THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

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SC Court of Appeals

R. Markley Dennis, Jr., Circuit Court Judge

C.A. No.: 2013-CP-10-1400

Robert J. Burke ....Respondent,

v.

Republic Parking System, Inc. ....Appellant.

RECORD ON APPEAL

VOLUME III OF III (Pages 1001 - 1406)

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Attorneys for Republic Parking System, Inc.

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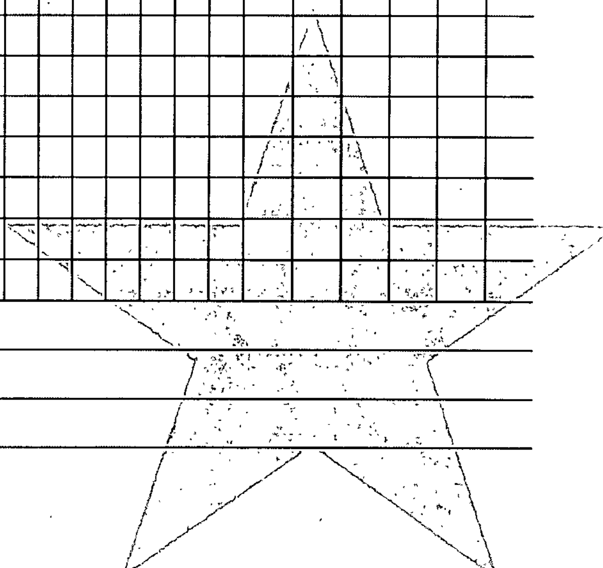
Maintenance Checklist

Time	Task	Freq.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Check all gates and spitters for correct time and ticket inventory.	D															
	Walk Facility and pick up trash.	D															
	Sweep assigned areas including Curbs.	D															
	Wipe down equipment.	D															
	Empty and clean trash cans; place liners in all trash cans	D															
	Clean Toilets, floors and fixtures	D															
	Elevator - floors, doors, lights; check alarms	D															
	Stairs - floors, windows, handrails, lights	D															
	Oil Dry on all floors as needed.	D															
	Lobby Office - floors, window, trash	D															
	Landscaping - remove trash from shrubs and grass	D															
	Floor Drains - Clear and Unclog	D															
	Clean Equipment completely	W															
	Doors - check for proper operation	W															
	Lights - Check and replace bulbs.	W															
	Landscaping - mow, trim, weed	W															
	Sump Pump - check for operation	W															
	Safety - Exit lights, emergency lights, trip hazards	W															
	Security Systems - proper operation, TV, audio, panic buttons, door alarms	W															
	Graphics - Clean all signs	W															
	Sweeping all areas including curbs.	M															
	Painting - check for rust and touch up; doors, handrails, guardrails, pipes, curbs and signs	M															
	Fire Protection System - Check Fire Extinguishers	M															
	Wash Parking Floors	SA															
	Structure - Check Floor surface deterioration, water leakage, cracking	SA															
	Check Icy spots in season; remove ice and snow, salt where needed.	DS															
	Fire Protection System - Drain water before winter season.	BW															



D Daily
M Montlhly
W Weekly
SA Semi-Annual
DS During Season

Notes: ______________________

WORK ORDERS

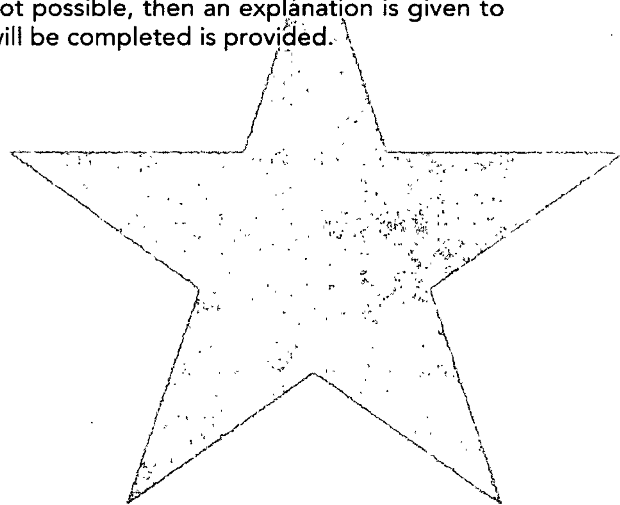
In addition to the maintenance checklist, Republic Parking System also uses maintenance work orders. The purpose of the two part work order form is to have an effective way of communicating amongst the management staff and the maintenance department. It not only helps Republic Parking System maintain the cleanliness of the facilities that our clients desire but also creates more awareness of projects that need to be completed.

All Republic Parking System managers walk their structures on a daily basis checking for cleanliness of the entire facility. Some of the areas they inspect are the elevator lobbies and cars, stairwells including handrails, windows, parking equipment, height bars, garbage cans, graffiti, sidewalks, landscape beds, and pipes. In addition they check the light bulbs, tickets, signage, freshness of paint, damage to the structure, slip and fall hazards, and any possible liability issues.

The Manager then fills out the location, the date, priority status (High or Low), description of maintenance issue (detailed), order written by and order assigned to. The Manager then will tear the two part work order form apart and place the white portion in the Maintenance Manager's in-box. They retain the yellow copy and provide a photo copy to the General Manager. The number of work orders are compiled by the General Manager on a monthly basis to ensure the other manager's are making rounds and walking the structures.

The Maintenance Manager gets the white portion from his in-box and presents it to the maintenance personnel. Once the work order is completed, the employee signs his/her name and has the lead maintenance person or Maintenance Manager inspect the project to ensure it is completed properly. They then sign off with the date completed and return the white copy to the supervisor to match up with the yellow slip. The supervisor will then double check the work order request to ensure that it is completed properly.

General cleaning and light bulbs are issued immediately to the maintenance personnel, and it is expected to be done right away. Some of the bigger projects like damage to the structure or electrical issues would be completed by the Maintenance Manager and or certified contractor to ensure it is completed properly. The goal is to have each work order completed within a one week period. If this is not possible, then an explanation is given to the General Manager and the date the project will be completed is provided.



EXHIBITS

EXHIBIT 1 - CERTIFICATE OF FAMILIARITY

EXHIBIT 2 - CERTIFICATE OF INSURANCE

EXHIBIT 3 - FULL MONTHLY BUDGET PACKAGE

EXHIBIT 4 - REPUBLIC PARKING SYSTEM'S FINANCIALS

EXHIBIT 5 - LETTERS OF RECOMMENDATION

EXHIBIT 6 - CITY OF CHARLESTON AMBASSADOR GUIDE

EXHIBIT 7 - MYSTERY PARKER REPORT SUMMARY

EXHIBIT 8 – 2008 PARKER MIX REPORT

EXHIBIT 9 - SIGNAGE REVIEW REPORT

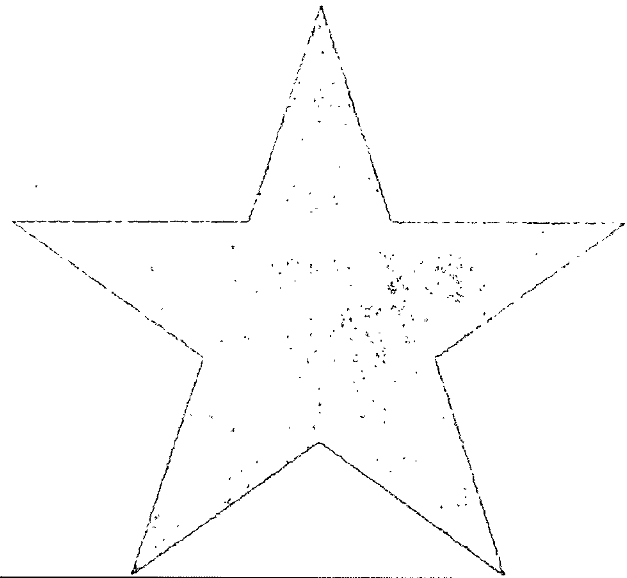
EXHIBIT 10 - 2007 RATE SURVEY

EXHIBIT 11 - REPAIR PROJECTS REPORT

EXHIBIT 12 - PROJECT IMPROVEMENT REPORT

EXHIBIT 13 - CLIENT SERVICES PORTFOLIO

EXHIBIT 14 - OPERATING STANDARDS GUIDE



STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	CASE NO.: 2013-CP-10-1400
	)	
Robert J. Burke and Jane B. Burke,	)	
	)	
Plaintiffs,	)	**SECOND AMENDED NOTICE OF DEPOSITION OF REPUBLIC PARKING SYSTEM, INC. PURSUANT TO RULE 30(b)(6), SCRCP**
v.	)	
Indigo Realty Company, LLC, Republic Parking System, Inc., and the City of Charleston,	)	
	)	
Defendants.	)	

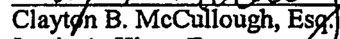
TO: STEPHEN E. DARLING, ESQ., COUNSEL FOR DEFENDANT REPUBLIC PARKING SYSTEM, INC.:

YOU WILL PLEASE TAKE NOTICE that the attorney for the Plaintiffs will take the deposition of **Republic Parking System, Inc.** at the offices of McCullough Khan, LLC. located at 68 ½ Queen Street, Charleston, South Carolina, 29401, on **Wednesday, May 21, 2014** beginning at **10:00 a.m.**, in accordance with the provisions of Rule 30(b)(6) of the South Carolina Rules of Civil Procedure ("SCRCP"). This deposition will be taken before a Notary Public for the State of South Carolina. The oral examination will continue from day to day until completed. This deposition is being taken for the purpose of discovery, for use at trial, and for all other purposes as are permitted under the rules of this Court and all applicable statutes and laws.

Republic Parking System, Inc., in accordance with Rule 30(b)(6), SCRCP, must designate one or more officers, directors, or managing agents to testify on the matters on which examination is requested. *See* **Exhibit A** attached hereto. The person or persons required to be designated pursuant to Rule 30(b)(6), SCRCP must be prepared to answer questions concerning

the matters on which examination is requested and to bring with them to the deposition any and all documents to support their testimony.

McCULLOUGH KHAN, LLC



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(843) 937-0400
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ATTORNEYS FOR PLAINTIFFS

4.29, 2014

Charleston, South Carolina

Exhibit A

1. Who was responsible for negotiating the Parking Garage Management Agreement;
2. Who was responsible for making sure the "regular and frequent inspections" of the parking lot at issue occurred;
3. What were the results of those inspections; when did they occur; what repairs were made; How was it documented;
4. Was the lighting tested, modified, changed in any way during the time Republic managed the lot;
5. Did the City make "routine inspections" and if so who was the City rep;
6. Did the City made repairs, modifications to the lighting of the Lot while Republic managed;
7. Were there any modifications to the parking space design of the lot while Republic managed;
8. What is Republic's regular practice as to
    a. Inspecting a parking lot when taking over the management;
    b. Regular inspections;
9. How much was spent per year on maintenance for this lot for the years Republic managed;
10. What were the gross and net income for this lot for each year Republic managed.

