRETION.

Appellant argues that the Trial Court erred in ruling that Monica Stobbs, R.N., was qualified as an expert in general nursing ("Nursing 101") (Trial Tr. 7-10, 10:4-6, Dec. 22, 2020 (R. pp. 43-46); Trial Tr. 78:1-19, Mar. 17, 2019 (R. p. 93)) and in allowing her to testify to the standard of care for pediatric nursing IV management. Def's Mot. *in lim.* to Exclude Monica Stobbs Testimony (R. p. 522-532), Def's Mot. for JNOV or in the alt. Motion for New Trial 4-5 (R. pp. 539-540); Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 6 (R. p. 7). Appellant argues that this an error that amounted to an abuse of discretion because the case was about pediatric, not adult, nursing and IV medicine; Ms. Stobbs failed to meet the qualifications as set forth in the South Carolina Rules of Evidence 702 and *Gooding*; and the court allowed Ms. Stobbs to testify outside of the scope of her expert qualification in this matter.

1. THIS MATTER WAS ABOUT PEDIATRICS, NOT GENERAL NURSING.

Appellant first argues that the Trial Court's error in qualifying Ms. Stobbs amounts to an abuse of discretion because there was no basis or rationale for qualifying Ms. Stobbs as an expert in general nursing in this matter. Pediatric nursing, not general nursing or "Nursing 101" (Trial Tr. 8:4-11, Dec. 22, 2020 (R. p. 44)), was the issue in this case. Medical literature indicates a clear distinction between IV administration and management for pediatrics and adults.[1] Veins in

[1] [1]The Infusion Nurses Society: Infusion Therapy in Clinical Practice, 2nd. eds Hankins J, Lonsway RA, Hendrick C and Perdue MB. Saunders, St. Louis, MO 2001, 561 "Children present a wide variety of physical characteristics different from those in adults. In addition, premature infants and newborns vary greatly from older children in their anatomy and physiology. These characteristics affect the ability of neonates and infants to cope with environmental stress and to manage the metabolism, absorption, distribution, and excretion of medications and solutions. Although body systems in infants and children are different from those in adults, for the purpose of this text, only those related to infusion therapy are addressed in detail."

infants are "obviously smaller" and can be "threadlike."[2] Trial Tr. 105:3-13, Mar. 17 2019 (R. p. 120). "Vein fragility and the high acuity levels of young patients can increase the likelihood of infiltration and extravasation, resulting in significant morbidity."[3] *Id.* at 129:19-130:1 (R. p. 144-145). Furthermore, testimony from Appellant's expert and Nurse Downing, both of whom have extensive experience in pediatric nursing and IV administration (Trial Tr. 298:8-299:1 (R. pp. 306-307), 323:10-324:21 (R. pp. 332-333), 350:15-19 (R. p. 359), Mar. 17, 2019), revealed distinct differences between pediatrics and adult IV management (Trial Tr. 266:11-25 (R. p. 274), 331:11-332:24 (R. pp. 340-341), Mar. 17, 2019). Pediatric patients and their veins are smaller, more fragile, and more mobile and therefore need to be more frequently assessed, whereas adults are more stable, have bigger veins, and thus, nurses are able to use larger catheters. *Id.* Because there is a clear distinction in pediatrics and adult IV care and the issue here was pediatrics, it was manifestly arbitrary, unfair, and unreasonable, an thus, an abuse of discretion, to qualify and allow the testimony of a general nurse who never practiced pediatric nursing.

2. MONICA STOBBS FAILED TO MEET THE REQUIREMENTS OF RULE 702 OF THE SOUTH CAROLINA RULES OF EVIDENCE AND *GOODING*.

In order to be qualified as an expert witness, a person must have the "knowledge, skill, experience, training or education" in order to testify. Rule 702, SCRE. "To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such

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[2] *Id.* at 562 "The size of venous and arterial vessels in the infant and child are obviously smaller than those in the adult. Although the vessels are anatomically positioned in the same locations throughout life, their sometimes-threadlike characteristics and tendency to hide make them difficult to locate in the young patient."

[3] *Policies and Procedures from Fusion Nursing of the Pediatric Patient*, The Infusion Nurses Society, supra at 125.

knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter.'" *Gooding*, 326 S.C. at 253, 487 S.E.2d at 598 (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995); *see, e.g.*, *State v. Douglas*, 367 S.C. 498, 508-509, 626 S.E.2d 59 (Ct. App. 2006); *Botehlo v. Bycura*, 282 S.C. 578, 586, 320 S.E.2d 59, 65 (Ct. App. 1984) (holding that an orthopedic surgeon was not qualified to testify on the standard of care for podiatrist where the orthopedic surgeon had no training in podiatry, was not familiar with any journals or periodicals in podiatry, and was not familiar with the surgical procedure performed).

Appellant argues the Trial Court's error amounts of abuse of discretion because, as per the requirements of South Carolina Rules of Evidence 702 and *Botehlo,* Ms. Stobbs was not qualified to testify as to pediatric IV administration, as her experience has only been to general, adult IV administration. Trial Tr. 8:13-9:19, Dec. 22, 2020 (R. pp. 44-45); Def's Mot. *in lim.* to Exclude Monica Stobbs Testimony (R. pp. 522-532). The issue is not over a *defect* in amount or quality of experience or knowledge but rather, much like *Botehlo*, is over whether she possessed *any* of the required knowledge or experience. Similar to the orthopedic surgeon in *Botehlo*, Ms. Stobbs has had no personal experience or training at all in pediatric nursing or IV administration. Trial Tr. 103:14-104:8 (R. pp. 118-119),108:22-110:21 (R. pp. 123-125), Mar. 17, 2019. Ms. Stobbs has never cared for a pediatric patient and has never started or managed a pediatric IV. *Id.* at 79:24-25 (R. p. 94), 108:22-110:21(R. pp. 123-125); Stobbs Dep. 13:9-24 (R. p. 526). Additionally, Ms. Stobbs does not have any education or knowledge as to pediatric nursing or IV administration. Ms. Stobbs testified that she did not perform any research, independent study, or

review any medical literature in preparation of formulating her opinions. Trial Tr. 111:14-23, Mar. 17, 2019 (R. p. 126); Stobbs Dep. 26:15-24 (R. p. 527).

Ms. Stobbs proved her lack of knowledge and expertise by making baseless and inaccurate claims and testifying directly contradictory to the literature. Ms. Stobbs' opinion is premised on her belief that the standard of care for IV management is the same for pediatric patients as it is for adults. Trial Tr. 111:22-23, Mar. 17, 2019 (R. p. 126); Stobbs Dep. 13:13-18 (R. p. 526). Her opinions are based on the speculative belief that pediatric patients are simply little adults. She believes the standard of care for both pediatrics and adults is "simple nursing 101." *Id.* at 96:22-23 (R. p. 111); Stobbs Dep. 26:17 (R. p. 527). Although she acknowledged that the literature indicates children have a wide variety of physical characteristics that differ from adults, including smaller, "obviously threadlike" veins, it is her opinion that a "vein is a vein." Trial Tr. 104:20-105:23 (R. pp. 119-120), 126:1-15 (R. p. 141), 128:1-5 (R. p. 143), Mar. 17, 2019. She also testified that she disagreed with literature provided by Respondent that stated "[l]arger amounts of subcutaneous fat in children can make the identification of an early infiltration difficult;"[4] however, she admitted she had no literature with her to support her opinion. *Id.* at 130:10-131:25 (R. pp. 145-146).

Ms. Stobbs further proved her lack of knowledge concerning pediatric IV administration when she testified that she "should get blood return from a vein whether it's a baby or whether it's an adult." Stobbs Dep. 32:24–33:7 (R. p. 528-529). Trial Tr. 97:2-3 (R. p. 112), 110:22-24 (R. p. 125), 133:2-14 (R. p. 148), 133:20-134:13 (R. pp. 148-149), Mar. 17, 2019. This is directly

[4] The Infusion Nurses Society, *supra*

contrary to the literature.[5] Trial Tr. 104:16-106:2 (R. pp. 119-121), 351:7-14 (R. p. 360), Mar. 17, 2019. Although Ms. Stobbs has obtained blood returns in adult patients, she has never attempted to obtain one in a pediatric patient, and therefore, she does not know what it could do to a pediatric vein. Trial Tr., 134:20-135:8, Mar. 17, 2019 (R. pp. 149-150). On the contrary, Appellant's expert, Cindy Hurley, and Nurse Downing both testified that trying to obtain a blood return in a pediatric is inappropriate because it could cause the vein to collapse or result in a false reading. Trial Tr. 271:8-21 (R. p. 279), 347:20-25-349:14 (R. pp. 356-358), Mar. 17, 2019.

Thus, Ms. Stobbs failed to meet the requirements of SCRE 702 and *Gooding*. The sole purpose of an expert is to educate a jury on the subject matter of his or her expertise, and that is impossible to do without prior experience or study. Without proper education, training, or experience regarding pediatric administration and management, Ms. Stobbs was not more qualified than the jury to form an opinion as to the same. Therefore, Appellant asserts it was arbitrary, unfair, and unreasonable, thus an abuse of discretion, to permit Ms. Stobbs to testify as an expert in the standard of care for pediatric IV administration and administration.

3. THE CONTENT OF MS. STOBBS' TESTIMONY EXCEEDED THE QUALIFICATION OF THE TRIAL COURT.

Lastly, Appellant argues that the Trial Court's error amounts to abuse of discretion because it allowed Ms. Stobbs to provide expert testimony beyond the scope for what she had been qualified in this matter. During the Motion *in limine* hearing, the Trial Court specifically

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[5] "The Infusion Nurses Society, *supra at 422.*" "Checking for a blood return, or backflow of blood, is not a reliable method for determining the absence of an infiltration. A blood return may not be present when small veins are used because they may not permit blood flow around the cannula; one may think the infusion has infiltrated when it has not."

indicated Ms. Stobbs would be qualified in general nursing and not pediatrics, as it acknowledged she had no prior experience with regards to pediatrics. Trial Tr. 8:18-19, 9:20-10:6, Dec. 22, 2020 (R. pp. 44-46). Despite this, during trial the Trial Court allowed Ms. Stobbs to testify as to the standard of care of pediatric nursing and IV administration. This was clearly beyond the scope of the Trial Court's qualification of her as an expert witness. Therefore, Appellant maintains that it was manifestly arbitrary, unfair, and unreasonable, and thus, an abuse of discretion, to allow Ms. Stobbs to testify regarding the standard of care for pediatric IV administration and management.

B. THE TRIAL COURT'S ABUSE OF DISCRETION WAS NOT HARMLESS

Appellant asserts this error was not harmless and was highly prejudicial to Appellant's case. "Whether an error is harmless depends on the circumstances of the particular case. No definite rule of law governs this finding. Rather, the materiality and prejudicial character of the error must be determined from its relationship to the entire case." *State v Douglas*, 367 S.C. at 519-520 (citations omitted). "Error is harmless where it could not reasonably have affected the result of the trial." *Id.* at 520 (citing *Arnold v. State,* 309 S.C. 157, 420 S.E.2d 834 (1992)). "The admission of improper evidence is harmless where the evidence is merely cumulative to other evidence." *Id.* at 520 (citations omitted); *see also*, *McGee,* 468 S.E.2d at 636 (allowing an expert to testify about the placement of catheters was harmless as it was cumulative to other evidence). "To show prejudice, there must be a reasonable probability that the jury's verdict was influenced by the challenged evidence or the lack thereof." *State v. Douglas,* 367 S.C. at 508 (citations omitted).

Given the arguably excessive verdict (Trial Tr. 446:18-447:1, Mar. 17, 2019 (R. pp. 457-458)) in light of no other testimony or evidence as to Appellant's negligence (*see infra* Argument II), Appellant asserts the error in allow Ms. Stobbs' qualification and testimony was not harmless. Appellant asserts that had Ms. Stobbs not been qualified as an expert and allowed to testify as to the standard of care for pediatric IV management, then the Respondent could not meet its burden of proof which would have resulted in a directed verdict against Respondent. Ms. Stobbs' testimony was not cumulative to other testimony or evidence presented. She was the only witness offered by Plaintiff on two critical issues. Appellant further asserts that the excessive verdict demonstrates that there is reasonable probability that the jury was highly influenced by Ms. Stobbs' testimony. Thus, Appellant asserts this error not harmless, but rather was highly prejudicial to Appellant's defense of the matter. Therefore, because the Trial Court's error amounted to an abuse of discretion and this error was not harmless, the Trial Court's ruling is warranted a reversal on this ground.

II. APPELLANT IS ENTITLED TO A REVERSAL ON THE GROUNDS THAT THE LOWER COURT SHOULD HAVE GRANTED A DIRECTED VERDICT IN FAVOR OF APPELLANT AS RESPONDENT DID NOT ESTABLISH GROSS NEGLIGENCE.

STANDARD OF REVIEW

"When reviewing the denial of a motion for directed verdict or JNOV, this Court must employ the same standard as the trial court by viewing the evidence and all reasonable inferences in the light most favorable to the nonmoving party." *Welch v. Epstein*, 342 S.C. 279, 299-300, 536 S.E.2d 408 (2000) (citations omitted). "In ruling on a motion for directed verdict, it is the duty of the court to view the evidence and all inferences which may reasonably be drawn

therefrom in the light most favorable to the non-moving party." *Hollins v. Richland Cnty. Sch. Dist. One*, 310 S.C. 486, 427 S.E.2d 654, 655 (1993) (citing *Horton v. Greyhound Corp.*, 241 S.C. 430, 128 S.E.2d 776 (1962)). "The trial court must deny the motions when the evidence yields more than one inference or its inference is in doubt." *Welch*, 342 S.C. at 300 (citing *Steinke v. S.C. Dept. of Labor, Licensing, & Reg*, 336 S.C. 373, 520 S.E.2d 142(1999)). "Th[e] Court will reverse the trial court only when there is no evidence to support the ruling below." *Id.* (citations omitted)."When considering directed verdict and JNOV motions, neither the trial court nor the appellate court has authority to decide credibility issues or to resolve conflicts in the testimony or evidence." *Id.* (citations omitted). "A motion for JNOV may be granted only if no reasonable jury could have reached the challenged verdict." *Id.* (citing *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 415 S.E.2d 393 (1992)). "The jury's verdict will not be overturned if any evidence exists that sustains the factual findings implicit in its decision." *Id.* (citations omitted).

ARGUMENT

Gross negligence is the standard that applies in this matter. *See Stewart v. Richland Mem'l Hosp.*, 350 S.C. 589, 592, 567 S.E.2d 510, 511 (2002) (holding gross negligence was the standard, as per the South Carolina Torts Claim Act, that the plaintiff had to prove in a matter where a nurse in a hospital was involved in restraining and monitoring the plaintiff). Appellant is a government entity, as defined by the statute, S.C. Code Ann. § 15-78-30(j); and *Smith v TRMC*, 713 S.E.2d 656 (Ct. App. 2011) thus, this matter is restricted to the confines prescribed within the South Carolina Torts Claims Act, S.C. Code Ann. § 15-78-200. Per the South Carolina Torts Claims Act §15-78-60(25),

> The governmental entity *is not liable* for a loss resulting from . . . responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any student, patient, prisoner, inmate, or client of any governmental entity, *except when the responsibility or duty is exercised in a grossly negligent manner*

S.C. Code Ann. § 15-78-60(25) (Cum. Supp. 1991) (emphasis added). Moreover, the Torts Claims Act "must be liberally construed in favor of limiting the liability of the State." S.C. Code Ann. § 15-78-20(f) and § 15-78-200. Therefore, gross negligence is the applicable standard, and the facts must be applied in such a way to limit the liability on the State.

This Court has defined gross negligence in a number of ways. "Gross negligence is the intentional failure to do something which it is incumbent upon one to do or the doing of a thing intentionally that one ought not to do." *Etheredge v. Richland Sch. Dist. One*, 341 S.C. 307, 310, 534 S.E.2d 275 (2007); *see, e.g., Clyburn v. Sumter Cnty. Dist. Seventeen*, 317 S.C. 50, 451 S.E. 2d 885, 887 (1994); *Richardson v. Hambright*, 296 S.C. 504, 506, 374 S.E.2d 296, 298 (1988). It is the "failure to exercise slight care." *Id.* Gross negligence has also been defined as "a relative term, and means the absence of care that is necessary under the circumstances." *Hollins v. Richland Cnty. Sch. Dist. One*, 427 S.E.2d at 656 (quoting *Hicks v. McCandlish*, 221 S.C. 410, 415, 70 S.E.2d 629 (1952)). Furthermore, "[w]hile gross negligence ordinarily is a mixed question of law and fact, when the evidence supports but one reasonable inference, the question becomes a matter of law for the court." *Etheredge*, 341 S.C. at 310; *see, e.g., Clyburn*, 451 S.E. 2d at 887-88.

Appellant maintains that the Trial Court erred in refusing to grant Appellant's motion for directed verdict (Trial Tr. 311:8-313:3 (R. pp. 320-322), 315:2-23 (R. p. 324), 382:8-21 (R. p.

