Attachments:

Medical Records, date of admissions to hospital (defendant feels they are entitled to $325.00 for an appointment missed because I was admitted to hospital) attorney was Rhonda Jennings and she did confirm that YCR office and Ms. Whitten was notified ,diagnosis, informal appellate statement(s) for Appellate Panel, writ of amicus (3) and Copies of post Office tracking for all certified mailing to YCR Law Firm by requests, Orders and notice by General Sessions-Common Pleas Court and any additional expenses if not already attached :

Dr. David Burke , ER Physician

Dr. John Steichen

Dr. Shawn Scott

Dr. Charles Jervey, DR. Marc Dubick and Dr. Timothy Zgleszewski

EXHIBITS

17
1 – 18

EXHIBIT 1 – DR. TIMOTHY ZGLEWSZSKI MD. DEMONSTRATING IMPAIRMENT AND PERMANENT DISABILITY. SUGGESTIONS FOR TREATMENT BASED ON EXPERTISE AND AMA GUIDELINES.

EXHIBIT 1A - DR. MARC DUBICK – DEMONSTRATING IMPAIRMENT AND RECOMMENDING THE DR. AND TREATMENT NEEDED BASED ON HIS MEDICAL ABILITIES AND AMA GUIDELINES

EXHIBIT 2 – BEFORE AND AFTER PICTURES OF SCARRING ON CLAIMANTS FACE.

EXHIBIT 3 – MOTION TO RESCIND "THE MOTION TO DISMISS" AND ACTUAL FORM 12

EXHIBIT 3A – TELEPHONE CONVERSATIONS IN EMAIL FORM OF ATTORNEY WHITTEN TO NURSE MANAGER IN FLORIDA THAT WAS SENT BY RHONDA JENNINGS OFFICE. AS PROOF THAT THEY CANCELED BECAUSE OF HOSPITAL ADMITTANCE.

EXHIBIT 4 – NO SIGNATURE OR DATE ON FISRT ORDER

4A - SIGNATURE AND DATE ON SECOND ORDER SENT ME/NOT AN ALTERED DATE BECAUSE OF DAYS PASSED.

EXHIBIT 5 – ANOTHER CLINCHER AFTER FIRST ONE IN 2012.

EXHIBIT 6 – COPY OF ER REPORT SHOWING FRACTURE/HEMATOMA

EXHIBIT 6A – REPORT FROM SURGEON DR. EVAN JONES SHOWING DAMAGE TO MY EYES BY SCATTERED ANEURYMS

FORM BLUNT FORCR TRAUMA

EXHIBIT 7 – EMPLOYABILITY EVALUATION BY JEAN HUTCHISON, OCCUPATIONAL THERAPY

EXHIBIT 8 – DR. BURKE EVALUATION AND RECOMMENDED TREATMENT REFERRED BY WORKER'S COMP. NEUROSURGEON DR. JOHN STEICHEN

EXHIBIT – 9-COPY OF FORM 59 AND OBSERVATIONS OF CONDITION BY CLIENT/ILLUSTRATIONS OR PICS OF FACIAL SCARRING

EXHIBIT 10- REPORTS BY PHYSICIANS

EXHIBIT 11 - HOSPITAL VISIT SUMMARIES

EXHIBIT 12 – DR. JERVEY'S SUMMARIES /TEST RESULTS EXPLAINING BY NYSTAGMOGRAM STUDY

EXHIBIT 13 – REPORT FROM DOCTOR PRIOR TO INJURY SHOWING NO HBP OR SEVERE COMPLICATIONS

EXHIBIT 14 APPEAL FILING WITH DATES AND TYPED APPEAL FOR CLARITY

EXHIBIT 15 – POST OFFICE TRACKING REPORTS 2013 1ND 2012

EXHIBIY 16 - WRIT OF AMICUS BY HUSBAND AND DAUGHTER

EXHIBIT 17 – ORIGINAL CLINCHER SENT TO MS. WHITTEN'S OFFICE/ SHE DENIED NOT RECEIVIG

Thank You,

If Questions, please call @ 407 522 7207

Palmetto Spine & Sports Medicine, P.A.

Timothy M. Zgleszewski, M.D.
Board Certified
- *Physiatry*
- *Pain Medicine*
- *Independent Medical Examiner*

Non-Operative Spine Care • Interventional Pain Medicine • Electrodiagnostics • Musculoskeletal Medicine

INDEPENDENT MEDICAL EXAMINATION

EXAMINEE:	**Sandra Kearse**
DATE OF EXAM:	**September 16, 2009**
DATE OF BIRTH:	**September 15, 1954**
DATE OF INJURY:	**January 3, 2007**
REFERRAL ORGANIZATION:	**Young Clement Rivers, LLP**
REFERRING INDIVIDUAL:	**Leslie M. Whitten, Esq.**
CLAIM NUMBER:	**0700666**
EVALUATING PHYSICIAN:	**Timothy M. Zgleszewski, M.D.**
LOCATION OF EVALUATION:	**Charleston, SC**

Ms. Kearse was referred for an Independent Medical Evaluation at the request of the above agent. The IME process was explained to the examinee, and the examinee understands that no patient/treating physician relationship exists and that a report will be sent to the requesting agent. Analysis is based upon the subjective complaints, history given by the examinee, review of medical records, tests provided to me and objective clinical findings on physical examination. History was provided by the examinee. Approximately 25 minutes were spent with the examinee. This included taking a history and performing a detailed physical examination. An additional 80 minutes were spent reviewing medical information and preparation of this report. As routinely performed in my medical practice, today's history was formulated by direct patient interview and, when available, medical records that from time to time are utilized for specific detail and accuracy of events regarding the mechanism of injury and the treatment rendered to the individual being evaluated.

HISTORY: Ms. Kearse is a 55 year old female who states she was in a work accident on or about January 3, 2007, while working in childcare. The examinee states the injury occurred when she fell at work after slipping. She states she fell forwards and hit her head. She reports initial head and left neck pain.

The examinee states the pain is located in the right and left neck. It does not radiate into the arms; however, she reports bilateral parathesis into the 1st, 2nd, 3rd, 4th, and 5th fingers of the hand. The pain is described as a throbbing, achy, tingling sensation. Aggravating factors include changing position, reaching, and backwards neck bending. Alleviating factors include nothing. The patient's current pain is reported to be around a 9/10 on the pain scale.
The examinee has progressed through physical therapy. The examinee has progressed through chiropractic treatment. The examinee is taking Loratab and Naproxen for the pain with minimal reduction of her discomfort.

The examinee's diagnostic testing includes x-rays, CT scan, Lumbar MRI, and EMG/NCS performed to date.

CURRENT MEDICATIONS: Lortab and Naprosen

ALLERGIES: No Known Drug Allergies

PAST MEDICAL HISTORY: Hypertension, heart murmur, and migraines

PAST SURGICAL HISTORY: "Gallbladder surgery"

SOCIAL HISTORY: The examinee is a non-smoker and a social drinker. She consumes a minimal amount of cafinated beverages per day. She is married with five children.

FAMILY HISTORY: Non-contributory

REVIEW OF SYSTEMS: Non-contributory

PHYSICAL EXAMINATION:

GENERAL APPEARANCE: Physical examination reveals a well-developed and well-nourished female in a minimal to moderate amount of pain; however she reports to be in a severe amount of pain. Grooming, nutrition, and body habitus is otherwise normal for her age. The examinee is alert and oriented to time, place, and person with normal mood and affect. Gait and station is nonantalgic. The examinee is able to rise up on her heels and toes.

Inspection of the upper and lower extremities demonstrates no edema with intact radial and pedal pulses. Inspection of cervical spine demonstrates a normal cervical lordosis. There are no prior surgical incisions. Range of motion of the cervical spine is painful. Pain is increased with extension.

On palpation, there is tenderness and spasms in the bilateral cervical paraspinals. There is tenderness in the bilateral cervical facet joints. There is no tenderness over the Greater Occipital Nerves. There are trigger points located in the bilateral upper trapezius and levator scapulae muscles today. There is tightness noted in the bilateral upper trapezius and levator scapulae muscles today. There are negative neural tension signs in both the right and the left arms in the median, ulnar, and radial biases.

Bilateral upper extremity motor examination was normal today. Bilateral upper extremity sensory examination was normal to soft touch and pinprick today. Deep tendon reflexes of the bilateral biceps, triceps and brachioradialis are normal and symmetric today.

DIAGNOSTIC TESTING/MEDICAL RECORDS:
1. Bon Secours St. Francis Hospital, Radiology Report
2. Neurology-Neurosurgery Clinic, P.A.
3. Carolina Neurological Clinic, L.L.P.
4. Charleston Spine and Physical Medicine, P.A.
5. Marc N. Dubick, M.D.
6. Charleston Neurology Associates, Dr. J. Lucas
7. Low Country Rheumatology, P.A.

DIAGNOSES:
1. Neck pain
2. Cervical myofascial pain
3. Probable cervical facet dysfunction and pain
4. Pre-existing cervical spondylosis, asymptomatic

DISCUSSION: After reviewing today's history, physical examination, review of the medical records and provided diagnostic testing, Ms. Kearse has the above diagnoses. It is my medical opinion that the examinee is not currently at Maximal Medical Improvement (MMI). It is my medical opinion that the above diagnoses are causally related to the work accident in question. The mechanism of injury described is consistent with the above diagnosis/diagnoses.

The examinee ~~will require rehabilitation therapy to address~~ the upper crossed muscle imbalances and cervical myofascial pain, as noted in the physical examination, and will require further diagnostic testing and treatment as out lined below prior to the initiation of proper rehabilitation therapy.

The examinee will require diagnostic cervical facet nerve blocks to the bilateral C3-4, C4-5, and C5-6 facet joints under fluoroscopic guidance utilizing a pain diary. If positive, she will need to proceed with therapeutic facet joint injections with corticosteroids. If no long term benefit is obtained, then she will need to proceed with radiofrequency ablation to the medial branches of the involved facet joints.

The examinee will require trigger point injections the bilateral upper trapezius and levator scapulae muscles.

Ms. Kearse is not currently at Maximal Medical Improvement (MMI). If Ms. Kearse is deemed to be at MMI, then based on the AMA Guides to the Evaluation of Permanent Impairment 5th Edition, the examinee is considered to be DRE Cervical Category II 5% impairment to the whole person. This translates to 14 % impairment to the regional cervical spine. Therefore the rating to the back/spine is 10%. Again however, it is my opinion that the examinee is currently not at MMI.

The examinee may return to modified duty with the following restrictions. She can return to light duty, lifting up to 20 pounds on an occasional basis. The examinee is not to: reach above a shoulder height, or use the arms on a repetitive basis.

Recommendations regarding the examinee's ability to work, or participate in activities of daily living and other opinions provided in this report are given totally independent of the requesting agents. If any new medical records are provided, the above recommendations and opinions may change. These recommendations and opinions are based upon reasonable medical certainty.

At the conclusion of the examination, the examinee was asked whether or not there was any information that was not asked that she wanted to include in this report. The answer to this question was no.

The above diagnostic and treatment recommendations will most probably tend to lessen the examinee's period of disability and impairment and prevent regression of her condition. The above recommendations and opinions are made with a reasonable degree of medical certainty and are made independent of the requesting agent.

"I certify and affirm that the foregoing report is true to the best of my knowledge under penalty of perjury."

Thank you for allowing me to complete this IME of Sandra Kearse. I believe I have answered all questions asked of me. If there are any further inquiries, please do not hesitate to contact me in writing.

Timothy M. Zgleszewski, M.D.
Board Certified Physical Medicine and Rehabilitation
Sub Specialty Board Certified, Pain Medicine
Fellowship Trained Interventional Spine/Pain Medicine

cc: Leslie M. Whitten, Esq.
Fax#: (843) 579-1329

Electronically signed by Timothy M. Zgleszewski, M.D. on 11/06/2009 at 10:52:05 AM

Marc N. Dubick, M.D.
2097 Henry Tecklenburg Drive
Suite 203 West
Charleston, South Carolina 29414
(843)573-3444 fax (843)769-4312

NEW PATIENT EVALUATION

PATIENT: Sandra Kearse
NUMBER: 248-98-9864

DATE: 08/08/08
DOB: 09/15/54

REFERRING PRACTITIONER: Leslie M. Whitten, Esq.

PRIMARY CARE PHYSICIAN: Betty Antia-Obong, M.D.

CHIEF COMPLAINT: Headaches, some earaches, dizziness, midback pain, facial pain.

HISTORY OF PRESENT ILLNESS: This pleasant 53-year-old lady slipped and fell in a school cafeteria January 3, 2007, striking her forehead on the floor. She suffered no loss of consciousness. She was taken at Saint Francis emergency room. She was diagnosed with a concussion. She developed vertigo as a result of her head injury. Prior to her injury she stated she had occasionally has some mild dizziness on a yearly basis, but nothing compared to this situation that followed the injury. She still has vertigo, with episodes on a daily basis, especially when bending forward. She saw Dr. Charles Jervey for quite awhile. Was tried on various medications without significant benefit. She had some balance problems, but they resolved now. She has had several falls secondary to her balance issues. She has had physical therapy at the RCC with Mr. Dave Morrisette. She had traction and joint mobilization of the cervical region, as well as exercise program and modality treatments. The patient notes only temporary benefits from that therapy. She also had physical therapy with Lowcountry Physical Therapy Associates predominantly on her lumbar region, lower extremities and midthoracic according to her history. She noted some good relief while she was performing the physical therapy, but nothing long lasting. Most of the therapy there was exercise therapy to strengthen her back and lower extremities. She has also seen Dr. Don Johnson who recommended some cervical facet blocks,but Mrs. Kearse did not desire interventional therapy. She saw Dr. Pacult who did not feel this injury required a surgical intervention. A physical therapy note from Lowcountry PT as of March 2008 reveals the patient was improving and feeling better and stronger. Noted benefit from balance training to decrease chances of falling. Her falls have diminished as she has strengthened her musculature in her back and extremities. The patient notices that when she preaches from a pulpit her back pain is exacerbated tremendously, predominantly in the thoracic region. Her pain has increased with driving, sitting, and lifting. The patient has no decreased sensation in her upper and lower extremities. She has had some intermittent feeling of weakness in her lower extremities, but nothing on a regular basis. The patient also notes some cognitive changes where she is having difficulty with memory and identifying certain objects.

10/13/2008 10:33 FAX 8437694312 PAIN CARE & NATURAL MED 003/006

Marc N. Dubick, M.D.
2097 Henry Tecklenburg Drive
Suite 203 West
Charleston, South Carolina 29414
(843)573-3444 fax (843)769-4312

Imaging studies including MRI of the cervical spine reveals degenerative changes in the cervical spine including disk space narrowing mild and anterior spinal-like changes at C4-C5 with broad-based disk bulge/osteophyte formation at C3-C4 with disk protrusion and disk bulge at C4-C5, mild narrowing of the neural foramen at C3-C4 on the left and in the left at C4-C5 and in the left C5-C6 were also noted. This exam is dated March 1, 2007. There is also a mild retrolisthesis at C4 and C5.

PAST MEDICAL HISTORY: Review of Systems: Constitutional: Negative for fever, weight loss, or fatigue. Eyes: Light sensitivity. ENT: Sensitivity to sound. CV: Hypertension. Respiratory: Past positive TB skin test. GI: Past history of gallstones with cholecystectomy. GU: Negative. Musculoskeletal: Negative. Integumentary: Occasional rash and pruritus. Neurological: Negative. Psychiatric: Insomnia. Endocrine: Negative. Hematologic/ Lymphatic: Negative. Allergic/Immunologic: Negative. Carcinoma: Negative.

HOSPITALIZATIONS AND SURGERIES: Cholecystectomy and small cyst removal from uterus after last child birth.

ALLERGIES: None.

MEDICATIONS: Include Flexeril, Benadryl.

FAMILY HISTORY: Carcinoma in father, diabetes in son.

SOCIAL HISTORY: Smoking and Alcohol: None.

PHYSICAL EXAM: Weight 148. Height 5'3". Oxygen saturation 98%. Pulse 77. Blood pressure 120/80. General Appearance: Well-developed, well-nourished pleasant female who is alert and cooperative. HEENT: Within normal limits. Oral: Teeth in good repair with exception of one broken down tooth in the right lower mandibular region. Soft tissue: Benign. Neck exam: Normal. Cranial nerves II-XII are grossly within normal limits. Upper extremity exam: Normal. There is some pain with full abduction secondary to pain in the midthoracic region. Cervical range of motion is good in all fields. The patient notes some "cracking" on lateral movement. There is some mild pain at the cervical facets in palpation. There is some facet pain primarily on the right side. There is some mild discomfort in the upper thoracic area on palpation and again at the T8 region more so in the facets and spinous processes than the costovertebral region. Reflexes: Biceps, triceps, brachioradialis, patellar, and Achilles were all bilateral and equal. Lower extremity exam is normal in dorsiflexion, plantarflexion, knee extension and flexion. Psoas testing is negative. No sensory deficits. In the supine position, straight leg raising is negative. Faber testing is negative. Resisted testing for hip adduction is

9/13/2008 10:33 FAX 8437694312 PAIN CARE & NATURAL MED 004/006

Marc N. Dubick, M.D.
2097 Henry Tecklenburg Drive
Suite 203 West
Charleston, South Carolina 29414
(843)573-3444 fax (843)769-4312

negative. ASIS pressure on the sacrum reveals mild restriction on the right side and moderate to severe restriction on left side. Posterior drawer sign reveals stable hip capsules bilaterally. FABER testing reveals a mild to moderate weakness on the left side. Bilateral knee-to-chest without a problem. There is a mild leg length discrepancy with the left leg being longer than the right. In the prone position, there is once again pain at the midthoracic area on palpation, also with some discomfort. There is mild pain noted in the left sacroiliac area. Yeoman test/hip extension does not exacerbate the pain. Forward flexion is not limited. There is no restriction noted to PSIS on forward flexion. The patient notes some low back pain with forward flexion.

IMPRESSION:

1. Status post fall on January 3, 2007, with developing concussion and vertigo.
2. Concurrent cervical facet and midthoracic facet dysfunction, continuing.
3. Mild lumbar and sacroiliac joint dysfunction predominantly left sided.
4. Associated cognitive changes with regards to memory with the vertigo and concussion.