STATE OF SOUTH CAROLINA	) IN THE COURT OF COMMON PLEAS) FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	) CASE NO.: 2013-CP-10-1400
Robert J. Burke and Jane B. Burke, Plaintiffs,	) **CERTIFICATE OF SERVICE**
v.	)
Indigo Realty Company, LLC, Republic Parking System, Inc., and the City of Charleston, Defendants.	)

I hereby certify that a true and correct copy of **Second Amended Notice of Deposition of Republic Parking System, Inc. Pursuant to Rule 30(b)(6), SCRCP** has been served upon the following by mailing a copy properly addressed and with sufficient postage affixed thereto on this 29th day of April, 2014.

Lisa A. Reynolds, Esq.
Anderson Reynolds & Stephens, LLC
37 ½ Broad Street
Charleston, SC 29401

Counsel for Defendant City of Charleston

Bonum S. Wilson, III, Esq.
Wilson & Heyward, LLC
P.O. Box 13177
Charleston, SC 29422

Counsel for Defendant Indigo Realty Company, LLC

Stephen E. Darling, Esq.
Haynsworth Sinkler Boyd, P.A.
P.O. Box 340
Charleston, SC 29402

Counsel for Defendant Republic Parking System, Inc.

Alicia Benton, Paralegal

Charleston, South Carolina

Exhibit 2 to
Deposition of Jack Skelton
included in record
as Plaintiff's Ex. 7

SELF INSPECTION CHECKLIST

An essential part of loss prevention is the recognition and removal or correction of hazards before a loss can occur. This checklist should serve as a tool, indicating those areas needing attention. A "NO" response to any question indicates corrective action is necessary. This survey form should be completed quarterly and reviewed by top management to monitor the loss control program.

SECTION A - OPEN SURFACE PARKING LOTS

Question	Yes	No	N/A
Parking area(s) well-illuminated with designated entrance(s), exit(s), and directional sign(s)?	✓		
Wheel stops in place and adequately secured? Wheel highlighted to contrast with back round?	✓		
Signs, utility poles, as meters, power transformers, fire hydrants, etc., in parking areas properly marked and protected?	✓		
Areas designated for pick-up, delivery, access routes and traffic directions controlled with lines or directional arrows?	✓		
Proper signs posted and in good condition and adequately secured?	✓		
Is the parking lot free of debris or trash?	✓		
Where needed, are fences &/or guard rails in good repair? Also Handrails?			✓
Is the parking lot surface in good repair (free of potholes, etc.)?	✓		
Perimeter Areas(Walkways) Entrance/Exits well lighted	✓		
Surface areas paved? Speed bumps smooth and wide and painted	✓		
Speed bumps smooth and wide and painted?			✓
Handicapped areas clearly posted and are sufficiently wide?	✓		

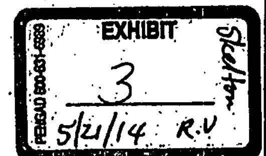
PARKING EQUIPMENT

Question	Yes	No	N/A
Are all equipment pieces i.e. gates, spitters, fee computers, cash registers, etc. in good condition and properly positioned?	✓		

PARKING BOOTH (NOTE CONDITION OF ALL EQUIPMENT & DEFECTS)

Question	Yes	No	N/A
Are the heating and air conditioning working properly?			
Are all booths free of debris or trash?	✓		
Are cabinets, shelves, etc., easily accessible?	✓		
Emergency phone numbers (i.e. doctor, ambulance & fire dept. available?	✓		
Do cashier booths have 360 degree visibility	✓		
Are attendants trained in emergency procedures- fire, medical, robbery, etc.?	✓		

[illegible]: George St. [illegible]: 440 Date: 7/27/2012



SELF INSPECTION CHECKLIST

SECTION B - PARKING GARAGES

Item	Yes	No	N/A
Emergency lighting system provided which will automatically activate in the event of power failure? Number units checked ____(at least 2)			✓
Glass entryways provided with decals, or otherwise conspicuously marked?			✓
Stairways with four or more steps provided with handrails? Handrails secure and in good condition?			✓
If English is not the predominant language among employees, are warning signs bilingual?			✓
Stairways and landings free of water, ice, debris and trash?			✓
All shrubs and trees trimmed to eliminate hiding places for felons?			✓
Outside doors secured to prevent unauthorized persons from entering garage?			✓
GFCI's provided in lavatories on electrical outlets?			✓
Elevators in good shape with current inspection certificates?			✓
Fire protection systems (fire extinguishers, alarms, sprinklers) in good shape and inspected regularly?			✓
Panic pedestrian push bars and safety or tempered glass installed on all glass doors?			✓
Stairway steps in good condition and equipped with non-slip tread surfaces?			✓
Emergency exits adequate in number properly marked, illuminated and kept clear at all times?			✓
Are concrete sidewalks & curbs in good condition and curbs clearly painted/ marked?			✓
Security is adequate to address exposures?			✓
Electrical wiring, lighting, and outlets in good condition?			✓
Security Cameras provided where needed and properly monitored?			✓
Videos are maintained for 30 days Signs posted prohibiting use of ramps for egress and access by customers and employees?			✓
Is there adequate fresh air to control carbon monoxide from vehicles? Warning signs?			✓
MANLIFTS PRESENT? IF SO, COMPLETE SPECIAL MANLIFT SAFETY FORM			✓

Charleston | 440/George | 7/27/2012

SELF INSPECTION CHECKLIST

SECTION C - SHUTTLE / VEHICLE / VALET

Item	Yes	No	N/A
Written procedures regarding driver restriction, personal use, etc. distributed to and reviewed with drivers of company vehicles?			✓
Driving records of all employees operating vehicles for company purposes, reviewed prior to hiring and on a periodic basis? Review minimum of 25% of files quarterly Number ________			✓
Are vehicles inspected daily for proper working order, (i.e., taillights, brakes, turn signals, etc.)			✓
A maintenance program provided and written records maintained on each vehicle? Number of records reviewed this quarter Number ________			✓
Are shuttles clean inside & out?			✓
Are steps on shuttle in good repair?			✓
All drivers have safety section of Valet Manual reviewed with them at least twice a year?			✓
Supervisors and managers conduct regular documented observations of drivers?			✓
Managers have driven route to evaluate special concerns such as sharp turns, blind intersections, etc.?			✓
Documented test drives/obstacle course conducted on all new vehicle operators by Management?			✓

City	Charleston SC	Location Number	440 / George	Date	7/27/2012

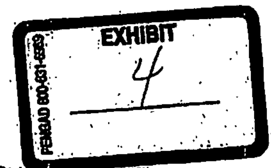
SELF INSPECTION CHECKLIST

SECTION D – MANAGEMENT / PROGRAMS

Item	Yes	No	N/A
Documented Orientation and Training for all new hires? Number of files audited ______(min 10).	✓		
Safety Committee meets monthly or quarterly in compliance with State or Corporate requirements?	✓		
Safety Inspections completed monthly or quarterly?	✓		
A current chemical list and MSDS's are available?	✓		
Written rules regarding work practices and personal protective equipment?	✓		
Regular (monthly or more frequently) meetings are held with all employees?	✓		
Universal Precautions/First aid kit provided and employees trained in its use?	✓		
Employees trained in chemical (hazard communication) requirements?	✓		
Thorough employee and customer accident investigations conducted and corrective actions are documented?	✓		
Responsibilities for inspections, meetings, investigations, employee training, etc., assigned to management individual?	✓		
Emergency Action Plans developed, posted, and reviewed with all employees?	✓		

Kenneth Lee

It was dark and it was during a college game the lot was full and the lady came up to the booth and said that her husband's father had fall and that the ambulance was coming to get him so the ambulance came and took him at the car inside the ambulance and they all left.



SELF INSPECTION CHECKLIST

An essential part of loss prevention is the recognition and removal or correction of hazards before a loss can occur. This checklist should serve as a tool, indicating those areas needing attention. A "NO" response to any question indicates corrective action is necessary. This survey form should be completed quarterly and reviewed by top management to monitor the loss control program.

SECTION A - OPEN SURFACE PARKING LOTS

Question	Yes	No	N/A
Parking area(s) well-illuminated with designated entrance(s), exit(s), and directional sign(s)?	✓		
Signs, utility poles, as meters, power transformers, fire hydrants, etc., in parking areas properly marked and protected?	✓		
Proper signs posted and in good condition and adequately secured?	✓		
Where needed, are fences &/or guard rails in good repair? Also Handrails?			✓
Perimeter Areas(Walkways) Entrance/Exits well lighted	✓		
Speed bumps smooth and wide and painted?			✓
Wheel stops in place and adequately secured? Wheel highlighted to contrast with back round?	✓		
Areas designated for pick-up, delivery, access routes and traffic directions controlled with lines or directional arrows?	✓		
Is the parking lot free of debris or trash?	✓		
Is the parking lot surface in good repair (free of potholes, etc.)?	✓		
Surface areas paved? Speed bumps smooth and wide and painted	✓		
Handicapped areas clearly posted and are sufficiently wide?	✓		

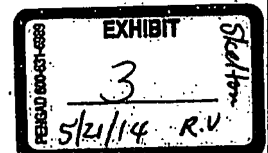
PARKING EQUIPMENT

Question	Yes	No	N/A
Are all equipment pieces i.e. gates, splitters, fee computers, cash registers, etc. in good condition and properly positioned?	✓		

PARKING BOOTH (NOTE CONDITION OF ALL EQUIPMENT & DEFECTS)

Question	Yes	No	N/A
Are the heating and air conditioning working properly?			
Are cabinets, shelves, etc., easily accessible?	✓		
Do cashier booths have 360 degree visibility	✓		
Are all booths free of debris of trash?	✓		
Emergency phone numbers (i.e. doctor, ambulance & fire dept. available?	✓		
Are attendants trained in emergency procedures- fire, medical, robbery, etc.?	✓		

City/St	George St.	Co/Lot Number	440	Date	7/27/2012

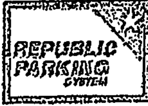


SELF INSPECTION CHECKLIST

SECTION B - PARKING GARAGES

Item	Yes	No	N/A
Emergency lighting system provided which will automatically activate in the event of power failure? Number units checked _____(at least 2)			✓
Glass entryways provided with decals, or otherwise conspicuously marked?			✓
Stairways with four or more steps provided with handrails? Handrails secure and in good condition?			✓
If English is not the predominant language among employees, are warning signs bilingual?			✓
Stairways and landings free of water, ice, debris and trash?			✓
All shrubs and trees trimmed to eliminate hiding places for felons?			✓
Outside doors secured to prevent unauthorized persons from entering garage?			✓
GFCI's provided in lavatories on electrical outlets?			✓
Elevators in good shape with current inspection certificates?			✓
Fire protection systems (fire extinguishers, alarms, sprinklers) in good shape and inspected regularly?			✓
Panic pedestrian push bars and safety or tempered glass installed on all glass doors?			✓
Stairway steps in good condition and equipped with non-slip tread surfaces?			✓
Emergency exits adequate in number properly marked, illuminated and kept clear at all times?			✓
Are concrete sidewalks & curbs in good condition and curbs clearly painted/ marked?			✓
Security is adequate to address exposures?			✓
Electrical wiring, lighting, and outlets in good condition?			✓
Security Cameras provided where needed and properly monitored?			✓
Videos are maintained for 30 days Signs posted prohibiting use of ramps for egress and access by customers and employees?			✓
Is there adequate fresh air to control carbon monoxide from vehicles? Warning signs?			✓
MANLIFTS PRESENT? IF SO, COMPLETE SPECIAL MANLIFT SAFETY FORM			✓