391), Mar. 17, 2019), or Appellant's motion for JNOV or a new trial as there was not more than one inference as to whether Appellant acted with gross negligence (Def. Mot. for JNOV or in the alt. Motion for New Trial 5-6 (R. pp. 540-541); Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 6-7 (R. pp. 7-8). This was not a case of credibility issue or conflict in evidence or testimony. Rather, Respondent failed to provide *any* evidence or testimony of gross negligence; and thus, no reasonable jury could have made any finding of such.

Respondent did not submit any question to its own expert about whether Nurse Stobbs or Appellant were grossly negligent. Moreover, when asked by counsel for Appellant, Respondent's expert had no opinion as to the intentional conduct of Nurse Downing. Trial Tr. 132:24-25, 133:17-19, Mar. 17, 2019 (R. pp. 147-148). Respondent's expert further agreed that just because an IV infiltrated does not automatically warrant a conclusion that there was negligence. *Id.* at 139:7-16. In fact, she agreed that infiltration is a known risk. *Id.* at 112:2-24 (R. p. 127), 139:4-6 (R. p. 154) Respondent's expert herself testified that she has had IVs infiltrate without her having been negligent and has known other nurses who had IVs infiltrate without them being negligent. *Id.* at 138:10-139:3 (R. pp. 153-154).

Nurse Downing testified that she acted in accordance with how she was trained with respect to pediatric IV administration. She testified regarding her knowledge on the differences between adult and pediatric IV administration and monitoring. *Id.* at 266:11-269:23 (R. pp. 274-277), 271:8-21 (R. p. 279). She testified that she checked on the patient regularly and assessed the IV to make sure it was in properly and the medication was being administered as it should be. She testified that at no time during her assessment and monitoring of the minor

Respondent did she see an infiltration score of anything other than zero. *Id.* at 303:25-305:19 (R. pp. 311-313). She further testified that she followed the required protocol regarding flushing, always flushed the IV prior to administering medication, and documented her interactions with the patient into the hospital computer system as required. *Id.* at 272:9-274:19 (R. pp. 280-282); 274:23-275:1 (R. pp. 282-283); 275:19-276:9 (R. pp. 283-284); 276:22-277:10 (R. pp. 284-285); 280: 2-3, 6-10, 13-18 (R. p. 288); 280:21-281:1 (R. pp. 288-289); 299:13-303:22 (R. pp. 307-311). This is evidence that Nurse Downing, at the very minimum exercised at least slight care.

Moreover, Cindy Hurley, Appellant's expert who has had extensive experience working in pediatric nursing (*Id.* at 323:10-324:21 (R. pp. 332-333), 350:15-19 (R. p. 359)), testified that Nurse Downing actually exceeded the standard and the hospital's policy and procedure requirements by checking on him seven times during her twelve hour shift when she was only required to check on him once (*Id.* at 327:21-331:10 (R. pp. 336-340), 333:2-347:25 (R. pp. 342-356), 349:15-350:14 (R. pp. 358-359), 352:8-354:13 (R. pp. 361-363), 356:20-357:4 (R. pp. 365-466)). Certainly, if there was no evidence of negligence, but rather there was testimony that the standard was actually exceeded, there could not possibly have been any gross negligence or any inference of the same as a matter of law.

Even in the light most favorable to the non-moving party, there was no evidence or testimony presented establishing an inference or possibility of gross negligence on the part of Appellant. Respondent had the burden, and they failed to meet that burden. Respondent failed to demonstrate through evidence or testimony that Nurse Downing failed to exercise slight care or intentionally failed to do what she ought to have done in the care and treatment of the minor

Respondent. Because Respondent failed to meet their burden of establishing any inference of gross negligence, and the courts favor limitations on liability on the State, the Trial Court erred by not granting a directed verdict in favor of Appellant. Thus, the decision must be reversed on this ground.

III. THE TRIAL COURT ABUSED ITS DISCRETION BY ALLOWING, OVER OBJECTION, THE ADMISSION OF PREJUDICIAL PHOTOGRAPHS OF THE MINOR CHILD TO THE JURY.

STANDARD OF REVIEW

"[T]he admission or exclusion of evidence in general is within the sound discretion of the trial court." *Fields*, 363 S.C. 19 at 25. "[T]he trial court's decision will not be disturbed on appeal absent an abuse of discretion." *Id.*; *Gooding*, 454 S.E.2d at 30. "An abuse of discretion occurs when there is an error of law or a factual conclusion which is without evidentiary support." *Gooding*, 326 S.C. at 487 (citing *Lee,* 318 S.C. 283, 457 S.E.2d 344); *Fields*, 363 S.C. at 26. "To warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Fields*, 363 S.C. at 26 (citations omitted).

ARGUMENT

Rule 403 of the South Carolina Rules of Evidence states, "[a]lthough relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE. "To constitute

unfair prejudice, the photographs must create 'an undue tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one.'" *State v. Holder*, 382 S.C. 278, 290, 676 S.E.2d 690 (2009) (quoting *State v. Jackson*, 364 S.C. 329, 334 (2005)). "Photographs calculated to arouse the sympathy or prejudice the jury should be excluded if they are irrelevant or not necessary to substantiate material facts or conditions." *State v. Torres*, 390 S.C. 618, 623, 703 S.E.2d 226 (2010).

In a Motion *in limine*, Appellant argued against the admission of photographs (Pltf.'s Exs. 1-3 (R. pp. 463-465) of the minor Respondent's hand into evidence. Trial Tr. 10-15, Dec. 22, 2020 (R. pp. 46-51); Def.'s Notice of Motion & Motion *in limine* to Exclude Photos (R. pp. 533-534). Appellant believes that the court erred in allowing the admission of the photographs (Trial Tr. 14:24-15:14, Dec. 22, 2020 (R. pp. 50-51)) and testimony during trial as to the same (Trial Tr. 151:7-152:15 (R. pp. 166-167), 154:20-156:3 (R. pp. 169-171), 228:1-230:15 (R. pp. 234-236), 235:8-236:4 (R. pp. 241-242), Mar. 17, 2019). Def.'s Motion for JNOV or in the alt. Mot. for New Trial 6-7 (R. pp. 541-542); Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 7 (R. p. 8). First, these photographs were not necessary to substantiate the Respondent's case. The fact that there was a wound was never disputed, and at no time did Appellant's argue that the infiltration did not occur or was not the cause of the wound. Trial Tr. 3:13-18, Dec. 22, 2020 (R. p. 39); Trial Tr. 399:3-5, Mar. 17, 2019 (R. p. 409). The Respondent had ample other evidence of the wound, such as the wound center records (Pltf.'s Ex. 6), testimony by the witnesses, and presentation of the minor child at trial (Trial Tr. 158:15-159:25, Mar. 17, 2019 (R. pp. 173-174)), that were less prejudicial than the photographs of the open flesh wound.

Second, these were grotesque, up-close images of the wound that made them appear substantially large than they were in reality. One of the photographs was actually quite blurry. Moreover, the photographs did not include a scale to indicate measurements and proportions. As such, Appellant argues that these images were graphic, inflammatory, and not an accurate reflection of the child's hand and injuries. Trial Tr. 12:23-14:1, Dec. 22, 2020 (R. pp. 48-50); Def.'s Notice of Motion & Motion *in limine* to Exclude Photos (R. pp. 533-534); Def.'s Motion for JNOV or in the alt. Mot. for New Trial 6-7 (R. pp. 541-542). The photos, by their very nature, had a prejudicial tendency to arouse the emotions of the jury. *Id.* Moreover, the photographs did not reflect the current state of the wound. The minor child appeared during trial and showed the jury his scar, which did not appear as it did in the photographs. Trial Tr. 158:15-159:25, Mar. 17, 2019 (R. pp. 173-174). There was also testimony, including from Respondent's own expert, that the child's scar appeared healed since February 2015 and did not look like the photographs shown. *Id.* at 243:12-20 (R. p. 249); 245:2-3, 5-8 (R. p. 251). Thus, as the photographs were not necessary to determine the identity of the child or that the injury had occurred; were grotesque, up-close images not appropriately scaled; and were not representative of the nature of the child's scar, Appellant asserts the admission of the photographs and testimony of the same was in error.

Appellant further asserts this error amounted to prejudice based upon the excessive verdict in favor of Respondent. Due to the excessive jury award, the Appellant is left to conclude that the admission of the grotesque, up-close nature of the photographs were designed to and succeeded in arousing the sympathy of the jury. As stated above, the photographs were not necessary to establish identity or that the infiltration did occur and was the cause of the wound, the photographs were of little probative value. Appellant argues that any probative value they

may have had was substantially outweighed by the fact that they were grotesque, up-close images of the open wound, not to scale, and not representative of the actual appearance of minor's scar. Despite hearing testimony that the minor child's scar has been healed since February 2015 (*Id.* at 245:2-8 (R. p. 251)), is well-healed and stable (*Id.* at 191:17-192:3 (R. pp. 206-207)), does not appear as it did in the photographs, and, in fact, seeing this for themselves, the jury return a grossly excessive verdict in favor of Respondent. Thus, this leaves Appellant to conclude that, without any additional presentation from the Respondent of evidence of gross negligence on the part of Appellant, the jury must have been highly persuaded by these grotesque images. Thus, Appellant asserts the admission of these photographs were highly prejudicial to its defense.

Therefore, Appellant asserts the admission of the photographs was in error, was highly prejudicial to Appellant's defense, and their admission and the allowance testimony to the same an abuse of discretion by the Trial Court, thereby warranting a reversal of the Trial Court's decision.

IV. THE TRIAL COURT ABUSED ITS DISCRETION IN PROHIBITING APPELLANT'S EXPERT CYNTHIA HURLEY FROM TESTIFYING IN FRONT OF THE JURY AS TO WHETHER THE APPELLANT WAS GROSSLY NEGLIGENT OR NEGLIGENT.

STANDARD OF REVIEW

"The qualification of an expert witness and the admissibility of the expert's testimony are matters within the trial court's discretion." *Gooding*, 326 S.C. at 252 (citing *McGee v. Bruce Hospital System*, 321 S.C. 340, 468 S.E.2d 633 (1996); *see, e.g., Fields,* 363 S.C. at 25.

"Similarly, the admission or exclusion of evidence in general is within the sound discretion of the trial court." *Fields,* 363 S.C. at 25. "In both instances, the trial court's decision will not be disturbed on appeal absent an abuse of discretion." *Id.*; *see, e.g., Gooding*, 454 S.E.2d at 330. "An abuse of discretion occurs when there is an error of law or a factual conclusion which is without evidentiary support." *Gooding,* 326 S.C. at 252 (citing *Lee,* 318 S.C. 283, 457 S.E.2d 344); *Fields*, 363 S.C. 19 at 26. "A trial court's ruling on the admissibility of an expert's testimony constitutes an abuse of discretion when the ruling is manifestly arbitrary, unreasonable, or unfair." *Fields*, 363 S.C. at 26 (citing *Means,* 348 S.C. at 166, 558 S.E.2d at 924). "To warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Fields,* 363 S.C. at 26 (citations omitted).

ARGUMENT

During trial, Respondent asked the court to prohibit Appellant's expert from testifying as to any legal conclusion. Trial Tr. 316:2-7, Mar. 17, 2019 (R. p. 325). Appellant argues that the court erred prohibiting counsel for Appellant from asking its expert in front of the jury whether she believed Appellant was negligent or grossly negligent and instead forcing counsel for Appellant to ask her outside the presence of the jury in a proffer. *Id.* at 316:2-320:1 (R. pp. 325-329), 378:1-381:13 (R. pp. 387-390); Def.'s Motion for JNOV or in the alt. Motion for New Trial 7-8 (R. pp. 542-543); Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the alt. for a New Trial 7 (R. p. 8). It was her opinion via the proffer that Nurse Downing, and therefore TRMC, was not negligent and was not grossly

neglect. (*Id.* at 380:3-18 (R. p. 389)). Appellant argues that the Trial Court's error in not allowing this testimony has amounted to an abuse of discretion because it was allowed under the Rules of Evidence and case law, and it resulted in prejudice to the Appellant and the presentation of its defense on the matter.

Pursuant to the South Carolina Rules of Evidence, "[t]estimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." Rule 704, SCRE. "There is no invasion of the province of the jury, for the jury retains its power and duty to judge both the credibility of the witness and the weight to be given to his opinion." *Redman v. Ford Motor Co.*, 253 S.C. 266, 278, 170 S.E.2d 207 (1969). In *Dawkins*, the court held that "[i]n general, expert testimony on issues of law is inadmissible. *Dawkins v. Fields*, 354 S.C. 58, 66, 580 S.E.2d 433 (2003). However, the court has held "that the trial judge has the discretion to permit expert testimony on the ultimate issue before the jury." *Redman*, 253 S.C. at 278 (citing *O'Kelley v. Mut. Life Ins. Co.*, 197 S.C. 109, 14 S.E.2d 582 (1941)); *see, e.g., Hughes v. Children's Clinic, P.A.*, 269 S.C. 389, 403, 237 S.E.2d 753 (1977).

Appellant's expert, Cindy Hurley, testified as to the standard of care for pediatric nursing and her opinions as to whether Nurse Stobbs complied with that standard. Trial Tr. 327:21-24 (R. p. 336), 328-331:10 (R. pp. 337-340), 333:2-347:25 (R. pp. 342-356), 349:15-350:14 (R. pp. 358-359), 352:8-354:13 (R. pp. 361-363), 356:20-357:4 (R. pp. 365-366), Mar. 17, 2019. For reasons previously discussed, the ultimate issue, the burden which Respondent had to establish, was gross negligence. Given her extensive experience and knowledge regarding pediatric nursing and IV administration (*Id.* at 323:10-324:21 (R. pp. 332-333), 350:15-19 (R. p. 359)), Appellant

sought to ask Ms. Hurley whether she believed Nurse Stobbs and Appellant hospital acted with negligence or gross negligence (*Id.* at 316:14-21 (R. p. 325), 318:1-5 (R. p. 327)). Ms. Hurley could not be prohibited from testifying to this solely on the grounds that it was the ultimate issue in this matter. *See* Rule 704. Moreover, counsel for Appellant was not asking Ms. Hurley to give an opinion as to an issue of law, as this was not possible since Ms. Hurley was a nurse and not a legal expert. Asking Ms. Hurley this question should not have led to any confusion, as the jury was aware that Ms. Hurley was an expert in nursing, not law. Unlike in *Dawkins*, Ms. Hurley did not make, and was not asked to make, a legal argument nor she did offer these opinions in a written affidavit. Appellant wanted to simply asked its expert what her opinion was based on her experience and background as a pediatric nurse.

Earlier in the trial proceedings, counsel for Appellant had asked Respondent's expert the same questions regarding her opinions as to negligence and intentionality on the part of Appellant hospital and Nurse Stobbs, without any objection from counsel for Respondent. Trial Tr. 132:24-25 (R. p. 147), 133:17-19 (R. p. 148), 138:10-139:16 (R. pp. 153-154), Mar. 17, 2019. Appellant thought that asking Ms. Hurley the same questioning would assist the jury in its decision and in weighing and comparing the testimony of both expert witnesses in this matter. Thus, because the jury did retain its power in judging the experts' credibility, allowing this part of Ms. Hurley's testimony would not have usurped its role. Therefore, Appellant argues that the Trial Court's ruling denying this portion of Ms. Hurley's testimony was arbitrary, unreasonable, and unfair to the presentations of Appellant's defense of this matter; thus, Defendants assert it was error for this to be kept from the jury for its consideration.

Appellant further assert that this error resulted in prejudice to Appellant's defense of this matter. The jury returned a grossly excessive verdict in favor of Respondent (Trial Tr. 446:18-447:1, Mar. 17, 2019 (R. pp. 457-458)), despite not hearing any testimony or seeing any evidence of gross negligence. Therefore, the Appellant is left to conclude that not being allowed to ask its expert this important question did, in fact, affect the results of the trial. Appellant maintains that the purpose of the question was to ask its expert her opinion, based on her experience in pediatric nursing, and this would have helped educate and better inform the jury. Thus, not allowing the testimony in the presence of the jury was prejudicial to Appellant.

Therefore, the Trial Court abused its discretion in not allowing Ms. Hurley's testimony regarding gross negligence in front of the presence of the jury, and the decision must be reversed.

V. THE TRIAL COURT ABUSED ITS DISCRETION IN PERMITTING THE REQUEST FOR ADMISSION TO BE PUBLISHED TO THE JURY.

STANDARD OF REVIEW

"[T]he admission or exclusion of evidence in general is within the sound discretion of the trial court." *Fields*, 363 S.C. at 25 "[T]he trial court's decision will not be disturbed on appeal absent an abuse of discretion." *Id.*; *Gooding*, 454 S.E.2d at 330. "An abuse of discretion occurs when there is an error of law or a factual conclusion which is without evidentiary support." *Gooding*, 326 S.C. at 487 (citing *Lee*, 318 S.C. 283, 457 S.E.2d 344); *Fields*, 363 S.C. at 26. "To warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Fields*, 363 S.C. at 26 (citations omitted).