RECOMMENDATIONS:

1. Physical therapy evaluation by Dr. David Morrisette for structural evaluation with joint mobilization in the cervical and thoracic area in particular to determine if the cervical facet dysfunction may be contributing to the vertigo.
2. If the patient responds well, but temporarily to Dr. Morrisette's treatment, she may benefit from interventional therapies to help resolve this significant dysfunction. I believe that her cervical area is the most severely dysfunctional one. Her thoracic area is causing quite a bit of pain, is a relatively small area, including the T6-T8 region. I feel that her lumbosacral region can be treated successfully with conservative measures using joint mobilization and exercise therapy. Ms. Kearse understands that the vertigo may not be associated at all with her cervical facet dysfunction, but the only way to assess its involvement is to treat this cervical region, beginning with the physical therapy. Dr. Morrisette is one of the most skillful physical therapist in Charleston and I strongly recommend Ms. Kearse being scheduled to see him.

88

Marc N. Dubick, M.D.
2097 Henry Tecklenburg Drive
Suite 203 West
Charleston, South Carolina 29414
(843)573-3444 fax (843)769-4312

To answer questions sent by Leslie M. Whitten, Esq.:

1. I believe that this patient's cervical and thoracic facet dysfunction/condition is related to her work accident of January 3, 2007, prior to her history. Our recommendations for treatment in this area were outlined above.
2. I do not believe this patient has fibromyalgia.
3. If this patient wishes to pursue the recommendations listed above, I do not feel that she has reached maximal medical improvement with regards to her back and thus permanent impairment per the AMA guidelines will not be done at this time. If the patient does not wish any further treatment, then I would be more than happy to place her at maximum medical improvement and issue an impairment rating.

Marc N. Dubick MD

Marc N. Dubick, M.D.
MND/eal/hba/nna
9666765

Exhibit 1A

WCC File # 0700666

Claimant Kendra A. Kearse

Picture taken 5/2006

Facial hairline before accident in 1/3/07

Residence Sent to Commissioners

STATE OF SOUTH CAROLINA)
)
COUNTY OF Charleston)

IN THE COURT OF COMMON PLEAS
____ JUDICIAL CIRCUIT

CASE NO.: 2013-CP-10-1223

Rev Sandra A. Kearse
Plaintiff,
vs.
Charleston County School District
Defendant.

MOTION AND ORDER INFORMATION FORM AND COVERSHEET

COPY

Plaintiff's Attorney:	Defendant's Attorney:
Pro Se, Bar No. ____ Sandra A. Kearse Address: 1725 London Crest Dr. # 301 Orlando, FL 32818 Phone: 407 522 7207Fax ____ E-mail: ____Other: ____	Leslie Whitten, Esq., Bar No. 69446 Address: YCR, LLP Post Office Box 993 Charleston, SC 29402-0993 Phone: (843) 724 6642 Fax(843) 579 1329 E-mail: ____Other: ____

☐ **MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III)**
☒ **FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III)**
☐ **PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)**

SECTION I: Hearing Information

Nature of Motion: Notice of Court to Cancel the Appeal to Dismiss and to seek if other party has "Clean Hands"

Estimated Time Needed: ____ Court Reporter Needed: ☒YES/☐ NO

SECTION II: Motion/Order Type

☒ Written motion attached
☐ Form Motion/Order

I hereby move for relief or action by the court as set forth in the attached proposed order.

Signature of Attorney for ☐ Plaintiff / ☐ Defendant — Date submitted: 04/18/2013

SECTION III: Motion Fee

☒ PAID – AMOUNT: $ 25.00
☐ EXEMPT: (check reason)
- ☐ Rule to Show Cause in Child or Spousal Support
- ☐ Domestic Abuse or Abuse and Neglect
- ☐ Indigent Status ☐ State Agency v. Indigent Party
- ☐ Sexually Violent Predator Act ☐ Post-Conviction Relief
- ☐ Motion for Stay in Bankruptcy
- ☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCP)
- ☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions
  Name of Court Reporter: ____
- ☒ Other: ____

JUDGE'S SECTION

☐ Motion Fee to be paid upon filing of the attached order.
☐ Other: ____

JUDGE CODE ____
Date: ____

CLERK'S VERIFICATION

Collected by: ____ Date Filed: ____
☐ MOTION FEE COLLECTED: $ ____
☐ CONTESTED – AMOUNT DUE: $ ____

NOTICE OF REQUEST FOR MOTION

SANDRA A. KEARSE, CLAIMANT
1725 London Crest Dr. # 301
Orlando, Florida 32818

JULY 08, 2013

Case Number: 2013-CP-10-1223
Date of Accident: 01/03/ 2007

Leslie Whitten, Partner
25 Calhoun Street, Suite 400
Post Office Box 993
Charleston, South Carolina 29402

To Attorney Whitten:

You are hereby being notified via certified mail and a call by 07/09/2013 of a Notice of Service for a motion(s) to Rescind Your Dismissal of the Case. You will find attached a *copy* of the motion and the previous letters of request(s) up until now.

Thank you kindly, I am

Rev. Dr. Sandra A. Kearse

Cc: Honorable Julie Armstrong, INGENIX, CIGNA, UNITED Healthcare, Leslie Whitten, Partner

JULY 08, 2013

VIA CERTIFIED MAIL-(RETURN RECEIPT REQUESTED)

Leslie M. Whitten, Partner
25 Calhoun Street, Ste. 400
P.O. Box 993
Charleston, S.C. 29402

Rev. Dr. Sandra A. Kearse vs. Charleston County School District

Case #: 2013-CP-10-1223 **Date of Accident: 01/03/2007**
WCC File #: 0700666

Ms. Whitten,

You are being notified via certified mail with a request for a return receipt of A Notice of Service for a Motion to receive a FORM 12 and a Motion to receive the Proposed "Clincher" originally written on March 14, 2013 . You will find attached, 1) a copy of Form 12 Motion, 2) Copy of Motion to receive Clincher and finally 3) an additional copy of the Motion Letter with a Cover sheet to cancel the appeal of your dismissal of this case for your records. Thank you for your cooperation!

Faithfully,

Rev. Dr. Sandra A. Kearse

Cc: INGENIX,CIGNA,UHC, HONORABLE JULIE J. ARMSTRONG, CLERK OF COURT

FORM 12
NOTICE THAT TRANSCRIPT HAS NOT BEEN TIMELY RECEIVED

February 21, 2013

The Honorable Rosalyn W. Frierson
Director, South Carolina Court Administration
1015 Sumter Street, Suite 200
Columbia, South Carolina 29201

WCC File: 0700666
CARRIER File: 07-07-000014

Re: Rev. Dr. Sandra A. Kearse, Claimant/ Circuit Court vs. Respondent, Charleston County Schools, Employer

Dear Ms. Frierson:

On December 17, 2012, there was a review done by the Appellate Panel to determine if the previous commissioner made a correct decision regarding case number 0700666. The Appellate Panel made their decision and ordered that Ms. Leslie Whitten representing the defense, Charleston County School District, would write up the "Response". In so doing, she neglected to send the response to me (the Claimant), Sandra A. Kearse, who at this time I had dismissed my previous counsel and appeared pro se. I questioned her by Electronic Transmission several times about the documents, and I and she knowing fully that there are time restrictions regarding this matter. When I finally received the order, the date was handwritten in. I called the circuit court and to my amazement, she had already sent them a copy almost a week prior to my inquiry.

Honorable Frierson, I am a preacher and not an attorney, but having dealt with this matter for 6 years after suffering brain and neck trauma, now sleeping with a CPAP machine at night and still having residual symptoms from this accident, I respectfully request that you investigate this matter with this attorney. Attached are conversations from the Email between us. I finally, physically received, (2) documents (1) on February 15th and the other was picked up a few days later. Defense Attorney Whitten contended that she sent it since a month earlier. See attached documents. I ask that by the letter of the law to please review and handle this issue accordingly.

Sincerely,

Sandra A. Kearse, Pro se/Pastor/Clergy & Honorary Doctorate
1725 London Crest Dr. #301, Orlando, Florida 32818
(407) 522 7207 Telephone & Facsimile

Cc: Circuit Court/ Bonnie Campbell

YAHOO! MAIL Classic

RE: Have Yet To Receive Written Response! Thursday, February 7, 2013 8:30 PM

From: "Sandra Kearse" <sask21pwm@yahoo.com>
To: "LeslieWhitten" <lwhitten@ycrlaw.com>, "Sandra Kearse" <sask21pwm@yahoo.com>

Ms. Whitten,
I am just receiving this order and cannot explain why I had not received it from you before this date. You will be hearing from me soon. Why do you continuously contend that I did not go to a doctor's appointment in Florida with Dr.Goll when it was noted that i did go and my husband and Nurse Jean was there also. Where are you getting your information from? I will not pay for any of this madness. If you require proofI shall send it.

Sincerely,

Rev. Dr. Sandra A. Kearse

--- On **Wed, 2/6/13, Whitten, Leslie <*lwhitten@ycrlaw.com*>** wrote:

> From: Whitten, Leslie <lwhitten@ycrlaw.com>
> Subject: RE: Have Yet To Receive Written Response!
> To: "Sandra Kearse" <sask21pwm@yahoo.com>
> Date: Wednesday, February 6, 2013, 6:44 AM
>
> I emailed that on January 15 and copied you then as well. I will forward it now.
>
> ---
>
> **From:** Sandra Kearse [mailto:sask21pwm@yahoo.com]
> **Sent:** Wednesday, February 06, 2013 1:04 AM
> **To:** Whitten, Leslie
> **Subject:** RE: Have Yet To Receive Written Response!
>
> No Mam,
> I am looking for the response/report you were required to send to Appellate Board / Commissioners based on their last decision.
>
> Mrs. Kearse
>
> --- On **Mon, 2/4/13, Whitten, Leslie <*lwhitten@ycrlaw.com*>** wrote:
>
> > From: Whitten, Leslie <lwhitten@ycrlaw.com>
> > Subject: RE: Have Yet To Receive Written Response!
> > To: "Sandra Kearse" <sask21pwm@yahoo.com>
> > Date: Monday, February 4, 2013, 11:57 AM
> >
> > I don't understand. I sent you two emails the same day and then the day after you emailed me. I'll forward them again. Please respond that you received this.
> >
> > **From:** Sandra Kearse [mailto:sask21pwm@yahoo.com]
> > **Sent:** Monday, February 04, 2013 2:56 PM
> > **To:** Whitten, Leslie; Sandra Kearse
> > **Subject:** Have Yet To Receive Written Response!
> >
> > Please forward your response.!!!

--- On **Mon, 2/4/13, Whitten, Leslie** ***<lwhitten@ycrlaw.com>*** wrote:

> From: Whitten, Leslie <lwhitten@ycrlaw.com>
> Subject: RE: Have Yet To Receive Written Response!
> To: "Sandra Kearse" <sask21pwm@yahoo.com>
> Date: Monday, February 4, 2013, 11:57 AM

I don't understand. I sent you two emails the same day and then the day after you emailed me. I'll forward them again. Please respond that you received this.

From: Sandra Kearse [mailto:sask21pwm@yahoo.com]
Sent: Monday, February 04, 2013 2:56 PM
To: Whitten, Leslie; Sandra Kearse
Subject: Have Yet To Receive Written Response!

Please forward your response.!!!

Thank You,
Rev. Dr. S.A. Kearse

cc: Virginia Crocker

Young Clement Rivers, LLP
http://www.ycrlaw.com
Charleston: (843) 577-4000
"ATTORNEY-CLIENT PRIVILEGED; DO NOT FORWARD WITHOUT PERMISSION." The information contained in this transmission is privileged and confidential. It is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone or by email to email@ycrlaw.com or by replying to this message and destroy all copies of this message and all attachments.

Young Clement Rivers, LLP
http://www.ycrlaw.com
Charleston: (843) 577-4000
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Jennings Law Firm, P.A.

Rhonda R. Jennings
Attorney at Law

July 18, 2013

Mrs. Sandra A. Kearse
1725 London Crest Drive
301
Orlando, FL 32818

via email: sandrakearse@gmail.com

Re: Sandra A. Kearse v. Charleston County School District 4
WCC File No.: 0700666
Date of Accident: 01/03/2007

Dear Sandra:

Pursuant to your request, enclosed please find correspondence relative to your hospital stay at Health Central Hospital for August 22, 2010 and August 23, 2010.

Sincerely,

Rhonda R. Jennings

RRJ/bjc
enc.

Office 843.225.0427 • Fax 843.225.0429 • Toll Free 866.868.6359
1365-D Ashley River Road • Charleston, South Carolina 29407
Email: rhonda@rhondajennings.com

3A

sandra Kearse 0 Share

2 of 8,428

COMPOSE

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Sandra Kearse

Inbox x

Rhonda Jennings <rhonda@rhondajennings.cor 10:35 AM (7 minutes ago)
to Leslie, me

From: Napier, Jeanne
To: Whitten, Leslie
CC: Erdmann, Heather; DANA ENCK; Rhonda Jennings
Subject: RE: Sandra Kearse
Received: 9/22/2010 5:39:34 PM

Hello,

Yes, Ms. Whitten

Per our phone conversation this afternoon, I received your message and after talking with you, immediately phoned Dr. Goll's office to notify that tomorrow's appointment needs to be cancelled.

As we discussed, I did not reschedule.....will await word that Ms. Kearse is stable and able to reschedule.

Jeanne Napier, RN, BSN, CRRN, CCM
Florida QRP WC1001695
phone: 386-562-7719
fax: 1-386-269-1214

From: Whitten, Leslie [mailto:lwhitten@ycrlaw.com]
Sent: Wednesday, September 22, 2010 2:58 PM

People (2)

Rhonda Jennings
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Gmail

Sandra Kearse <sandrakearse@gmail.com>

Sandra Kearse - canceled appointment with Dr. Goll

1 message

Rhonda Jennings <rhonda@rhondajennings.com> Thu, Feb 28, 2013 at 10:33 AM
To: "Whitten, Leslie" <lwhitten@ycrlaw.com>
Cc: sandrakearse@gmail.com

From: Whitten, Leslie
To: Napier, Jeanne
CC: Erdmann, Heather; DANA ENCK; Rhonda Jennings
Subject: Sandra Kearse
Received: 9/22/2010 2:57:56 PM

Jeanne,

I just left you a voicemail. I just a call from Ms. Kearse's lawyer's office. Apparently she is currently being admitted to the ER with chest pains and high bp. As a result, the appointment with Dr. Goll tomorrow is going to need to be rescheduled. Please let me know you got this.

Thanks,

Leslie M. Whitten

Attorney at Law

Young Clement Rivers, LLP

Phone: (843) 724-6691

Fax: (843) 579-1329

To receive updates on Workers' Compensation Issues in South Carolina from Young Clement Rivers' Workers' Compensation Practice Group, please visit our new website at www.ycrlaw.com <http://www.ycrlaw.com/> and opt-in for emails and RSS feeds.

Young Clement Rivers, LLP
http://www.ycrlaw.com
Charleston: (843) 577-4000

Exhibit 3A

COPY

DECISION AND ORDER
BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
APPELLATE PANEL

WCC FILE 0700666

SANDRA KEARSE,

Claimant/Appellant,

vs.

CHARLESTON COUNTY SCHOOL DISTRICT,

Employer/Self-Insured,
Respondent.

Appellate Panel Review
Columbia, South Carolina
December 17, 2012

Appellate Panel Decision & Order filed

on 2-12, 2013.

AFFIRMED IN FULL.

Sandra Kearse, appearing *pro se*.

Leslie M. Whitten, of Young Clement Rivers LLP, on behalf of Employer/Respondent.

Scanned
2007-0594
(WCC)-

CONCURRING:

Commissioner T. Scott Beck

Commissioner Andrea C. Roche

CERTIFICATE OF SERVICE

I hereby certify that the undersigned has this ... has caused by depositing a copy ... in the United States mail addressed to ... attorneys for said parties ...

12 day of February 2013

Valerie D Keller

Sandra Kearse) (Regular & cert)
Leslie M. Whitten

DECISION AND ORDER
BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
APPELLATE PANEL

WCC FILE 0700666

SANDRA KEARSE,

Claimant/Appellant,

vs.

CHARLESTON COUNTY SCHOOL DISTRICT,

Employer/Self-Insured,
Respondent.

Appellate Panel Review
Columbia, South Carolina
December 17, 2012

Appellate Panel Decision & Order filed

on _____, 2012.

AFFIRMED IN FULL

Sandra Kearse, appearing *pro se*.

Leslie M. Whitten, of Young Clement Rivers LLP, on behalf of Employer/Respondent.

CONCURRING:

_____

Commissioner T. Scott Beck

_____

Commissioner Andrea C. Roche

NOTICE OF REQUEST FOR CLINCHER

Sandra A. Kearse, Claimant
1725 London Crest Dr. # 301
Orlando, Florida 32818

March 14, 2013

Leslie Whitten Esquire
25 Calhoun Street Suite 400
Post Office Box 993
Charleston, South Carolina 29402

File Number: 0700666
Date of Accident: 01/03/2007
Claim # : 0707000014

To Attorney Whitten and All concerned:

Enclosed you will find my settlement offer of $297,479.03 to settle all claims on the above case by "clincher". After you have discussed this settlement offer, please respond to me within ten (10) days. It is as follows: Based on $225.30 per week (does not include commute)

1) Temporary Total Benefits from 01/03/2007 to 04/15/2013 (minus 3 weeks paid in '07 in amt. of $225.30) -$3675.90.00 TTB Total = $297,479.03
2) 10% to Back as related to neck and head per Dr. Zieglewski = $67,590.00
3) 10% to Neck as related to Head $11,265.00 (50 weeks)
4) Scarring to Head and Face = $22,530.00 = (100 weeks)
5) 50% loss of right Ear/ (Tinitus still persists) and Left ear = $37,174.50
6) 50% loss of left Ear/Tinnitus(need HA-confirmed in 2012)
   UHealthcare refused to pay because says WC should have =Hearing Aids 2800.00
7) 25% total body to encompass general diminishing of function to eyes, head, ears, jaws, throat, upper left arm and right hair = $28,162.50 Total 239,588.63 +57,890.40
   If by chance this settlement is not agreed to, then we shall seek specific penalties for Defendant unlawfully stopping Temporary Total Benefits and refusing to re-start, even though there were findings in the record by Commissioner Susan Barden and Commissioner Avery Wilkerson and affirmed on appeal by the Appellate Panel since June 21,2010, where the *first* review of the Appellate Panel affirmed that I was not at MMI even then. Furthermore, Defendant has refused to pay for the "numerous medical expenses", as required under the Worker's Compensation Act and was confirmed by the Single Commissioners Barden and Wilkerson and the First Appellate Panel. In lieu of the just law, please, consider this settlement offer.