Charleston 440 / George 7/27/2012



SELF INSPECTION CHECKLIST

SECTION C - SHUTTLE / VEHICLE / VALET

Item	Yes	No	N/A
Written procedures regarding driver restriction, personal use, etc. distributed to and reviewed with drivers of company vehicles?			✓
Are vehicles inspected daily for proper working order, (i.e., taillights, brakes, turn signals, etc.)			✓
Are shuttles clean inside & out?			✓
All drivers have safety section of Valet Manual reviewed with them at least twice a year?			✓
Managers have driven route to evaluate special concerns such as sharp turns, blind intersections, etc.?			✓
Driving records of all employees operating vehicles for company purposes, reviewed prior to hiring and on a periodic basis? Review minimum of 25% of files quarterly Number ________			✓
A maintenance program provided and written records maintained on each vehicle? Number of records reviewed this quarter Number ________			✓
Are steps on shuttle in good repair?			✓
Supervisors and managers conduct regular documented observations of drivers?			✓
Documented test drives/obstacle course conducted on all new vehicle operators by Management?			✓

City	Charleston SC	Lot Number	440 / George	Date	7 / 27 / 2012

SELF INSPECTION CHECKLIST

SECTION D – MANAGEMENT / PROGRAMS

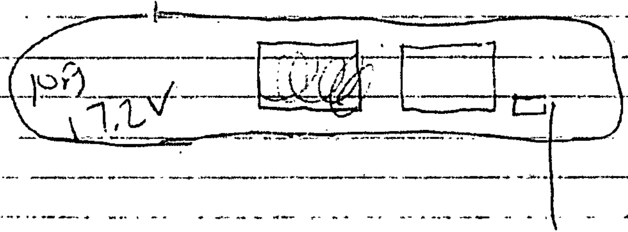
Item	Yes	No	N/A
Documented Orientation and Training for all new hires? Number of files audited _____(min 10).	✓		
Safety Committee meets monthly or quarterly in compliance with State or Corporate requirements?	✓		
Safety Inspections completed monthly or quarterly?	✓		
A current chemical list and MSDS's are available?	✓		
Written rules regarding work practices and personal protective equipment?	✓		
Regular (monthly or more frequently) meetings are held with all employees?	✓		
Universal Precautions/First aid kit provided and employees trained in its use?	✓		
Employees trained in chemical (hazard communication) requirements?	✓		
Thorough employee and customer accident investigations conducted and corrective actions are documented?	✓		
Responsibilities for inspections, meetings, investigations, employee training, etc., assigned to management individual?	✓		
Emergency Action Plans developed, posted, and reviewed with all employees?	✓		

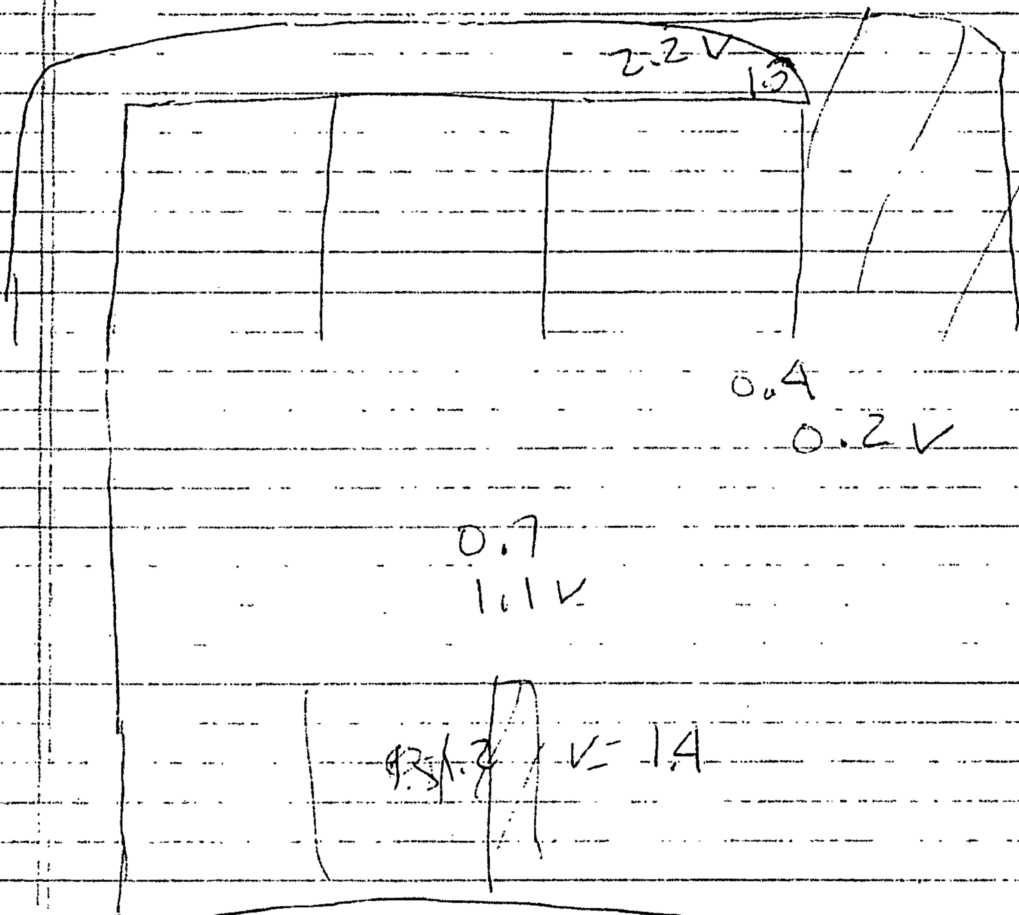
Kenneth Lee

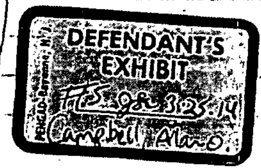
It was dark and it was during a college game the lot was full and the lady came up to the booth and said that her husband or father had fall and that the ambulance was coming to get him so the ambulance came and took him at the car inside the ambulance and they all left.