ARGUMENT

Appellant asserts that the publication of its Request to Admit was an error that prejudiced Appellant's defense of the matter and amounted to an abuse of discretion by the Trial Court. Trial Tr. 250:21-258:25, Mar. 17, 2019 (R. pp. 257-265); Def.'s Motion for JNOV or in the alt. Motion for New Trial 8-10 (R. p. 543-545); Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the alt. for a New Trial 8 (R. p. 9); Def. RTA (R. pp. 35-36). Appellant concedes this is an unusual circumstance and the case law seems to only address issues for withdrawal by the admitting party. As per Rule 36(b) of the South Carolina Rules of Civil Procedure, "[t]he Court may permit withdrawal or amendment when the presentation of the merits of the action will be subserved thereby and the party who obtained the admission fails to satisfy the court that withdrawal or amendment will prejudice him in maintaining or defense on the merits." Rule 36, SCRCP; *see, e.g., Commerce Ctr. of Greenville, Inc. v. W. Powers McElveen*, 347 S.C. 545, 557, 556 S.E.2d 718, 724 (Ct. App. 2001) ("The trial court may allow a party to amend or withdraw its answers to a request to admit when: (1) the presentation of the merits is furthered by the amendment; and (2) the party who obtained the admission cannot demonstrate prejudice because of the amendment."). However, Appellant asserts that, pursuant to Rule 403 of the South Carolina Rules of Evidence, publishing the Request to Admit was in error and was highly prejudicial to the Appellant, as it did nothing but confuse the issues for the jury. Trial Tr. 251:24-11 (R. p. 258), 253:9-18 (R. p. 260), 255:20-257:5 (R. pp. 262-264). "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or

misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE.

In its Request to Admit, Appellant asked Respondent to admit or deny that the amount in controversy and amount of Respondent's actual damage exceeded one hundred thousand dollars. Trial Tr. 258:18-25, Mar. 17, 2019 (R. p. 265); Def.'s RTA (R. pp. 35-36). The Request to Admit were not a stipulation under South Carolina Rules of Civil Procedure Rule 43(k)[6] but rather a discovery tool. Trial Tr. 253:9-18, Mar. 17, 2019 (R. p. 260). *See* The purpose of the request to admit was to obtain an Independent Medical Examination under Rule 35(a)[7] of the South Carolina Rules of Civil Procedure, not for Respondent to represent that Appellant admitted the damages were in excess of $100,000.00. *Id.* at 251:24-252:6 (R. pp. 258-259). Although facts may be stipulated under the rule, these Request to Admit were subjective, as they went to damages. Because the purpose was for obtaining were to obtain Respondent's view of the case in order to obtain an Independent Medical Examination under South Carolina Civil Procedure Rule 35(a), these were subjective, not factual, and thus, could not be stipulated. *Id.* at 253:21-254:11 (R. pp. 260-261).

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[6] Rule 43(k), SRCRP. "No agreement between counsel affecting the proceedings in an action shall be binding unless reduced to the form of a consent order or written stipulation signed by counsel and entered in the record, or unless made in open court and noted upon the record, or reduced to writing and signed by the parties and their counsel. Settlement agreements shall be handled in accordance with Rule 41.1, SCRCP."

[7] Rule 35(a), SRCP. "In any case in which the amount in controversy exceeds $100,000 actual damages, and the mental or physical condition . . . of a party, or of a person in the custody or under the legal control of a party, is in controversy, the court in which the action is pending may order the party to submit to a physical or mental examination by a physician or to produce for examination the person in his custody or legal control. . . ."

Although the Trial Court stated that the modification of the Request to Admit would have to go to the merits, not damages, *Id.* at 254:12-255:17 (R. pp. 261-262), Appellant argued that that publication to the jury would prejudice the merits of its defense, *Id.* at 255:20-257:5 (R. pp. 262-264). Reading the Request to Admit to the jury had the effect of confusing them as to the issues in dispute and the purpose of the Request to Admit. Allowing the Request to Admit to be published to the jury made the effect that a verdict had to be awarded for Respondent in the amount of at least $100,000.00. *Id.* at 252:8-11 (R. p. 259), 255:20-257:5 (R. pp. 262-264). This effectively directed a verdict of liability in the Respondent's favor, thereby impeding presentation of the merits of Appellant's case. Throughout the case, liability was contested, and Appellant maintained that it was not negligent. Therefore, publishing the Request to Admit to the jury subserved and impeded the presentation of the merits of the defense.

Appellant argued that the burden was on the Respondent to show that they would be prejudiced if the Request to Admit were not allowed to be published. *Id.* at 256:22-25 (R. p. 263). Appellant argued that they would not be able to meet that burden, as Respondent certainly had every right to argue for whatever verdict amount they wanted. *Id.* at 256:25-257:3 (R. pp. 263-264). Appellant, on the other hand, would be and was in fact highly prejudiced by allowing the admission of the Request to Admit. Moreover, The Request to Admit was not mentioned in Respondent's pretrial brief. Pltf.'s Pretrial Br. Respondent intentionally failed to mention the Request to Admit to Appellant's counsel until they were about to publish it to the jury. This highly prejudiced Appellant, as it had no time to prepare argument or rebuttal evidence. Thus, when balancing the little, if any, probative value of the Request to Admit with the high amount of

confusion and prejudicial effect publishing it would and did have, the admission of the Request to Admit was improper under Rule 403.

As such, the Trial Court should have not have allowed the admission into evidence of the Request for Admission because it was of little probative value and was highly prejudicial to Appellant as it directly confused the issues and impeded the merits of the Appellant's case. Thus, the decision of the Trial Court must be reversed.

VI. THE TRIAL COURT ABUSED ITS DISCRETION IN NOT GRANTING A NEW TRIAL ABSOLUTE OR NEW TRIAL *NISI REMITTITUR* WHEN THE VERDICT WAS GROSSLY EXCESSIVE AND SHOCKINGLY DISPROPORTIONATE AND CONTRARY TO THE EVIDENCE ADMITTED AT TRIAL, OR, AT THE VERY MINIMUM, WAS AT LEAST MERELY EXCESSIVE GIVEN THE EVIDENCE.

STANDARD OF REVIEW

> The decision to grant or deny a new trial absolute based on the excessiveness of a verdict rests in the sound discretion of the trial court and ordinarily will not be disturbed on appeal. An abuse of discretion occurs if the trial court's findings are wholly unsupported by the evidence or the conclusions reached are controlled by an error of law.

Welch, 342 S.C. at 302 (citing *Krepps v. Ausen*, 324 S.C. 597, 479 S.E.2d 290 (Ct.App.1996)); *see, e.g.*, *Stevens v. Allen*, 336 S.C. 439, 446, 520 S.E.2d 625 (Ct. App. 1999). "In deciding whether to assess error when a new trial motion is denied, this Court must consider the testimony and reasonable inferences therefrom in the light most favorable to the nonmoving party." *Welch*, 342 S.C. at 302-03 (citing *Vinson v. Hartley*, 324 S.C. 389, 477 S.E.2d 715 (Ct.App.1996)).

ARGUMENT

A. THE TRIAL COURT ERRED IN NOT GRANTING A NEW TRIAL ABSOLUTE BECAUSE THE VERDICT WAS GROSSLY EXCESSIVE AND SHOCKINGLY DISPROPORTIONATE AND CONTRARY TO THE EVIDENCE ADMITTED AT TRIAL.

> When a party moves for a new trial based on a challenge that the verdict is either excessive or inadequate, the trial judge must distinguish between awards that are merely unduly liberal or conservative and awards that are actuated by passion, caprice or prejudice. The trial court must set aside a verdict only when it is shockingly disproportionate to the injuries suffered and thus indicates that passion, caprice, prejudice, or other considerations not reflected by the evidence affected the amount awarded. In other words, to warrant a new trial absolute, the verdict reached must be so 'grossly excessive' as to clearly indicate the influence of an improper motive on the jury.

Welch, 342 S.C. at 302 (citations omitted); *see, e.g.*, *Stevens*, 336 S.C. at 447 ("The trial judge must grant a new trial absolute if the amount of the verdict is grossly inadequate or excessive so as to shock the conscience of the court and clearly indicates the figure reached was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives."); *Duncan v. Hampton Cnt. Sch. Dist. No. 2*, 235 S.C. 535, 517 S.E.2d 449, 455 (Ct. App. 1990); *see also*, *Sullivan v. Davis*, 317 S.C. 462, 467, 454 S.E.2d 907, 912 (Ct. App. 1995) (holding that the Trial Court abused its discretion in not granting the new trial absolute motion when the verdict was "shockingly disproportionate" to the evidence presented); *Zorn v. Crawford*, 252 S.C. 127, 138, 165 S.E.2d 640, 646 (1969) (granting a new trial in a wrongful death action where "a verdict of $250,000.00 for the actual damages sustained by the beneficiaries . . . [was] not supported by the

evidence and [could] only be explained upon the basis of sympathy, passion, or prejudice on the part of the jury").

The term "passion and prejudice" does not "necessarily imply bad faith, wrongful purpose, or moral delinquency," but rather, results when the award is "against the overwhelming weight of the evidence." *Beasley v. Ford Motor Co.*, 237 S.C. 506, 513, 117 S.E.2d 863, 867 (1961)."Ordinarily the only means of discovering the existence of passion and prejudice as influencing the verdict is by comparing the amount of the verdict with the evidence before the trial court." *Nelson v. Charleston W.C. Ry. Co.*, 231 S.C. 351, 362, 98 S.E.2d 798, 802 (S.C. 1957). However, in some instances,

> [t]he size of the verdict alone may show that it must have been the result of passion or prejudice, as for instance, when it is apparent that the award is obviously so disproportionate to the injury proved as to justify the conclusion that the verdict is not the result of the cool and dispassionate discretion of the jury.

Id. (quoting 15 Am. Jur., *Damages* § 205, p. 623); *see also. Smalls v. Springs Indus., Inc.* 292 S.C. 481, 486, 357 S.E.2d 452, 455 (1987) (stating that under the facts of the case, "the size of the jury's verdict alone establishes it is grossly excessive"). For further clarification,

> [a] close analysis of the results reached in the cases justifies the statement that the courts generally grant relief if convinced that the verdict substantially exceeds any rational appraisal or estimate of the damages even though the inference of passion, prejudice, partiality, or other improper motive on the part of the jury is no more natural or reasonable than the inference of mistake or misapprehension on their part.

Beasley, 237 S.C. at 512-513 (quoting 15 Am. Jur. *Damages* § 205, p. 623).

In this matter, the jury returned a verdict in the amount of $1,127,280 for the minor and $135,477.00 for Respondent Tekayah Hamilton. Trial Tr. 446:18-447:1, Mar. 17, 2019 (R. pp.

457-458); (R. p. 535). Subsequently, Appellant filed a Motion for Judgment Notwithstanding the Verdict or in the alternative Motion for New Trial, in which one of the grounds for a new trial absolute was because the verdict was grossly excessive as compared to the evidence presented at trial. Def.'s Mot. for JNOV or in the alt. Mot. for New Trial 11-13 (R. pp. 546-548). Appellant asserts the Trial Court's denial of its motion on this ground was an error in law, as the verdict was grossly excessive and shockingly disproportionate, wholly unsupported by and contradictory to the evidence presented a trial for the following reasons. Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 8 (R. p. 9)

First, there was little testimony regarding any pain and suffering. Dr. Devito testified that the minor seemed to be experiencing pain during his examination of him, although Dr. Davis testified that during his examination of the minor, the minor denied any pain, burning, or itching (*Id.* at 192:13-25 (R. p. 207)). Dr. Davis testified that Respondent Tekayah Hamilton told him the minor would ask her if he could scratch it. (*Id.* at 192:25-193:2 (R. pp. 207-208)). The only testimony from Respondent Hamilton regarding pain was some itching and cramping that is alleviated with some exercises and crying during the infiltration and wound care follow up treatment.

Second, there was testimony establishing that very little has been done or is planned in regards to treatment. The minor treated at the wound care center at The Regional Medical Center immediately after the infiltration occurred and for a short period of time in 2015. *See* Plf.'s Ex. 6. He saw Respondent's expert Dr. Devito on February 2, 2015; March 5, 2015; and did not go back to him for three years until March 2018. Trial Tr. 163:13-15, 23-25 (R. p. 178); 165:10-12 (R. p.

180), Mar. 17, 2019. At the time of trial, the minor was not currently on any medications for this wound. *Id.* at 169:16-18 (R. p. 184). Nonsurgical options, such as steroidal injections and compression, have been recommended by both the physician referred by Respondent's lawyer and the court-appointed plastic surgeon; however, the minor has not gotten this treatment. *Id.* at 163:13-18 (R. p. 178), 163:23-164:13 (R. pp. 178-179), 195:23-196:18 (R. pp. 210-211), 198:20-199:15 (R. pp. 213-214), 248:23-249:17 (R. pp. 254-255). Surgery had also been recommended by both physicians as another method of treatment to improve the scar (*Id.* at 195:23-196:18 (R. pp. 210-211), 238:5 (R. p. 244)), but Respondent Tekayah Hamilton testified she has no plans for surgery at this time, although she testified she may consider it when the minor is older (*Id.* at 170:3-4, 11-15 (R. p. 185); 171:10-1 (R. p. 186)). Although surgery would improve the appearance of the scar, surgery is not needed for any functionality reasons. *Id.* at 210:2-12 (R. p. 225).

Third, although there is scar tissue (*Id.* at 191:5-14 (R. p. 206)) and the scar is permanent (*Id.* at 210:23-211:5 (R. pp. 225-226)), his hand is fully functioning (*Id.* at 193:3-195:22 (R. pp. 208-210)), and the wound is "well-healed" and "stable" (*Id.* at 191:17-192:3 (R. pp. 206-207)) and will not get worse (*Id.* at 199:16-25 (R. p. 214)). There are no functional deficits and "nothing inhibiting full functioning of the wrist": no diminished finger strength, no impairment of the tendons or wrist, and no issue with range of motion of the wrist. *Id.* at 192:6-12 (R. p. 207), 193:3-2-195:22 (R. pp. 208-210). The child "should have normal functionality throughout the rest of his life." *Id.* at 194:14-15 (R. p. 209). The child will be able to do things a normal child would, such as a throwing a ball, playing a music instrument, holding a fishing pole, writing and drawing, and driving a car. *Id.* at 200:25-202:9 (R. pp. 215-217).

As the evidence presented cannot support a $1,127,280 verdict for the minor and $135,477.00 for Respondent Tekayah Hamilton, the size of the verdict alone is sufficient to show that the jury must have been moved by passion or prejudice,. The verdict of $1,127,280 for minor Respondent is 54 times the amount of actual damages of $20,854. This is grossly excessive and shocks the conscience, as there was little testimony of pain and suffering; there is no ongoing treatment or plans for any in the future; the scar is well-healed and stable; and there are no functionality deficits. Additionally, the $135,477.00 verdict for Respondent Tekayah Hamilton is also grossly excessive, as past and future medical damages only amount to $20,854.00 (*Id.* at 412:24-413:12 (R. pp. 422-423)); she testified she has no plans for the child to undergo any steroidal injections or scar revision surgery (*Id.* at 170:3-4 (R. p. 185)); and she is not entitled to any pain or suffering.

Thus, the verdict in this matter is "without any rational support whatever in the evidence and is so grossly excessive as to show that the jury was actuated by considerations not founded on the evidence and/or the instructions of the court." *Joyner v. St. Matthews Builders*, 263 S.C. 136, 140-41, 208 S.E.2d 48, 50 (1974) (granting a new trial due to the "actual damages" being so manifestly and grossly excessive"). Given the complete lack of any cognizable basis to support the damages award, it is clear that in awarding these amounts for both the minor and his mother, the jury did not pay attention to the jury instructions. "[I]t is fundamental that a jury must abide by the judge's charge, be it right or wrong. Where the jury renders a verdict in disregard of his charge, it is error for the judge not to grant a new trial upon motion." *Southeastern Mobile Homes Inc., v. Walicki*, 282 S.C. 298, 302, 317 S.E.2d 773 (Ct. App. 1984). Appellant is left to conclude that, in light of the excessive verdict as compared to the evidence of actual damages,

the jury arrived as its award as a result of passion, caprice, or other improve motives. "If the amount of the verdict is grossly excessive so as to be the result of passion, caprice, prejudice or some other influence outside the evidence, the trial judge must grant a new trial absolute, not a new trial *nisi remittitur*." *Welch*, 342 S.C. at 303 (citing *O'Neal v. Bowles*, 314 S.C. 525, 431 S.E. 2d 555 (1993)). Therefore, it was an abuse of discretion for the Trial Court not to grant Appellant's motion for a new trial absolute based on the grossly excessive verdict, and thus, the decision must be reversed.

B. IN THE ALTERNATIVE, IF THE APPELLANT COURT DOES NOT BELIEVE THE TRIAL COURT ABUSED ITS DISCRETION IN DENYING THE MOTION FOR A NEW TRIAL ABSOLUTE, APPELLANT ASSERTS THAT THE TRIAL COURT ABUSED ITS DISCRETION BY NOT GRANTING ITS MOTION FOR NEW TRIAL *NISI REMITTITUR* BECAUSE THE VERDICT WAS, AT THE VERY LEAST, MERELY EXCESSIVE.

> The trial court has wide discretionary power to reduce the amount of a verdict which in his or her judgment is excessive. Indeed, when the verdict indicates the jury was unduly liberal in determining damages, the trial court alone has the power to reduce the verdict by the granting of a new trial *nisi remittitur*. A motion for new trial *nisi remittitur* asks the trial court in its discretion to reduce the verdict because it is merely excessive, although not motivated by considerations such as passion, caprice or prejudice.