Faithfully, I am

Rev. Dr. Sandra A. Kearse

NOTICE OF REQUEST FOR MOTION FOR CLINCHER

SANDRA A. KEARSE, CLAIMANT
1725 LONDON CREST DR. # 301
ORLANDO, FLORIDA 32818

JULY 08, 2013
CASE NUMBER: 2013-CP-1223
DATE OF ACCIDENT: 01/03/2007

HONORABLE JULIE J. ARMSTRONG
CHARLESTON COUNTY CLERK OF COURT
100 BROAD STREET, SUITE 106
CHARLESTON, SOUTH CAROLINA

SUBJECT: NOTICE OF REQUEST FOR MOTION TO RECEIVE CLINCHER

Dear Madam Clerk,

I respectfully request for the court to receive this Motion that was proposed on March 13, 2013, for a Clincher of $297,479.03 (according to calculations from state of S.C. Worker's Compensation Table and The American Medical Association Guide to evaluating permanent impairment as stated by regulations 67-1101 and 67-1105). It is inclusive of damages from a slip and fall accident that included injuries and scarring to head, face, neck, right and left ear, diminishing function(s) of eyes, ears, jaws, throat, upper right and left arm, loss of hair and total use of these body parts. (This does not include gas mileage, travel accommodations to and from doctors' offices, court hearings, and administrative fees, ex. postage and copying charges).

Counsel for the defendant has made an offer of $1, 554.50 in which I rejected. It would not have covered one of my MRI's or Dr.'s visits. Please positively consider my request!

Thank You Kindly, I am

Rev. Dr. Sandra A. Kearse,

Cc: UHC, INGENIX, CIGNA, Leslie Whitten, Partner, Honorable Julie J. Armstrong, Clerk of Court.

Roper St. Francis Emergency Services

EMS Communication Log

Date:	Time:	ETA: 10-12

Initials:	Medic: 9	Age: 52	Sex: F

CC: fall - slip
LOC
hemodynamic fault
headache

BP	HR	RR
MS/HX	90	28

Yes No
992

RA NC NRB

C Spine Other

MD Orders:

[redacted] 01/03/07

Other Pertinent Info:

Exh. 7

Carolina Eye Center
Evan D Jones, MD 843-652-8220

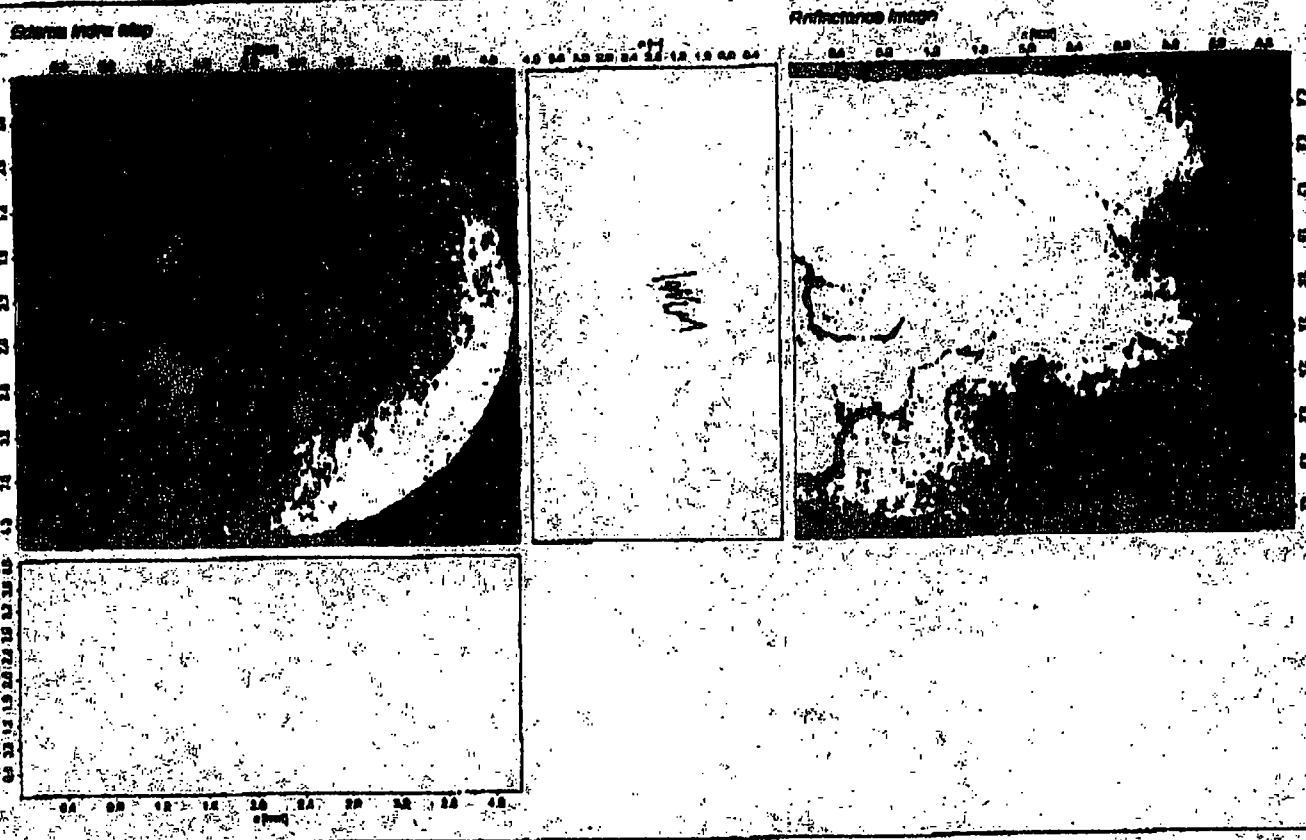
HEIDELBERG ENGINEERING
Initial Report

Patient: Kearse, Sandra
Sex: female DOB: Sep/15/1954 Pat-ID: —

OS

Examination: Date: Jun/16/2008
Circle Diameter 1.00 mm

Scan: Focus: 2.00 dpt Depth: 4.00 mm Operator: rcb



Circle parameters	Value
Central Sclera Index []	0.0
Curvature [mm]	0.01 / 0.00
Radius [mm]	0.59
Area [mm²]	0.79
Std. Dev. Sclera Index []	0.36
Std. Dev. Topography [µm]	34

Comments
Fine drusen, few scattered dot hemorrhages OU.
Patient has been sent to Dr. Kerrison for evaluation.

Date: 6/16/2008 Signature:

Software: IR1-V 2.0.2/3948

KEARSE, SANDRA
#34458 FCL: PRIMARY PAY
Appt: 06/10/08 09:00AM Ref.Pt:
Reason: 1N-CE-NEW Age/Sex: NO BDATE F
Ref.Dr: 53 yo BF
LastCE: LastVF:
Primary:

MEDS: same Premarin, allegra-D, Synthroid.

ALLERGIC TO: same
MENTAL STATUS: Oriented to TPP: (Y) N

GLAB RX: OD ___ - ___ x ___ = ___

Type: OS ___ - ___ x ___ = ___ (B)

add +1.25 = ___ No Line

Vision: OD(Dist) (Near)
cc/sc
OS(Dist) (Near)

Man Refr: OD +1.00 - x = 20/20
P T R
OS +1.00 - x = 20/20
add +1.75 = 20/20

Pupils 3.0/3.0 (wnl) afferent Tear BUT: ___ sec.
Lids: (wnl)

SLIT OD wnl
Cornea
A/C
Iris
Lens
S M (D)

VIT./FUNDI: OD wnl c/d ___ few scattered dot hem

DIAG: BDR; Hx head trauma

DISP: PHOTOS, (HRT), (NERVE/MAC), IOLSCAN, VF, RX GLASSES,
RX CL'S, DL.FORM, RX, REFILL/CONTINUE MEDS
to Dr. Keenan for eval

SAMPLE GIVEN: TEARS
RETURN: 1 yr DICT: ___ INITIALS: EJ
June 20th at 10:00 AM

EVAN D. JONES, M.D.

Fam. M.D. Okam Gen Health: good
DM HBP Glaucoma HCVD
Marital Status: S M W Is Spouse Living? Y N
CC: ↓ VA - wears +1.25 for all distances - doesn't like glasses
Improvement of VA needed for
P. OcHx. same
P. Med./Surg Hx. same
Fam.Hx. Glau ___ DM SMGM, MD
Soc. Hx. Alcohol ___ Tobacco ___

(AR) OD +1.50 - .50 x 75 = ___
OS +1.50 - .25 x 35 = ___

K: OD ___ / ___ @ ___
OS ___ / ___ @ ___

CYCLO: OD ___ - ___ x ___ = ___
OS ___ - ___ x ___ = ___

(AT)TP: 16/16 TIME ___

GONIO: OD OS
insertion:
pigment:
PAS:
angle:

✓ Mydr 0.5%
___ Fluoress
___ Reveyes

GLARE: OD ___ OS ___

Motility (wnl) VF (wnl) CFF
Conj: (wnl) tr GPC

SLIT OS wnl
S M (D)

VIT./FUNDI: OS wnl c/d ___

✓ Previous records reviewed
✓ Dx and Tx discussed/Questions answered
✓ Potential side effects of meds discussed
✓ Compliance in use of meds stressed
✓ Advised pt to call if condition worsens
___ R,B & A of surgery discussed-infection, hemorrhage, capsule rupture, retained lens material, LOV, LOE, IOL exchange, corneal transplant, reoperation
___ Printed info: IOL types, cataracts, pre/postop instr.
___ IOL scan/Shared care discussed, Target refraction ___
___ Informed consent given ___ oral ___ written

Carolina Eye Center
Evan D.Jones, MD. 843-552-8220

HEIDELBERG ENGINEERING

Initial Report

Patient: Kearse, Sandra

Sex: female DOB: Sep/15/1954 Pat-ID: —

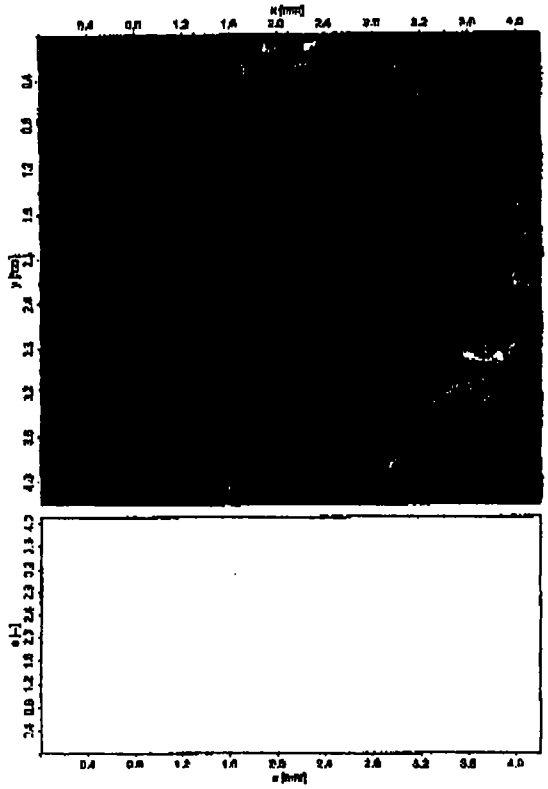
OD

Examination: Date: Jun/10/2008

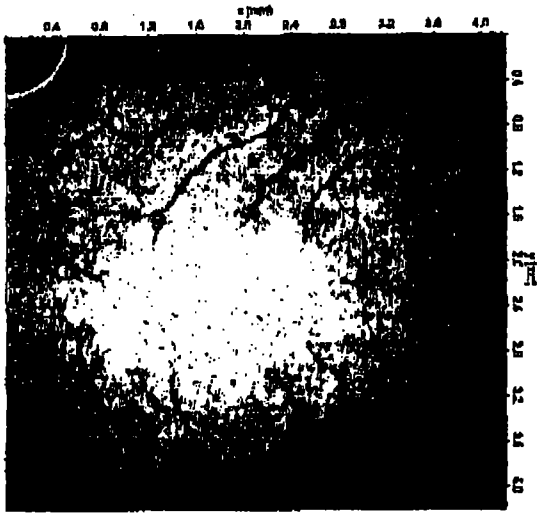
Circle Diameter
1.00 mm

Scan: Focus: 2.00 dpt Depth: 4.00 mm Operator: rcb

Edema Index Map



Reflectance Image



Circle parameters	*Value*
Central Edema Index []	*n.a.*
Center x/y [mm]	*0.00 / 0.00*
Radius [mm]	*0.50*
Area [mm²]	*0.79*
Std. Dev. Edema Map []	*0.09*
Std. Dev. Topography [µm]	*15*

Comments

Fine drusen, few scattered dot hemorrhages OU.
Patient has been sent to Dr. Kerrison for evaluation.

Date: 6/10/2008 Signature:

Software: IR1-V 2.0.2/3948

JEAN R. HUTCHINSON, M.ED., CRC, CVE
Vocational Consultant

715 N. Godfrey Park Place
Charleston, S.C. 29407

(843)766-1418
Fax(843)763-0501

May 4, 2009

Rhonda R. Jennings
Attorney at Law
1365 D Ashley River Road
Charleston, South Carolina 29407

RE: Sandra A. Kearse

Dear Rhonda:

Enclosed please find the Employability Evaluation and statement of charges for the above referenced individual. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Jean R. Hutchinson, M.Ed., CRC, CVE

JRH/hf
Enclosures

JEAN R. HUTCHINSON, M.ED., CRC, CVE
Vocational Consultant

715 N. Godfrey Park Place
Charleston, S.C. 29407

(843)766-1418
Fax(843)763-0501

EMPLOYABILITY EVALUATION

PERSONAL DATA:

Name: Sandra A. Kearse
Date of Birth: September 15, 1954 (53 years of age)
Marital Status: Married
Height: 5'3"
Weight: 153 pounds
Date of Injury: January 3, 2007
Date Interviewed: April 21, 2009
Date of Report: May 4, 2009

EDUCATIONAL BACKGROUND:

Ms. Kearse stated that she graduated from high school, was certified as a nursing assistant, holds an associate's degree, and holds a bachelor's degree in religion and psychology from Charleston Southern University. She has also taken numerous courses through her work as a Baptist minister. Ms. Kearse served in the United States Navy for two years in administration. She has a current driver's license, but reported that she rarely drives alone due to dizziness and has increased pain when riding or driving longer distances.

WORK HISTORY:

Ms. Kearse reported the following work experience: She first worked as a substitute teacher on and off for approximately ten years. Ms. Kearse then worked as a school nursing assistant for three years. She last worked as a teacher's assistant working with severely disabled students and had worked in this capacity for four years when she was injured.

DESCRIPTION OF ACCIDENT/INJURY/CONDITION:

Ms. Kearse was injured on January 3, 2007, while employed as a teacher's assistant. She

stated that she slipped and fell, landing on her face. Ms. Kearse noted that she became very dizzy, had double vision, and was taken by EMS to the hospital. She has since undergone physical therapy, balance therapy, and use of medications. Ms. Kearse has diagnoses of concussion/left frontal cephalohematoma, post-concussive symptoms, a functionally significant mild traumatic brain injury with symptoms of memory loss, word-finding difficulty, fatigue, sweating, heart racing, emotional lability, and sleep disorder, paroxysmal positional vertigo, broad central disc protrusion/bulge at C3-4, degenerative disc disease and disc protrusion/bulge at C4-5, disc protrusion at C5-6, central syrinx from C5 through C6, cervical spondylosis, cervical facet and mid-thoracic facet dysfunction, mild lumbar and sacroiliac joint dysfunction, fibromyalgia, superior subluxation of the distal clavicle relative to the acromion process, pain disorder associated with both psychological factors and a general medical condition, mild to moderate sensorineural hearing loss, tinnitus, post-traumatic headaches, photophobia, presbyopia/hyperopia, mild early nuclear lenticular opacities, sonophobia, sleep disorder, cognitive changes, and depression.

At the present time, Ms. Kearse states that she continues to have headaches that occur often. She described these headaches as significant "pressure", lasting at times for several days. Ms. Kearse noted that when having a headache, she is often nauseated and very sensitive to light and sound. For very limited relief, she stated that she lies down in a dark, quiet room and takes pain medications.

Ms. Kearse also reported difficulty with her vision. She noted that her vision is especially "blurry" when she awakens and she now must wear glasses. Additionally, Ms. Kearse stated that she now has difficulty with her hearing in that she has "screaming ringing" in her ears. She noted that this noise is becoming worse. Ms. Kearse reported very significant difficulty with balance. She noted that she is often dizzy and "light-headed" and has fallen several times.

Ms. Kearse stated that she continues to have pain in her neck that she described as "cracking"; in her left shoulder that she described as "aching"; and in her lower back that she described as "hurting". She noted that her pain is constant though varying in intensity and is exacerbated by any increase in activity. For limited and temporary relief of pain, Ms. Kearse stated that she takes medications.

With regard to functional activities, Ms. Kearse reported the following: She noted that she can walk, but frequently become dizzy. Ms. Kearse stated that she now cannot run, jump,

negotiate rough or uneven terrain, always maintain balance, climb a ladder, stand for extended periods of time, reach up, out, or around to the back on the left side, or lift/carry more than approximately five pounds.

With regard to activities of daily living, Ms. Kearse stated that she now performs some light household chores, but cannot vacuum. She termed her ability to sleep as "horrible" in that she cannot sleep through the night and has difficulty breathing when lying down. Ms. Kearse noted that she now takes naps during the day, experiences fatigue, and is irritable. She reported that she continues to be independent in self-care tasks, but requires more time to perform them. Ms. Kearse stated that she now cannot perform yardwork tasks.

Ms. Kearse also noted very significant difficulty with word-finding and reading comprehension. She stated that she now cannot multi-task and has problems with short-term memory.

DESCRIPTION OF USUAL OCCUPATIONS:

Most recently and for approximately four years, Ms. Kearse has worked as a teacher's assistant working with severely disabled students. Her students were in wheelchairs and required assistance in feeding and toileting. The 1991 Edition of the Dictionary of Occupational Titles defines this job as:

TEACHER AIDE I (099.327-010)
"Performs any combination of following instructional tasks in classroom to assist teaching staff of public or private elementary or secondary school: Discusses assigned teaching area with classroom teacher to coordinate instructional efforts. Prepares lesson outline and plan in assigned area and submits outline to teacher for review. Plans, prepares, and develops various teaching aids, such as bibliographies, charts, and graphs. Presents subject matter to students, utilizing variety of methods and techniques, such as lecture, discussion, and supervised role playing. Prepares, administers, and grades examinations. Assists students, individually, or in groups, with lesson assignments to present or reinforce learning concepts. Confers with parents on progress of students. May specialize in single subject area. May be required to have completed specified number of college education credits."