@ pole
13.5 V

≈ 1400
2/12/14

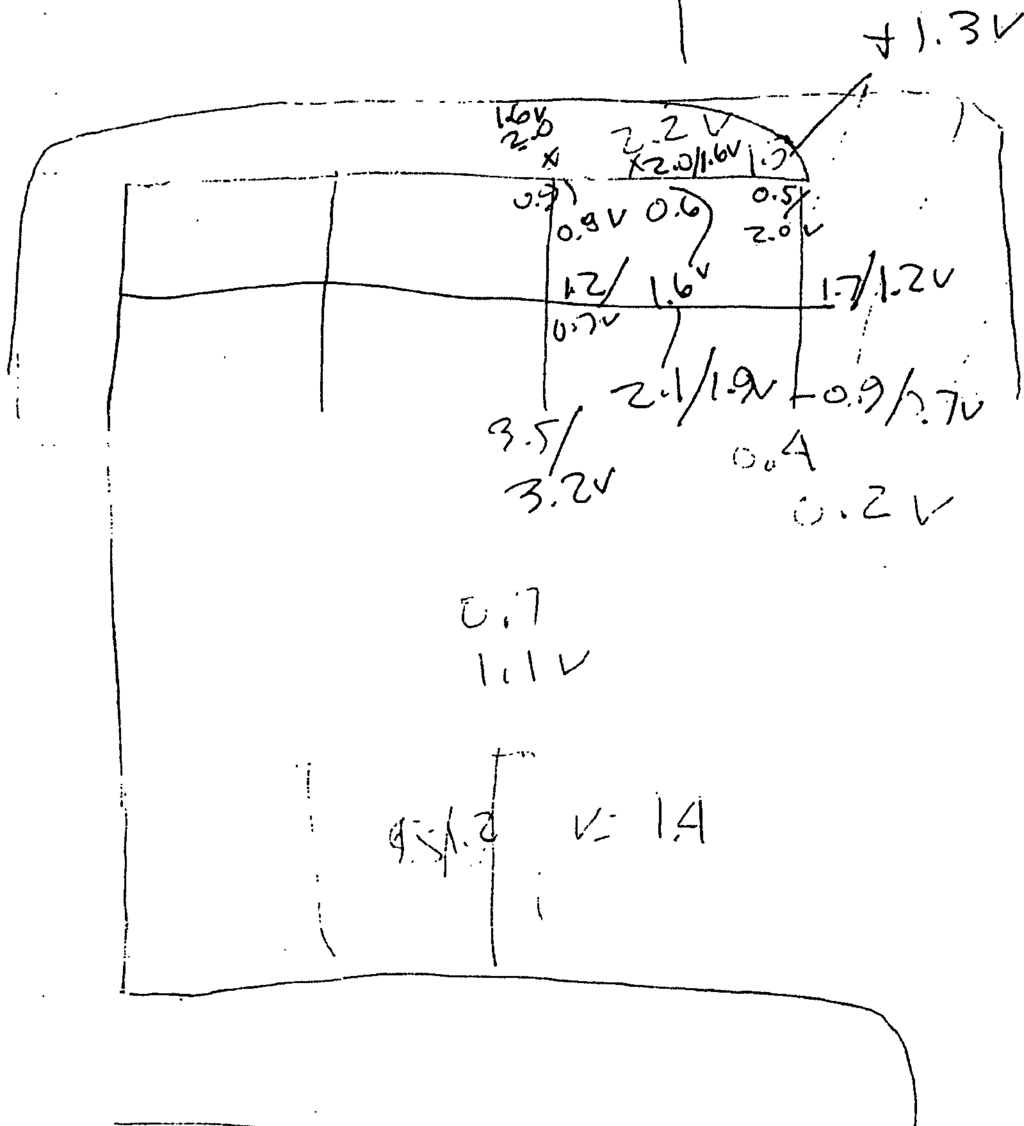


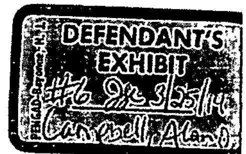


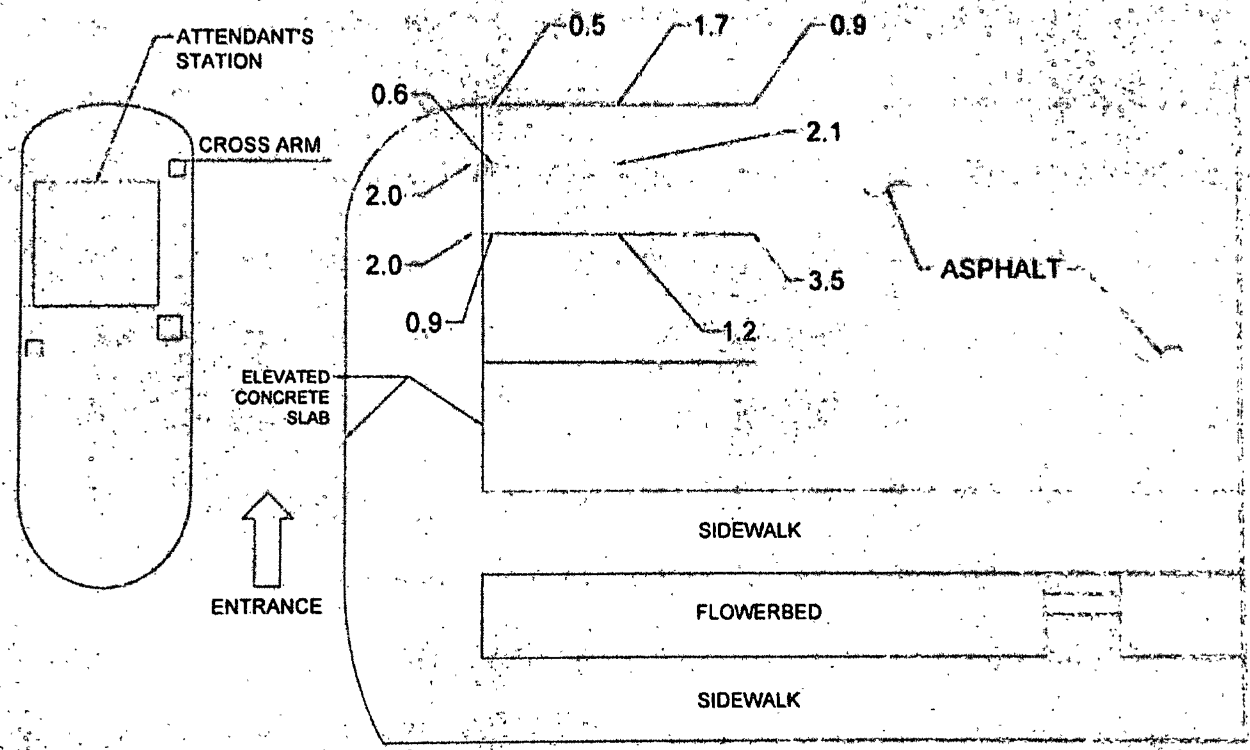


~~4.4~~
4.9, 3
@ pole
13.5 V

2/21/14







GEORGE STREET

HORIZONTAL ILLUMINANCE MEASUREMENTS (ALL VALUES IN LUX)
FROM AOC FIELD NOTES - FEB. 21, 2014

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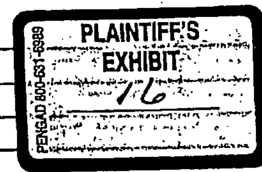

Date of Accident: August 30, 2012

Damages Summary

Our File No.: 1113.001

Provider	Date	Reference No.	Amount	Description	Bates #
Medical University Hospital Authority	1/24/2013	36061372	$ 144.00	admin iv inf hydrate	0051
Medical University Hospital Authority	1/24/2013	36061380	$ 144.00	admin iv inf hydrate	0051
Medical University Hospital Authority	1/24/2013	36090223	$ 555.00	er visit adult intermediate	0060
Medical University Hospital Authority	1/24/2013	46710208	$ 354.00	chest 2 views	0058
Medical University Hospital Authority	1/24/2013	46730701	$ 293.00	elbow ap/lat	0058
Medical University Hospital Authority	1/24/2013	46731303	$ 608.00	hand min 3 views	0058
Medical University Hospital Authority	1/24/2013	46735502	$ 369.00	femur ap/lat	0058
Medical University Hospital Authority	1/24/2013	83600072	$ 57.00	sodium-l stat	0053
Medical University Hospital Authority	1/24/2013	83600080	$ 57.00	potassium-l stat	0053
Medical University Hospital Authority	1/24/2013	83600114	$ 57.00	glucose venous-l stat	0053
Medical University Hospital Authority	1/24/2013	83600122	$ 46.00	hematocrit-l	0056
Medical University Hospital Authority	1/24/2013	83600213	$ 296.00	ph, pc01, p02 bill	0054
Medical University Hospital Authority	1/24/2013	83600262	$ 57.00	venous ionized calcium	0054
Medical University Hospital Authority	1/24/2013	85311637	$ 102.00	hepatic function panel A	0055
Medical University Hospital Authority	1/24/2013	85311645	$ 107.00	basic metabolic panel	0052
Medical University Hospital Authority	1/24/2013	85320372	$ 66.00	hemogram	0056
Medical University Hospital Authority	1/24/2013	85330215	$ 42.00	prothrombin time	0057
Medical University Hospital Authority	1/24/2013	12853678	$ 52.00	x-ray thigh	0043
MUSC Physicians	1/24/2013	12853678	$ 47.00	x-ray elbow	0043
MUSC Physicians	1/24/2013	12853678	$ 48.00	x-ray hand LT	0043
MUSC Physicians	1/24/2013	12853678	$ 48.00	x-ray hand RT	0043
MUSC Physicians	1/24/2013	12853679	$ 54.00	chest x-ray	0043
MUSC Physicians	1/24/2013	12886176	$ 900.00	initial critical care	0045
MUSC Physicians	1/25/2013	37701109	$ 4.00	iv fluid bax	0051
Medical University Hospital Authority	1/25/2013	41260019	$ 92.00	ekg 12-lead tracing	0064
Medical University Hospital Authority	1/25/2013	43025899	$ 39.00	sodium chlor	0051
Medical University Hospital Authority	1/25/2013	43039775	$ 7.30	vitamin k	0061
Medical University Hospital Authority	1/25/2013	43054782	$ 388.00	insulin aspart	0062
Medical University Hospital Authority	1/25/2013	43062322	$ 655.00	potassium chlor	0061
Medical University Hospital Authority	1/25/2013	43067321	$ 36.00	famotidine	0050
Medical University Hospital Authority					

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Medical University Hospital Authority	1/25/2013	43072578	$ 30.00	hydromorphone	0051
Medical University Hospital Authority	1/25/2013	46704508	$ 1,830.00	ct head w/o cont	0058
Medical University Hospital Authority	1/25/2013	46712501	$ 2,572.00	ct chest w/o cont	0059
Medical University Hospital Authority	1/25/2013	46741765	$ 4,487.00	ct abd&pelvis	0059
Medical University Hospital Authority	1/25/2013	85310787	$ 57.00	potassium	0055
Medical University Hospital Authority	1/25/2013	85311645	$ 107.00	basic metabolic panel	0052
Medical University Hospital Authority	1/25/2013	85320364	$ 115.00	hemogram	0056
Medical University Hospital Authority	1/25/2013	85320372	$ 264.00	hemogram	0056
Medical University Hospital Authority	1/25/2013	85330215	$ 126.00	prothrombin time	0057
Medical University Hospital Authority	1/25/2013	85330223	$ 51.00	thromboplas	0057
Medical University Hospital Authority	1/25/2013	85360428	$ 121.00	antibody screen 2 cell	0053
Medical University Hospital Authority	1/25/2013	89200018	$ 46.00	abo w/rh	0055
Medical University Hospital Authority	1/25/2013	89200174	$ 44.00	d (rho) type	0056
Medical University Hospital Authority	1/25/2013	89220248	$ 210.00	electronic crossmatch	0056
Medical University Hospital Authority	1/25/2013	89220255	$ 89.00	hemoglobin	0053
Medical University Hospital Authority	1/25/2013	89500128	$ 1,044.00	ffp	0059
Medical University Hospital Authority	1/25/2013	89500219	$ 1,310.00	red blood cells lkp	0059
Medical University Hospital Authority	1/25/2013	99598138	$ 3,024.00	ICU	0050
MUSC Physicians	1/25/2013	12853680	$ 346.00	ct scan head brain	0043
MUSC Physicians	1/25/2013	12853681	$ 377.00	ct scan thorax	0044
MUSC Physicians	1/25/2013	12853681	$ 740.00	computed tomography	0044
MUSC Physicians	1/25/2013	12860151	$ 73.00	electrocardiogram	0044
MUSC Physicians	1/25/2013	12987294	$ 198.00	hospital care level II	0048
Medical University Hospital Authority	1/26/2013	37701802	$ 4.00	iv fluid bax	0051
Medical University Hospital Authority	1/26/2013	43021336	$ 35.00	oxycodone	0062
Medical University Hospital Authority	1/26/2013	43067321	$ 18.00	famotidine	0050
Medical University Hospital Authority	1/26/2013	43072578	$ 10.00	hydromorphone	0051
Medical University Hospital Authority	1/26/2013	46735601	$ 270.00	knee ap/lat	0058
Medical University Hospital Authority	1/26/2013	85310696	$ 89.00	magnesium	0054
Medical University Hospital Authority	1/26/2013	85311645	$ 107.00	basic metabolic panel	0052
Medical University Hospital Authority	1/26/2013	85320372	$ 198.00	hemogram	0056
Medical University Hospital Authority	1/26/2013	85330215	$ 84.00	prothrombin time	0057
Medical University Hospital Authority	1/26/2013	89500219	$ 655.00	red blood cells lkp	0059
Medical University Hospital Authority	1/26/2013	99549131	$ 3,024.00	ICU	0050
MUSC Physicians	1/26/2013	12864662	$ 51.00	x-ray knee RT	0044
MUSC Physicians	1/26/2013	12987294	$ 198.00	hospital care level II	0048
Medical University Hospital Authority	1/27/2013	37701091	$ 12.00	iv fluid bax	0051