Welch, 342 S.C. at 303 (citations omitted); *see, e.g., RRR, Inc v. Toggas*, 378 S.C. 174, 183, 662 S.E.2d 438 (Ct. App. 2008) ("[T]he circuit court alone has the power to grant a new trial nisi when it finds the amount of the verdict to be merely inadequate or excessive."); *Howard v. Roberson*, 376 S.C. 143, 154, 654 S.E.2d 877 (Ct. App. 2007) (stating that the court "may grant a

new trial nisi additur or remittitur when it finds the verdict is merely inadequate or excessive."); *Becker v. Walmart Stores, Inc.*, 339 S.C. 629, 636, 529 S.E.2d 758 (Ct. App. 2000) (affirming trial court's granting of motion for remittitur on grounds that amount awarded by jury was "merely excessive"). "In considering a motion for new trial *nisi*, the trial court must evaluate the adequacy of the verdict in light of the evidence presented." *Welch*, 342 S.C. at 303 (citing *Waring v. Johnson*, 341 S.C. 248, 533 S.E.2d 906 (Ct.App.2000)).

In its motion, Appellant asked the Trial Court that if did not agree with Appellant that the verdict is grossly excessive to the extent of shocking the conscience and did not appear to be motivated by considerations such as passion, caprice or prejudice, then to grant a new trial *nisi remittitur* because the verdict was, at the very least, merely excessive. Def.'s Mot. for JNOV or in the alt. Mot. for New Trial 11-14 (R. pp. 546-549). The Trial Court denied Appellant's motion for a new trial *nisi remittitur*, although it did grant, in part, Appellant's motion to cap the damages as required by the South Carolina Torts Claims Act (§15-78-10, et seq.). Court's Order Granting Def.'s Motion for Reduction to Statutory Cap & Denying Def.'s Motion for JNOV or in the Alt. for a New Trial 4-6, 8 (R. pp. 5-7, 9); Def.'s Post Trial Mot. for Reduction to Statutory Cap (R. pp. 552-554). The Trial Court capped the judgment for the minor at $300,000.00 because §15-78-120(a)(1) provides a maximum of $300,000.00 for a loss arising from a single occurrence.

Additionally, Appellant moved for a reduction in Respondent Tekayah Hamilton's verdict, which was in the amount of $135,477.00, as she was only entitled to past and future medical costs, which totaled $20,854.00. Trial Tr. 412:24-413:12 (R. pp. 422-423); Def.'s Post Trial Mot. for Reduction to Statutory Cap (R. p. 552-554). *See, Patton v. Miller*, 420 S.C. 471, 804 S.E.2d

252 (2017) (a parent is the proper party in interest with respect to past and future medical expenses while the child is a minor); *Wright v. Colleton Cnty. Sch. Dist.*, 301 S.C. 282, 289-90, 391 S.E.2d 564 (1990) (finding that a parent may recover medical expenses separately from the child's claim). However, the Trial Court denied Appellant's motion to reduce the verdict for Respondent Tekayah Hamilton.

Even after capping the minor's judgment at $300,000.00 as required by §15-78-120(a)(1), the judgment is still, at the very minimum, merely excessive. As discussed above, there was no testimony of current, ongoing treatment or plans for any in the future, and there was little testimony of pain or suffering. The wound is well-healed (Trial Tr. 191:17-192:3, Mar. 17, 2019 (R. pp. 206-207)), and the hand fully functioning (*Id.* at 193:3-195:22 (R. pp. 208-210)). The jury saw this for themselves. Moreover, the verdict for Respondent Tekayah Hamilton in the amount of $135,477.00 was also, at the very minimum, merely excessive, as she testified she has no plans for steroidal injections or surgery (*Id.* at 170:3-4 (R. p. 185)), and the only evidence of actual damages, past and future medical expenses, were in the amount of $20,854 (*Id.* at 412:24-413:12 (R. pp. 422-423)). She was not entitled to any damages for pain and suffering. Therefore, the verdict rendered by the jury, as well as the statutory cap placed on the minor's verdict, was at least merely excessive as compared to the evidence presented at trial. As such, the Trial Court abused its discretion in denying Appellant's alternative motion for new trial *nisi remittitur.*

Since the verdict was grossly excessive or at least merely excessive, the Trial Court's error in not granting either a new trial absolute or in the alternative a new trial *nisi remittitur* amounted to an abuse of discretion, and the decision must be reversed.

CONCLUSION

For the reasons stated, Appellant respectfully requests the Appellate Court to reverse the decision of the Trial Court and dismiss this action with prejudice or, in the alternative, reverse the decision of the Trial Court and grant Appellant a new trial.

Respectfully submitted,

May 20, 2021

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

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May 20 2021
SC Court of Appeals

Honorable Edgar W. Dickson, Circuit Court Judge

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of 18,..... Respondent

v.

Regional Medical Center, ...Appellant

PROOF OF SERVICE

I certify that I have served the Final Brief of The Regional Medical Center, by depositing a copy of it in the United States Mail, a postage prepaid, and via email on May 20, 2021, addressed to the attorneys of record, Jonathan F. Krell, Esquire, Post Office Box 299, Charleston, S.C., 29402, and David R. Williams, Esquire, Post Office Box, 1084, Orangeburg, S.C., 29116, and Kathleen Chewning Barnes, Esquire, Post Office Box, 897, Hampton, S.C., 29924.

May 20, 2021

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CERTIFICATE OF COUNSEL

The undersigned certifies that this Final Brief complies with Rule 211, SCACR.

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FINAL REPLY BRIEF OF THE REGIONAL MEDICAL CENTER

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I. THIS CASE IS ABOUT PEDIATRIC NURSING AND IV ADMINISTRATION AND MONITORING AND RESPONDENT'S EXPERT MONICA STOBBS FAILED TO MEET THE REQUIREMENTS OF RULE 702, SCRE, AND GOODING AS IT PERTAINED TO PEDIATRICS

In its brief, Respondent falsely states that Appellant is incorrect about this case being about pediatric nursing, and instead, characterizing it as "IV management safety practice of doing and documenting a saline flush before administering medication." (Br. of Resp. 8) Respondent falsely characterizes Appellant's discussion of blood return and IV management irrelevant on the basis that this case is about whether a flush was done, (Br. of Resp. 6), and that Appellant's arguments regarding Nurse Downing's qualifications are mute or "does not make a difference." (Br. of Resp. 7) on the basis that the standard of care is the same for pediatrics and adults.

This case *is* about pediatric nursing, and there *are* differences between pediatrics and adults and the care provided to each during IV administration and monitoring. App. Br. 11 (App. Final Br. 11). There are various physiological differences that vary greatly among infants, children, and adults. App. Br. 11 fn 1, 2, 3 (App. Final Br. 11-12). Veins in infants are "obviously smaller" and can be "threadlike." App. Br. 11 fn 2 (App. Final Br. 12). "Vein fragility and the high acuity levels of young patients can increase the likelihood of infiltration and extravasation, resulting in significant morbidity." App. Br. 11-12, fn 3 (App. Final Br. 12). Since infants, children, and adults are all different, there are different procedures in place, different equipment used, and different techniques utilized in the IV administration. Trial Tr. 331:4-17; 332:7-12, 15-20, Mar. 17, 2019 (R. pp. 340-341). It requires a certain skill. *Id.* at 332:7-9 (R. p. 341).

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As this matter was about pediatric nursing, not general nursing, to testify as to the standard of care regarding *pediatric* standard of care for IV administration and monitoring, Nurse Stobbs was required, by Rule 702 of the South Carolina Rules of Evidence, to possess the "knowledge, skill, experience, training or education" as it pertained to *pediatrics*. Rule 702, SCRE. "To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter.'" *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 253, 487 S.E.2d 596, 598 (1997) (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995); *see, e.g.*, *State v. Douglas*, 367 S.C. 498, 508-509, 626 S.E.2d 59 (Ct. App. 2006); *Botehlo v. Bycura*, 282 S.C. 578, 586, 320 S.E.2d 59, 65 (Ct. App. 1984). Nurse Stobbs fails to meet the requirements of both Rule 702 and Gooding as to *pediatric* nursing and IV administration. App. Br. 12-15 (App. Final Br. 12-15). Nurse Stobbs has never cared for a pediatric patient; has never started or managed a pediatric IV; does not have any education or knowledge as to pediatric nursing or IV administration; and did not perform any research, independent study, or review any medical literature in preparation of formulating her opinions. App. Br. 13 (App. Final Br. 13-14). Moreover, Nurse Stobbs actually testified in direct contradiction with the medical literature regarding obtaining blood return, as well as testimony from Nurse Downing and Cynthia Hurley, both of whom actually practice in pediatrics. App. Br. 13-14 (App. Final Br. 14-15). This argument is not irrelevant, as it is further proof of Nurse Stobb's lack of experience or knowledge regarding *pediatric* nursing and IV administration.

Respondent incorrectly states in its brief that Nurse Stobbs "is qualified in the field of IV management." Resp. Br. 11. Nurse Stobbs was qualified as to *general nursing*, not the field of IV management. Trial Tr. 10:4-6, Dec. 22, 2020 (R. p. 46); Trial Tr. 78:1-9, Mar. 17, 2019 (R. p. 93). Moreover, Respondent argues that she was "not required to specifically practice in pediatric IV management." Resp. Br. 11. However, the argument is not that Nurse Stobbs has to specifically practice in pediatrics. The issue is not over a *defect* in amount or quality of experience or knowledge. App. Br. 13 (App. Final Br. 13). Rather, the issue is whether Nurse Stobbs possessed *any* of the required "knowledge, skill, experience, training or education" "acquired by reason of study or experience or both" such that she is "better qualified than the jury to form an opinion on" *pediatric* nursing and *pediatric* IV administration and monitoring. Rule 702, SCRE; *Gooding*, 326 S.C. at 253, 487 S.E.2d at 598; App. Br. 12-13 (App. Final Br. 12-13). Nurse Stobbs must have gained knowledge or experience in *pediatric* nursing and IV administration by some means to be qualified to testified as to the standard of care of the same. She has no such knowledge or experience in *pediatric* nursing and IV administration, and therefore was not qualified to testified as to the standard of care for *pediatric* nursing and IV administration. App. Br. 12-15 (App. Final Br. 12-15).

Respondent is incorrect that Appellant's arguments against the qualification of Nurse Stobbs goes to the weight and not admissibility of her testimony. Br. of Resp. 8. Similar to the orthopedic surgeon in *Botehlo*, Ms. Stobbs has had no personal experience or training at all in pediatric nursing or IV administration. App. Br. 13 (App. Final Br. 13). Respondent is incorrect in that *Botehlo* is not easily distinguishable from the facts of this matter. Resp. Br. 10. In *Botehlo*, the court held that an orthopedic surgeon was not qualified to testify on the standard of care for

podiatrist where the orthopedic surgeon 1) had no training in podiatry, 2) was not familiar with any journals or periodicals in podiatry, and 3) was not familiar with the surgical procedure performed. *Botehlo v. Bycura*, 282 S.C. 578, 586, 320 S.E.2d 59, 65 (Ct. App. 1984). Similar to *Botehlo*, Nurse Stobbs 1) has had no training, education, or any experience at all in *pediatric* nursing or IV administration; 2) was not familiar with any medical literature regarding *pediatric* nursing or IV administration and had not performed any research, independent study, or review any medical literature as to *pediatric* nursing and IV administration in preparation of formulating her opinions; and 3) has never cared for a *pediatric* patient and has never started or managed a *pediatric* IV. App. Br. 13 (App. Final Br. 13-14); Trial Tr. 79:24-25 (R. p. 94), 108:22-110:21 (R. p. 123), 103:14-104:8 (R. pp. 118-119), 111:14-23 (R. p. 126), Mar. 17, 2019; Stobbs Dep. 13:9-24 (R. p. 518), 26:15-24 (R. p. 519). Thus, similar as to how the orthopedist in *Botehlo* "not versed at all in the practice of podiatry," *McMillan v. Durant*, 312 S.C. 200, 204, 439 S.E.2d 829, 832 (1993) (referring to *Botehlo*), Nurse Stobbs is not versed at all in the practice of *pediatric* nursing and IV administration.

Respondent relies on *McMillian, Lee, Graves,* and *Creed* for its argument that Nurse Stobbs lack of experience in pediatrics is not sufficient in prohibiting her from testifying as to the standard of care for pediatric nursing and IV administration. Resp. Br. 8-10; *McMillan v. Durant*, 312 S.C. 200, 439 S.E.2d 829 (1993); *Lee v. Suess*, 318 S.C. 283, 457 S.E.2d 344 (1995); *Graves v. CAS Med. Sys.*, 401 S.C. 63, 735 S.E.2d 650 (2012); *Creed v. Columbia*, 310 S.C. 342, 426 S.E.2d 785 (1993). However, these cases are easily distinguishable.

Unlike *McMillian*, where a neurosurgeon was qualified to testify as to the appropriate standard of care of nursing on the basis that he taught nursing courses at a university, *McMillan*,

439 S.E.2d at 833, and *Lee*, where a plastic surgeon who was qualified to testify as to where he was a professor who taught family practitioner residents how to identify skin cancers and perform biopsies, *Lee*, 457 S.E.2d at 346, Nurse Stobbs has not had any experience teaching any courses regarding pediatric nursing or pediatric IV administration. In fact, she has no experience —knowledge or skill, training or education—whatsoever in pediatric IV administration. App. Br. 12-13 (App. Final Br. 13).

Unlike in *Graves,* where the doctor stayed current on sudden infant death syndrome (SIDS) literature and routinely encountered SIDS in her practice, *Graves*, 401 S.C. at 78, Nurse Stobbs was unfamiliar with the medical literature regarding pediatric IV administration and management and had not done any research during her time spent prepping for this trial. App. Br. 13 (App. Final Br. 13-14). Further, not only does she not "routinely encounter" pediatrics in her practice, she has *never* treated a single pediatric patient during her *entire* career. App. Br. 12-13 (App. Final Br. 13). She has never started or monitored an IV in a single pediatric patient in her nursing career. App. Br. 12-13 (App. Final Br. 13).

This case is also not similar to *Creed*. In *Creed*, the general practitioner who was qualified to give an opinion on the plaintiff's mental and emotional injuries had personally examined the plaintiff and referred him to a neuro-psychologist as a part of his course of treatment. *Creed*, 426 S.E.2d at 786. In the present matter, Nurse Stobbs did not personally treat, examine, or care for the minor Respondent and did not refer him to an outside specialist as a part of his course of treatment. In fact, she has not personally treated or care for *any* pediatric patient. App. Br. 12-13 (App. Final Br. 13).

Additionally, in its brief, Respondent maintains that Appellant relies on *Gooding* but that *Gooding* supports Respondent's position. Resp. Br. 10. However, the present matter is also distinguishable from *Gooding*. In *Gooding*, the EMT who was qualified to testify as to intubation procedure had personal, hands-on experience with intubation and had intubated over 100 patients. *Gooding*, 326 S.C. at 251. This case is about *pediatric* IV management, and Nurse Stobbs has had *no experience whatsoever* in pediatric IV management or pediatric nursing. App. Br. 12-13 (App. Final Br. 13).

Respondent's expert Nurse Stobbs was the only witness it produced as it pertained to two critical issues. The jury returned a verdict that was excessive in light of the testimony and evidence presented at trial. Thus, the issue concerning her qualification or lack of *does* matter and *does* make a difference. App. Br. 15-16 (App. Final Br. 17).

In its brief, Respondent incorrectly argues that Appellant's argument regarding Nurse Stobbs' testimony on the pediatric standard of care for IV administration and monitoring was not preserved for appeal. Resp. Br. 11-12. In its Motion in limine, counsel for Appellant made it known to the court that he felt like this was a situation in which Respondent was attempting to have her qualified in pediatric nursing. Trial Tr. 8:13-17, 8:20-9:19, Dec. 22, 2020 (R. pp. 44-45). The Trial Court specifically indicated Ms. Stobbs would be qualified in general nursing and not pediatrics, as it acknowledged she had no prior experience with regards to pediatrics. Trial Tr. 8:18-19, 9:20-10:6, Dec. 22, 2020 (R. pp. 44-46). In its decision, the Trial Court stated that it would qualify her for nursing care but not neonatal. Trial Tr. 10:5-6, Dec. 22, 2020 (R. p. 46). Respondent incorrectly maintains the position that Appellant's argument was not preserved

but it was never objected to during trial. Br. of Resp. 11. However, during the qualification of Nurse Stobbs at trial, counsel for Appellant contemporaneously objected and stated on the record that Nurse Stobb's qualification was "subject to my prior objection." Trial Tr. 78:5-6, Mar. 17, 2019 (R. p. 93).

Nurse Stobbs was qualified as an expert in nursing, *general* nursing, not pediatrics or neonatal and not in the "field of IV management" as stated in Respondent's brief (Resp. Br. 11). Trial Tr. 10:4-6, Dec. 22, 2020 (R. p. 46); Trial Tr. 78:1-9, Mar. 17, 2019 (R. p. 93). As suspected, Nurse Stobbs did in fact testify during trial regarding the standard of care for *pediatric* nursing and IV administration and care. All supporting arguments and authority as it pertains to Nurse Stobb's testimony regarding pediatric nursing and IV administration and monitoring have already been discussed in this brief, as well as Appellant's Initial Brief. *See* Rule 702, SCRE; *Gooding,* 326 S.C. 248, 487 S.E.2d 596; *Botehlo*, 282 S.C. 578, 320 S.E.2d 59; App. Br. 9-16 (App. Final Br. 9-17).