Other significant work experience for Ms. Kearse has been as school nursing assistant and

substitute teacher. The 1991 Edition of the Dictionary of Occupational Titles describes these jobs as:

NURSE ASSISTANT (355.674-014)
"Performs any combination of following duties in care of patients in hospital, nursing home, or other medical facility, under direction of nursing and medical staff: Answers signal lights, bells, or intercom system to determine patients' needs. Bathes, dresses, and undresses patients. Serves and collects food trays and feeds patients requiring help. Transports patients, using wheelchair or wheeled cart, or assists patients to walk. Drapes patients for examinations and treatments, and remains with patients, performing such duties as holding instruments and adjusting lights. Turns and repositions bedfast patients, alone or with assistance, to prevent bedsores. Changes bed linens, runs errands, directs visitors, and answers telephone. Takes and records temperature, blood pressure, pulse, and respiration rates, and food and fluid intake and output, as directed. Cleans, sterilizes, stores, prepares, and issues dressing packs, treatment trays, and other supplies. Dusts and cleans patients' rooms. May be assigned to specific area of hospital, nursing home, or medical facility. May assist nursing staff in care of geriatric patients and be designated Geriatric Nurse Assistant. May assist in providing medical treatment and personal care to patients in private home setting and be designated Home Health Aide."

TEACHER AIDE II (249.367-074)
"Performs any combination of following duties in classroom to assist teaching staff of public or private elementary or secondary school: Takes attendance. Grades homework and tests, using answer sheets, and records results. Distributes teaching material to students, such as textbooks, workbooks, or paper and pencils. Maintains order within school and on school grounds. Operates learning aides, such as film and slide projectors and tape recorders. Prepares requisitions for library materials and stockroom supplies. Types material and operates duplicating equipment to reproduce instructional materials."

Ms. Kearse's significant past work experience is consistent with these definition.

EVALUATION SUMMARY:

In determining employability, it is necessary to consider many factors. These factors include

age, educational background, past work experience and transferable skills, and physical limitations and pain.

Ms. Kearse is fifty-three years of age. Her age may affect her ability to adjust to a significant number of jobs in the national economy.

Ms. Kearse graduated from college. Education at this level refers to abilities in reasoning, arithmetic, and language skills that would enable the individual to perform the required job tasks of semi-skilled through skilled work.

Relevant past work experience for Ms. Kearse has been as a teacher's assistant for severely disabled students, school nursing assistant, and substitute teacher. The 1991 Edition of the Dictionary of Occupational Titles further defines these jobs as follows:

Work as a teacher's assistant for severely disabled students is defined as a light, skilled work. Light work is defined as the ability to lift twenty pounds occasionally and up to ten pounds frequently. The abilities to walk and stand to a significant degree, to sit and push or pull arm or leg controls, or to work at a production rate are also required. Skilled work requires qualifications in which an individual uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating quality, determining the suitability and needed quantities of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustment to control or regulate the work. Dealing with people, facts, or figures or abstract ideas at a high level of complexity may be required as well.

Work as a school nursing assistant is defined as medium, semi-skilled work. Medium work requires the ability to lift fifty pounds and to frequently carry twenty-five pounds. Semi-skilled work is work which needs some skills, but does not require the more complex work duties. Semi-skilled work may require alertness and close attention to watching machine processes; inspecting, testing, or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage, or injury. Coordination and dexterity may be necessary in the performance of repetitive tasks as well.

Work as a substitute teacher is defined as light, semi-skilled work. Light work is defined as the ability to lift twenty pounds occasionally and up to ten pounds frequently. The abilities

to walk and stand to a significant degree, to sit and push or pull arm or leg controls, or to work at a production rate are also required. Semi-skilled work is work which needs some skills, but does not require the more complex work duties. Semi-skilled work may require alertness and close attention to watching machine processes; inspecting, testing, or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage, or injury. Coordination and dexterity may be necessary in the performance of repetitive tasks as well.

Transferability of skills applies to work skills which a person has demonstrated in vocationally relevant past jobs that can be used to meet the requirements of other jobs. Transferability of skills is most probable and meaningful among jobs requiring similar skills, when similar tools and machines are utilized, and when similar processes and services are involved. Jobs of transferability for Ms. Kearse may include education and child care.

Ms. Kearse has significant physical limitations. In a report dated March 13, 2009, Dr. David T. Burke indicates that Ms. Kearse has a functionally significant mild traumatic brain injury with symptoms of memory loss, word-finding difficulty, fatigue, sweating, heart racing, emotional lability, and sleep disorder. Dr. Burke recommends further diagnostic testing to include a sleep study, neurosurgical evaluation, occupational therapy, referral to a speech language pathologist, referral to a physical medicine and rehabilitation physician, and continuation with her neuropsychologist.

In an Independent Medical Evaluation dated March 18, 2009, Dr. Leonard E. Forrest indicates that Ms. Kearse has permanent restrictions, although her current prominent symptoms need to be evaluated and treated first.

In considering these aforementioned factors, approaching advanced age, college level of education, past work experience as a teacher's assistant for severely disabled students, school nursing assistant, and substitute teacher, and physical limitations, cognitive problems, and unrelenting pain of more than two years' duration, I am of the opinion that Ms. Kearse is unable to perform the required job tasks of her former work as a teacher's assistant for severely disabled students, is unable to return to any past employment, and does not have transferable skills to perform other work that is within her residual functional capacity. I am of the opinion that Ms. Kearse is not able to engage in an eight-hour workday in a substantial number of jobs and cannot perform work tasks on a sustained basis. Her impairments prevent her from making an adjustment to any work that exists in significant numbers in the

CHARLESTON NEUROSURGICAL ASSOCIATES, L.L.C.

STEPHEN E. RAWE, M.D., PH.D.
GEORGE H. KHOURY, M.D.
BRIAN G. CUDDY, M.D.
JOHN D. STEINCHEN, M.D.
CYNTHIA W. ANDERSON, R.N., A.N.P.
LARRY G. HARRIS, P.A.-C., M.P.A.S.

7/14/2009

PATIENT NAME:	Sandra Kearse
DOB:	09/15/1954
SS#	248989864
PHYSICIAN REQUESTING CONSULT:	Workers' Compensation

NEUROSURGICAL CONSULTATION

CHIEF COMPLAINT: Headaches and dizziness.

The patient is a 54-year-old right-handed woman who reports suffering a work-related injury in 2007. She states that she had a slip-and-fall injury, fell forward, and hit her head on the ground. She suffered subsequently from dizziness, spinning sensations, nausea, all of which worsened with head movement. These symptoms of vertigo have persisted since the injury. She also has persistent headaches.

On detailed questioning, the patient describes pain in the bilateral mastoid regions immediately after the injury. She is not clear as to whether or not there was bruising, indicating Battle sign.

The patient's persistent symptoms include "swimmer's ear" and tinnitus, headaches, pain on the right side of her body including her neck, arm, leg and toe.

This patient has undergone extensive evaluation by multiple physicians including multiple neurologist, neuropsychiatric specialist, and closed head injury specialist. She has seen David Burke, M.D., who she reports to me as being a specialist in post concussive disorders and head injury management.

PAST MEDICAL HISTORY:
Allergies: Nubain.
Current Medications: Flexeril and Hydrocodone.
Medical: Noncontributory.
Surgical: Gallbladder surgery, bladder surgery.

PHYSICAL EXAMINATION:
General Findings: well appearing individual in no acute distress

faxed 7/14

DICTATED BUT NOT READ

120

HEENT: AT/NC, sclera clear, conjunctiva pink, nares patent, throat benign
CHEST: clear; COR; RRR; ABDOMEN: ND, NT
NECK: supple, full ROM, nontender to palpation, no paraspinal muscle spasm
DORSAL/LUMBAR SPINE: supple, full ROM, nontender to palpation
EXTREMITIES: benign
NEUROLOGIC:
Mental Status: alert, oriented x 3, speech fluent, affect appropriate
Motor: full symmetric strength throughout with normal bulk and tone
Sensory: intact to pinprick, light touch, vibration and position sense
DTR (L/R):
Triceps (2/2+)
Biceps (2/2+)
Brachioradialis (2/2+)
Patellar (2/2)
Achilles (2/2)

SUMMARY OF RADIOGRAPHIC FINDINGS: I reviewed multiple studies, including the report of her MR angiogram, which states there is no evidence for aneurysm. Otherwise, the studies reviewed include CT scans of the head and MRI of the head, brain, and cervical spines. She does indeed have a syrinx in her cervical cord at the C5-C6 level. When compared to an MRI performed in 2003, there is an apparent syrinx or hydromyelia present at that level pre-injury.

IMPRESSION/PLAN: The patient suffers from post concussive syndrome. She is appropriately managed by Dr. Burke. Her symptoms of vertigo, neck pain, and headaches are consistent with that diagnosis.

Appropriate treatment is being rendered and has been recommended by Dr. Burke. I concur and recommend that her care be monitored and managed by a neurologist such as Dr. Burke who cares for patients with longstanding problems with post concussive disorder after head injury. At this juncture, there is not a role for surgical intervention.

John D. Steichen, M.D.

C: Heather Erdmann, adj 746-9931
Teri, ncm 377-8489
JDS/mpa

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* Final Report *

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* Final Report *

REHAB NTE (Verified)

THE EMORY CLINIC, INC.
DEPARTMENT OF REHABILITATION MEDICINE
CENTER FOR REHABILITATION MEDICINE AT CENTRAL CAMPUS

PATIENT NAME:	KEARSE, SANDRA
MRN:	25315271
ENCOUNTER NO:	17348799
DATE OF SERVICE:	03/13/2009
DOB:	09/15/1954
DOCUMENT TYPE:	REHAB NTE
PHYSICIAN NO:	01788
ATTENDING MD:	DAVID T. BURKE, MD
REFERRING PHYSICIAN:	

FIRST-EVER CLINIC APPOINTMENT

CHIEF COMPLAINT: Fall, with trauma to the head.

HISTORY OF PRESENT ILLNESS: Ms. Kearse is a 54-year-old female who was in her usual state of good health, when on 01/03/2007 she fell forward, striking the front of her head, with an altered level of consciousness and a hematoma. She was taken to the emergency room, where a CAT scan was negative, and she was discharged home. Since that time, she has complained of difficulties with headaches, short-term memory difficulties, and some difficulties with breathing, as well as visual distortion. She had at that also noticed some dizziness and balance issues as well, and has sought treatment for all of these since then. She comes in today complaining of headaches and breathing problems as her primary complaints. The patient states that she has had difficulties which has improved since the time of her trauma, with dizziness

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being the most improved of her symptoms since that time, but that she still has headaches twice per week, word-finding difficulties, language difficulties, cognitive difficulties, emotional difficulties, and sleep problems that persist. She has had no other significant past medical history to note.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: The patient has no weight gain or loss, no unexplained fever, visual problems, dizziness, lightheadedness, high blood pressure, heart problems, breathing problems. She does have acid reflux, some swallowing problems for which she has seen ENT, and had a procedure to open her esophagus. She does not come with medical records, and therefore the nature of this procedure was unclear. She does have constipation at times. She has no urinary problems, diabetes, difficulty with heat or cold. No stroke, no bleeding problems, no circulation problems by diagnosis, but does note that she feels cold in the top of her head at times. She has had no depression, but does have anxiety. She has memory loss for certain things. She has difficulty with naming items. She has a rash on her arms and neck at times. She has difficulty with sleeping, wakes up gasping at times.

SOCIAL HISTORY: She lives with her husband in a two-story home with 14 steps to enter. She has two young adult children. She is involved in the church, and describes herself as part-time clergy. She, however, does not get paid for this, and describing herself as unemployed. She does not use tobacco or alcohol. Functional History: She can move herself without any difficulty, but has had to retire from paid work because of her cognitive difficulties and headaches. She also complains of ringing in the ears, and therefore this interferes with her ability to concentrate.

PHYSICAL EXAMINATION: The patient is a very pleasant female, who is able to interact quite well. She has no hearing or vision distortion. Extraocular muscles are intact, no nystagmus is noted with movement of the eyes. Good peripheral vision noted. Neck movement is slightly diminished in rotation, but several diminished in lateral flexion. She notes cracking in her neck which seems to scare her. Palpation at the neck demonstrates midline tenderness in the suboccipital region, although no radiation, no paraspinal tenderness, no tenderness in the trapezius. Heart: Regular rate and rhythm, without murmurs, gallops or rubs. Lungs: Clear to auscultation. Abdomen: Not examined. Strength: 4+/5 strength bilaterally in the upper extremities, and 5/5 strength in the lower extremities are within normal limits. Right frontal release sign. No Babinski, no oppenheim, no clonus noted.

SUBJECTIVE: The patient does complain of fatigue, word-finding difficulties, has had some difficulty with reading, but this has improved. She notes that her vision has deteriorated significantly since the time of the accident, and

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she has had to change her glasses since then. This seems to have stabilized 3 months after the accident. She does not tinnitus that is constant, and has had an ENT evaluation which has not been productive for reducing this. She does have PND, for which she sits up in bed at times, but has had a cardiac examination which has been negative for cardiovascular dysfunction. She does have headaches, for which sinus medication does seem to help, but notes thunderclap-type headaches which last for less than a minute, and are focused on the right side of her parietal region of her head.

IMPRESSION: Mild brain injury/complicated: The patient has had an MRI negative, but functionally significant mild traumatic brain injury. Her symptoms of memory loss, word-finding difficulty, fatigue, sweating, heart racing, emotional lability and sleep disorder are all consistent with this diagnosis. I suggested that she have diagnostic tests including:

1. Sleep study to rule out sleep apnea. If positive, this could be treated with a CPAP or BIPAP.
2. Neurosurgery: The patient should have a neurosurgical evaluation to rule out aneurysms, especially in the right occipital parietal region.
3. Occupational therapy: The patient should seek out occupational therapy to assist with her neck pain, as well as relaxation therapy for symptoms of tinnitus.
4. Speech language pathologist: A speech language pathologist can assist with pragmatics and word-finding difficulty, cognitive processing, and recovery from her brain injury.
5. Physical medicine and rehabilitation physician: The patient should seek out a PMR specialist who specializes in brain injury so that neurochemical intervention might be entertained.
6. The patient does have a neuropsychologist, and this individual will be helpful in allowing her access to the appropriate diagnostic and therapeutic entities that she does need.

Overall, we spent approximately one hour with the patient, with most of that time spent in counseling and coordination of care.

_____
David T. Burke, MD

D: 03/13/2009 12:32:03 T: 03/13/2009 15:19:49
DTB/MB 637184/363870597/

Signature Line
Electronically Signed by: Burke, David T, MD on 03/16/09 11:37

Ashley River Family Physicians

Lowcountry
Medical Associates
Family Practice Internal Medicine Pediatrics

JoAnn Hiott, M.D.
Family Practice
James Lipke, M.D.
Family Practice

Betty Antia-Obong, M.D.
Family Practice
Caroline Bailey, P.A.

March 8, 2007

Re: Sandra Kearse

To Pre Admissions St. Francis
Attn: Charlotte

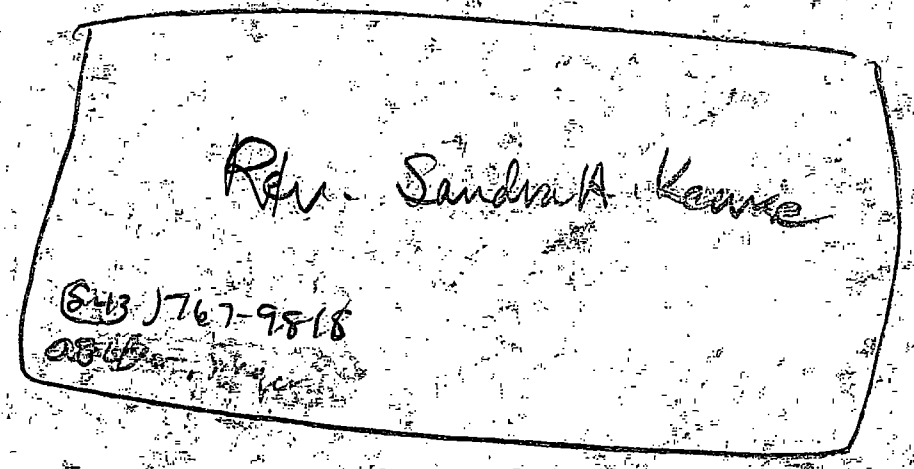
Ms. Kearse is cleared for surgery. The only concern is neck manipulation. Her MRI showed clearing of scalp hematoma.

Sincerely,
Betty Antia Obong, M.D.

Betty Obong, M.D.
BO/po

Faxed 3/8/07

2270 Ashley Crossing Drive #165
Charleston, South Carolina 29414
phone (843) 763-9472 ▪ fax (843) 763-7411



Grief workshop Coordinator
Continuing Instructor
Grief Services

Symptoms of Brain Injury

A wide variety of symptoms can occur after a brain injury. Below is a list of possible symptoms, which can arise from damage to specific areas of the brain:

Frontal Lobe: Forehead

- Loss of simple movement of various body parts (Paralysis).
- Unability to plan a sequence of complex movements needed to complete multi-stepped tasks, such as making coffee.
- Loss of spontaneity in interacting with others.
- Loss of flexibility in thinking. ✓
- Persistence of a single thought.
- Inability to focus on task. ✓
- Mood changes. ✓
- Changes in social behavior. ✓
- Changes in personality.
- Difficulty with problem solving. ✓
- Inability to express language. ✓

Parietal Lobe: near the back and top of the head

- Inability to attend to more than one object at a time. ✓
- Inability to name an object. ✓ sometimes
- Inability to locate the words for writing. a lot of times
- Problems with reading.
- Difficulty with drawing objects.
- Difficulty in distinguishing left from right. ✓ sometimes
- Difficulty with doing mathematics.
- Lack of awareness of certain body parts and/or surrounding space that leads to difficulties in self-care.
- Inability to focus visual attention. ✓
- Difficulties with eye and hand coordination.

Occipital Lobes: most posterior, at the back of the head

- Defects in vision. ✓ definitely
- Difficulty with locating objects in environment. ✓✓
- Difficulty with identifying colors.
- Production of hallucinations.
- Visual illusions - inaccurately seeing objects. ✓✓
- Word blindness - inability to recognize words. ✓ sometimes
- Difficulty in recognizing drawn objects.
- Inability to recognize the movement of object. ✓
- Difficulties with reading and writing.

Work Comp Doctor

Consistent w/ Dr. Burk + Dr Steichen findings

THOMAS A. PRIVETT, M.D.
CHARLESTON NEUROLOGY ASSOCIATES
9313 MEDICAL PLAZA DRIVE, SUITE 310
CHARLESTON, SC 29406

TELEPHONE (843) 569-1856
DEA Reg No. BP7208041
Lic. No. SC 23116

NAME: Sandra Kearse DATE: 9/16/03

ADDRESS:

℞ Ms. Kearse is cleared for massage.
ind: cervical spondylosis

☐ Label
Refill — 0 — 1 — 2 — 3 — 4 — 5 — 6

_________ M.D. _________ M.D.
Dispense As Written — Substitution Permitted

THOMAS A. PRIVETT, M.D.
CHARLESTON NEUROLOGY ASSOCIATES
9313 MEDICAL PLAZA DRIVE, SUITE 310
CHARLESTON, SC 29406

TELEPHONE (843) 569-1856
DEA Reg No. BP72...
Lic. No. SC 2...