Medical University Hospital Authority	1/27/2013	37701802	$ 4.00	iv fluid bax	0051
Medical University Hospital Authority	1/27/2013	43021336	$ 14.00	oxycodone	0062
Medical University Hospital Authority	1/27/2013	43025857	$ 37.00	sodium chlor	0051
Medical University Hospital Authority	1/27/2013	43033828	$ 38.00	insulin novolin	0062
Medical University Hospital Authority	1/27/2013	43067321	$ 18.00	famotidine	0051
Medical University Hospital Authority	1/27/2013	43780378	$ 95.00	therapeutic proc/gait	0059
Medical University Hospital Authority	1/27/2013	43780386	$ 111.00	therapeutic act/1 on 1	0059
Medical University Hospital Authority	1/27/2013	43780873	$ 162.00	pt eval 30min simple	0060
Medical University Hospital Authority	1/27/2013	85310696	$ 89.00	magnesium	0054
Medical University Hospital Authority	1/27/2013	85310746	$ 51.00	phosphorus	0054
Medical University Hospital Authority	1/27/2013	85310894	$ 45.00	sodium urine	0055
Medical University Hospital Authority	1/27/2013	85311645	$ 107.00	basic metabolic panel	0052
Medical University Hospital Authority	1/27/2013	85320372	$ 132.00	hemogram	0056
Medical University Hospital Authority	1/27/2013	85330215	$ 42.00	prothrombin time	0057
Medical University Hospital Authority	1/27/2013	85330223	$ 51.00	thromboplas	0057
Medical University Hospital Authority	1/27/2013	89200018	$ 46.00	abo w/rh	0055
Medical University Hospital Authority	1/27/2013	89200174	$ 44.00	d (rho) type	0056
Medical University Hospital Authority	1/27/2013	89220248	$ 70.00	electronic crossmatch	0056
Medical University Hospital Authority	1/27/2013	89220255	$ 89.00	hemoglobin	0053
Medical University Hospital Authority	1/27/2013	89500219	$ 1,310.00	red blood cells lkp	0059
Medical University Hospital Authority	1/27/2013	99549131	$ 3,024.00	ICU	0050
Medical University Hospital Authority	1/27/2013	12886177	$ 900.00	initial critical care	0046
MUSC Physicians	1/27/2013	43021336	$ 36.00	oxycodone	0062
Medical University Hospital Authority	1/28/2013	43060136	$ 42.00	carvedilol	0063
Medical University Hospital Authority	1/28/2013	43067321	$ 18.00	famotidine	0051
Medical University Hospital Authority	1/28/2013	43780386	$ 222.00	therapeutic act/1 on 1	0059
Medical University Hospital Authority	1/28/2013	46735601	$ 270.00	knee ap/lat	0058
Medical University Hospital Authority	1/28/2013	85310696	$ 89.00	magnesium	0054
Medical University Hospital Authority	1/28/2013	85310746	$ 51.00	phosphorus	0055
Medical University Hospital Authority	1/28/2013	85311645	$ 107.00	basic metabolic panel	0052
Medical University Hospital Authority	1/28/2013	85320372	$ 132.00	hemogram	0056
Medical University Hospital Authority	1/28/2013	85330215	$ 84.00	prothrombin time	0057
Medical University Hospital Authority	1/28/2013	85330223	$ 102.00	thromboplas	0057
Medical University Hospital Authority	1/28/2013	99149056	$ 1,170.00	private	0050
Medical University Hospital Authority	1/28/2013	109	$ 6.00	parking	0077
MUSC Parking Garage	1/28/2013	12864663	$ 51.00	x-ray knee LT	0045
MUSC Physicians	1/28/2013	12987294	$ 198.00	hospital care level II	0048
MUSC Physicians					

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Medical University Hospital Authority	1/29/2013	37701109	$ 4.00	iv fluid bax	0051
Medical University Hospital Authority	1/29/2013	43021336	$ 14.00	oxycodone	0062
Medical University Hospital Authority	1/29/2013	43027580	$ 6.00	furosemide	0062
Medical University Hospital Authority	1/29/2013	43027598	$ 9.00	furosemide	0061
Medical University Hospital Authority	1/29/2013	43056258	$ 24.00	docusate sodium	0063
Medical University Hospital Authority	1/29/2013	43060136	$ 28.00	carvedilol	0063
Medical University Hospital Authority	1/29/2013	43074806	$ 17.16	insulin glargine	0064
Medical University Hospital Authority	1/29/2013	43780386	$ 333.00	therapeutic act/1 on 1	0059
Medical University Hospital Authority	1/29/2013	46710109	$ 297.00	chest frontal	0058
Medical University Hospital Authority	1/29/2013	46737003	$ 2,002.00	ct low ext w/o cont	0059
Medical University Hospital Authority	1/29/2013	46741765	$ 4,487.00	ct abd&pelvis	0059
Medical University Hospital Authority	1/29/2013	85310696	$ 89.00	magnesium	0054
Medical University Hospital Authority	1/29/2013	85310746	$ 51.00	phosphorus	0055
Medical University Hospital Authority	1/29/2013	85311645	$ 107.00	basic metabolic panel	0052
Medical University Hospital Authority	1/29/2013	85320372	$ 132.00	hemogram	0056
Medical University Hospital Authority	1/29/2013	85330215	$ 42.00	prothrombin time	0057
Medical University Hospital Authority	1/29/2013	85330223	$ 51.00	thromboplas	0058
Medical University Hospital Authority	1/29/2013	85360428	$ 121.00	antibody screen 2 cell	0053
Medical University Hospital Authority	1/29/2013	89500219	$ 655.00	red blood cells lkp	0059
Medical University Hospital Authority	1/29/2013	89500730	$ 813.00	blood irradiated	0059
Medical University Hospital Authority	1/29/2013	99149056	$ 1,170.00	private	0050
MUSC Parking Garage	1/29/2013	266	$ 6.00	parking	0077
MUSC Physicians	1/29/2013	12873233	$ 332.00	ct scan lower extr	0045
MUSC Physicians	1/29/2013	12873234	$ 740.00	computed tomography	0045
MUSC Physicians	1/29/2013	12881601	$ 46.00	chest x-ray	0045
MUSC Physicians	1/29/2013	12987294	$ 198.00	hospital care level II	0048
Medical University Hospital Authority	1/30/2013	43021336	$ 22.00	oxycodone	0062
Medical University Hospital Authority	1/30/2013	43056258	$ 12.00	docusate sodium	0063
Medical University Hospital Authority	1/30/2013	43060136	$ 28.00	carvedilol	0063
Medical University Hospital Authority	1/30/2013	43072578	$ 20.00	hydromorphone	0051
Medical University Hospital Authority	1/30/2013	43074806	$ 17.16	insulin glargine	0064
Medical University Hospital Authority	1/30/2013	43780386	$ 222.00	therapeutic act/1 on 1	0059
Medical University Hospital Authority	1/30/2013	43780410	$ 95.00	therapeutic exercise	0060
Medical University Hospital Authority	1/30/2013	47400239	$ 188.00	wound care complex	0065
Medical University Hospital Authority	1/30/2013	85310696	$ 89.00	magnesium	0054
Medical University Hospital Authority	1/30/2013	85310746	$ 51.00	phosphorus	0055
Medical University Hospital Authority	1/30/2013	85311645	$ 107.00	basic metabolic panel	0052

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Medical University Hospital Authority	1/30/2013	85320372	$	66.00	hemogram	0056
Medical University Hospital Authority	1/30/2013	85330215	$	42.00	prothrombin time	0057
Medical University Hospital Authority	1/30/2013	85330223	$	51.00	thromboplas	0058
Medical University Hospital Authority	1/30/2013	99149056	$	1,170.00	private	0050
MUSC Physicians	1/30/2013	13098065	$	198.00	hospital care level II	0049
Medical University Hospital Authority	1/31/2013	37522935	$	1.00	kit sag	0051
Medical University Hospital Authority	1/31/2013	43016633	$	24.00	ferrous gluconate	0061
Medical University Hospital Authority	1/31/2013	43021336	$	31.34	oxycodone	0062
Medical University Hospital Authority	1/31/2013	43027580	$	6.00	furosemide	0062
Medical University Hospital Authority	1/31/2013	43027739	$	12.00	metolazone	0062
Medical University Hospital Authority	1/31/2013	43042332	$	472.08	enoxaparin	0061
Medical University Hospital Authority	1/31/2013	43056258	$	18.00	docusate sodium	0063
Medical University Hospital Authority	1/31/2013	43060094	$	26.00	atorvastatin	0063
Medical University Hospital Authority	1/31/2013	43060136	$	28.00	carvedilol	0063
Medical University Hospital Authority	1/31/2013	43064559	$	17.01	lisinopril	0064
Medical University Hospital Authority	1/31/2013	43074806	$	17.16	insulin glargine	0064
Medical University Hospital Authority	1/31/2013	43780386	$	222.00	therapeutic act/1 on 1	0060
Medical University Hospital Authority	1/31/2013	73017771	$	11.00	diltiazem	0061
Medical University Hospital Authority	1/31/2013	85310696	$	89.00	magnesium	0054
Medical University Hospital Authority	1/31/2013	85310746	$	51.00	phosphorus	0055
Medical University Hospital Authority	1/31/2013	85311645	$	107.00	basic metabolic panel	0052
Medical University Hospital Authority	1/31/2013	85320372	$	66.00	hemogram	0056
Medical University Hospital Authority	1/31/2013	99136053	$	1,170.00	private	0050
MUSC Parking Garage	1/31/2013	270	$	6.00	parking	0077
MUSC Physicians	1/31/2013	12987294	$	152.00	hospital care level I	0048
Medical University Hospital Authority	2/1/2013	43016633	$	18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/1/2013	43021336	$	30.00	oxycodone	0062
Medical University Hospital Authority	2/1/2013	43024785	$	10.00	tuberculin	0050
Medical University Hospital Authority	2/1/2013	43025527	$	10.00	potassium chloride	0062
Medical University Hospital Authority	2/1/2013	43027580	$	6.00	furosemide	0062
Medical University Hospital Authority	2/1/2013	43027739	$	12.00	metolazone	0062
Medical University Hospital Authority	2/1/2013	43042332	$	354.06	enoxaparin	0061
Medical University Hospital Authority	2/1/2013	43056258	$	12.00	docusate sodium	0063
Medical University Hospital Authority	2/1/2013	43060094	$	26.00	atorvastatin	0063
Medical University Hospital Authority	2/1/2013	43060136	$	28.00	carvedilol	0063
Medical University Hospital Authority	2/1/2013	43064559	$	17.01	lisinopril	0064
Medical University Hospital Authority	2/1/2013	43074806	$	17.16	insulin glargine	0064

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Medical University Hospital Authority	2/1/2013	43780378	$ 95.00	therapeutic proc/gait	0059
Medical University Hospital Authority	2/1/2013	43780386	$ 222.00	therapeutic act/1 on 1	0060
Medical University Hospital Authority	2/1/2013	73017771	$ 11.00	diltiazem	0061
Medical University Hospital Authority	2/1/2013	83800011	$ 26.00	venipuncture	0051
Medical University Hospital Authority	2/1/2013	85310696	$ 89.00	magnesium	0054
Medical University Hospital Authority	2/1/2013	85310746	$ 51.00	phosphorus	0055
Medical University Hospital Authority	2/1/2013	85311645	$ 107.00	basic metabolic panel	0052
Medical University Hospital Authority	2/1/2013	85320372	$ 66.00	hemogram	0056
Medical University Hospital Authority	2/1/2013	99136053	$ 1,170.00	private	0050
MUSC Physicians	2/1/2013	12925218	$ 198.00	hospital care level II	0046
Sodexo Healthcare	2/1/2013	296554	$ 5.45	meal	0025
Medical University Hospital Authority	2/2/2013	43016633	$ 18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/2/2013	43021336	$ 8.00	oxycodone	0062
Medical University Hospital Authority	2/2/2013	43024066	$ 6.00	lorazepam	0062
Medical University Hospital Authority	2/2/2013	43027580	$ 6.00	furosemide	0062
Medical University Hospital Authority	2/2/2013	43027739	$ 12.00	metolazone	0062
Medical University Hospital Authority	2/2/2013	43028273	$ 7.00	lortab	0062
Medical University Hospital Authority	2/2/2013	43042332	$ 236.04	enoxaparin	0061
Medical University Hospital Authority	2/2/2013	43056258	$ 12.00	docusate sodium	0063
Medical University Hospital Authority	2/2/2013	43060094	$ 26.00	atorvastatin	0063
Medical University Hospital Authority	2/2/2013	43060136	$ 28.00	carvedilol	0063
Medical University Hospital Authority	2/2/2013	43064559	$ 17.01	lisinopril	0064
Medical University Hospital Authority	2/2/2013	43074806	$ 34.32	insulin glargine	0064
Medical University Hospital Authority	2/2/2013	73017771	$ 11.00	diltiazem	0061
Medical University Hospital Authority	2/2/2013	83800011	$ 26.00	venipuncture	0051
Medical University Hospital Authority	2/2/2013	85320372	$ 66.00	hemogram	0056
Medical University Hospital Authority	2/2/2013	99136053	$ 1,170.00	private	0050
MUSC Parking Garage	2/2/2013	140	$ 6.00	parking	0078
MUSC Physicians	2/2/2013	12925219	$ 198.00	hospital care level II	0046
Medical University Hospital Authority	2/3/2013	43016633	$ 18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/3/2013	43028273	$ 35.00	lortab	0062
Medical University Hospital Authority	2/3/2013	43042332	$ 236.04	enoxaparin	0061
Medical University Hospital Authority	2/3/2013	43056258	$ 12.00	docusate sodium	0063
Medical University Hospital Authority	2/3/2013	43060094	$ 26.00	atorvastatin	0063
Medical University Hospital Authority	2/3/2013	43060136	$ 28.00	carvedilol	0063
Medical University Hospital Authority	2/3/2013	43074806	$ 17.16	insulin glargine	0064
Medical University Hospital Authority	2/3/2013	73017771	$ 11.00	diltiazem	0061