II. GROSS NEGLIGENCE IS THE STANDARD THAT APPLIES IN THIS MATTER AND RESPONDENT FAILED TO MEET THEIR BURDEN

Gross negligence is the standard that applies in this case. App. Br. 17 (App. Final Br. 18); Trial Tr , 214:12-215:16, 434:10-17 (R. p. 445), Mar. 17, 2019. *Stewart* is the governing law in this matter. *See Stewart v. Richland Mem'l Hosp.*, 350 S.C. 589, 592, 567 S.E.2d 510, 511 (Ct. App. 2002). As defined by S.C. Code Ann. § 15-78-30(j) and *Smith v. TRMC,* Appellant is a governmental entity, and therefore this matter is strictly governed by the confines of the South Carolina Torts Claims Act. App. Br. 17 (App. Final Br. 18); *see Smith v TRMC*, 713 S.E.2d 656 (Ct. App. 2011); S.C. Code Ann. §15-78-200. The South Carolina Torts Claims Act limits

liability of a governmental entity unless there is gross negligence. S.C. Code Ann. § 15-78-60(25); App. Br. 17 (App. Final Br. 18-19). Respondent argues that gross negligence is the applicable standard because "because it concerns a nurse's administration of medication and not 'supervision, protection, control, confinement, or custody' of a patient." Br. of Resp. 15, fn 2. However, although Stewart involved the custody of an inmate, it also involved the monitoring of him as a patient. *Stewart,* 350 S.C. 589, 591-592; Trial Tr. 213:14-22, Mar. 17, 2019. Therefore, the gross negligence standard is applicable in cases involving the monitoring of patients, and thus, as the Trial Court agreed, is applicable in this case.

Respondent is incorrect in its presumption that Appellant is arguing that the words "gross negligence" must have been used for the evidence of the same to exist. Resp. Br. 15. Appellant's position is that Respondent failed to establish *any* evidence of gross negligence, and thus, they failed to meet their burden and a directed verdict should have been returned in favor of Appellant. App. Br. 18 (App. Final Br. 20).

Respondent believes the issue in this matter is whether the IV was flushed before administering ampicillin, and Respondent's theory is based on "if it wasn't documented, it wasn't done." Resp. Br. 3. However, this theory is directly contradictory to the testimony as to the policies and procedures of pediatric nursing and IV administration at The Regional Medical Center (RMC) and is based on a complete misread of the policy itself. In its brief, Respondent maintains that there was evidence that RMC "consciously failed to do or document a saline flush." Resp. Br. 16. Respondent bases assertion by stating "RMC's policies require a saline flush prior to administering medication and documentation of that flush." Resp. Br. 16. However, this is factually incorrect and blatantly mischaracterizing the testimony as to what the policy requires.

Both Nurse Downing and Cynthia Hurley testified numerous times that flushing a site is part of the assessment with administering a medication, and there is no way to give the medication without flushing the IV first. Trial Tr. 272 25-273:8 (R. pp. 280-281), 273:18-274:1 (R. pp. 281-282), 276:22-25 (R. p. 284), 277:5-10 (R. p. 285), 280:2-281:1 (R. pp. 288-289), 364:2-19 (R. p. 373), 365:9-13 (R. p. 374), Mar. 17, 2019. It is considered a part of the process and therefore it is not to be documented separately. *Id.* at 284:19-21 (R. p. 292). Even Respondent acknowledged in its brief that Nurse Downing testified it is her practice to flush prior to administering medication (Resp. Br. 3); that Downing testified flushing prior to administration of medication is "ingrained in you in nursing school" and "it makes no sense not to" flush (Resp. Br. 16); and that Downing testified there is "no way to really tell if the site is open and flowing without flushing it" (Resp. Br. 17).

The issue comes down to the fact that there are two types of flushes and different policies and procedures for each: 1) flushes done when administering medication, and 2) four-hour flushes that are automatically populated in the MAR computer system. The flushes that are given prior to and after administering medication, are considered a part of the process for administering medication, and they are not to be documented separately in the MAR system. Trial Tr. 284:19-21 (R. p. 292), 336:19 -337:2 (R. pp. 345-346), Mar. 17, 2019. In fact, there is not a flow sheet or space in which to document it. *Id.* at 284:19-21 (R. p. 292). In contrast, the flushes that task automatically in four-hour increments in the computer MAR program automatically populate when the ordering physicians puts in the order for the IV. *Id.* at 285:18-23 (R. p. 293). Although the timing of these flushes could align with the administration of medication, these flushes are not associated with medication administration. *Id.* at 275:23 (R. p. 283). These four-

hour flushes are a part of an intermittent, not continuous, IV schedule, as was the case here, and are to be documented pursuant to RMC policy. *Id.* at 274:6-19 R. p. 282), 274:23-275:1 (R. pp. 282-283), 275:19-276:9 (R. pp. 283-284), 364:14-19 (R. p. 373). Per RMC policy, infants are to be flushed in four-hour increments, which is a different in adult IV administration. *Id.* at 331:4-8 (R. p. 340). Nurse Downing and Cynthia Hurley both testified several times that although these four hour flushes automatically populate in the system to be tasked at a certain time, it is not always appropriate to do those flushes at that time. It would not be appropriate when a nurse has already flushed the IV prior to that time as part of the process of administering a medication. *Id.* at 331:1-3 (R. p. 340), 365:18-19 (R. p. 374). If a medication is already being administered when the four-hour flush tasks, it would not be appropriate to flush at that time and would instead be appropriate once that medication has finished being administered. *Id.* at 285:2-7 (R. p. 293). It would also not be appropriate to flush if it has infiltrated. *Id.* at 285:7-9 (R. p. 293), 343:4-8 (R. p. 352).

The very notable and important distinctions between these two flushes that were discussed at length during trial. Respondent is basing its position on that Downing did not remember doing a flush prior to administering the ampicillin and "if something is not documented, then it was not done." Resp. Br. 17. Respondent is misreading the RMC policy, mischaracterizing the testimony, and attempting to make it seem like Nurse Downing did not follow the correct policy, when in fact, she and Appellant's expert Cynthia Hurley, testified that she did, in fact, follow RMC policy and procedure. Although Nurse Stobbs could not recall specifically flushing at that particular time due the length of time that has transpired, she testified that flushing prior to administering medication is a part of the process, is "ingrained in you in

nursing school,"and "it makes no sense not to" flush. *Id.* at 280:21-281:1 (R. pp. 288-289). Moreover, she testified it was not documented because it was not supposed to be, as it was considered a part of the process for administering medication, and there was not a place in the computer system to document it separately. *Id.* at 272:25-273:8 (R. pp. 280-281), 273:12-14 (R. p. 281)

Not only did Nurse Downing testify that she complied with the policy and that at no time she did see an infiltration score of 5, Trial Tr. 303:25-305:21, Mar. 17, 2019 (R. pp. 311-313), Cynthia Hurley, in her testimony, gave a detailed description and timeline of the flushes that Nurse Downing performed in her treatment and care of the minor. Nurse Downing began working at 6:45 pm and got a report saying the patient's hand was flushing well. Trial Tr. 327:12, Mar. 17, 2019 (R. p. 336). At 7:30 pm, Nurse Downing wrote her nurse's note and documents indicate the patient was resting in his mother's arms and the IV flushing properly. *Id.* at 328:6 (R. p. 337), 333:25-334:3 (R. pp. 342-343), 336:11-16 (R. p. 345). The first IV check was at 7:44. *Id.* at 328:7, 21-24 (R. p. 337). A four-hour flush was tasked at 8 pm, but a previous nurse had already flushed when administering an antibiotic, so it did not make sense to do it at the time and was instead done at 9:19 p.m. *Id.* at 330:9-331:10 (R. pp. 339-340). At 10:05 pm Nurse Downing performed an IV check and flush. *Id.* at 333:4-10 (R. p. 342). At 11:08 p.m. Nurse Downing administered ampicillin, which would have included a flush before and after administration of medication. *Id.* at 336:19-337:2 (R. pp. 345-346). At 11:23 p.m. she checked the IV; it was documented that the IV infiltration score was 0, phlebitis score was 0, and there were no problems. *Id.* at 337:8-338:8 (R. pp. 346-347). Nurse Downing went in again at 11:44 p.m. for

another IV administration and flush. *Id.* at 338:10-17 (R. p. 347). Vitals were taken at 11:59 p.m. and were normal. *Id.* at 338:19-21 (R. p. 347).

A four-hour flush was tasked at midnight; however, it tasked after Claraforan, an antibiotic, was given at 11:44 p.m. *Id.* at 339:1-9 (R. p. 348). Since it had just been flushed during that process of administering that medication, the IV was flushed after the completion of the administration of Claraforan. *Id.* at 339:1-12 (R. p. 348). It would have made no sense to give it at midnight. *Id.* at 365:18-19 (R. p. 374). Nurse Downing checked the IV at 12:37 a.m. and performed the flush at 1:04 a.m. *Id.* at 339:11-12 (R. p. 348).. The minor had a phlebitis score of zero, infiltration zero, no signs of complication, and was sleeping. *Id.* at 307:4-9 (R. p. 315), 339:15-23 (R. p. 348).

Nurse Downing then checked on the minor as a part of her periodic nursing rounds. *Id.* at 339:24-340:3 (R. p. 348-349). At 2:30 a.m. a note was made in the nursing charts that the patient was asleep, no signs of distress, and will continue to monitor. *Id.* at 341:7-12 (R. p. 350). At 2:41 a.m. Nurse Downing performed another IV check. *Id.* at 340:9-12 (R. p. 349). At 2:43 vitals were assessed by a nursing assistant and were confirmed to be okay by Nurse Downing at 2:49 a.m. *Id.* at 340:22-341:6 (R. pp. 349-350). At 4:04 Nurse Downing performed another IV assessment that showed an infiltration score of zero and phlebitis score of zero. *Id.* at 341:14-24 (R. p. 350). Cynthia Hurley testified that this 4:04 a.m. assessment "certainly met the standard of care." *Id.* at 350:9-14 (R. p. 359).

Ampicillin medication was administered at 4:27 a.m.. *Id.* at 341:25-342:4 (R. pp. 350-351). Nurse Downing testified that when she gave the medication, she assessed the site and it was 0 and flushing well. *Id.* at 292:12-14 (R. p. 300). A four-hour flush tasked at 4:45 a.m., but

Nurse Downing and Cynthia Hurley both testified that it was not appropriate to flush at that time because medication was already infusing and was not appropriate to flush after the medication was finished being administered because the IV had infiltrated. *Id.* at 285:4-5 (R. p. 293), 342:22 -343:8 (R. pp. 351-352). The medical records indicate at 4:50 a.m. Nurse Downing had a discussion with the Respondent Tekeyah Hamilton about the infiltration, discharged the IV antibiotics, stopped the pump from administering anymore ampicillin, removed dressing, removed peripheral IV removed, noted catheter intact, and called the physician. *Id.* at 343:21-345:3 (R. pp. 352-354), 346:17-21 (R. p. 355). Nurse Downing testified that she went in as soon as the alarm sounded, and "you do the best you can" with regards to charting real time because "[o]obviously, at the moment the more pressing circumstance would be to assess the patent and follow proper procedures for removing an IV." *Id.* at 286: 22-287:5 (R. pp. 294-295). Cynthia Hurley testified that Nurse Downing took the appropriate course of action. *Id.* at 343:14-20 (R. p. 352).

At 5:16 and 5:17 a.m., vitals were confirmed and the IV was removed. *Id.* at 347:3-4 (R. p. 356). At 6 am the patient was assessed and was asleep. *Id.* at 347:7-10 (R. p. 356). At 6:22 and 6:26 a.m. vitals were confirmed, and at 6:45 a.m., Nurse Downing gave a shift report to another nurse as her shift was ending. *Id.* at 347:13-14 (R. p. 356).

Cynthia Hurley testified that not only did Nurse Downing abide by the standard of care and do everything she was supposed to do, but she actually exceeded the standard of care. *Id.* at 347:19 (R. p. 356), 352:8 - 354:13 (R. pp. 361-363), 356:20-357:4 (R. pp. 365-366), 371:22-23 (R. p. 380). Ms. Hurley testified that according to RMC's policy, "The phlebitis and infiltration scale is to be utilized to address IV site conditions a minimum of once per shift. That's all she

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had to do." *Id.* at 353:11-18 (R. p. 362). However, Nurse Downing checked on the minor and the IV about every hour and gave seven flushes during her twelve hour shift when the policy required one flush every four hours. *Id.* at 353:11-14 (R. p. 362). Nurse Downing assessed the IV 19:44, 20:54, 22:05, 23:23, 0:37, 1:00, 2:42 and 4:04. *Id.* at 354:3-10 (R. p. 363). She only had to do one of these assessment per RMC policy. *Id.* at 331:6-8 (R. p. 340), 354:11-13 (R. p. 363). This is evidence that Nurse Downing not only followed protocol, but she *exceeded* it and exceeded the standard of care required.

Contrary to Respondent's brief, Respondent did not put forth any evidence of conscious failure to act or intentionality. In fact, Nurse Stobbs had no opinion as to the intentional conduct of Nurse Downing. Br. of App. 19 (App. Final Br. 19). Respondent failed to put forth evidence that Nurse Stobbs failed to abide by RMC policy, and in fact, there was much testimony to the contrary. Furthermore, Nurse Stobbs agreed that just because there is an IV infiltration does not mean there is negligence and that it is a known risk and admitted to having had IVs infiltrate without having been negligent herself. Br. of App. 19 (App. Final Br. 19). This is not a situation of "competing evidence" such that "evidence yields more than one reasonable inference or its inference is in doubt" as suggested in Respondent's brief. *See* Resp. Br. 15 & 17. Respondent did not put forth "any evidence. . .to support the jury verdict." *See* Resp. Br. 17. Respondent did not put forth any evidence establishing gross negligence, and therefore did not meet their burden and the jury's verdict is not supported by the evidence. A directed verdict or JNOV should have been granted.

III. RESPONDENT TEKAYAH HAMILTON'S VERDICT AWARD WAS EXCESSIVE AS SHE WAS LIMITED TO PAST AND FUTURE MEDICAL DAMAGES

As discussed previously, this case is subject to the limitations of the South Carolina Torts Claims Act. In *Wright*, the court in finding that a parent may recover medical expenses separately from the child's claim, provided that parent's claim for loss of services and medical expenses resulting from the injury of a minor child is within the tort claims act statutory definition of "loss." *Wright v. Colleton Cnty. Sch. Dist.*, 301 S.C. 282, 289-90, 391 S.E.2d 564 (1990).

Respondent relies on *Doe v. Greenville County School District.* Resp. Br. 32-34. *Doe v. Greenville Cnty. Sch. Dist.*, 375 S.C. 63, 651 S.E.2d 305 (2007). In *Doe*, the parents argued that the trial court erred in dismissing their claim for loss of consortium as it pertained to their child. The Supreme Court disagreed. What Respondent is relying on in the case is a text pertaining to a description of what was allowed at common law.

> At common law, a father possessed the right to maintain an action for the injuries of his minor child. This right was based upon the concept that a father was entitled to compensation for the loss of services and earning capacity of his minor child. Additionally, the father could recover for other pecuniary losses, including medical expenses incurred as a result of the injury.

Id. at 68 (internal citations omitted). The Court went on to explain that in *Taylor*, the Court, in declining to recognize a cause of action for loss of parental consortium, "held that the determination of which relationships may give rise to a loss of consortium claim in South Carolina is one best left to the discretion of the legislature."*Id.* at 69 (quoting *Taylor v. Medenica*, 324 S.C. 200, 222, 479 S.E.2d 35, 47 (1996)). The Court further explained that in *Kirkland*, the South Carolina District Court adopted the *Taylor* analysis and found "that South Carolina law did not provide a cause of action for loss of consortium of a child or for filial consortium." *Id.* (quoting *Kirkland v. Sam's East, Inc.*, 411 F.Supp.2d 639, 641 (D.S.C.2005)). The Court in *Doe*

extended *Taylor* and held "that South Carolina law does not recognize claims for loss of filial consortium" as "[s]uch rights did not exist under the common law, and the legislature has not provided such a right by statute." *Id.*

> ...our common law only allowed a parent to maintain an action for the loss of a child's services and earning capacity. These common law claims did not include the intangible losses of aid, companionship, and society which have traditionally defined loss of consortium claims. Accordingly, in absence of some action from the legislature, this Court has no authority upon which it could rely in finding that South Carolina law recognizes claims for loss of filial consortium.

Id. 69-70.

In 2017 the Court was presented with the issue of whether a minor may bring an action for her own medical expenses. *Patton v. Miller,* 420 S.C. 471, 804 S.E.2d 252 (2017). The Court stated that this invoked the"real party in interest" requirement of Rule 17(a) of the South Carolina Rules of Civil Procedure and found that a parent is the proper party in interest with respect to past and future medical expenses while the child is a minor. *Id.* at 479-80.