NAME: Sandra Kearse DATE: 9/16/03

ADDRESS:

℞ skelaxin 800 mg
1/2 - 1 tab po SY-6° prn neck pain
do not drive while taking this medication
the 4s (Friday)

☐ Label
Refill — 0 — 1 — 2 — 3 — 4 — 5 — 6

_________ M.D. _________ M.D.
Dispense As Written — Substitution Permitted

Admitted condition but exacerbated by Trauma

THOMAS A. PRIVETT, M.D.
CHARLESTON NEUROLOGY ASSOCIATES
9313 MEDICAL PLAZA DRIVE, SUITE 310
CHARLESTON, SC 29406

PHONE (84.) .69-1856
DEA Reg No. BP7208041
Lic. No. SC 23116

NAME: Sandra Kearse DATE: 9/16/03

ADDRESS:

℞ Cervical spondylosis
– disc protrusion at C2C3, C3-C4 and C4-C5 – mild

Very 1st diagnosis of my admitted condition

☐ Label
Refill — 0 — 1 — 2 — 3 — 4 — 5 — 6

_________ M.D. _________ M.D.
Dispense As Written

- Low-energy weapons include hand-driven weapons, such as knives or ice picks, which damage with only their sharp point or cutting edge.
- Firearms may be classified as medium-energy (ie, handguns) and high-energy weapons (ie, military assault weapons), with the latter usually defined as having 461 joules or more.
- Projectiles (ie, bullets, missiles) often are differentiated by mass, velocity, shape, and construction because these characteristics affect the extent of tissue disruption.
- Bullet velocity is the most important characteristic considered, with high velocity defined as greater than 2500 ft/s.

See Attachment from Health Central Hosp.

- Location of injury and human tissues involved
- Tissue injury results from either a direct impact by the penetrating projectile or tissue displacement from temporary cavitation.
- Wound sites and, if present, the wounding agent in the neck provide an indication of the likely injury complex.

Presentation

I experience all these

Evidence of significant injury to vital structures of the neck may be indicated by the following clinical manifestations:

- Dysphagia – Tracheal and/or esophageal injury
- Hoarseness – Tracheal and/or esophageal injury (especially recurrent laryngeal nerve)
- Oronasopharyngeal bleeding – Vascular, tracheal, or esophageal injury
- Neurologic deficit – Vascular and/or spinal cord injury
- Hypotension – Nonspecific; may be related to the neck injury or may indicate trauma elsewhere

Proposed hard signs of airway injury include the following:

- Subcutaneous emphysema – Tracheal, esophageal, or pulmonary injury
- Air bubbling through the wound
- Stridor or respiratory distress – Laryngeal and/or esophageal injury

Dr. D. Burke CPAP Injured

Several so-called hard signs that strongly indicate vascular injury are as follows:

- Hematoma (expanding) – Vascular injury
- Active external hemorrhage from the wound site – Arterial vascular injury
- Bruit/thrill – Arteriovenous fistula
- Pulselessness/pulse deficit
- Distal ischemia (neurologic deficit in this case)

The evaluation of a patient with penetrating neck trauma always should start with advanced trauma life support (ATLS), a paradigm that begins with a directed primary survey emphasizing airway, breathing, and circulation (ABC). After patients are stabilized, they undergo a secondary survey that includes a complete history and a thorough physical examination. These steps, together with the studies discussed in Workup, are used to identify the likely injury complex and to direct further treatment or diagnostic testing.

There is evidence to suggest that the hard signs of airway injury are more reliable and result in less negative operative explorations compared with hard signs of vascular injury. The rate of negative exploration for patients with hard signs of vascular injury varies widely, but it may be estimated at 10%. However, series that report these cases as "nonsignificant" injury or as negative explorations lack clear definition, and it is difficult to draw any useful conclusion from the data.

Indications

The standard of care is immediate surgical exploration for patients who present with signs and symptoms of shock and continuous hemorrhage from the neck wound. The type of incision depends on the neck zone and the structures at risk for injury.

The following specific injuries must be confirmed and treated during neck exploration:

- Carotid artery injuries
- Vertebral artery injuries
- Jugular vein injury
- Laryngotracheal injuries

- Esophageal injuries
- Nerve injuries
- Thoracic duct injuries
- Thyroid injuries

explain excessive weight gain

Relevant Anatomy

In few other regions of the body are so many vital structures (that would be of immediate concern following injury) located in so small a volume. An injury is not considered to have penetrated the neck unless the injury penetrates the platysma muscle layer. Injuries through the platysma and injuries crossing the midline usually cause a greater degree of damage. The sternocleidomastoid muscle delineates the posterior and anterior regions of the neck. The area of the neck posterior to the cervical vertebral body and the scalene muscles is composed mainly of muscle, bone, and nonvital vessels and lymphatics. Most of the vital structures are located in the anterior or lateral regions.

The neck may be divided into 3 zones using anatomic landmarks. Each zone has a group of vital structures that can be injured and may determine the kind of trauma management.

- Zone I is the horizontal area between the clavicle/suprasternal notch and the cricoid cartilage encompassing the thoracic outlet structures. The proximal common carotid, vertebral, and subclavian arteries and the trachea, esophagus, thoracic duct, and thymus are located in zone I.
- Zone II is the area between the cricoid cartilage and the angle of the mandible. It contains the internal and external carotid arteries, jugular veins, pharynx, larynx, esophagus, recurrent laryngeal nerve, spinal cord, trachea, thyroid, and parathyroids.
- Zone III is the area that lies between the angle of the mandible and the base of the skull. It has the distal extracranial carotid and vertebral arteries and the uppermost segments of the jugular veins.

Tight fascial compartments of neck structures may limit external hemorrhage from vascular injuries, minimizing the chance of exsanguination. However, these tight fascial boundaries may increase the risk of airway compromise because the airway is relatively mobile and compressible by an expanding hematoma.

Contraindications

No role exists for probing or local exploration of the neck in the trauma bay or emergency department because this may dislodge a clot and initiate uncontrollable hemorrhage. If no significant injuries requiring surgery are present, surgical therapy is unnecessary and observation or expectant management may proceed.

Contributor Information and Disclosures

Author
Daniel Mark Alterman, MD, RN Resident Physician, Department of Surgery, University of Tennessee Graduate School of Medicine

Daniel Mark Alterman, MD, RN is a member of the following medical societies: American College of Surgeons and International College of Surgeons

Disclosure: Nothing to disclose.

Coauthor(s)
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Brian James Daley, MD, MBA, FACS, FCCP, CNSC is a member of the following medical societies: American Association for the Surgery of Trauma, American College of Chest Physicians, American College of Surgeons, American Medical Association, Association for Academic Surgery, Association for Surgical Education, Eastern Association for the Surgery of Trauma, Shock Society, Society of Critical Care Medicine, Southeastern Surgical Congress, and Tennessee Medical Association

Disclosure: Nothing to disclose.

Val Selivanov, MD Consulting Staff, Administrative Chief, Department of Surgery, Kaiser Permanente of Santa Teresa

Levels of Brain Injury

There are 3 levels of brain injury used to describe the severity of an injury. They are mild, moderate, severe and very severe. Some categories include a 4th level, very severe. These ratings are based on the responsiveness of a person who may have just suffered a brain injury. The more responsive they are mentally and physically, the higher their score and the less severe their head injury rating.

Mild head injuries are the most common type of injury and many times go undiagnosed. A person who has suffered a mild head injury may have had a brief loss of consciousness or may feel dazed or confused after an accident of some sort. Many times they do not show up on CT scans or MRIs. Symptoms of a mild head injury include headaches, fatigue, sleep disturbance, irritability, balance problems, nausea, change in mood or appetite. Many times sufferes of mild brain trauma recover fully.

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A person who has suffered from a **moderate** head injury may have loss of consciousness that may last from a few minutes to a few hours. Sometimes the confusion continues for a few days or a few weeks and the physical, cognitive and behavioral changes are permanent. These people usually make a good recovery and through treatment learn to compensate for any permanent disabilities. They may also suffer from the same symptoms of a person with mild head trauma.

Severe brain injury occurs when a person persists in an unconscious state for days, weeks or months. One state they may be in is a coma, where they cannot be awakened and there is no meaningful response to stimulation. A person may recover from a coma but many times they have permanent mental or physical disabilities, and may suffer from amnesia.

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A person may also be in a vegetative state. In this state, the person may be able to open their eyes as a response to a stimulus, they have sleep-wake cycles, respiratory function and digestive functions, and they have general physical responses to pain (like increased heart rate). Someone in a persistent vegetative state has the same symptoms, but has been in that state for over a month. Oftentimes, this level is referred to as very severe, other times it is simply considered in the severe category.

Someone who has suffered a severe brain injury may also be in a minimally responsive state. Here they have some reflexes and are aware of their environment but cannot follow simple commands. A person may move from a coma or vegetative state into this minimally responsive state.

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Akinetic Mutism is another state that can occur from a severe brain injury. These sufferers have little to no body movement, minimal spontaneous speech, eye opening and visual tracking, and infrequent and incomplete ability to follow commands. This differs from the Minimally Responsive State because Akinetic Mutism is not a neuromuscular disorder like the Minimally Responsive State.

The last state is **Locked-In State**. In this state the person can move noting but their eyes and is conscious and able to think. They can use their eyes to communicate with others. In this state the person is basically trapped inside their body.

If a person is said to be suffering from brain death, that means that their brain shows no signs of functioning.

If the force that hits a person's head is great enough, the skull can fracture or become out of place. When this happens, the person is described as having an "open head injury". This terminology is referring to the condition of the skull and not the brain. Separate terms are used to describe the condition of the brain. For example, a person may be described to have an open head injury with a severe traumatic brain injury.

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Open vs. Closed Head Injuries

An **Open Head Injury** occurs when an outside force hits the brain and fractures or is put out of place. This type of injury refers only to the condition of the head and not to the brain. When the head receives an impact from an outside source the brain may be injured may swell. If the skull is fractured or displaced, this can allow the brain room to swell and can assist in reducing the pressure on the brain tissue. On the other hand, the bone fragments can get

Effects of Blunt Force Trauma To The Head and Neck

Background:

Sandra slipped while walking on a floor that had a slippery surface. It was the floor was "cleaned" by staff prior to the day of her fall. No warning signs were posted to inform persons that the floor had the potential to cause a fall (Violation of General Clause - OSH Act). Sandra slipped and fell; with her head hitting the floor on impact.

Potential Energy = mgh

Sandra's height in meters (h) = 1.59 meters

Sandra's weight in kilograms (m) = 66.23 kilograms

Gravity (g) = 9.8 meters per second

Distance after impact = Sandra's head bounced upward ~ 4 inches (0.1 meters) after hitting concrete floor

Velocity (m/s) = $\sqrt{2gh}$ = 5.58 m/s

Kinetic Energy = ½ mv^2 = (0.5)(66.23)$(5.58)^2$ = 1031 Joules

Impact Force = 1031/0.1 = 10310 Newtons = 2318 pounds - force

A **Newton** is the force necessary to accelerate a 1- kilogram object at a rate of 1 meter per second.

The blow to Sandra's head and neck was equal to 2318 pounds of force applied (calculated).

My questions: What type and degree of injury would be expected based on the force exerted on Sandra's head and neck? Secondly, what long-term effects would such a traumatic force exerted to the head and neck cause?

This is to supply Appellate Commission w/ info demonstrating every Diagnosis/Prognosis given in past 5.5 yrs. ↑ Correct

High lighted areas demonstrate diagnosis by several doctors / Specialists in area of neck & brain injuries

Medscape REFERENCE Drugs, Diseases & Procedures

Penetrating Neck Trauma

• Author: Daniel Mark Alterman, MD, RN; Chief Editor: John Geibel, MD, DSc, MA more...

Updated: Sep 20, 2012

Background

Penetrating neck trauma is an important area of trauma care that has undergone evolution in the recent past. A remarkable number of changes have occurred in the treatment paradigm as new technologies have developed and as surgeons have explored the outcomes from different treatment protocols. Therapy has evolved from no treatment (before effective anesthesia and instrumentation), to nonoperative management, to routine exploration, to selective exploration and adjunctive invasive or noninvasive assessment. Penetrating neck injuries remain challenging, as there are a number of important structures in a small area and injury to any of these structures may not be readily apparent. See the image below.

A Zone II penetrating neck injury in a young boy. This child fortunately had no other documented injuries.

Recent studies

Two recent reports demonstrate the importance of the setting in which penetrating neck injuries occur, particularly treatment protocols in combat zones. Sarkar et al presented 2 cases from Western Baghdad,[1] and Ramasamy et al performed a retrospective medical record review of British military casualties from Iraq and Afghanistan who sustained penetrating neck injuries to determine the need for prehospital cervical immobilization, given current ATLS protocols requiring spinal precautions when a significant mechanism of injury may damage the cervical spine.[2]

In the study by Ramasamy et al, of 90 patients with a penetrating neck injury, 66 (73%) were from explosions and 24 (27%) were from gunshot wounds. In 20 (22%) patients, cervical spine injuries were present; only 6 (7%) survived to reach the hospital, and 4 of these 6 died within 72 hours of their injuries.[2] Of 56 survivors that reached a surgical facility, only 1 (1.8%) had an unstable cervical spine injury requiring surgical stabilization, and this patient subsequently died due to a concomitant head injury.

The investigators determined a high mortality rate is associated with penetrating ballistic trauma to the neck.[2] Furthermore, it appears unlikely that survivors of penetrating ballistic trauma to the neck will have unstable cervical spines; therefore, not only is the risk/benefit ratio of mandatory spinal immobilization unfavorable, but cervical collars may also hide potential life-threatening conditions, in addition to putting medical teams at prolonged personal risk.[2]

History of the Procedure

For centuries, carotid ligation was the only reliable treatment of severe penetrating neck injury. In 1552, Ambrose Pare ligated both common carotid arteries and the jugular vein of a soldier with a traumatic neck injury. The patient survived but developed aphasia and hemiplegia. In 1803, Fleming ligated a lacerated common carotid artery and reported a successful outcome with a 5-month follow-up. The noted author George Orwell suffered a penetrating neck injury causing a unilateral vocal fold paresis in 1936 as a result of his involvement in Spain's Civil War.

Nonoperative management of penetrating neck wounds was the standard until World War I.

During World War II, a more aggressive approach to neck exploration was adopted. The types of injuries seen on the battlefields of World War II and the then available diagnostic armamentarium are significantly different in the modern civilian trauma center. The changes associated with improved imaging modalities and nonmilitary injuries have resulted in a dramatic change in the treatment paradigm for penetrating neck injury. Continual advances in anesthesia and perioperative management since World War II have improved the care and the outcome of these patients.

Problem

Penetrating neck trauma involves a missile or sharp object penetrating the skin and violating the platysma layer of the neck. This includes gunshot wounds, stab or puncture wounds, and impalement injuries.[3, 4, 5]

Epidemiology

Frequency

Penetrating neck trauma represents approximately 5-10% of all trauma cases that present to the emergency department. About 30% of these cases are accompanied by injury outside of the neck zones as well.

The current mortality rate in civilians with penetrating neck injuries ranges from 3-6%. During World War II, the mortality rate was 7%, and, in World War I, it was 11%. Higher mortality rates occur with injuries to large vessels, such as the carotid or subclavian arteries and veins.

Recent experience in the treatment of casualties from the Iraq War at Walter Reed Army Medical Center reported the common carotid artery as the most frequently injured cervical vessel.[6]

Etiology

Penetrating neck injuries, like any trauma, may be classified as intentional or nonintentional. The objects causing these injuries can be divided into stabbing instruments (eg, knives, cutting instruments, puncturing objects, impaling objects) and shooting instruments (eg, missiles, projectiles). Wounding instruments have specific characteristics that affect surgical findings. For example, stab wounds typically have a 10% higher rate of negative exploration than injuries from projectiles.

Pathophysiology

Two factors in the mechanism of injury or kinematics in penetrating neck trauma determine the extent of damage to the tissue.

- Weapon characteristics
  - The amount of kinetic energy delivered by the wounding agent has to be considered together with its interaction with the involved tissue.
  - Kinetic energy (KE) is described by the following equation: KE = 1/2 mass X velocity (squared).

South Carolina Worker's Compensation Commission

Response to Form 59 by Rev. Dr. Sandra A. Kearse

1) **Did the Commissioner fail to consider important reasons for award of compensation and what are reasons? Yes the commissioner did fail to consider important reasons for compensation. They are as follows:**
   - **A) I can no longer lift anything 5 lbs or more (see attachments by Ms. Jean Hutchison and Dr. Jervey.**
   - **B) My neck, back, trunk and right hip are not in intermittent pain , but constant, chronic pain, which makes it hard for concentration and normal activity.**
   - **C) I can no longer hear clearly from both my ears. The tinnitus has become aggressively worst over the years. Presently being treated. Last resort is to be fitted for hearing aids.**
   - **D) Can no longer walk a period of time without experiencing Dysphagia or Shortness of Breath.**
   - **E) Can no longer do no more than 2 hours of activities w/o extreme Fatigue.**
   - **F) Can no longer function on a full days schedule because of Sleep Apnea /Asphyxiation type experiences at night thus causing lack of sleep.**
   - **G) Since the Brain/Neck injury, I experience severe Migraines that impede my progress and mobility in any activity.**

2) Did Commissioner incorrectly decide fact and what facts? The Commissioner did indeed incorrectly decide the facts.

a) The facts are, I presently experience both Hypo and Hypertension, which are fluctuating Blood Pressure conditions going either too high or too low as shown in hosp. records @Health Central/ Florida and Roper St. Francis/SC during several admittances after injury. See attachments. These conditions, (according to Medscape, research & studies done by Doctor and Author Daniel Mark Alterman MD, RN at University of Tennessee, Graduate School of Medicine, along with Dr. Brain James Daley, MD, MBA, FACS, FCCP, CNSC Prof and Associate Program Director, Consulting Staff and Director of Trauma and Critical Care) and especially hypotension is indicative of penetrating neck trauma, where neck tissue is damaged or traumatized therefore when your BP is dropping you are in danger of dying quicker. In addition it causes a pulse deficit in which I have and experienced it w/nurse at Dr. Goll's office where my husband was a witness to him not being able to find my pulse.

b) If Dr. Jervey had not thought my neck injury was that severe he would not have required me to wear a neck brace for several days. In addition I was diagnosed with dysphagia, in whichDr. O'Bong, my treating Physician, ordered a treatment for me to have a procedure that would widen my neck to alleviate dysphagia , which was performed by Dr. Nevin Hadjejic. I do now, indeed experience a neurologic deficit in my left thigh and leg area that has since worsened over time and never recognized by the attending physician Dr. Jervey. He always would tell me one thing at time when I was severely incapacitated by vertigo (not being able to move my head even an inch w/o sever spinning, not merely dizziness, but spinning which caused nausea and vomiting.