Medical University Hospital Authority	2/3/2013	83800011	$	52.00	venipuncture	0051
Medical University Hospital Authority	2/3/2013	85100170	$	79.00	c ur	0058
Medical University Hospital Authority	2/3/2013	85310381	$	59.00	creatine urine	0054
Medical University Hospital Authority	2/3/2013	85310696	$	89.00	magnesium	0054
Medical University Hospital Authority	2/3/2013	85310738	$	89.00	osmolality urine	0054
Medical University Hospital Authority	2/3/2013	85310746	$	51.00	phosphorus	0055
Medical University Hospital Authority	2/3/2013	85310894	$	45.00	sodium urine	0055
Medical University Hospital Authority	2/3/2013	85310951	$	48.00	urea nitrogen	0055
Medical University Hospital Authority	2/3/2013	85311645	$	321.00	basic metabolic panel	0052
Medical University Hospital Authority	2/3/2013	85320372	$	66.00	hemogram	0057
Medical University Hospital Authority	2/3/2013	85340180	$	61.00	urinalysis	0058
Medical University Hospital Authority	2/3/2013	99136053	$	1,170.00	private	0050
MUSC Physicians	2/3/2013	12925220	$	152.00	hospital care level I	0046
Medical University Hospital Authority	2/4/2013	37701802	$	8.00	iv fluid bax	0051
Medical University Hospital Authority	2/4/2013	43016633	$	18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/4/2013	43016856	$	120.00	heparin sodium	0050
Medical University Hospital Authority	2/4/2013	43028273	$	21.00	lortab	0062
Medical University Hospital Authority	2/4/2013	43056258	$	12.00	docusate sodium	0063
Medical University Hospital Authority	2/4/2013	43060136	$	28.00	carvedilol	0063
Medical University Hospital Authority	2/4/2013	43061787	$	23.00	tamsulosin	0064
Medical University Hospital Authority	2/4/2013	43066752	$	42.00	ceftriaxone	0061
Medical University Hospital Authority	2/4/2013	43074806	$	17.16	insulin glargine	0064
Medical University Hospital Authority	2/4/2013	46767703	$	523.00	us retroperiton	0059
Medical University Hospital Authority	2/4/2013	73017771	$	11.00	diltiazem	0061
Medical University Hospital Authority	2/4/2013	83800011	$	52.00	venipuncture	0051
Medical University Hospital Authority	2/4/2013	85310696	$	89.00	magnesium	0054
Medical University Hospital Authority	2/4/2013	85310738	$	89.00	osmolality urine	0054
Medical University Hospital Authority	2/4/2013	85310746	$	51.00	phosphorus	0055
Medical University Hospital Authority	2/4/2013	85311645	$	214.00	basic metabolic panel	0053
Medical University Hospital Authority	2/4/2013	85320372	$	66.00	hemogram	0057
Medical University Hospital Authority	2/4/2013	85340404	$	113.00	prealbumin	0055
Medical University Hospital Authority	2/4/2013	99136053	$	1,170.00	private	0050
MUSC Physicians	2/4/2013	12912299	$	206.00	ultrasound	0046
MUSC Physicians	2/4/2013	12932251	$	198.00	hospital care level II	0047
Sodexo Healthcare	2/4/2013	440300	$	1.43	meal	0026
Medical University Hospital Authority	2/5/2013	43016633	$	18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/5/2013	43016856	$	60.00	heparin sodium	0050

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Medical University Hospital Authority	2/5/2013	43028273	$	21.00	lortab	0062
Medical University Hospital Authority	2/5/2013	43056258	$	12.00	docusate sodium	0063
Medical University Hospital Authority	2/5/2013	43060136	$	28.00	carvedilol	0063
Medical University Hospital Authority	2/5/2013	43061787	$	23.00	tamsulosin	0064
Medical University Hospital Authority	2/5/2013	43074806	$	17.16	insulin glargine	0064
Medical University Hospital Authority	2/5/2013	43780386	$	222.00	therapeutic act/1 on 1	0060
Medical University Hospital Authority	2/5/2013	73017771	$	11.00	diltiazem	0061
Medical University Hospital Authority	2/5/2013	74100223	$	952.00	echo complete	0061
Medical University Hospital Authority	2/5/2013	83800011	$	26.00	venipuncture	0051
Medical University Hospital Authority	2/5/2013	85200681	$	168.00	c difficile pcr	0058
Medical University Hospital Authority	2/5/2013	85310696	$	89.00	magnesium	0054
Medical University Hospital Authority	2/5/2013	85310720	$	101.00	osmolality serum	0054
Medical University Hospital Authority	2/5/2013	85311637	$	102.00	hepatic function panel A	0055
Medical University Hospital Authority	2/5/2013	85311645	$	107.00	basic metabolic panel	0053
Medical University Hospital Authority	2/5/2013	85313351	$	196.00	psa total	0055
Medical University Hospital Authority	2/5/2013	85320372	$	66.00	hemogram	0057
Medical University Hospital Authority	2/5/2013	99136053	$	1,170.00	private	0050
MUSC Physicians	2/5/2013	12932252	$	152.00	hospital care level I	0047
MUSC Physicians	2/5/2013	12946046	$	292.00	hospital care level I	0047
MUSC Physicians	2/5/2013	12955269	$	1,150.00	echocardiography	0047
Medical University Hospital Authority	2/6/2013	43016633	$	18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/6/2013	43016856	$	60.00	heparin sodium	0050
Medical University Hospital Authority	2/6/2013	43028273	$	28.00	lortab	0062
Medical University Hospital Authority	2/6/2013	43056258	$	12.00	docusate sodium	0063
Medical University Hospital Authority	2/6/2013	43060136	$	28.00	carvedilol	0063
Medical University Hospital Authority	2/6/2013	43061787	$	23.00	tamsulosin	0064
Medical University Hospital Authority	2/6/2013	43074806	$	17.16	insulin glargine	0064
Medical University Hospital Authority	2/6/2013	47400098	$	70.00	follow-up asmnt/30 min	0064
Medical University Hospital Authority	2/6/2013	47400239	$	188.00	wound care complex	0065
Medical University Hospital Authority	2/6/2013	73017771	$	11.00	diltiazem	0061
Medical University Hospital Authority	2/6/2013	83800011	$	52.00	venipuncture	0051
Medical University Hospital Authority	2/6/2013	85100170	$	79.00	c ur	0058
Medical University Hospital Authority	2/6/2013	85311645	$	107.00	basic metabolic panel	0053
Medical University Hospital Authority	2/6/2013	85320372	$	66.00	hemogram	0057
Medical University Hospital Authority	2/6/2013	99136053	$	1,170.00	private	0050
MUSC Parking Garage	2/6/2013	154	$	1.50	parking	0078
MUSC Physicians	2/6/2013	12946046	$	198.00	hospital care level II	0047

Sodexo Healthcare	2/6/2013	391748	$ 0.93	meal	0025
Medical University Hospital Authority	2/7/2013	43016633	$ 18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/7/2013	43016856	$ 80.00	heparin sodium	0050
Medical University Hospital Authority	2/7/2013	43028273	$ 35.00	lortab	0062
Medical University Hospital Authority	2/7/2013	43056258	$ 12.00	docusate sodium	0063
Medical University Hospital Authority	2/7/2013	43060136	$ 28.00	carvedilol	0063
Medical University Hospital Authority	2/7/2013	43061787	$ 23.00	tamsulosin	0064
Medical University Hospital Authority	2/7/2013	43074806	$ 17.16	insulin glargine	0064
Medical University Hospital Authority	2/7/2013	43780386	$ 222.00	therapeutic act/1 on 1	0060
Medical University Hospital Authority	2/7/2013	43800457	$ 220.00	evaluation - full	0060
Medical University Hospital Authority	2/7/2013	73017771	$ 11.00	diltiazem	0061
Medical University Hospital Authority	2/7/2013	83800011	$ 26.00	venipuncture	0052
Medical University Hospital Authority	2/7/2013	85311645	$ 107.00	basic metabolic panel	0053
Medical University Hospital Authority	2/7/2013	85320372	$ 66.00	hemogram	0057
Medical University Hospital Authority	2/7/2013	85340180	$ 61.00	urinalysis	0058
Medical University Hospital Authority	2/7/2013	99136053	$ 1,170.00	private	0050
MUSC Parking Garage	2/7/2013	197	$ 3.75	parking	0078
MUSC Physicians	2/7/2013	12946046	$ 198.00	hospital care level II	0047
MUSC Physicians	2/7/2013	12963403	$ 198.00	hospital care level II	0047
Rutledge Cab Co.	2/7/2013	39299	$ 52.44	meal	0025
Medical University Hospital Authority	2/8/2013	43016633	$ 18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/8/2013	43016856	$ 60.00	heparin sodium	0050
Medical University Hospital Authority	2/8/2013	43028273	$ 42.00	lortab	0062
Medical University Hospital Authority	2/8/2013	43056258	$ 12.00	docusate sodium	0063
Medical University Hospital Authority	2/8/2013	43060136	$ 28.00	carvedilol	0063
Medical University Hospital Authority	2/8/2013	43061787	$ 23.00	tamsulosin	0064
Medical University Hospital Authority	2/8/2013	43074806	$ 17.16	insulin glargine	0064
Medical University Hospital Authority	2/8/2013	43780386	$ 222.00	therapeutic act/1 on 1	0060
Medical University Hospital Authority	2/8/2013	73017771	$ 11.00	diltiazem	0061
Medical University Hospital Authority	2/8/2013	83800011	$ 26.00	venipuncture	0052
Medical University Hospital Authority	2/8/2013	85311645	$ 107.00	basic metabolic panel	0053
Medical University Hospital Authority	2/8/2013	85320372	$ 66.00	hemogram	0057
Medical University Hospital Authority	2/8/2013	99136053	$ 1,170.00	private	0050
MUSC Parking Garage	2/8/2013	103	$ 6.00	parking	0079
MUSC Physicians	2/8/2013	12963404	$ 152.00	hospital care level I	0048
Medical University Hospital Authority	2/9/2013	43016633	$ 18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/9/2013	43016856	$ 60.00	heparin sodium	0050