Based on previous argument regarding Respondent's failure to establish evidence of gross negligence, Appellant maintains its position that a directed verdict, JNOV, or in the alternative, a new trial, should have been granted, as the verdict rendered was shockingly disproportionate, wholly unsupported by and contradictory to the evidence presented. However, in the event the court disagrees, Appellant believes its motion for a new trial *nisi remittitur* should have been granted, as the verdict was, at the very least, merely excessive in light of the evidence presented, and the damages are subject to the above limitations.

Loss of services is not at issue in this case. Therefore, Respondent Tekeyah Hamilton is limited to past and future medical damages only. Respondent presented past and future medical

costs in the amount $20,854.00. Trial Tr. 412:24 - 413:12, Mar. 17, 2019 (R. pp. 422-423). This included $4,699 TRMC bills; $635 for Dr. Devito; future surgery $2500; $12,000 future hospital charge; and $1,020 for steroidal injection. *Id.* As loss of service is not at issue in this matter, these past and future medical bills, which total $20,854.00, is all Respondent Tekayah Hamilton is entitled to recover. Therefore, the jury verdict for Respondent Tekayah Hamilton in the amount of $135,477.00 must be reduced to $20,854.00.

IV. OTHER ARGUMENTS: PHOTOGRAPHS, REQUEST TO ADMIT, TESTIMONY OF CYNTHIA HURLEY. EXCESSIVE DAMAGES REGARDING MINOR

For sake of brevity, as a response to Respondent's arguments as to photographs of minor's hand, Request to Admit, testimony of Cynthia Hurley regarding gross negligence, and excessive verdict rendered to minor, please see Appellant's Initial Brief.

CONCLUSION

For the reasons stated, Appellant respectfully requests the Appellate Court to reverse the decision of the Trial Court and dismiss this action with prejudice or, in the alternative, reverse the decision of the Trial Court and grant Appellant a new trial.

Respectfully submitted,

May 31, 2021

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

Honorable Edgar W. Dickson, Circuit Court Judge

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of 18,..... Respondent

v.

Regional Medical Center, ...Appellant

CERTIFICATE OF COUNSEL

The undersigned certifies that this Final Reply Brief complies with Rule 211, SCACR.

May 31, 2021

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PROOF OF SERVICE

I certify that I have served a copy of the Final Reply Brief by depositing a copy of same in the United States Mail, postage prepaid on June 1, 2021, and via emails addressed to the Respondent's attorney as follows:

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June 1, 2021

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18, Respondent,

v.

Regional Medical Center, Appellant.

Appellate Case No. 2019-001921

Appeal From Orangeburg County
Edgar W. Dickson, Circuit Court Judge

Opinion No. 6008
Heard December 8, 2022 – Filed August 2, 2023

AFFIRMED

Michael C. Tanner, of Michael C. Tanner, LLC, of Bamberg, and Morgan Rebekkah Long, of Michael Tanner, LLC, of Trenton, North Carolina, both for Appellant.

Jonathan F. Krell, of Uricchio Howe Krell Jacobson Toporek Theos & Keith, PA, of Charleston; David Reynolds Williams and Virginia Watson Williams, both of Williams & Williams, of Orangeburg; and Kathleen Chewning Barnes, of Barnes Law Firm, LLC, of Hampton, all for Respondent.

KONDUROS, J.: In this medical negligence action, Regional Medical Center (Regional) appeals the trial court's (1) determinations of issues concerning expert witnesses, (2) admission of photographs, (3) publishing requests to admit to the jury, and (4) denial of its motions for a directed verdict and for a new trial absolute or new trial *nisi* remittitur. We affirm.

FACTS/PROCEDURAL HISTORY

On October 25, 2014, a five-week old child, Robert Lee M., Jr. (Minor), was admitted to Regional for a high fever. Jamie Downing worked at Regional as a nurse and treated Minor during his hospital stay. Medical personnel at Regional did not initially know the cause of Minor's fever but on the day of his admission, they started him on IV antibiotic therapy in case he had an infection. In the early morning of October 28, 2014, Downing administered an antibiotic, ampicillin, into Minor's IV. Shortly thereafter, Minor's hand became swollen with a dark spot and his mother, Tekayah Hamilton, called the nurses' station because Minor was "really crying." The antibiotic Downing gave Minor through the IV caused a third-degree burn to his hand because it infiltrated outside of his vein. On October 30, 2014, Minor was discharged from Regional.

On October 7, 2015, Hamilton, individually and as parent and guardian ad litem for Minor, filed an action against Regional[1] for medical negligence. Regional answered, denying liability and any wrongdoing and asserting numerous affirmative defenses.

Prior to trial, Regional moved to exclude Hamilton's expert, Monica Stobbs, a nurse, from being qualified as an expert witness "in administering/managing pediatric IV therapy." Regional argued Stobbs was not qualified to testify about IV therapy for pediatric patients because she had not administered IV therapy to a pediatric patient and did not review literature specifically about IV therapy for pediatric patients. Hamilton argued the administration and monitoring of an IV is the same for a pediatric or an adult patient and Regional's argument went to Stobbs's credibility rather than her qualifications. The trial court determined it

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[1] Downing was also named as a defendant in the complaint but was dismissed from the action on June 29, 2016, pursuant to the South Carolina Tort Claims Act. *See* S.C. Code Ann. § 15-78-70(c) (2005) (requiring a person who brings an action against a governmental entity under the Tort Claims Act to "name as a party defendant only the agency or political subdivision for which the employee was acting").

would qualify Stobbs as a nursing care expert and Regional could "make all the hay you want to" about her pediatric experience.

Regional also moved to exclude photographs of Minor's hand on the ground that the danger of unfair prejudice substantially outweighed the probative value of the photographs. The trial court denied that motion as well.

At trial, Hamilton's expert witness, Stobbs, testified the standard of care for IV management is the same for pediatric and adult patients. She indicated that before administering medication through an IV, a nurse must flush the IV with saline to ensure the IV is actually going into the vein and not instead into the skin. She explained saline would not harm the area and cause a burn type of injury if it went into the surrounding tissue of the vein, unlike like an antibiotic which could if it did not go directly into the vein. Stobbs testified that Regional's policies and procedures for IV therapy state a saline flush should be given. Stobbs provided that Minor's medical chart indicated his IV was flushed on several occasions before the medication was administered but that on the occasion when the injury occurred, the chart did not indicate the IV was flushed. Stobbs noted Regional's policies and procedures state that the flush should be documented on the medication record. Stobbs stated: "If it's not documented, it wasn't done." Stobbs testified that Regional breached the standard of care by not documenting the saline flush and by not staying with Minor for at least five minutes after starting medication.

Downing testified that at the time she treated Minor, she had worked as a nurse at Regional for less than three months and had been allowed to work on her own for about two weeks. Downing stated Regional's policies and procedures "are direct instructions" and there is "not room for interpretation" of them. Downing testified that Regional's policies require a saline flush before putting medication into an IV. She believed the policies require flushing be documented on the electronic medical record only when not associated with giving a medication. Downing testified she could not specifically remember administering a saline flush prior to ampicillin that morning but testified her practice is to flush prior to giving medication. Downing stated Minor's medical records indicated a saline flush was given every four hours but Regional's system provided no way to document giving a saline flush before an antibiotic.

Hamilton testified that early in the morning on October 28, Minor's hand swelled and turned black with a "bubble," which burst the following day. She introduced photographs and testified they accurately showed Minor's hand at the time the injury occurred. Hamilton provided she does "a lot of hand motion things with

[Minor] because his hand . . . cramp[s] up." She testified he sometimes has itching and irritation under the skin and tells her it hurts. Hamilton explained she was hesitant to have Minor get injections into the injury site because he had already gone through so much. She was afraid that if he received injections, he would need to have his hand and arm wrapped and would not be able to do anything. She testified that after the initial injury, he could not crawl because of his hand and she had to constantly watch him to make sure he did not hurt himself. During Hamilton's testimony, Minor was brought into the court room for the jury to observe his hand. Hamilton testified she lives in Santee but she takes Minor to MUSC in Charleston to see two doctors.

Minor visited a wound care center fifteen times due to his injury. Dr. Peter DeVito, an expert in plastic surgery, examined Minor in February 2015, when he was four months old. Dr. DeVito testified the injury was "too contaminated for a skin graft" and took "a lot of wound care" and time to heal. Dr. Devito believed the burn resulted in a keloid. He explained a keloid is "a tumor of scar tissue" that "invades" the normal skin surrounding it and causes burning and itching. He testified that some areas of the injury were painful while other parts were not due to the nerve damage but that "[t]he whole nature of the wound [wa]s painful." During Dr. Devito's testimony, Hamilton entered medical bills into evidence. Hamilton also questioned Dr. DeVito as to the cost of surgery to repair Minor's hand. He provided it could cost $6,500 to $14,500 or even more if a hospital stay needed to be extended.

During trial, Hamilton moved to publish certain requests to admit from Regional as a stipulation.[2] Those requests to admit stated:

> 1. Admit the value of the amount in controversy in this action is less than $100,000.00.
>
> . . . .
>
> 2. Admit the value and amount in controversy in this action is greater than $100,000.00.
>
> . . . .
>
> 3. Admit the value of Plaintiff's actual damages exceeds $100,000.00.

Hamilton denied the first request to admit and admitted the second and third.

[2] The Record contains Hamilton's responses to the requests to admit but does not contain Regional's document in which it made the requests.

Regional objected, arguing the purpose of the requests was to obtain an independent medical examination (IME) under Rule 35, SCRCP,[3] and it was not a stipulation or admission. Regional asserted the prejudicial effect of publishing the requests outweighed the probative value under Rule 403, SCRE, because it would "reemphasiz[e] for the jury" Hamilton's position that "the case is worth more than a [$100,000]." Hamilton asked to "explain to the jury what a request to admit is." The trial court allowed Hamilton to read the exact language of the requests and answers to the jury with no explanation.

After Hamilton rested, Regional made a directed verdict motion, arguing Hamilton failed to present any evidence of gross negligence, particularly because Stobbs did not testify Regional was grossly negligent. The trial court denied the motion. Thereafter, Hamilton moved to exclude Regional from asking its expert, Cindy Hurley, a nurse, whether Regional committed gross negligence. The trial court granted the motion because Hurley was not qualified to testify about the legal concepts of negligence and gross negligence and Regional could elicit testimony about those topics without using the exact legal terminology.[4]

Following Regional's presentation of its case, it renewed its motion for a directed verdict, which the trial court again denied. After the parties made their closing arguments and the trial court gave the jury instructions, the jury deliberated and found Regional was grossly negligent; the gross negligence proximately caused Minor's and Hamilton's injuries; Minor sustained actual damages of $1,127,280; and Hamilton sustained actual damages of $135,477.

Regional filed a posttrial motion for judgment notwithstanding the verdict (JNOV), for a new trial absolute, or alternatively, for a new trial *nisi* remittitur. Regional also filed a motion to reduce Minor's damages to the $300,000 statutory cap

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[3] *See* Rule 35(a), SCRCP ("In any case in which the amount in controversy exceeds $100,000 actual damages, and the mental or physical condition (including the blood group) of a party, or of a person in the custody or under the legal control of a party, is in controversy, the court in which the action is pending may order the party to submit to a physical or mental examination by a physician or to produce for examination the person in his custody or legal control.").

[4] The trial court allowed Regional to proffer Hurley's testimony as to if Regional was negligent or grossly negligent.

pursuant to the Tort Claims Act[5] and to reduce Hamilton's damages to the amount of the medical expenses, which it asserted was $20,854. Hamilton filed a memorandum in opposition to the motions. The trial court granted the motion to reduce Minor's damages to $300,000 and denied all other motions. This appeal followed.

STANDARD OF REVIEW

"In an action at law, on appeal of a case tried by a jury, the jurisdiction of the appellate court extends merely to the correction of errors of law . . . ." *Byrd ex rel. Julia B. v. McLeod Physician Assocs. II*, 427 S.C. 407, 412, 831 S.E.2d 152, 154 (Ct. App. 2019) (quoting *Wright v. Craft*, 372 S.C. 1, 18, 640 S.E.2d 486, 495 (Ct. App. 2006)). Additionally, the jury's factual findings will not be disturbed unless the record contains no evidence to reasonably support those findings. *Id.*

LAW/ANALYSIS

I. Hamilton's Expert Testimony

Regional maintains the trial court abused its discretion in qualifying Hamilton's expert Stobbs as a general nurse and in permitting her to testify as to the standard of care for pediatric IV administration. Regional argues the case was about pediatric—not adult—nursing and IV medicine; Stobbs failed to meet the qualifications as set forth in Rule 702, SCRE, and *Gooding v. St. Francis Xavier Hospital*[6]; and the court allowed Stobbs to testify outside of the scope of her expert qualification. We disagree.

"If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." Rule 702, SCRE. "In determining a witness's qualifications as an expert, the trial court should not have a solitary focus, but rather, should make an inquiry broad in scope." *Watson v. Ford Motor Co.*, 389 S.C. 434, 447, 699 S.E.2d 169, 176 (2010). "All expert testimony must meet the requirements of Rule 702, regardless of whether it is scientific, technical, or

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[5] *See* S.C. Code Ann. § 15-78-120(a)(1) (2005) (providing "no person shall recover in any action or claim brought hereunder a sum exceeding [$300,000] because of loss arising from a single occurrence").

[6] 326 S.C. 248, 487 S.E.2d 596 (1997).

otherwise." *Graves v. CAS Med. Sys., Inc.*, 401 S.C. 63, 74, 735 S.E.2d 650, 655 (2012).

"The test for qualification of an expert is a relative one that is dependent on the particular witness's reference to the subject. The qualification of a witness as an expert is within the trial court's discretion, and this [c]ourt will not reverse that decision absent an abuse of discretion." *Watson*, 389 S.C. at 447, 699 S.E.2d at 176 (citation omitted). "The qualification of an expert witness and the admissibility of the expert's testimony are each matters largely within the trial [court's] discretion." *McMillan v. Durant*, 312 S.C. 200, 204, 439 S.E.2d 829, 831 (1993). "An abuse of discretion occurs when the [trial] court's rulings 'either lack evidentiary support or are controlled by an error of law.'" *Graves*, 401 S.C. at 74, 735 S.E.2d at 655 (quoting *State v. Pagan*, 369 S.C. 201, 208, 631 S.E.2d 262, 265 (2006)).

"To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject of his testimony.'" *Gooding*, 326 S.C. at 252-53, 487 S.E.2d at 598 (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995), *overruled on other grounds by I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 526 S.E.2d 716 (2000)). For expert testimony to be admissible, "the expert must have 'acquired the requisite knowledge and skill to qualify as an expert in the particular subject matter,' although he 'need not be a specialist in the particular branch of the field.'" *Graves*, 401 S.C. at 74, 735 S.E.2d at 655 (quoting *Watson*, 389 S.C. at 446, 699 S.E.2d at 175); *see also Melton v. Medtronic, Inc.*, 389 S.C. 641, 655, 698 S.E.2d 886, 893 (Ct. App. 2010) ("Expert testimony need not come from a specialist in the same field as the defendant."). "The test is a relative one, depending on the particular witness's reference to the subject; an expert is not limited to any class of persons acting professionally." *Botehlo v. Bycura*, 282 S.C. 578, 586, 320 S.E.2d 59, 64 (Ct. App. 1984). "The fact that a witness is not a specialist in the particular branch involved affects only the weight of the witness's testimony, and affords no basis for completely rejecting it." *Bonaparte v. Floyd*, 291 S.C. 427, 439, 354 S.E.2d 40, 48 (Ct. App. 1987).

"In *Creed*[*v. City of Columbia*], a general practitioner was allowed to testify as an expert witness on the mental and emotional damages suffered by a tort victim, even where the [defendant] objected to the evidence because the expert was not a neurologist or psychologist." *McMillan*, 312 S.C. at 204, 439 S.E.2d at 831 (citing *Creed v. City of Columbia*, 310 S.C. 342, 426 S.E.2d 785 (1993)). In that case, the

supreme court determined "[a] physician is not incompetent to testify merely because he is not a specialist in the particular branch of his profession involved." *Creed*, 310 S.C. at 345, 426 S.E.2d at 786. The court held, "The fact that [the physician was] not a specialist [went] to the weight of his testimony, not its admissibility." *Id.*

In *Botehlo*, this court affirmed the grant of summary judgment to the defendant podiatrist when the plaintiff submitted expert testimony by an orthopedic surgeon as to the standard of care for a podiatrist. 282 S.C. at 585-87, 320 S.E.2d at 64-65. The court recognized the standard of care for a podiatrist is different from that of a physician or surgeon. *Id.* at 585, 320 S.E.2d at 64. The court noted the orthopedic surgeon had no knowledge of or experience in the practice of podiatry. *Id.* at 587, 320 S.E.2d at 65. The court found the plaintiff "had to present evidence on the standard of care required of podiatrists, not physicians and surgeons." *Id.* at 585, 320 S.E.2d at 64.