(See attachments w/ Dr. Jervey's diagnosis) In addition, I suffered swelling on the brain and was indicated on the original ER form that there was a fracture, which was totally ignored. (See original Attachment)

Did you think the Commissioner applied the wrong law? If so what?

3) **Yes, I felt like he overstepped the law by decreasing my impairment rating for my neck from 10% to 5%. In addition, he refused to accept an apparent disfigurement injury to my head which was the focal point of direct trauma to my head and he did not accurately review my records to see all the inconsistencies, misdiagnosis and reviews by the original Workman Compensation doctors that did recommend treatment in which I never received on a consistent basis. In addition, my ailments that I admitted to having (Ex. C-3, c-4, and C-5 of my spine was exacerbated by the fall; and not excluding the T-6 and 7 that were moved out of place during the accident.**

4) **Do you feel there are any other reasons why the Commissioner's judgment was wrong? If so what? Yes Sir and Mam. I feel that he was very prejudicial in his findings and was led by the defendant attorney, even while we were still present in the courtroom discussion was still going on even after we were adjourned.**

5) **What action do you want the Commission to take in this case? I would like for the Commission to grant me the award of all compensation(s) due me for in this settlement for my neck/ no full rotation, head/severe migraines, ears/tinnitus, throat/damaged muscles-nerves in throat area, uncontrollable Hyper-Hypotension which can bring on swift heart disease, Spine/exacerbated, Right Hip/Must use assistance device, Jaws/TMJ, Hair totally depleted in front area of head/ See pictures or will show in private only, Eustachian Tube Dysfunction/Auditory Processing Disorder, Scarring to Head and Eyes and Severe decrease in vision(Dr. Evan spotted floaters or aneurysms and said there was nothing that could be done to risky and can cause blindness and Temporary Total disability for entire tie since 01/03/07and lastly, my Partial Loss of Earning Potential for all other skills**

that were hindered because of this. All medical bills paid to individuals and insurance companies that are now lawfully seeking their monies.

6) **I want The Commission to know that I attempted on several occasions to go back to work because I worked all my life and I felt like I could have done it without incident, but I found during the course of my trying, my body became weak and I fell several(documented by Dr. Dubick) other times because lead physician neglected to recommend strengthening exercises and therapy that would strengthen my upper body and lower regions to stabilize and mobilize my gait. I attempted the last time 04/2012, because I thought it was a job with less stress than what I had before, but I became ill once again and ended up in the hospital for several days(HC) and did not return again because I needed to fully heal and like before it is hard to take meds that make you drowsy and work around individuals.**

Specific Damages Done Since Head and Neck Trauma in 2007

Specific Damages Experienced and/or Exacerbated:

Heart: heart races, shortness of breath even in relaxed position(s) or pulse becomes very slow or low. (Cannot walk up flight of stairs w/o sitting down, breathing becomes extremely difficult). * Never experienced this before accident.

Eyes: Micro-aneurysyms developed from blunt force trauma. Eyes would water profusely (still waters today, not as bad). Eye sight or the ability to see with and w/o readers has decreased tremendously after trauma. Eyesight has gone from a low 1.25 to a 2.50. Must wear glasses at all times. Without them now cannot see but blurs. Eyes extremely reactive to light. *(Very normal eyesight before, was able to see w/o glasses clearly. Used readers before to assist in extensive reading in college and other studies.)

Ears: ears still ringing(seems louder) Tinnitus has never stopped ringing(was told to leave on tv and take some type of meds. Sometimes cannot understand words, can hear sounds, but not understand what is being said. Dr. Scott was very anxious to send me to another specialist and he wrote down words- Auditory Processing Disorder.?? I never went because I was tired of the run around.

Jaw or face: makes noise when I open my mouth wide. PCP & Specialists stated that everything concerning my face, head, trunk area and spine had become misaligned due to impact or force. She compared it to an automobile collision. Also there was tearing in muscle in upper lft shoulder. Body was always extremely weak after the trauma.(Show Effects of Blunt Force Trauma) depiction/must have this for hearing to show lay persons actual effect) Dr. Gamble or Mattia.

Head: coldness on top of head(right side particularly/sometimes would fluctuate. WC Dr. Steichen suggested that it was due to trauma and is

consistent w/ ER Report

possible hairline fracture on top right side of brain. He ask specifically about bruising in which I told him to ask my husband; he never did. Dr. Steichen specifically called them war wounds. For 3 months my husband bathed and showered me. He did see bruising on my back, but did not realize the significance. I have scars and discolorations now not visible on back and hips, but visibly on forehead(more right than left) both eyes significantly darker than usual, my right seems to be worse in appearance.

Sciatic Nerve Damage: Constant pain in left and right big toe. More rt than lft) Pain in mid-back(vertically) area. Gave some temporary therapy for 2 weeks for upper back only. Pain continued received a note not to ride school buses because they constantly shake so much. See notes in Nurses file.

Neck and Base of Brain: Neck still makes crackling sound when I move it up and down and left to right. Some pain stillbut have taken out of pocket expense for therapy similar to Dr. Dubick's recommendation and WC never approved to have just tons of evaluations. Have a obstruction in neck, Inever knew what it was. Every medical professional I met in ER's etc. said it was scar tissue from neck trauma. Dr. Jervey and Scott never even mentioned my neck or tried to treat.

Mastoid Area: Pain in back of ear on hard boned area. Severe pain, sharp and sticking sensation in inner ear(even after 5 years).

Vestibular Disorders Association

A nonprofit organization dedicated to serving people with inner ear balance disorders
(800) 837-8428 or (503) 229-7705 • *fax:* (503) 229-8064
www.vestibular.org • veda@vestibular.org
PO Box 13305 • Portland, OR 97213

VEDA Publication No. M-3

Possible Symptoms of Vestibular Disorders

Many of the symptoms experienced by people affected by dizziness and balance disorders can be obscure or frightening. This list is incomplete. It does not apply to everyone with an inner-ear disorder, and some of these symptoms can be unrelated to the ear. Even so, this list may aid those who have been unable to make sense out of their seemingly abnormal sensations and symptoms.

Vision

- Objects appear to jump.
- Reading difficulty. (Printed words move. Vision blurs or doubles.)
- Lights glow or emit rays; glare intensifies.
- You have a tendency to look down; discomfort increases when focusing at a distance.
- Increased night blindness.
- Poor depth perception.
- Moving or flickering lights may be disturbing.

Hearing

- Hearing can fluctuate, be lost, be unaffected, or distort (e.g., popping, clicking, ringing, or buzzing)
- Loud environments may be uncomfortable
- Your ears may feel full.

Coordination

- Clumsiness. (You may drop things, have difficulty threading needles or with handwriting.)
- Sensation of being heavily weighted.
- Imbalance, difficulty walking straight.
- Muscle and joint pain.
- Rocking sensation (as if you are in a rowboat).
- Slurred speech.

Memory

- You may forget what you are talking about, or grope for words.
- Confusion, disorientation, inability to comprehend directions and instructions.

Emotions

- Loss of self-reliance, self-confidence, self-esteem.
- Distraction, anxiety, phobias, panic attacks.
- Depression.

Nausea

- Continual or intermittent nausea.
- A "hangover" feeling or seasick sensation in the head and/or stomach.
- Motion sickness.

Other

- Headaches.
- Discomfort caused by temperature changes, pressure changes, wind currents.
- Symptoms may worsen with altitude changes.
- Fatigue; everyday tasks are exhausting.
- Violent whirling sensations (vertigo), vomiting.

The human balance system depends on information that the brain receives from the eyes, the muscles and joints of the body, and the inner ear. If the inner ear is damaged, the brain may receive incorrect information. The result may be dizziness or imbalance problems.

There are many different symptoms of inner-ear vestibular disorders and many degrees of severity. An inner-ear disorder may be present even in the absence of imbalance, a hearing problem, or vertigo.

People affected by some of these symptoms may be perceived as inattentive or lazy, or may be thought to be hypochondriacs. Well-educated people may have difficulty reading or doing simple math. Keeping a job, going to school, performing routine tasks, or just getting out of bed in the morning may be difficult for some people.

Getting a diagnosis, adhering to your treatment, and learning as much as you can about your problem will assist you in your recovery.

This document is not intended as a substitute for professional health care.
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Health Central Patient Inquiry Processor

Fri Aug 17, 2012 09:16

Unit #	Name	Sx	Birthdate	Room	Physician	Srv	ICD	Status
A525916	KEARSE,SANDRA	F	09/15/1954		ALLWOOD,KENN	ERS	9	DIS HOM

Allergies Exhibited

Exam Summary

Page: 1

Opt#	PC	Request/ Chk-In #		Exam Name	Ordered for/ Chk-In time	Status
1	*	1430330		CHEST (1 VIEW)	06/16/12 2138	FINAL***ST*
2	*	1429928		MRI ABDOMEN WO CONTRAS	06/15/12 0921	FINAL
3	*	1429845		CT HEAD W/O CONTRAST	06/14/12 2246	FINAL***ST*
4	*	1429844		CT ABD/PELVIS-NO ORAL	06/14/12 2246	FINAL***ST*
5	*	1360067		CTA CHEST W&WO CONTRAS	10/14/11 0827	FINAL***ST*
6	*	1360045		CHEST (1 VIEW)	10/14/11 0617	FINAL***ST*
7	*	1349690		VENOUS DUPLEX BILAT LO	09/08/11 1657	FINAL***ST*
8	*	1309241		CHEST 2 VIEWS	04/15/11 2214	FINAL***ST*
9	*	1251221	L	NUC MED EXAM	09/23/10 1120	FINAL***ST*
10	*	1251218	L	NM MYOCARD MULTI SPECT	09/23/10 1119	FINAL
11	*	1250938		CHEST (1 VIEW)	09/22/10 1316	FINAL***ST*

All Listed!

Enter option number(s) or all(A) [A]--

V in Question

Some of Hospital Visits since 2010

Progress Note

Rehabilitation Centers RCC of Charleston

To: Jervey, Charles
From: Doug Miller (WP)
Date: 3/1/2007
Re: Sandra Kearse Visits: 4

Diagnosis
PAIN - Neck - Cervical (723.1)

Problem Site(s)
Cervical

Objective Findings

Assessment
Patient with apparent left C5 radicular symptoms which are mechanically alterable this date. Positive response to intervention. She continues with predominantly right mid to upper neck pain which is very sharp and episodic in nature. Sustained postures, handling of school children, riding in a bus, etc remain very aggravating. Patient needs to have restricted work obligations and physical exertion level requirement for 2-3 more weeks at least to allow pain cycle to be broken in sustained manner.

Plan
Continue per MD.

I certify that the above rehabilitative services are required and authorized by me, and that the patient's plan will be reviewed every thirty- (30) days.

Physician: _____ Date: _____

Physician's Instructions:
☐ Evaluate and Treat ☐ Other: _____

Please sign the above authorization and fax to (843) 402-1285.

Carolina Neurological Clinic
125 Doughty Street, Suite 460, Charleston, SC 29403
Phone 843-723-0202 Fax 843-723-1052

MEDICAL EXCUSE/WORK LIMITATIONS

This is to certify that Kause Sandra was seen in/phoned the office today, March 16, 07 and is under my treatment for _____

INSTRUCTIONS:

____ **Return to work/school, starting** _____

____ **Regular duties, starting** _____

____ **No work until further notice.**

✓ **Light Duty w/ following restrictions:** * No lifting greater than 25 lbs.

____ **Please excuse from work/school** _____.

____ Head injury/Dizziness: Avoid driving, operating heavy/moving machinery, climbing/heights.

____ Neck injury: No repetitive bending/turning of neck. No lifting more than 10 pounds.

____ Back injury: No repetitive bending/stooping of back. No lifting more than 20 pounds.

____ Hand injury: No repetitive use of affected hand. Limit gripping/grasping.

____ Brain injury/Cognitive impairment/Seizures: No driving or operation of heavy, moving machinery. No work at heights. _____.

____ No prolonged standing/sitting for more than ____ hours at a time.

____ Part time work limited to ____ hours total/day; ____hours total/week.

____ Other Job/Injury specific limitations: _____

Charles Jervey

James L. Bumgartner, MD

Charles S. Jervey, MD

Thomas H. Dukes, MD

Thomas F. Stout, MD

FAMILY HISTORY & ROS: Noted in the chart.

PHYSICAL EXAMINATION: She is alert and oriented X3. She appears in some distress and was laying on the exam table when I entered the room. She was able to sit up without assistance but moved very slowly to bring herself to a seated position, and then had to sit motionless for a few minutes before she could cooperate with the exam. She complained of feeling dizzy when she sat upright. Head - There is a slight swelling in the midline of the forehead. This area is very tender to the palpation. The remainder of her head is nontender to palpation. Her neck is nontender to palpation. Cranial nerves II-XII intact per protocol. Ears - Canals clear and TM's gray with good light reflexes and landmarks. Sensation is intact to pinprick throughout. Motor exam shows symmetrical bulk and tone with 5/5 strength throughout and no drift. She has symmetrical coordination throughout, and normal reflexes. Gait - She ambulates very slowly.

DIAGNOSTIC STUDIES: She had a non-contrast head CT scan dated 1/3/07. It showed left frontal cephalohematoma, also incidental findings of basal ganglia calcifications bilaterally and also incidental findings of some maxillary and ethmoid sinus disease.

IMPRESSION: I think she is probably having vertigo as a result of her recent head injury. It is relatively severe and accompanied by considerable nausea and vomiting.

RECOMMENDATION: I plan on getting a video nystagmogram within the next few days. I will see her for a follow-up visit as soon as that has been completed. I think she will probably need to be out of work for at least a week. I am hoping, however, that she will be able to return to work after next week.

Charles S. Jarvey, M.D.

CSJ/jl

cc: The Schaffer Group, Att: Heather Erdmann, Fax 843-937-4990

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

JAMES L. BUMGARTNER, M.D.
THOMAS H. DUKES, III, M.D.
CHARLES S. JERVEY, M.D.
THOMAS F. STOUT, M.D.

125 Doughty Street
Suite 460
Charleston, SC 29403
(843) 723-0202
Fax (843) 723-1052

INFRARED/VIDEO NYSTAGMOGRAM STUDY AND FALLTRAK BALANCE ANALYSIS

PATIENT: SANDRA KEARSE
REFERRING PHYSICIAN: CHARLES JERVEY, M.D.
DATE OF STUDY: JANUARY 9, 2007

HISTORY: Patient is a 52 year old female with dizziness.

FINDINGS:

a) **OCULOMOTOR BATTERY** (abnormalities are consistent with a central vestibular pathology). The results of this portion of the test maybe adversely affected by poor visual acuity, peripheral field deficits, and oculomotor abnormalities (strabismus, cranial nerve palsy, etc.)

	Normal	Abnormal
Tracking	✔(borderline morphology)	
Saccades		✔ (↑ latency)
OPK	✔	
Spontaneous (normal)	✔	
Torsion swing	✔	

b) **POSITIONAL TESTING BATTERY** Rotary (torsional) nystagmus with brief latency on Hallpike Dix indicates peripheral vestibular pathology on that side (usually indicates benign paroxysmal positional nystagmus BPPV). Abnormalities may respond to canalith repositioning maneuver, however medical clearance and clinical correlation is recommended. More than 5 deg/sec of nystagmus is also abnormal.

	Normal	Abnormal
Supine head center	✔	
Supine head left	✔	
Supine head right	✔	
Body left	✔	
Body right	✔	
Dix Hallpike left		✔ (7 deg/sec left)
Dix Hallpike right		✔ (torsional nystagmus)

c) **ROTATIONAL TESTING BATTERY** (Active Head Rotation (AHR) was performed at head speeds of 1-3 Hz for both the vertical and horizontal Vestibulo-Ocular Reflex (VOR). Increased VOR gain is consistent with central vestibular pathology while decreased gain is generally consistent with peripheral vestibular pathology. Many elderly patients and closed head injury patients exhibit increased VOR gain, often as the only abnormal finding on the VNG test battery. VOR exercises are recommended when gain is abnormal and after correlating the physical exam, patient history and other medical tests.

	Normal	**Abnormal**
Horizontal AHR	✔	
Vertical AHR	✔	

d) **CALORIC TESTING BATTERY** in the presence of abnormal calorics, it is recommended that a Unilateral Peripheral Vestibular Lesion be ruled out prior to starting any vestibular rehabilitation program.

	Normal	**Abnormal**
Left	✔	
Right	✔ (borderline)	

TECHNICIAN'S COMMENTS: The technician monitoring the video did see rotary nystagmus in the right Hallpike position.

IMPRESSION: This study shows evidence of right peripheral vestibular pathology consistent with BPPV. There is also possible left peripheral vestibular pathology as well.

Charles S. Jervey, M.D.
CSJ/sf

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JAMES L. BUMGARTNER, M.D.
THOMAS H. DUKES, III, M.D.
CHARLES S. JERVEY, M.D.
THOMAS F. STOUT, M.D.

January 24, 2007

Heather Erdmann
Claims Adjuster
Schaffer Companies Ltd.
171 Church Street, Suite 140
Charleston, SC, Fax 937-4990

RE: SANDRA KEARSE

Dear Ms. Erdmann:

Sandra Kearse came in for a follow-up visit today accompanied by her husband. She had her video nystagmogram which shows abnormalities in both Hallpike positions. The right Hallpike had torsional nystagmus which is consistent with BPPV. The left Hallpike had an increase in degrees/sec of nystagmus but there was no torsional seen.

IMPRESSION: I think she has a right BPPV and may very well have bilateral.

PLAN: My plan for that is to put her through a corrective Epley re-positioning maneuver. If her symptoms persist a week later, then I will do the Epley on the left side as well.

The patient also had another complaint today about pain in the bilateral upper extremities. I am uncertain as to the cause of that. I plan on waiting until her dizziness is better before pursuing that problem. She will be seen for a follow-up visit in about two weeks.

Sincerely,

Charles S. Jervey, M.D.

CSJ/jl

FAMILY HISTORY & ROS: Noted in the chart.