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Medical University Hospital Authority	2/9/2013	43017771	$	11.00	diltiazem	0062
Medical University Hospital Authority	2/9/2013	43028273	$	35.00	lortab	0062
Medical University Hospital Authority	2/9/2013	43056258	$	12.00	docusate sodium	0063
Medical University Hospital Authority	2/9/2013	43060136	$	28.00	carvedilol	0063
Medical University Hospital Authority	2/9/2013	43061787	$	23.00	tamsulosin	0064
Medical University Hospital Authority	2/9/2013	43074806	$	17.16	insulin glargine	0064
Medical University Hospital Authority	2/9/2013	83800011	$	26.00	venipuncture	0052
Medical University Hospital Authority	2/9/2013	85311645	$	107.00	basic metabolic panel	0053
Medical University Hospital Authority	2/9/2013	85320372	$	66.00	hemogram	0057
Medical University Hospital Authority	2/9/2013	99136053	$	1,170.00	private	0050
MUSC Parking Garage	2/9/2013	159	$	6.00	parking	0079
Sodexo Healthcare	2/9/2013	395125	$	7.13	meal	0026
Medical University Hospital Authority	2/10/2013	43016633	$	18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/10/2013	43016856	$	60.00	heparin sodium	0050
Medical University Hospital Authority	2/10/2013	43017771	$	11.00	diltiazem	0062
Medical University Hospital Authority	2/10/2013	43028273	$	35.00	lortab	0062
Medical University Hospital Authority	2/10/2013	43056258	$	12.00	docusate sodium	0063
Medical University Hospital Authority	2/10/2013	43060136	$	28.00	carvedilol	0063
Medical University Hospital Authority	2/10/2013	43061787	$	23.00	tamsulosin	0064
Medical University Hospital Authority	2/10/2013	43074806	$	17.16	insulin glargine	0064
Medical University Hospital Authority	2/10/2013	83800011	$	26.00	venipuncture	0052
Medical University Hospital Authority	2/10/2013	85311645	$	107.00	basic metabolic panel	0053
Medical University Hospital Authority	2/10/2013	99136053	$	1,170.00	private	0050
MUSC Parking Garage	2/10/2013	51	$	6.00	parking	0078
Sodexo Healthcare	2/10/2013	444276	$	6.75	meal	0027
Medical University Hospital Authority	2/11/2013	43016633	$	18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/11/2013	43016856	$	60.00	heparin sodium	0050
Medical University Hospital Authority	2/11/2013	43017771	$	11.00	diltiazem	0062
Medical University Hospital Authority	2/11/2013	43028273	$	35.00	lortab	0062
Medical University Hospital Authority	2/11/2013	43056258	$	12.00	docusate sodium	0063
Medical University Hospital Authority	2/11/2013	43060136	$	28.00	carvedilol	0063
Medical University Hospital Authority	2/11/2013	43061787	$	23.00	tamsulosin	0064
Medical University Hospital Authority	2/11/2013	43074806	$	17.16	insulin glargine	0064
Medical University Hospital Authority	2/11/2013	43780386	$	222.00	therapeutic act/1 on 1	0060
Medical University Hospital Authority	2/11/2013	43800036	$	380.00	sup functional train	0060
Medical University Hospital Authority	2/11/2013	83800011	$	52.00	venipuncture	0052
Medical University Hospital Authority	2/11/2013	85311645	$	107.00	basic metabolic panel	0053

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Medical University Hospital Authority	2/11/2013	85320372	$ 66.00	hemogram	0057
Medical University Hospital Authority	2/11/2013	99136053	$ 1,170.00	private	0050
MUSC Parking Garage	2/11/2013	210	$ 6.00	parking	0080
MUSC Physicians	2/11/2013	12963405	$ 152.00	hospital care level I	0048
Kickin' Chicken	2/12/2013	668175	$ 12.20	meal	0026
Medical University Hospital Authority	2/12/2013	43016633	$ 18.00	ferrous gluconate	0061
Medical University Hospital Authority	2/12/2013	43016856	$ 60.00	heparin sodium	0050
Medical University Hospital Authority	2/12/2013	43017771	$ 11.00	diltiazem	0062
Medical University Hospital Authority	2/12/2013	43028273	$ 28.00	lortab	0062
Medical University Hospital Authority	2/12/2013	43056258	$ 12.00	docusate sodium	0063
Medical University Hospital Authority	2/12/2013	43060136	$ 28.00	carvedilol	0063
Medical University Hospital Authority	2/12/2013	43061787	$ 23.00	tamsulosin	0064
Medical University Hospital Authority	2/12/2013	43074806	$ 17.16	insulin glargine	0064
Medical University Hospital Authority	2/12/2013	43780386	$ 222.00	therapeutic act/1 on 1	0060
Medical University Hospital Authority	2/12/2013	83800011	$ 26.00	venipuncture	0052
Medical University Hospital Authority	2/12/2013	85311645	$ 107.00	basic metabolic panel	0053
Medical University Hospital Authority	2/12/2013	99136053	$ 1,170.00	private	0050
MUSC Physicians	2/12/2013	12970562	$ 152.00	hospital care level I	0048
Medical University Hospital Authority	2/13/2013	43028273	$ 21.00	lortab	0062
Medical University Hospital Authority	2/13/2013	43780386	$ 111.00	therapeutic act/1 on 1	0060
Medical University Hospital Authority	2/13/2013	83800011	$ 26.00	venipuncture	0052
Medical University Hospital Authority	2/13/2013	85311645	$ 107.00	basic metabolic panel	0053
MUSC Parking Garage	2/13/2013	92	$ 6.00	parking	0079
MUSC Physicians	2/13/2013	12995293	$ 214.00	hospital discharge services	0048
Roper Hospital	2/13/2013	8	$ 189.00	culture mrsa screen	0799
Roper Hospital	2/13/2013	15	$ 1,542.00	room 3907	0789
Roper Hospital	2/13/2013	19088983	$ 4.50	hydrocodone	0789
Roper Hospital	2/13/2013	19088984	$ 2.50	diltazam	0789
Roper Hospital	2/13/2013	19088987	$ 2.50	carvedilol	0789
Roper Hospital	2/14/2013	17	$ 513.00	ot eval 60 min	0801
Roper Hospital	2/14/2013	18	$ 532.00	adl training	0801
Roper Hospital	2/14/2013	21	$ 513.00	pt eval 60 min	0801
Roper Hospital	2/14/2013	22	$ 266.00	adl training	0800
Roper Hospital	2/14/2013	24	$ 102.00	glycosylated hemoglobin	0799
Roper Hospital	2/14/2013	25	$ 36.00	venipuncture	0799
Roper Hospital	2/14/2013	52	$ 1,542.00	room 3907	0789
Roper Hospital	2/14/2013	19088973	$ 2.50	tamsulosin	0789

Roper Hospital	2/14/2013	19088983	$	4.50	hydrocodone	0789
Roper Hospital	2/14/2013	19088983	$	4.50	hydrocodone	0789
Roper Hospital	2/14/2013	19088983	$	4.50	hydrocodone	0789
Roper Hospital	2/14/2013	19088984	$	2.50	diltazam	0789
Roper Hospital	2/14/2013	19088987	$	2.50	carvedilol	0789
Roper Hospital	2/14/2013	19088987	$	2.50	carvedilol	0789
Roper Hospital	2/14/2013	19088992	$	2.50	folic acid	0790
Roper Hospital	2/14/2013	19089041	$	2.50	insulin lispro	0790
Roper Hospital	2/14/2013	19100191	$	2.50	furosemide	0790
Roper Hospital	2/14/2013	19100195	$	2.50	labetalol	0789
Roper Hospital	2/14/2013	19100195	$	2.50	labetalol	0789
Dixie Supply & Bakery	2/15/2013	0026	$	15.36	meal	0027
Roper Hospital	2/15/2013	55	$	798.00	adl training	0801
Roper Hospital	2/15/2013	57	$	532.00	ther exer 15 min	0800
Roper Hospital	2/15/2013	58	$	266.00	adl training	0800
Roper Hospital	2/15/2013	84	$	1,542.00	room 3907	0789
Roper Hospital	2/15/2013	19088973	$	2.50	tamsulosin	0790
Roper Hospital	2/15/2013	19088983	$	4.50	hydrocodone	0790
Roper Hospital	2/15/2013	19088983	$	4.50	hydrocodone	0790
Roper Hospital	2/15/2013	19088984	$	2.50	diltiazem	0790
Roper Hospital	2/15/2013	19088987	$	2.50	carvedilol	0790
Roper Hospital	2/15/2013	19088987	$	2.50	carvedilol	0790
Roper Hospital	2/15/2013	19088992	$	2.50	folic acid	0790
Roper Hospital	2/15/2013	19089041	$	2.50	insulin lispro	0790
Roper Hospital	2/15/2013	19100191	$	2.50	furosemide	0790
Roper Hospital	2/15/2013	19100195	$	2.50	labetalol	0790
Roper Hospital	2/15/2013	19100195	$	2.50	labetalol	0790
Roper Hospital	2/16/2013	110	$	1,542.00	room 3907	0789
Roper Hospital	2/16/2013	19088983	$	2.50	tamsulosin	0790
Roper Hospital	2/16/2013	19088983	$	4.50	hydrocodone	0790
Roper Hospital	2/16/2013	19088983	$	4.50	hydrocodone	0790
Roper Hospital	2/16/2013	19088983	$	4.50	hydrocodone	0790
Roper Hospital	2/16/2013	19088984	$	2.50	diltiazem	0790
Roper Hospital	2/16/2013	19088987	$	2.50	carvedilol	0790
Roper Hospital	2/16/2013	19088987	$	2.50	carvedilol	0790
Roper Hospital	2/16/2013	19088992	$	2.50	folic acid	0790
Roper Hospital	2/16/2013	19089041	$	2.50	insulin lispro	0790