In *McMillan*, the supreme court determined the trial court did not abuse its discretion in admitting the expert's testimony. 312 S.C. at 205, 439 S.E.2d at 832. The supreme court stated, "[T]he expert physician was thoroughly examined as to his credentials and background, which included his professional interaction with a multitude of various nursing staffs and his teaching nursing courses at" universities. *Id.* The court noted the hospital "based its objection to the physician's qualification as an expert on nursing on the contention that a neurosurgeon was not qualified to testify about the appropriate standard of nursing care." *Id.* The court found, "The fact that the expert was a physician and not a nurse would merely go to the weight of his testimony, not to its admissibility. As a teacher in the field of nursing, the neurosurgeon here . . . was amply qualified to render an opinion in the field of nursing." *Id.*

In *Gooding*, the plaintiff patient "sought to have [an emergency medical technician (EMT) and paramedic] qualified as an expert witness in intubation, not as an expert in the field of anesthesiology. [The EMT's] training and experience qualified him to testify as an expert in the limited area of intubation." 326 S.C. at 253, 487 S.E.2d at 598. "There was no requirement that [the plaintiff's] expert witness be an anesthesiologist in order to testify about intubation procedures." *Id.* "The fact that [the EMT] may have had less medical training and education than [the anesthesiologist defendant] is relevant to his credibility as a witness and affects the weight, not the admissibility of his testimony." *Id.* at 253-54, 487 S.E.2d at 598. Accordingly, both the supreme court and this court found the EMT

"should have been permitted to testify as an expert witness." *Id.* at 254, 487 S.E.2d at 598.

In the present case, the trial court did not abuse its discretion in allowing Stobbs to testify as an expert witness. Regional's concerns with Stobbs not having experience in pediatric IVs as opposed to general IV knowledge went to the weight of the evidence, not Stobbs's qualification as an expert. Stobbs testified that there was not a difference in the IV treatment for children and adults. Therefore, we affirm the trial court's qualification of her as an expert witness.[7]

II. Directed Verdict and JNOV

Regional asserts because Hamilton did not establish gross negligence, the trial court erred by denying its motions for a directed verdict and JNOV. It contends because it is a governmental entity, Hamilton was required to prove gross negligence. Regional maintains Hamilton failed to demonstrate through evidence or testimony that Downing failed to exercise slight care or intentionally failed to do what she ought to have done in the care and treatment of Minor. It argues because Hamilton failed to provide any evidence or testimony of gross negligence, no reasonable jury could have made any such finding. We disagree.

When ruling on a directed verdict or JNOV motion, the trial court must view the evidence and the inferences that reasonably can be drawn from it in the light most

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[7] To the extent Regional argues Stobbs's testimony exceeded the scope for which the trial court qualified her, we find this issue unpreserved. "[A]n expert's testimony may not exceed the scope of his expertise." *State v. Commander*, 396 S.C. 254, 264, 721 S.E.2d 413, 418 (2011). In its motion in limine, Regional argued Hamilton was "actually trying [to] qualify[] [Stobbs] as a pediatric nurse or a nurse familiar with pediatric IVs." The trial court qualified Stobbs as a nursing care expert, "[n]ot neonatal or anything like that." At the beginning of Stobbs's testimony, Hamilton stated she was introducing Stobbs as an expert in nursing, and the trial court informed the jury she was qualified as an expert in nursing. At this point, Stobbs had testified regarding only her educational and employment background. Regional asked the court to note its prior objection for the record; Regional made no further objection regarding her qualification. Once Stobbs provided testimony Regional believed exceeded her qualification in nursing, Regional was required to object at that point. *See Cogdill v. Watson*, 289 S.C. 531, 537, 347 S.E.2d 126, 130 (Ct. App. 1986) ("The failure to make an objection at the time evidence is offered constitutes a waiver of the right to object.").

favorable to the nonmoving party. *Sabb v. S.C. State Univ.*, 350 S.C. 416, 427, 567 S.E.2d 231, 236 (2002). This court must follow the same standard. *Welch v. Epstein*, 342 S.C. 279, 299, 536 S.E.2d 408, 418 (Ct. App. 2000). "If more than one reasonable inference can be drawn or if the inferences to be drawn from the evidence are in doubt, the case should be submitted to the jury." *Chaney v. Burgess*, 246 S.C. 261, 266, 143 S.E.2d 521, 523 (1965). The issue must be submitted to the jury if material evidence tends to establish the issue in a reasonable juror's mind. *Parrish v. Allison*, 376 S.C. 308, 319, 656 S.E.2d 382, 388 (Ct. App. 2007). The appellate court will reverse the trial court's ruling only when no evidence supports the ruling or when an error of law controls the ruling. *Law v. S.C. Dep't of Corr.*, 368 S.C. 424, 434-35, 629 S.E.2d 642, 648 (2006). "[N]either the trial court nor the appellate court has authority to decide credibility issues or to resolve conflicts in the testimony or evidence." *Erickson v. Jones St. Publishers, LLC*, 368 S.C. 444, 463, 629 S.E.2d 653, 663 (2006).

"When reviewing a motion for directed verdict, this court . . . may only reverse a jury's verdict if the factual findings implicit within it are contrary to the only reasonable inference from the evidence." *Maher v. Tietex Corp.*, 331 S.C. 371, 376, 500 S.E.2d 204, 207 (Ct. App. 1998). An appellate court must affirm a trial court's denial of a directed verdict motion unless it determines the jury could not reasonably have found in favor of the nonmoving party. *Broyhill v. Resol. Mgmt. Consultants, Inc.*, 401 S.C. 466, 472, 736 S.E.2d 867, 870 (Ct. App. 2012). The appellate court must determine whether a verdict for the nonmoving party would be reasonably possible if the facts were liberally construed in that party's favor. *Erickson*, 368 S.C. at 463, 629 S.E.2d at 663.

A "governmental entity is not liable for a loss resulting from . . . responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any . . . patient . . . of any governmental entity, except when the responsibility or duty is exercised in a grossly negligent manner." S.C. Code Ann. § 15-78-60(25) (2005). Gross negligence is the absence of care necessary under the circumstances. *Grooms v. Marlboro Cnty. Sch. Dist.*, 307 S.C. 310, 313, 414 S.E.2d 802, 804 (Ct. App. 1992). "It 'connotes the failure to exercise a slight degree of care.'" *Id.* (quoting *Wilson v. Etheredge*, 214 S.C. 396, 400, 52 S.E.2d 812, 814 (1949)). "A defendant is guilty of gross negligence if he is so indifferent to the consequences of his conduct as not to give slight care to what he is doing." *Jackson v. S.C. Dep't of Corr.*, 301 S.C. 125, 126, 390 S.E.2d 467, 468 (Ct. App. 1989), *aff'd*, 302 S.C. 519, 397 S.E.2d 377 (1990) (per curiam). Gross negligence concerns the intentional, conscious failure to do something that it is incumbent upon one to do or the intentional doing of a thing one ought not to do. *Grooms*,

307 S.C. at 313, 414 S.E.2d at 804. "[T]he fact that the [defendant] might have done more does not negate the fact that it exercised 'slight care.'" *Etheredge v. Richland Sch. Dist. One*, 341 S.C. 307, 312, 534 S.E.2d 275, 278 (2000).

"Additionally, while gross negligence ordinarily is a mixed question of law and fact, when the evidence supports but one reasonable inference, the question becomes a matter of law for the court." *Id.* at 310, 534 S.E.2d at 277. "In most cases, gross negligence is a factually controlled concept whose determination best rests with the jury." *Faile v. S.C. Dep't of Juv. Just.*, 350 S.C. 315, 332, 566 S.E.2d 536, 545 (2002).

The trial court properly denied Regional's motions for directed verdict and JNOV. Hamilton's expert was not required to state that Minor's treatment at Regional amounted to gross negligence.[8] The testimony presented a question of fact for the jury as to whether the facts amounted to gross negligence. Accordingly, we affirm the denial of the motions.

III. Photographs

Regional argues the trial court abused its discretion by admitting into evidence photographs of Minor's hand. It contends the photographs were not necessary to substantiate Hamilton's case because it did not dispute the existence of a wound and Hamilton had ample other evidence of the wound that was less prejudicial than the photographs. It maintains the photographs were grotesque, up-close images that made the wound appear substantially larger than reality and the photographs did not include a scale to indicate measurements and proportions. Regional argues the photographs were graphic, inflammatory, and not an accurate reflection of the child's hand and injuries. It asserts the photographs, by their very nature, had a prejudicial tendency to arouse the emotions of the jury. Regional further contends the photographs did not reflect the current state of the wound. It asserts Minor appeared during trial and showed the jury his scar, which did not appear as it did in

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[8] Hamilton notes that she "argued at trial that a medical malpractice, not a gross negligence, standard applies to this case because it concerns a nurse's administration of medication and not 'supervision, protection, control, confinement, or custody' of a patient." But she states that due to the jury's verdict and Regional's arguments, her argument on appeal is based on the gross negligence standard. However, she asserts this case should not be construed as establishing that the gross negligence standard in section 15-78-60(25) applies to a nurse's administration of medication.

the photographs. It argues that witnesses, including Hamilton's own expert, testified the scar appeared healed since February 2015 and did not look like the photographs shown. Accordingly, it maintains the photographs were of little probative value. Regional contends the excessive jury verdict demonstrates the prejudice from the photographs and the purpose of the photographs was to arouse the sympathy of the jury. We disagree.

"The trial court has broad discretion in the admission or rejection of evidence and will not be overturned unless it abuses that discretion." *Johnson v. Sam Eng. Grading, Inc.*, 412 S.C. 433, 448, 772 S.E.2d 544, 551 (Ct. App. 2015) (quoting *Davis v. Traylor*, 340 S.C. 150, 157, 530 S.E.2d 385, 388 (Ct. App. 2000)). "The trial court's ruling on the admission of evidence will not be disturbed on appeal absent an abuse of discretion amounting to an error of law." *Hawkins v. Pathology Assocs. of Greenville, P.A.*, 330 S.C. 92, 108, 498 S.E.2d 395, 404 (Ct. App. 1998). "An abuse of discretion occurs when the ruling is based on an error of law or a factual conclusion that is without evidentiary support." *Fields v. Reg'l Med. Ctr. Orangeburg*, 363 S.C. 19, 26, 609 S.E.2d 506, 509 (2005). "To warrant reversal based on the admission or exclusion of evidence, the appellant must prove both the error of the ruling and the resulting prejudice, i.e., that there is a reasonable probability the jury's verdict was influenced by the challenged evidence or the lack thereof." *Id.*

"As a general rule, all relevant evidence is admissible. '"Relevant evidence" means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.'" *State v. Collins*, 409 S.C. 524, 534, 763 S.E.2d 22, 27 (2014) (citation omitted) (quoting Rule 401, SCRE). "Evidence is relevant and admissible if it tends to establish or make more or less probable some matter in issue." *Hoeffner v. Citadel*, 311 S.C. 361, 365, 429 S.E.2d 190, 192 (1993). "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE. "A trial [court's] decision regarding the comparative probative value and prejudicial effect of evidence should be reversed only in exceptional circumstances." *Johnson v. Horry Cnty. Solid Waste Auth.*, 389 S.C. 528, 534, 698 S.E.2d 835, 838 (Ct. App. 2010) (quoting *State v. Adams*, 354 S.C. 361, 378, 580 S.E.2d 785, 794 (Ct. App. 2003)).

"Demonstrative evidence includes items such as a photograph, chart, diagram, or video animation that explains or summarizes other evidence and testimony. Such

evidence has secondary relevance to the issues at hand; it is not directly relevant, but must rely on other material testimony for relevance." *Clark v. Cantrell*, 339 S.C. 369, 383, 529 S.E.2d 528, 535 (2000). "Demonstrative evidence is distinguishable from exhibits that comprise 'real' or substantive evidence, such as the actual murder weapon or a written document containing allegedly defamatory statements." *Id.*

"The relevancy, materiality, and admissibility of photographs as evidence are matters left to the sound discretion of the trial court. If [an] offered photograph serves to corroborate testimony, it is not an abuse of discretion to admit it." *State v. Nance*, 320 S.C. 501, 508, 466 S.E.2d 349, 353 (1996) (citation omitted). "Courts must often grapple with disturbing and unpleasant cases, but that does not justify preventing essential evidence from being considered by the jury, which is charged with the solemn duty of acting as the fact-finder." *Collins*, 409 S.C. at 535, 763 S.E.2d at 28. "[I]t is the duty of courts and juries to examine the evidence in even the most unpleasant of circumstances: 'Courts and juries cannot be too squeamish about looking at unpleasant things, objects, or circumstances in proceedings to enforce the law and especially if truth is on trial.'" *Id.* (quoting *Nichols v. State*, 100 So. 2d 750, 756 (Ala. 1958)). "The mere fact that an item of evidence is gruesome or revolting, if it sheds light on, strengthens or gives character to other evidence sustaining the issues in the case, should not exclude it." *Id.* (quoting *Nichols*, 100 So. 2d at 756); *id.* ("Even the most gruesome photographs may be admissible if they tend to shed light on any issue, to corroborate testimony, or if they are essential in proving a necessary element of a case, are useful to enable a witness to testify more effectively, or enable the jury to better understand [the] testimony. Other acceptable purposes are to show the condition of the victims' bodies, the probable type or location of the injuries, and the position in which the bodies were discovered." (alteration by court) (quoting *Camargo v. State*, 940 S.W.2d 464, 467 (Ark. 1997))).

"Numerous jurisdictions have found that photos are not inadmissible merely because they are gruesome, especially where . . . the photos simply mirror the unfortunate reality of the case." *Id.* at 535-36, 763 S.E.2d at 28. "As one court has stated, 'The law is well settled that the mere fact that a photograph is gruesome is not a reason for its non admission.'" *Id.* at 536, 763 S.E.2d at 28 (quoting *State v. Ernst*, 114 A.2d 369, 373 (Me. 1955)).

"Moreover, the standard is not simply whether the evidence is prejudicial; rather, the standard under Rule 403, SCRE[,] is whether there is a danger of *unfair* prejudice that *substantially* outweighs the probative value of the evidence." *Id.*

In *Holmes v. Black River Electric Cooperative, Inc.*, the defendant asserted "pictures of [the plaintiff's] injured and amputated arm should not have been admitted in evidence because they may have aroused the sympathy of the jury to [the defendant's] prejudice." 274 S.C. 252, 258, 262 S.E.2d 875, 878 (1980). The defendant argued "the injuries depicted by the photographs were hideous, grotesque, and grossly unfair" but did not contend the photographs did not accurately reflect the plaintiff and the injuries at the time taken. *Id.* The supreme court stated the photographs undoubtedly "prejudiced the defendant's case in the sense that they were detrimental, but they showed a condition [that the plaintiff] was entitled to either describe to the jury in words or by pictures, or a combination of the two." *Id.* The court held, "This demonstrative evidence aided the jury in its evaluation of the injuries and pain suffered." *Id.* The court found the photographs were not introduced "for the sole purpose of inflaming the minds of the jury; they served the proper purpose of bringing vividly to the jurors the details of tremendous injuries." *Id.* Accordingly, the court held the trial court did not abuse its discretion in admitting the photographs into evidence. *Id.*

In the present case, the photographs at issue were relevant as the injury was to Minor's hand. Particularly given Minor's age, the photographs were helpful in showing what the injury was like for him. The photographs helped corroborate the testimony concerning the extent of the injury. Regional provides no support for its argument that the jury could consider the injury in only its current state and not when it occurred or was still healing. Further, the danger of unfair prejudice does not substantially outweigh the probative value. Accordingly, the trial court did not abuse its discretion in allowing the photographs. Therefore, we affirm the trial court's admission of the photographs of Minor's injured hand.

IV. Regional's Expert Testimony

Regional asserts the trial court abused its discretion in prohibiting its expert Hurley from testifying as to whether Regional was grossly negligent or negligent. It argues it was not asking Hurley to give an opinion as to an issue of law, as this was not possible because Hurley was a nurse and not a legal expert. It contends that asking Hurley this question should not have led to any confusion, as the jury was aware that Hurley was an expert in nursing, not law. Regional maintains that the purpose of the question was to ask its expert her opinion, based on her experience in pediatric nursing, and this would have helped educate and better inform the jury. Regional further asserts that this error prejudiced it as evidenced by the fact that the jury returned a grossly excessive verdict. We disagree.

"The trial court's ruling on the admission of evidence will not be disturbed on appeal absent an abuse of discretion amounting to an error of law." *Hawkins*, 330 S.C. at 108, 498 S.E.2d at 404. "An abuse of discretion occurs when the ruling is based on an error of law or a factual conclusion that is without evidentiary support." *Fields*, 363 S.C. at 26, 609 S.E.2d at 509.

"If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." *Graves*, 401 S.C. at 73-74, 735 S.E.2d at 655 (quoting Rule 702, SCRE). The supreme court has held that "[w]hile it is true that 'an opinion . . . is not objectionable because it embraces an ultimate issue to be decided by the trier of fact,'" an affidavit that "attempted to usurp the trial court's role in determining whether" a party was entitled to summary judgment was inadmissible. *Dawkins v. Fields*, 354 S.C. 58, 65, 580 S.E.2d 433, 437 (2003) (omission by court) (quoting Rule 704, SCRE). "In general, expert testimony **on issues of law** is inadmissible." *Id.* at 66, 580 S.E.2d at 437. In *O'Quinn v. Beach Associates*, the supreme court found "testimony . . . was offered to establish a conclusion of law within the exclusive province of the court and thus was properly excluded." 272 S.C. 95, 107, 249 S.E.2d 734, 740 (1978).