PHYSICAL EXAMINATION: She is alert and oriented X3. She appears in some distress and was laying on the exam table when I entered the room. She was able to sit up without assistance but moved very slowly to bring herself to a seated position, and then had to sit motionless for a few minutes before she could cooperate with the exam. She complained of feeling dizzy when she sat upright. Head - There is a slight swelling in the midline of the forehead. This area is very tender to the palpation. The remainder of her head is nontender to palpation. Her neck is nontender to palpation. Cranial nerves II-XII intact per protocol. Ears - Canals clear and TM's gray with good light reflexes and landmarks. Sensation is intact to pinprick throughout. Motor exam shows symmetrical bulk and tone with 5/5 strength throughout and no drift. She has symmetrical coordination throughout, and normal reflexes. Gait - She ambulates very slowly.

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Charles S. Harvey, M.D.

CSJ/jl

cc: The Schaffer Group, Att: Heather Erdmann, Fax 843-937-4990

Bon Secours St. Francis

Diagnostics
3-1-07
MRI - Brain
- C Spine

Name: KEARSE,SANDRA A
Exam Date: 03/01/07 0708
Ord. Phy.: OBONG,BETTY

OBONG,BETTY
2270 ASHLEY CROSSING DRIV
SUITE 165
CHARLESTON SC 29414

Chk-in #	Order	Exam	
1680542	0001	36134	MR HEAD W/WO CONTRAST MRI

Ord Diag: CLOSED HEAD INJURY

MRI BRAIN: 3/1/07

CLINICAL HISTORY: Status post fall, closed head injury; headaches.

The brain was imaged utilizing the following pulse sequences:

Sagittal T1 weighted spin echo; axial T1 weighted spin echo, T2 weighted fast spin echo, FLAIR sequence and diffusion weighted images; post contrast axial and coronal T1 weighted spin echo.

COMPARISON: Head CT, 1/3/07 and 1/7/07.

There are a couple of small foci of increased T2 signal intensity in the frontal periventricular white matter, which are nonspecific in this age group. No other sites of pathologically altered signal intensity are seen in the brain. No pathologic areas of intracranial enhancement, mass effect or significant midline shift are seen.

The focal site of soft tissue swelling/contusion at the left frontal scalp area seen on the previous head CT scans has resolved in the interval. Minimal focal mucosal thickening is noted in the left anterior ethmoid air cells and there are also small focal sites of increased T2 signal intensity along the margins of the right maxillary sinus, which could reflect focal mucosal thickening or small mucous

Dictated
C Peter

FINAL

into the brain and the skull cannot protect the brain like it once could, leaving room for further injury. A person with an open head injury may be assigned to wear a helmet to protect the exposed brain from impact and further injury. If a piece of the skull has been displaced during the traumatic event, that piece of skull may be surgically replaced at a later date or an artificial bone flap may be used to cover the open area.
Return to top

There are many types of open head injuries, one is the **depressed skull fracture** which is where the broken piece of skull bone moves in towards the brain. There is a **compound skull fracture** which is where the scalp is cut and the skull is fractured. A **basilar skull fracture** is when the skull fracture is located at the base of the skull (neck area) and may include the opening at the base of the skull. This type of injury can cause damage to the nerves and blood vessels that pass through the opening at the base of the skull. A **Cribiform Plate Fracture** is when the cribiform plate, which is a thin structure located behind the nose area is fractured. When this happens cerebral spinal fluid can leak from the brain area out the nose.

Battle's Sign is when the skull fracture is located at the ear's petrous bone. This produces large black and blue marks on the areas below the ear, on the jaw and neck and it may include damage to the nerve for hearing. Sometimes blood or cerebral spinal fluid may leak out of the ear.

Another type of open head injury is **Racoon Eyes**, which sometimes occurs when the skull fracture is located in the anterior cranial fossa. This produces black and blue mark looking areas around the eyes. Cerebral spinal fluid may leak into the sinuses. Nerve damage for the sense of smell or eye functions may occur.
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A **Closed Head Injury** occurs when a person receives an impact to the head from an outside force, but the skull does not fracture or displace. After a closed head injury the brain has no place to expand if it starts to swell. This can cause an increase in pressure inside the skull, causing brain tissues to compress, which causes more damage.

If the brain starts to swell, it may expand through any available opening in the skull, including the eye sockets. When the brain expands through the eye sockets, it can compress and impair the functions of the eye nerves. For instance, if an eye nerve is compressed, a person's pupil will appear dilated (big). One reason why medical personnel may monitor a person's pupil size after and accident is to ensure that there is not too much intracranial pressure.
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Other Effects of Traumatic Brain Injury

Many times the brain is not the only part of the body that is damaged from a traumatic brain injury. Since the brain is the main control center for the body, anything that goes wrong inside the brain, will likely have effects on the rest of the body. **Polytrauma** is term used by physicians to explain injuries in other parts of the body. Popular complications include lung, heart and gastrointestinal dysfunction, plus excessive blood clotting ns nerve injuries. Some trauma victims develop hypermetabolism, where their body needs so much energy to keep the body functioning that it starts to pull energy from muscles and other tissues. Many brain trauma victims can develop permanent behavioral and mental disorders like depression and increased irritability, that can cause problems at home and in the work force. Others retain the inability to think and reason like they could before the accident. Some have permanent physical disabilities or lose senses like taste and smell. Alzheimers, Parkinsons and dementia can be some of the long-term effects of a traumatic brain injury.
Return to top

Ways to Prevent Brain Injuries

The Center for Disease Control and Prevention recommend the following tips for preventing a brain injury:

- always wear a seatbelt, and buckle your child into a seatbelt
- be sure you and your children wear a helmet when you ride a motorcycle, horse or bike, and when you ski, play contact sports or play baseball
- keep firearms and bullets stored n a locked cabinet when not in use and keep children away from them at all times
- avoid falls by using a step stool with grab bar, using handrails on steps, installing window guards to prevent children from falling and make sure your child plays on shock absorbing material, like mulch or sand (not blacktop)

Return to top

Caring for a loved one who is a survivor of a brain injury can be hard, but you are not alone. Organizations that specialize in the care, education and prevention of brain injuries are as follows:

Symptoms of Brain Injury

A wide variety of symptoms can occur after a brain injury. Below is a list of possible symptoms, which can arise from damage to specific areas of the brain:

Frontal Lobe: Forehead

- Loss of simple movement of various body parts (Paralysis).
- Unability to plan a sequence of complex movements needed to complete multi-stepped tasks, such as making coffee.
- Loss of spontaneity in interacting with others.
- Loss of flexibility in thinking. ✓
- Persistence of a single thought.
- Inability to focus on task. ✓
- Mood changes. ✓
- Changes in social behavior. ✓
- Changes in personality.
- Difficulty with problem solving. ✓
- Inability to express language. ✓

Parietal Lobe: near the back and top of the head

- Inability to attend to more than one object at a time. ✓
- Inability to name an object. ✓ Sometimes
- Inability to locate the words for writing. a lot of times
- Problems with reading.
- Difficulty with drawing objects.
- Difficulty in distinguishing left from right. ✓ Sometimes
- Difficulty with doing mathematics.
- Lack of awareness of certain body parts and/or surrounding space that leads to difficulties in self-care.
- Inability to focus visual attention. ✓
- Difficulties with eye and hand coordination.

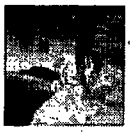
Occipital Lobes: most posterior, at the back of the head

- Defects in vision. ✓ definitely
- Difficulty with locating objects in environment. ✓ ✓
- Difficulty with identifying colors.
- Production of hallucinations.
- Visual illusions - inaccurately seeing objects. ✓ ✓ Sometimes
- Word blindness - inability to recognize words. ✓
- Difficulty in recognizing drawn objects.
- Inability to recognize the movement of object. ✓
- Difficulties with reading and writing.

Work Camp Doctor

Consistent w/ Dr. Burk + Dr Stechen findings

BLUNT HEAD TRAUMA AND EFFECTS



Aug 8, 2009 | By Liz Stannard

Liz Stannard has her bachelor's of science degree in neuroscience, with minors in classics and Japanese. She has been a freelance writer for five years, covering women's health, politics and medicine.

Blunt head trauma can happen from a blow to the head, and result in serious damage to the brain. According to the National Institutes of Health, the impact can range from a minor bump to severe brain injury. According to braininjury.com, the majority of traumatic brain injuries (61 percent) occurs due to traffic accidents. Even if the head trauma does not result in an open wound, injury can occur to the brain. The effects of blunt head trauma are irreversible and severe, and can interfere with normal brain function.

Types

Initial Diagnosis from ER Attach is

Two types of head trauma can occur: concussion and contusion. With a concussion, the brain is shaken, while a contusion causes direct injury to the brain. According to braininjury.com, the loss of consciousness from a blunt head trauma leads to even more damage to the brain. In addition, injury can occur to the opposite side of the brain---called contrecoupe---when the head is moving and hits a stationary object. This blunt force results in the opposite side of the brain pulling away from the skull and becoming injured.

Causes

Blunt head trauma occurs from accidents; according to the National Institutes of Health, the most common causes of head injury are traffic accidents, sport injuries, physical assaults and falls. In sports, wearing a helmet can reduce the risk of head injury. Using proper restraining devices in the car can prevent head injury from occurring.

Symptoms

Symptoms of blunt head trauma can either occur immediately after injury or develop slowly within a few hours or days. Severe symptoms that can arise from head injury include convulsion, changes in the pupils, inability to move one or more limbs, irritability, personality changes, unusual behavior, loss of consciousness, confusion, drowsiness, low breathing rate, drop in blood pressure, lack of coordination, severe headache, slurred speech, blurred vision, stiff neck and vomiting.

Effects

Injury to the head can result in severe damage to the brain. According to the National Institutes of Health, serious head trauma can result in speech and language problems, coma, chronic headaches, paralysis, seizure, changes in sensation, and changes in hearing, vision, taste or smell. In addition, bleeding can occur within the brain, which can exacerbate brain damage.

Warning

According to the National Institutes of Health, after a blunt head trauma, do not move the patient unless necessary. Do not clean any wounds, remove objects or shake the person if he seems dazed. Timing is essential, so call for medical attention immediately.

LONG-TERM EFFECTS OF TRAUMA ON THE BRAIN

Trauma can occur in two ways that affect the brain: traumatic brain injury and traumatic stress. The National Institute of Neurological Disorders and Stroke (NINDS) defines traumatic brain injury as an impact to the head, such as one caused by blunt force. Even if the skull is not fractured, the brain can be damaged from the force. With a traumatic experience, the stress negatively affects the amygdala, hippocampus and prefrontal cortex in the brain, according to Dr. JD Bremner, author of the article "Traumatic Stress: Effects on the Brain." Both types of trauma can result in long-term effects.

Decreased Memory Function

Both types of stress can negatively impact a person's memory. In traumatic brain injury, damage to the brain can disrupt cognition; however, that symptom depends on where in the head the injury occurs. The NINDS notes that thinking, memory and reasoning can be affected after the injury. As a result, neuropsychological rehabilitation is recommended, which helps the patient adapt to learning after the brain damage.

During traumatic stress, the brain releases increased levels of cortisol, which Bremner notes has an adverse effect on the hippocampus. The hippocampus is found in the medial temporal lobe of the brain, and is responsible for converting short-term memories to long-term memories. In his article, Bremner mentions that in animal studies, those who underwent traumatic stress have smaller hippocampi.

Personality Changes

Personality changes can also occur from traumatic stress and traumatic brain injury. One of the areas affected from traumatic stress is the amygdala, which is part of the limbic system in the brain. During heightened traumatic stress, the amygdala has an increased function. As a result, the patient develops "conditioned fear."

In traumatic brain injury, changes in personality is another long-term effect if damage occurs in the frontal lobe. The frontal lobe is one of the areas of the brain responsible for personality. The traumatic brain injury patients can exhibit aggression, acting out and social inappropriateness after the injury.

Sensory Processing

The NINDS notes that permanent sensory damage can occur with traumatic brain injury, such as deficits with smell, sight, taste, touch and hearing. The damage to the brain from the injury is irreversible. While traumatic stress does not result in damage to the senses, it can cause an adverse reaction to certain stimuli. Activation of the amygdala during a specific stimulus can result in an emotional response when exposed to that stimulus again.

Before Accident 11/3/2007

CHARLESTON NEUROLOGY ASSOCIATES

Marshall A. White, M.D.
John W. Plyler, M.D.
John H. Lucas IV, M.D.
Thomas A. Privett, M.D.

9313 Medical Plaza Drive, Suite 310
Charleston, South Carolina 29406

Telephone (843) 569-1856
Facsimile (843) 569-1879

Re: KEARSE, SANDRA
ID#: 44682
Date: 06/05/03

FOLLOW-UP

SUBJECTIVE: Ms. Kearse is seen today in follow-up for evaluation of paresthesias to her left upper extremity.

DIAGNOSTIC STUDIES: Her current workup includes carotid ultrasound performed May 22, 2003, which revealed a moderate right ICA stenosis of 50-79%, which was a technically limited study.

MRI of brain performed May 22. 2003 was normal except for incidental finding a mucous retention cyst in the left maxillary sinus. MRI of cervical spine revealed a broad central disc protrusion with extension to the left at C3-C4. Similar degenerative disc disease is seen at C4-C5. She has evidence of a central syrinx from mid C5 thru C6. These MRI reports are the only information that I have. Films are not available for my review at this time.

Nerve conduction study was performed, which was normal for both left upper and lower extremities.

LABORATORY DATA: We obtained baseline labs from Dr. Pappas' office. She has essentially a normal CBC, CMP, mildly elevated total cholesterol of 207 and normal ESR of 2. The report is from November 2001.

She has had no other change in her condition since last visit.

She was supposed to bring the MRI films of cervical spine and brain, which she left at her residence. In addition, she also left her sleep diary.

VITAL SIGNS: Pulse 76 Blood pressure 108/70.

PHYSICAL EXAMINATION: Neurological examination is unchanged from previous visit.

In addition, after I explained the MRI report to her, she points out paresthesias to the superior cervical paraspinal/inferior occipital area. She has had no other change in her condition since last visit.

IMPRESSION/PLAN:

1. Forty-seven-year-old woman with symptoms as mentioned above.
2. Evidence of a cervical syrinx. I would like to review the MRI films.
3. Degenerative disc disease. Once again, I would like to review the MRI films.
4. Evidence of borderline stenosis to the right ICA. I will place her on baby aspirin.
5. Given the above laboratory results, it would be worthwhile to obtain a fasting lipid panel.
6. She needs a repeat carotid ultrasound in six months.
7. Delay in completing the needle EMG study since I have not had a chance to review the MRI films. She will obtain these films from her residence and follow-up with me next week.

TAP

Thomas A. Privett, M.D., Ph.D.

TAP/cdk

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

CIVIL ACTION COVERSHEET

Rev. Sandra A. Kearse Plaintiff(s)

vs.

Chas. Cty School Dist Defendant(s)

2013 -CP-10-1993

(Please Print)
Submitted By: Rev. Sandra A. Kearse SC Bar #:
Address: 1725 London Crest Dr # 301 Telephone #: 407-522-7207
Orlando, FL 32818 Fax #: " " same
(407) 902-4015 Other:
E-mail: Sandrakearse@gmail.com

NOTE: The cover sheet 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 filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (*Check all that apply*)

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

☐ 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.
☐ 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
- ☐ Constructions (100)
- ☐ Debt Collection (110)
- ☐ Employment (120)
- ☐ General (130)
- ☐ Breach of Contract (140)
- ☐ Other (199)

Torts - Professional Malpractice
- ☐ Dental Malpractice (200)
- ☐ Legal Malpractice (210)
- ☐ Medical Malpractice (220)

Previous Notice of Intent Case # 20____-CP-____-_____
- ☐ Notice/ File Med Mal (230)
- ☐ Other (299)

Torts – Personal Injury
- ☐ Assault/Slander/Libel (300)
- ☐ Conversion (310)
- ☐ Motor Vehicle Accident (320)
- ☐ Premises Liability (330)
- ☐ Products Liability (340)
- ☐ Personal Injury (350)
- ☐ Wrongful Death (360)
- ☐ Other (399)

Real Property
- ☐ Claim & Delivery (400)
- ☐ Condemnation (410)
- ☐ Foreclosure (420)
- ☐ Mechanic's Lien (430)
- ☐ Partition (440)
- ☐ Possession (450)
- ☐ Building Code Violation (460)
- ☐ Other (499)

Inmate Petitions
- ☐ PCR (500)
- ☐ Mandamus (520)
- ☐ Habeas Corpus (530)
- ☐ Other (599)

Judgments/Settlements
- ☐ Death Settlement (700)
- ☐ Foreign Judgment (710)
- ☐ Magistrate's Judgment (720)
- ☐ Minor Settlement (730)
- ☐ Transcript Judgment (740)
- ☐ Lis Pendens (750)
- ☐ Transfer of Structured Settlement Payment Rights Application (760)
- ☐ Other (799)

Administrative Law/Relief
- ☐ Reinstate Driver's License (800)
- ☐ Judicial Review (810)
- ☐ Relief (820)
- ☐ Permanent Injunction (830)
- ☐ Forfeiture-Petition (840)
- ☐ Forfeiture—Consent Order (850)
- ☐ Other (899)

Appeals
- ☐ Arbitration (900)
- ☐ Magistrate-Civil (910)
- ☐ Magistrate-Criminal (920)
- ☐ Municipal (930)
- ☐ Probate Court (940)
- ☐ SCDOT (950)
- ☒ Worker's Comp (960)
- ☐ Zoning Board (970)
- ☐ Public Service Commission (990)
- ☐ Employment Security Comm (991)
- ☐ Other (999)

Dr. Jinks Application for Appeal

Special/Complex /Other
- ☐ Environmental (600)
- ☐ Automobile Arb. (610)
- ☐ Medical (620)
- ☐ Other (699)
- ☐ Pharmaceuticals (630)
- ☐ Unfair Trade Practices (640)
- ☐ Out-of State Depositions (650)
- ☐ Motion to Quash Subpoena in an Out-of-County Action (660)
- ☐ Sexual Predator (510)

Submitting Party Signature: _____ Date: 2/14/2013

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.

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON 2013-CP-10-1223

Sandra A. Kearse -SC-

PLAINTIFF

- VERSUS -

Charleston Cty. School District

DEFENDANT

FILED
2013 MAR -1 PM 3:23
BY
CLERK OF COURT

APPEAL Decision and Order Workers Comp. Commission Appellate Panel

I, Sandra A. Kearse, PLAINTIFF/DEFENDANT IN THIS CIVIL ACTION MAKE THE FOLLOWING CLAIM.