"Generally, '[t]estimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.' However, expert testimony on issues of law is rarely admissible." *Carter v. Bryant*, 429 S.C. 298, 313, 838 S.E.2d 523, 531 (Ct. App. 2020) (alteration by court) (quoting Rule 704, SCRE). In excluding opinion testimony in the form of a legal conclusion, "courts have advanced such reasons as it allows a witness to tell the jury what verdict to reach, it tends to confuse jurors, and . . . it increases the likelihood that jurors will look to the witness rather than the trial [court] for guidance as to the law." *Hermitage Indus. v. Schwerman Trucking Co.*, 814 F. Supp. 484, 486 n.4 (D.S.C. 1993).

"The common law and the federal rules of evidence forbid opinions on issues of law, except foreign law." *Carter*, 429 S.C. at 313, 838 S.E.2d at 531. "Rule 704, SCRE, is identical to Rule 704 of the Federal Rules of Evidence as it existed before a 1984 amendment." *Id.* "The federal advisory committee note emphasizes that Rule 704's 'abolition of the ultimate issue rule does not lower the bar so as to admit all opinions,' because an opinion on the ultimate issue has to be 'otherwise admissible' . . . ." *Id.* In *Carter*, this court found this meant the opinion "must be

helpful to the jury as required by Rule 702, SCRE, and satisfy the strictures of Rule 403, SCRE." *Id.* The court determined the opinion in that case "was not helpful to the jury because it stated a legal conclusion and essentially told the jury what result to reach on the probable cause question." *Id.*

"[S]everal courts have held that the term 'negligence' conveys a legal conclusion and is therefore inadmissible." *Hermitage Indus.*, 814 F. Supp. at 487 (citing *Shahid v. City of Detroit*, 889 F.2d 1543, 1547 (6th Cir. 1989); *Andrews v. Metro N. Commuter R.R. Co.*, 882 F.2d 705, 709 (2d Cir. 1989)). "With respect to negligence actions, an opinion phrased in terms of negligence itself, involving not only the formulation of a legal standard by the witness but also one substantially immune to exploration, seems calculated to confuse or mislead rather than assist the trier." *Id.* (quoting Michael H. Graham, *Federal Practice and Procedure* § 6661, at 319 (interim ed. 1992)). "[T]he term 'negligence' in the common vernacular encompasses a much broader standard" than the legal definition. *Id.* "While there are undoubtedly non-lawyers whose definition of the term 'negligent' more closely resembles the legal term, the conclusion is inescapable that the legal definition of the term has a separate meaning which is distinct from the common vernacular." *Id.* In *Hermitage Industries*, the South Carolina federal district court found "the proffered testimony of [the] defendant's expert witness that [the] plaintiff was 'negligent' constitute[d] a legal conclusion and [wa]s therefore inadmissible." *Id.*

When a plaintiff "relies solely upon the opinion of medical experts to establish a causal connection between the alleged negligence and the injury, the experts must, with reasonable certainty, state that in their professional opinion, the injuries complained of most probably resulted from the defendant's negligence." *Ellis v. Oliver*, 323 S.C. 121, 125, 473 S.E.2d 793, 795 (1996). "[T]he highly technical nature of malpractice litigation" mandates this rule. *Id.* Because "many malpractice suits involve ailments and treatments outside the realm of ordinary lay knowledge, expert testimony is generally necessary." *Id.*

The trial court did not abuse its discretion by preventing Regional from asking Hurley explicitly if Regional committed negligence or gross negligence. Asking Hurley that question would have been asking her to form a legal conclusion, which would have been inadmissible. The fact that she is a nurse and not a lawyer or other legal expert does not make a difference; her answer could confuse the jury particularly because negligence could have a broader meaning outside of the legal definition. Accordingly, we affirm the trial court's prohibiting Hurley from testifying if she believed Regional was negligent or grossly negligent.

V. Requests to Admit

Regional maintains the trial court abused its discretion in permitting the requests to admit to be published to the jury. Regional asserts the publication prejudiced it, violating Rule 403, SCRE, because the publication only confused the issues for the jury. Regional concedes this is an unusual circumstance and the case law seems to address only issues with withdrawal by the admitting party. Regional asserts the requests to admit were not stipulations under Rule 43(k), SCRCP,[9] but rather were a discovery tool. It contends the purpose of the requests to admit was to obtain an IME, not for Hamilton to represent that Regional admitted the damages exceeded $100,000. Regional contends that although facts may be stipulated, the requests to admit were subjective, as they went to damages. It argues that because the purpose for the requests was to get Hamilton's view of the case in order to obtain an IME, the requests were subjective, not factual, and thus, could not be stipulated. It maintains that allowing the requests to admit to be published caused the jury to believe it had to award a verdict of at least $100,000. Regional argues this effectively directed a verdict of liability in Hamilton's favor, thereby impeding presentation of the merits of its case. We disagree.

The South Carolina Rules of Civil Procedure provide:

> A party may serve upon any other party a written request for the admission, for purposes of the pending action only, of the truth of any matters within the scope of [the rules of discovery] set forth in the request that relate to statements or opinions of fact or of the application of law to fact . . . .

Rule 36(a), SCRCP.

"Any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission." Rule 36(b), SCRCP. "Requests for [a]dmissions [a]re just as binding as pleadings on the parties . . . ."

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[9] Rule 43(k), SCRCP ("No agreement between counsel affecting the proceedings in an action shall be binding unless reduced to the form of a consent order or written stipulation signed by counsel and entered in the record, or unless made in open court and noted upon the record, or reduced to writing and signed by the parties and their counsel.").

Scott v. Greenville Hous. Auth., 353 S.C. 639, 648, 579 S.E.2d 151, 156 (Ct. App. 2003). "The efficacy of these admissions is akin to the doctrine of judicial estoppel: an admission precludes the admitting party from arguing facts at trial contrary to its responses to a request to admit, absent an amendment to or revocation of the admission as allowed under the rules." *Com. Ctr. of Greenville, Inc. v. W. Powers McElveen & Assocs., Inc.*, 347 S.C. 545, 554, 556 S.E.2d 718, 723 (Ct. App. 2001) (footnote omitted). "Admissions under Rule 36 are treated as admissions in pleadings." *Id.* at 554-55, 556 S.E.2d at 723 (citing James F. Flanagan, *South Carolina Civil Procedure* 304 (1996) ("Admissions are similar to pleadings."); *Pulte Home Corp. v. Woodland Nursery & Landscapes, Inc.*, 496 S.E.2d 546, 548 (Ga. Ct. App. 1998) ("In form and substance [a response to a request to admit] is comparable to an admission in pleadings or stipulation of facts and as such is generally regarded as a judicial admission rather than evidentiary admission of a party.")). "Pleadings are not evidence." 71 C.J.S. *Pleading* § 1; *see also Sears v. Smith*, 142 S.E.2d 792, 795 (Ga. 1965) ("Pleadings per se are not evidence . . . ."); *TNT Cattle Co. v. Fife*, 937 N.W.2d 811, 831 (Neb. 2020) ("The pleadings in a cause are not a means of evidence, but a waiver of all controversy, so far as the opponent may desire to take advantage of them, and therefore, a limitation of the issues.").

Similarly, "[j]udicial admissions . . . 'are "not evidence at all but rather have the effect of withdrawing a fact from contention."'" *Wells Fargo Bank, N.A. v. Mesh Suture, Inc.*, 31 F.4th 1300, 1313 (10th Cir. 2022) (quoting *Keller v. United States*, 58 F.3d 1194, 1198 n.8 (7th Cir. 1995)). "In the same category are admissions in response to a request to admit under" Rule 36 of the Federal Rules of Civil Procedure. 2 Kenneth S. Broun et al., *McCormick On Evidence* § 254 n.12 (Robert P. Mosteller ed., 8th ed.).

"[R]equests to admit are not submitted to the jury; rather, the proper course of action is to publish the admissions to the jury." *Scott*, 353 S.C. at 649, 579 S.E.2d at 156; *see also* Rule 43(g), SCRCP ("Counsel for any party may read his pleadings to the jury. . . .").

"Once an answer to a [r]equest for [a]dmissions is amended under Rule 36, both the initial answer and the amended answer may be published to the jury." *Tuomey Reg'l Med. Ctr., Inc. v. McIntosh*, 315 S.C. 189, 191, 432 S.E.2d 485, 487 (1993). "The jury may consider the initial answers as evidence, while the party who made such answers 'is free to explain why it was made and [amended].'" *Id.* (alteration by court) (quoting Charles Alan Wright & Arthur R. Miller, *Federal Practice and*

Procedure: Civil § 2264 at 745 (1970)). "It was for the jury to weigh the evidence along with" the answers to the requests for admissions. *Id.*

As Regional acknowledges, case law is limited on this issue, as most of the law speaks to conflicts over publishing to the jury requests to admit *responses*. Here, the dispute is over publishing the actual request. However, based on the South Carolina Rules of Civil Procedure, publishing requests to admit is proper. Rule 403, SCRE, does not apply to the publication of a request to admit. Moreover, in addition to the requests to admit that the damages, amount in controversy, or value were over $100,000, a request to admit "the value of the amount in controversy in this action is less than [$100,000]" was also published to the jury. The trial court also instructed the jury to evaluate the evidence and if it decided any damages were warranted, it was to determine the amount. *See McLean v. Godwin Props., Inc.*, 292 S.C. 518, 522, 357 S.E.2d 473, 475 (Ct. App. 1987) ("[A] jury is presumed to understand the charge."). Accordingly, the trial court did not err in allowing the requests to admit to be published to the jury.

VI. New Trial Absolute or New Trial *Nisi* Remittitur

Regional asserts the trial court abused its discretion in not granting a new trial absolute when the verdict was grossly excessive and shockingly disproportionate and contrary to the evidence admitted at trial. It contends (1) little testimony was given regarding any pain and suffering; (2) testimony was given establishing that very little has been done or is planned in regards to treatment; and (3) although there is scar tissue and the scar is permanent, the hand is fully functioning, and the wound is "well-healed" and "stable" and will not get worse. Regional argues the evidence presented cannot support a $1,127,280 verdict for Minor and $135,477 for Hamilton, and thus, the size of the verdict alone is sufficient to show that the jury must have been moved by passion or prejudice. It asserts the verdict of $1,127,280 for Minor is 54 times the amount of actual damages of $20,854, which is grossly excessive and shocks the conscience. It further contends the $135,477 verdict for Hamilton is also grossly excessive, as past and future medical damages only amount to $20,854, she testified she has no plans for Minor to undergo any steroidal injections or scar revision surgery, and she is not entitled to any pain or suffering.

In the alternative, Regional argues the verdict was, at the very least, merely excessive entitling it to a new trial *nisi* remittitur. It contends that even after capping Minor's judgment at $300,000 as required by the Tort Claims Act, the judgment is still, at the very minimum, merely excessive. Moreover, it contends

the amount awarded to Hamilton was also, at the very minimum, merely excessive. We disagree.

In reviewing the jury's verdict, appellate courts give great deference to the trial court because the trial court "possesses a better-informed view of the damages than" an appellate court because the trial court "heard the evidence and is more familiar with the evidentiary atmosphere at trial." *Vinson v. Hartley*, 324 S.C. 389, 405-06, 477 S.E.2d 715, 723 (Ct. App. 1996). "Accordingly, the decision to grant a new trial is left to the sound discretion of the trial court and generally will not be disturbed on appeal." *Wright v. Craft*, 372 S.C. 1, 36, 640 S.E.2d 486, 505 (Ct. App. 2006). "An abuse of discretion occurs when the trial court's findings are wholly unsupported by the evidence or the conclusions reached are controlled by an error of law." *Id.* "In deciding whether to assess error when a new trial motion is denied, this [c]ourt must consider the testimony and reasonable inferences therefrom in the light most favorable to the nonmoving party." *Id.* (alteration by court) (quoting *Welch*, 342 S.C. at 302-03, 536 S.E.2d at 420). "[T]he jury's determination of damages is entitled to substantial deference." *Welch*, 342 S.C. at 303, 536 S.E.2d at 420.

"When a party moves for a new trial based on a challenge that the verdict is either excessive or inadequate, the trial [court] must distinguish between awards that are merely unduly liberal or conservative and awards that are actuated by passion, caprice, or prejudice." *Riley v. Ford Motor Co.*, 414 S.C. 185, 192, 777 S.E.2d 824, 828 (2015) (quoting *Allstate Ins. Co. v. Durham*, 314 S.C. 529, 530, 431 S.E.2d 557, 558 (1993)).

"[W]hen the verdict indicates the jury was unduly liberal in determining damages, the trial court alone has the power to reduce the verdict by the granting of a new trial *nisi remittitur*." *Welch*, 342 S.C. at 303, 536 S.E.2d at 420. "A motion for new trial *nisi remittitur* asks the trial court in its discretion to reduce the verdict because it is merely excessive, although not motivated by considerations such as passion, caprice[,] or prejudice." *Id.* "The denial of a motion for a new trial nisi is within the trial court's discretion and will not be reversed on appeal absent an abuse of discretion." *James v. Horace Mann Ins. Co.*, 371 S.C. 187, 193, 638 S.E.2d 667, 670 (2006). "In considering a motion for new trial *nisi*, the trial court must evaluate the adequacy of the verdict in light of the evidence presented." *Welch*, 342 S.C. at 303, 536 S.E.2d at 420.

"If the amount of the verdict is grossly excessive so as to be the result of passion, caprice, prejudice[,] or some other influence outside the evidence, the trial [court]

must grant a new trial absolute, not a new trial *nisi remittitur*." *Id.* "The trial [court] must grant a new trial absolute if the amount of the verdict is grossly inadequate or excessive so as to shock the conscience of the court and clearly indicates the figure reached was the result of passion, caprice, prejudice, partiality, corruption[,] or some other improper motives." *Vinson*, 324 S.C. at 404, 477 S.E.2d at 723. "To warrant a new trial, the verdict must be so grossly excessive as to clearly indicate the influence of an improper motive on the jury." *Wright*, 372 S.C. at 36, 640 S.E.2d at 505. "The failure of the trial [court] to grant a new trial absolute in this situation amounts to an abuse of discretion and on appeal this [c]ourt will grant a new trial absolute." *O'Neal v. Bowles*, 314 S.C. 525, 527, 431 S.E.2d 555, 556 (1993).

The trial court did not abuse its direction in denying Regional's motion for a new trial absolute or a new trial *nisi* remittitur. The record contains evidence to support the damages award. The verdict does not shock the conscience or clearly indicate it was reached as the result of passion, caprice, prejudice, partiality, corruption or other improper motives. Additionally, the verdict was not excessive. Moreover, the trial court substantially reduced the damages awarded for Minor pursuant to the Tort Claims Act. Accordingly, we affirm the denial of the motions.

CONCLUSION

Based on the foregoing, the trial court did not abuse its discretion in qualifying Hamilton's expert witness and allowing her to testify as to the standard of care, prohibiting Regional's expert from testifying as to whether Regional was grossly negligent or negligent, or admitting the photographs of Minor's hand. Additionally, the trial court did not err in publishing the requests to admit to the jury. Further, the trial court did not err in denying Regional's motion for a directed verdict or abuse its discretion in denying Regional's motion for a new trial absolute or new trial *nisi* remittitur. Accordingly, the trial court's determinations are

AFFIRMED.

HEWITT and VINSON, JJ., concur.

The South Carolina Court of Appeals

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18, Respondent,

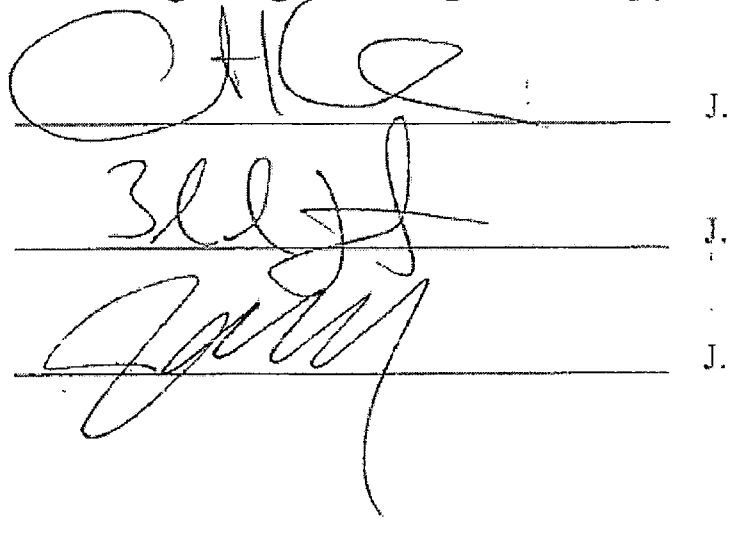
v.

Regional Medical Center, Appellant.

Appellate Case No. 2019-001921

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.



J.

J.

J.

Columbia, South Carolina

cc:
Michael C. Tanner, Esquire
Jonathan F Krell, Esquire
David Reynolds Williams, Esquire

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Kathleen Chewning Barnes, Esquire
Morgan Rebekkah Long, Esquire
Virginia Watson Williams, Esquire
Winnifa Brown-Clark
The Honorable Edgar W. Dickson

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Sep 21 2023