1. I BELIEVE THAT THE PLAINTIFF/DEFENDANT RESIDES IN CHARLESTON COUNTY AND IS WITHIN THE JURISDICTION OF THIS COURT. (Now reside in Florida Plaintiff.

2. I MAKE THIS APPEAL BASED ON THE FOLLOWING ERRORS COMMITTED BY THE LOWER COURT: Home several impairments from this work related injury + Admitted ones (Spine) was exacerbated by head + neck trauma.
- That I have as was stated by Dr. 2, 10% impairment to neck am related to back.
- I am entitled to full benefits for Disfigurement.
- I am entitled to ongoing medical benefits Ex. ear/tinnitus/loss of hearing
- My cancellation w/Dr. Goll is an error. Do not remember cancelation needed.
- I Am still required to have CPAP to assist w/ breathing + hearing Aids for loss of hearing in rt ear

(Copy of hospital stay attached)

3. I BELIEVE, BECAUSE OF THE ABOVE INFORMATION, THAT I AM ENTITLED TO AND REQUEST: All compensation for medical + travels to receive proper care

I STATE UNDER PENALTY OF PERJURY THAT THE ABOVE IS CORRECT AND TRUTHFUL.

DATED: 2/14/2013

SIGNED: Sandra A. Kearse

ADDRESS OF PLAINTIFF

1725 London Crest Dr. #301
Orlando, FL 32818
C# (407) 902-4015

(407) 522-7207
TELEPHONE (BUSINESS)

Email: SandraKearse@gmail.com

(CELL-407) 902-4015

ADDRESS OF DEFENDANT

C/O Leslie Whitten Esq.
Chas. Cty. School District
4720 Jenkins Ave N. Chas 29405

(843) 577 4000
TELEPHONE (BUSINESS)

I ask to type over to be able to read!

2013-CP-10-1223

FILED
2013 MAR -1 PM 3:25
JULIE J. ARMSTRONG
CLERK OF COURT
BY

STATE OF SOUTH CAROLIA

IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON

Rev. Sandra A. Kearse
Vs.
Charleston County School District

APPEAL: DECISION AND ORDER OF WORKER'S COMP. COMMISSION APPELLATE PANEL

February 25, 2013

To: The Honorable Judge

I make this appeal based on the following "errors " committed by the Lower Court. 1)They erred in carrying out orders given by Commissioner Wilkerson and Barden. 2) The single Commissioner erred by reducing the Disability Status to neck that was given by certified doctors. 3) There was no basis given and Commissioner was not qualified. 4) Also, he neglected to give a true assessment, as did the Appellate Panel of Facial Disfigurement with a before and after picture. 5) The Commissioner erred in not entitling Claimant to Total Temporary Benefits, which are required by Law since April of 2007. 6) The Defense has totally ignored the decision of the Full Commission as was given back in June 21, 2010 by Appealing and still not given appropriate care to Claimant, as required by AMA for someone having suffered an apparent Blunt Head/ Neck Trauma. 7) Defense went on to find bogus and incompetent doctors in Florida to state (after 3 of their very competent doctors said I was not at MMI and to ignore all orders for recommended treatment from these doctors) and selectively pay for one (Dr. Leland and not for Dr. Burke's care who was precisely given a referral from Dr. Steichen, a noted Neuro-Surgeon here in Charleston). 8) My admitted having 3 bulging disc, that were exacerbated by the fall and being grossly ignored , showing negligence by Dr. Jervey, a neurologist of over 2 decades of experience and proclaiming that he knew not of my barrage of symptoms and allowing me to suffer and my condition to worsen because of the neglect. Indeed my complaints are different and not similar as stated by Defense. They are more magnified(painful) and definitely excessively more often or chronic. Defense does not seem to be able to differentiate having experienced some symptoms of a diagnosis of vertigo to slight dizziness, which is different(according to balance mobility center(s)). Starkie vs. Ballenger, 268 S.C. 536(1977). 9) It was confirmed by Dr. Jervey, Dr. Zieglewski and Dr. Dubick of my inability to perform same duties I had before. Dr. Jervey and Dr. Z. recommended not lifting anything over 20 - 25 lbs. According to S.C. Worker's Comp Manual, G.E. Moore Company vs. Walker, 232S.C. 32 , 120 S.E.2d, 106(1958). in addition , the therapist recommended by Dr. Jervey concluded me to not ride on school bus because of the shaking up and down. 10)Finally, I believe because of the above information, that I am entitled to and respectfully request all Temporary Total benefits from 01/03/2007 to 04/01/2012 minus the 3 weeks they did send. 10% as stated by their doctor to Neck as related to Back. Scarring to Head and Face. 50% Loss of hearing which was acknowledged of Minimal Hearing Loss and ignored through this entire process for both ears. 25% of Total Body to encompass General Diminution of Function to eyes, ears jaws, throat, head and upper left and right arm. I am also considering seeking penalties against the Defendant for unlawfully stopping my Temporary Total benefits and their refusal to restart back in 2008. They refused to restart even after the findings of Commissioner Avery Wilkerson and Barden after their findings in the record that I had not met Maximum Medical Improvement. And as stated earlier Defendant has refused to pay numerous Medical Expenses associated with this claim as required under The Worker's Compensation Act and confirmed by the Single Commissioner and The

ck please

Track & Confirm

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70121010000174709509 Restore Archived Details	First-Class Mail®	Delivered	May 1, 2013, 12:03 pm	CHARLESTON, SC 29407	Scheduled Delivery Day: May 2, 2013 Certified Mail™ Return Receipt
70121640000129913567 Restore Archived Details	First-Class Mail®	Delivered	April 11, 2013, 9:27 am	CHARLESTON, SC 29401	Scheduled Delivery Day: April 12, 2013 Certified Mail™ Return Receipt
70121640000129914717 Restore Archived Details	First-Class Mail®	Delivered	April 12, 2013, 9:53 am	CHARLESTON, SC 29402	Scheduled Delivery Day: April 12, 2013 Certified Mail™ Return Receipt
70121640000129913772 Restore Archived Details	First-Class Mail®	Delivered	March 18, 2013, 9:23 am	CHARLESTON, SC 29401	Scheduled Delivery Day: March 18, 2013 Certified Mail™ Return Receipt
70121640000129867549 Restore Archived Details	First-Class Mail®	Delivered	December 10, 2012, 11:08 am	CHARLESTON, SC 29401	Scheduled Delivery Day: December 10, 2012 Certified Mail™
70121640000129897027 Restore Archived Details	First-Class Mail®	Delivered	November 29, 2012, 8:32 am	CHARLESTON, SC 29402	Scheduled Delivery Day: November 29, 2012 Certified Mail™
70121640000129867556 Restore Archived Details	First-Class Mail®	Delivered	December 12, 2012, 8:34 am	COLUMBIA, SC 29202	Scheduled Delivery Day: December 10, 2012 Certified Mail™
70123050000000650212 Show Details	First-Class Mail®	Delivered	July 25, 2013, 9:31 am	CHARLESTON, SC 29401	Scheduled Delivery Day: July 26, 2013 Certified Mail™ Return Receipt
70123050000000650151 Show Details	First-Class Mail®	Delivered	July 26, 2013, 9:35 am	CHARLESTON, SC 29401	Scheduled Delivery Day: July 26, 2013 Certified Mail™ Return Receipt

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70123050000000650144	First-Class Mail®	Delivered	July 26, 2013, 9:17 am	CHARLESTON, SC 29402	Scheduled Delivery Day: July 26, 2013 Certified Mail™ Return Receipt
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70101060000128805254					
Delivery status information is not available for your item via this web site. A return receipt after mailing may be available through your local Post Office.					
70111570000015404769	First-Class Mail®	Delivered	January 17, 2012, 3:24 pm	COLUMBIA, SC 29201	Scheduled Delivery Day: January 14, 2012 Certified Mail™
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70121640000129913567	First-Class Mail®	Delivered	April 11, 2013, 9:27 am	CHARLESTON, SC 29401	Scheduled Delivery Day: April 12, 2013 Certified Mail™ Return Receipt
Restore Archived Details					
70121640000129914717	First-Class Mail®	Delivered	April 12, 2013, 9:53 am	CHARLESTON, SC 29402	Scheduled Delivery Day: April 12, 2013 Certified Mail™ Return Receipt
Restore Archived Details					
70123460000212039044	First-Class Mail®	Delivered	February 28, 2013, 9:25 am	CHARLESTON, SC 29401	Scheduled Delivery Day: March 1, 2013 Certified Mail™
Restore Archived Details					
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70121640000129887820	First-Class Mail®	Delivered	November 1, 2012, 2:43 pm	COLUMBIA, SC 29201	Scheduled Delivery Day: November 3, 2012 Certified Mail™
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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS
CASE NUMBER: 2013-CP-10-1223

Honorable Julie J. Armstrong
Charleston County Clerk of Court
100 Broad Street, Suite 106
Charleston, South Carolina 29401

Sandra A. Kearse vs. Charleston County School District

Writ of Amicus

Dear Madam:

I request that you accept this petition on behalf of my wife, Rev. Dr. Sandra Kearse, the plaintiff in this case. I have witnessed the pain and sufferings that my wife has experienced due to this incident. My wife was always an energetic, very articulate, and professional person. Due to this incident my wife no longer can stand nor sit for long periods of time without experiencing pain in her cervical and thoracic spine areas. My wife also has breathing difficulties such as shortness of breath or irregular breathing patterns (a couple of rapid, shallow breaths followed by a pause in breathing) when she sleeps. Some nights my wife has difficulty going to sleep and walking up stairs due to shortness of breath that she experiences.

It has been over 5 years now and my wife's cognitive skills and motor coordination have rapidly diminished. At times my wife seem to have a very difficult time processing information communicated in a general conversation and has to be told parts of what was communicated to her over and over. An example of this is that her answer to a question asked are far removed from what was asked. I would constantly reiterate what was communicated. This has happened during several business transactions between my wife and third parties. I have to act as the "interpreter". My wife also has difficulty with short-term memory.

I am employed as the SES (Safety, Environmental, and Security) Manager for The Coca-Cola Company. A part of my responsibilities is incident investigation and handling worker compensation injury cases. I have never witnessed a case that was so skewed with no diagnoses, misdiagnoses and untruthfulness. My wife slipped while walking on the school's cafeteria floor that had been recently waxed. No warning signs were posted. She fell (face first); striking her head onto the stone floor from a height of approximately 5 feet (distance from her head in a standing position to the walking surface--- the stone floor). A hematoma on her head was very evident when EMS arrived (I was at the scene). Since that day everyone in my family has suffered; not only my wife. We have had to tend to her physical and

emotional well-being; and we have paid dearly financially. Because Charleston County School District has refused to act in a responsible manner, my family continues to suffer. We are asking that the Court consider the contents of this letter.

Lastly, I pose these questions: What type and severity of injury is expected from a slip and free fall (mechanism of injury) with the head impacting a stone floor? Secondly, why is there no recommended treatment program in place to cater to my wife's physical condition since the injury? My wife medical condition deteriorating due to lack of proper treatment.

Respectfully submitted,

Carroll L. Kearse

Carroll L. Kearse

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS
CASE NUMBER: 2013-CP-10-1223

Honorable Julie J. Armstrong
Charleston County Clerk of Court
100 Broad Street, Suite 106
Charleston, South Carolina 29401

Sandra A. Kearse vs. Charleston County School District

Writ of Amicus

Dear Madam:

I am respectfully asking that you honor this letter on behalf of my mother, the Claimant, Sandra Kearse. During my Christmas break from college, immediately after the accident, instead of enjoying my break with my family doing fun things, such as going out places, sight-seeing, I was taking my mother back and forth to the hospital. After the accident, when my mom was released to come home, she didn't even look the same. At that time she had an enormous protrusion on her head and up until today she ambulates very slowly. My mom was at a point where we had to help her with everything and had to take special precautions.

Her injuries were apparent and judging from the look of this gigantic knot on her forehead revealed the seriousness of the head injury. We had to help her get in and out of bed, she was off balance and she could not hear as well as she used to; and up until today, we are still having to repeat ourselves to her. Then, when she repeated things back, she said the wrong thing. This is embarrassing and extremely frustrating. My mother was not like this at all before this happened to her.

She was capable of doing more activities on her own. Now she can no longer do many things in a timely manner or without assistance. These dis-abilities have not just affected me, but my children who want to climb on their grandmother and are painful for her to even hold them. I pray that I have given the court a small picture of how this event about my mom's illness has had a direct effect on how our lives have changed. As a science major, this brain and neck injury has been a wake - up call for me and has made me want to pursue additional studies in Chemistry and Pharmaceuticals to help make more informed decisions about the different types of medicine and therapy. My only disappointment was observing how her employer was very slack about her care and there was a lack of concern for my mom's condition. Just when she thought the doctors were going to help her, they would come up with a delay in treatment or either terminated the therapy that really was working. How was she supposed to get better with trauma to the brain causing migraine headaches, impacting judgment, diminishing her hearing and sight when all you're doing is evaluating

How was she supposed to get better with trauma to the brain causing migraine headaches, impacting judgment, diminishing her hearing and sight when all you're doing is evaluating her? Judging from this experience, many of these medical professionals have proven inadequacy and indifference. I am a friend of the court!

Sincerely,

Brittany Kearse

Brittany Kearse

February 21, 2012

Sandra A. Kearse, Pastor, Writer, Clergy
1725 London Crest Dr.
Unit 301
Orlando, Florida 32818

Leslie M. Whitten, Esquire
Young Clement Rivers LLP
P.O. Box 993
Charleston, SC 29402-0993

Re: Sandra A. Kearse vs. Charleston County School District

WCC File Number: 0700666
Claim Number: 07 - 07-000014
Date/Accident: 01/03/2007
YCR File: 6959-20070594

Dear Attorney Whitten:

Enclosed please find my settlement offer of $210,430.20 to settle all claims on the above case by "clincher". After you have had an opportunity to discuss this settlement offer with your client, please respond within seven (7) days.

1. Temporary total benefits from 1/3/2007 to 4/1/2012 minus 3 weeks paid $60,605.70

2. Seventy Percent (70%) to neck $ 78,855.00

3. Ten Percent (10%)to back $ 11,265.00

4. Scarring to head and face $ 22,530.00

5. Fifty Percent (50%) loss of hearing left ear $ 9,012.00

6. Fifty Percent (50%) loss of hearing right ear $ 9,012.00

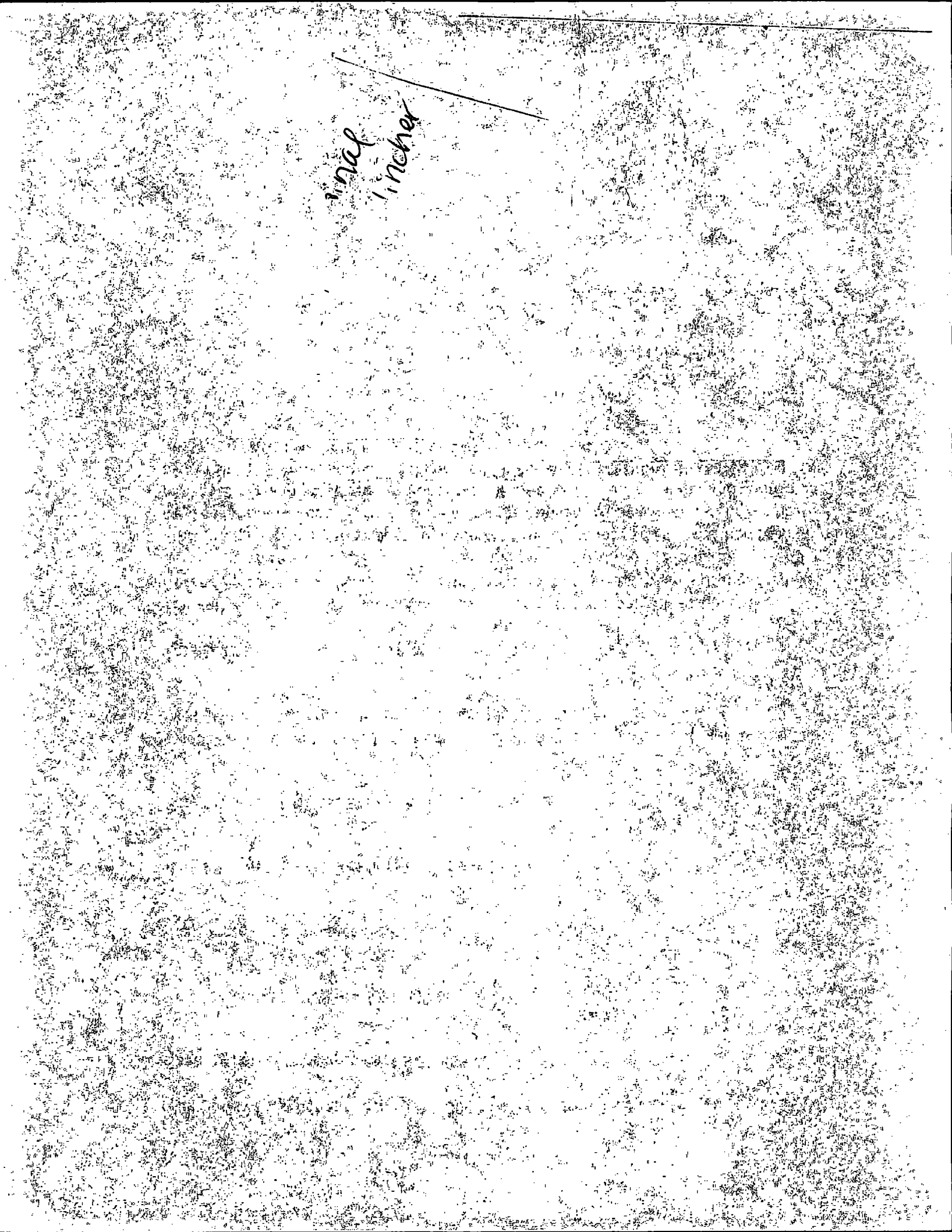
7. Twenty Five Percent (25%) Total body to encompass general diminution of function to eyes, jaw, throat,upper left arm, and right hip. $ 28, 162.50

Total $ 217,342.20

This settlement offer considers, but does NOT seek specific penalties against the Defendant for unlawfully stopping temporary total benefits or their refusal to re-start benefits even though there were findings in the record by Commissioner Barden and affirmed on appeal by the Appellate Panel that the claimant had NOT reached Maximum Medical Improvement. Further, Defendant has refused to pay for numerous medical expenses of claimant as required under the Workers Compensation Act and confirmed by the Single Commissioner and the Appellate Panel. **ALL MEDICAL BILLS RELATED TO THIS CASE MUST BE PAID BY DEFENDANT.**

Sincerely, I am

Pastor Sandra A. Kearse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