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Roper Hospital	2/16/2013	19100191	$	2.50	furosemide	0791
Roper Hospital	2/16/2013	19100195	$	2.50	labetalol	0790
Roper Hospital	2/16/2013	19100195	$	2.50	labetalol	0790
Roper Hospital	2/17/2013	113	$	532.00	adl training	0801
Roper Hospital	2/17/2013	114	$	266.00	ther exer 15 min	0801
Roper Hospital	2/17/2013	115	$	532.00	ther exer 15 min	0800
Roper Hospital	2/17/2013	116	$	266.00	adl training	0800
Roper Hospital	2/17/2013	143	$	1,542.00	room 3907	0789
Roper Hospital	2/17/2013	19088973	$	2.50	tamsulosin	0791
Roper Hospital	2/17/2013	19088983	$	4.50	hydrocodone	0791
Roper Hospital	2/17/2013	19088983	$	4.50	hydrocodone	0791
Roper Hospital	2/17/2013	19088984	$	2.50	diltiazem	0791
Roper Hospital	2/17/2013	19088987	$	2.50	carvedilol	0791
Roper Hospital	2/17/2013	19088987	$	2.50	carvedilol	0791
Roper Hospital	2/17/2013	19088992	$	2.50	folic acid	0791
Roper Hospital	2/17/2013	19089041	$	2.50	insulin lispro	0791
Roper Hospital	2/17/2013	19100195	$	2.50	labetalol	0791
Roper Hospital	2/17/2013	19100195	$	2.50	labetalol	0791
Roper Hospital	2/18/2013	145	$	532.00	ther exer 15 min	0801
Roper Hospital	2/18/2013	146	$	266.00	adl training	0801
Roper Hospital	2/18/2013	147	$	399.00	adl training	0800
Roper Hospital	2/18/2013	148	$	399.00	ther exer 15 min	0800
Roper Hospital	2/18/2013	174	$	1,542.00	room 3907	0789
Roper Hospital	2/18/2013	19088973	$	2.50	tamsulosin	0791
Roper Hospital	2/18/2013	19088983	$	4.50	hydrocodone	0791
Roper Hospital	2/18/2013	19088983	$	4.50	hydrocodone	0791
Roper Hospital	2/18/2013	19088984	$	2.50	diltiazem	0791
Roper Hospital	2/18/2013	19088987	$	2.50	carvedilol	0791
Roper Hospital	2/18/2013	19088987	$	2.50	carvedilol	0791
Roper Hospital	2/18/2013	19088992	$	2.50	folic acid	0791
Roper Hospital	2/18/2013	19089041	$	2.50	insulin lispro	0791
Roper Hospital	2/18/2013	19100195	$	2.50	labetalol	0791
Roper Hospital	2/18/2013	19100195	$	2.50	labetalol	0791
Roper Hospital	2/19/2013	176	$	532.00	adl training	0801
Roper Hospital	2/19/2013	177	$	266.00	ther exer 15 min	0801
Roper Hospital	2/19/2013	178	$	532.00	adl training	0800
Roper Hospital	2/19/2013	179	$	266.00	ther exer 15 min	0800

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Roper Hospital	2/19/2013	206	$	1,542.00	room 3907	0789
Roper Hospital	2/19/2013	19088973	$	2.50	tamsulosin	0792
Roper Hospital	2/19/2013	19088973	$	2.50	tamsulosin	0792
Roper Hospital	2/19/2013	19088983	$	4.50	hydrocodone	0792
Roper Hospital	2/19/2013	19088983	$	4.50	hydrocodone	0792
Roper Hospital	2/19/2013	19088984	$	2.50	diltiazem	0792
Roper Hospital	2/19/2013	19088987	$	2.50	carvedilol	0792
Roper Hospital	2/19/2013	19088987	$	2.50	carvedilol	0792
Roper Hospital	2/19/2013	19088992	$	2.50	folic acid	0792
Roper Hospital	2/19/2013	19089041	$	2.50	insulin lispro	0792
Roper Hospital	2/19/2013	19100195	$	2.50	labetalol	0791
Roper Hospital	2/19/2013	19100195	$	2.50	labetalol	0791
Roper Hospital	2/19/2013	19131706	$	2.50	furosemide	0792
Roper Hospital	2/19/2013	19131715	$	4.50	temazepam	0792
Roper Hospital	2/20/2013	209	$	455.00	xr knee 3 views	0800
Roper Hospital	2/20/2013	213	$	532.00	adl training	0800
Roper Hospital	2/20/2013	216	$	266.00	ther exer 15 min	0800
Roper Hospital	2/20/2013	216	$	665.00	ther exer 15 min	0801
Roper Hospital	2/20/2013	217	$	133.00	functional trng 15 min	0801
Roper Hospital	2/20/2013	245	$	1,542.00	room 3907	0789
Roper Hospital	2/20/2013	19000992	$	2.50	folic acid	0792
Roper Hospital	2/20/2013	19088973	$	2.50	tamsulosin	0792
Roper Hospital	2/20/2013	19088983	$	4.50	hydrocodone	0792
Roper Hospital	2/20/2013	19088984	$	2.50	diltiazem	0792
Roper Hospital	2/20/2013	19088987	$	2.50	carvedilol	0792
Roper Hospital	2/20/2013	19088987	$	2.50	carvedilol	0792
Roper Hospital	2/20/2013	19100195	$	2.50	labetalol	0792
Roper Hospital	2/20/2013	19100195	$	2.50	labetalol	0792
Roper Hospital	2/20/2013	19131706	$	2.50	furosemide	0792
Roper Hospital	2/20/2013	19131706	$	2.50	furosemide	0792
Roper Hospital	2/20/2013	19131715	$	4.50	temazepam	0792
Roper Hospital	2/20/2013	19143033	$	2.50	metolazone	0792
Roper Hospital	2/20/2013	19144668	$	2.50	metolazone	0792
Roper Hospital	2/21/2013	247	$	399.00	gait training	0800
Roper Hospital	2/21/2013	248	$	399.00	ther exer 15 min	0800
Roper Hospital	2/21/2013	249	$	665.00	adl training	0801
Roper Hospital	2/21/2013	250	$	133.00	ther exer 15 min	0801

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Roper Hospital	2/21/2013	288	$	1,542.00	room 3907	0789
Roper Hospital	2/21/2013	19088973	$	2.50	tamsulosin	0793
Roper Hospital	2/21/2013	19088983	$	4.50	hydrocodone	0793
Roper Hospital	2/21/2013	19088984	$	2.50	diltiazem	0793
Roper Hospital	2/21/2013	19088987	$	2.50	carvedilol	0793
Roper Hospital	2/21/2013	19088987	$	2.50	carvedilol	0793
Roper Hospital	2/21/2013	19088992	$	2.50	folic acid	0793
Roper Hospital	2/21/2013	19089041	$	2.50	insulin lispro	0793
Roper Hospital	2/21/2013	19100195	$	2.50	labetalol	0793
Roper Hospital	2/21/2013	19100195	$	2.50	labetalol	0793
Roper Hospital	2/21/2013	19131706	$	2.50	furosemide	0793
Roper Hospital	2/21/2013	19131715	$	4.50	temazepam	0793
Roper Hospital	2/21/2013	19144668	$	2.50	metolazone	0793
Roper Hospital	2/21/2013	19144668	$	2.50	metolazone	0793
Roper Hospital	2/22/2013	293	$	532.00	adl training	0800
Roper Hospital	2/22/2013	294	$	532.00	adl training	0801
Roper Hospital	2/22/2013	295	$	266.00	ther exer 15 min	0801
Roper Hospital	2/22/2013	297	$	266.00	adl training	0800
Roper Hospital	2/22/2013	329	$	1,542.00	room 3907	0789
Roper Hospital	2/22/2013	19088973	$	2.50	tamsulosin	0793
Roper Hospital	2/22/2013	19088983	$	4.50	hydrocodone	0794
Roper Hospital	2/22/2013	19088983	$	4.50	hydrocodone	0794
Roper Hospital	2/22/2013	19088983	$	4.50	hydrocodone	0794
Roper Hospital	2/22/2013	19088984	$	2.50	diltiazem	0793
Roper Hospital	2/22/2013	19088987	$	2.50	carvedilol	0793
Roper Hospital	2/22/2013	19088987	$	2.50	carvedilol	0793
Roper Hospital	2/22/2013	19088992	$	2.50	folic acid	0794
Roper Hospital	2/22/2013	19089041	$	2.50	insulin lispro	0794
Roper Hospital	2/22/2013	19089041	$	2.50	insulin lispro	0794
Roper Hospital	2/22/2013	19100195	$	2.50	labetalol	0793
Roper Hospital	2/22/2013	19100195	$	2.50	labetalol	0793
Roper Hospital	2/22/2013	19131706	$	2.50	furosemide	0794
Roper Hospital	2/22/2013	19131715	$	4.50	temazepam	0793
Roper Hospital	2/22/2013	19144668	$	2.50	metolazone	0794
Roper Hospital	2/22/2013	19144668	$	2.50	metolazone	0794
Roper Hospital	2/22/2013	19165317	$	2.50	warfarin sodium	0793
Roper Hospital	2/22/2013	19165319	$	38.90	lidocaine hcl	0793

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Roper Hospital	2/22/2013	19165348	$	2.50	methocarbamol	0794
Roper Hospital	2/22/2013	19165348	$	2.50	methocarbamol	0794
Roper Hospital	2/23/2013	331	$	139.00	pt	0799
Roper Hospital	2/23/2013	332	$	36.00	venipuncture	0799
Roper Hospital	2/23/2013	367	$	1,542.00	room 3907	0789
Roper Hospital	2/23/2013	19088973	$	2.50	tamsulosin	0794
Roper Hospital	2/23/2013	19088984	$	2.50	diltiazem	0794
Roper Hospital	2/23/2013	19088987	$	2.50	carvedilol	0794
Roper Hospital	2/23/2013	19088987	$	2.50	carvedilol	0794
Roper Hospital	2/23/2013	19088992	$	2.50	folic acid	0794
Roper Hospital	2/23/2013	19089041	$	2.50	insulin lispro	0794
Roper Hospital	2/23/2013	19089041	$	2.50	insulin lispro	0794
Roper Hospital	2/23/2013	19100195	$	2.50	labetalol	0794
Roper Hospital	2/23/2013	19100195	$	2.50	labetalol	0794
Roper Hospital	2/23/2013	19131706	$	2.50	furosemide	0794
Roper Hospital	2/23/2013	19131715	$	4.50	temazepam	0794
Roper Hospital	2/23/2013	19144668	$	2.50	metolazone	0794
Roper Hospital	2/23/2013	19144668	$	2.50	metolazone	0794
Roper Hospital	2/23/2013	19165317	$	2.50	warfarin sodium	0794
Roper Hospital	2/23/2013	19165319	$	38.90	lidocaine hcl	0794
Roper Hospital	2/23/2013	19165348	$	2.50	methocarbamol	0794
Roper Hospital	2/24/2013	372	$	266.00	ther exer 15 min	0801
Roper Hospital	2/24/2013	375	$	266.00	adl training	0800
Roper Hospital	2/24/2013	376	$	266.00	ther exer 15 min	0800
Roper Hospital	2/24/2013	380	$	139.00	pt	0799
Roper Hospital	2/24/2013	381	$	36.00	venipuncture	0799
Roper Hospital	2/24/2013	416	$	1,542.00	room 3907	0789
Roper Hospital	2/24/2013	19000992	$	2.50	folic acid	0795
Roper Hospital	2/24/2013	19088973	$	2.50	tamsulosin	0795
Roper Hospital	2/24/2013	19088983	$	4.50	hydrocodone	0795
Roper Hospital	2/24/2013	19088984	$	2.50	diltiazem	0795
Roper Hospital	2/24/2013	19088987	$	2.50	carvedilol	0795
Roper Hospital	2/24/2013	19088987	$	2.50	carvedilol	0795
Roper Hospital	2/24/2013	19089041	$	2.50	insulin lispro	0795
Roper Hospital	2/24/2013	19089041	$	2.50	insulin lispro	0795
Roper Hospital	2/24/2013	19100195	$	2.50	labetalol	0795
Roper Hospital	2/24/2013	19100195	$	2.50	labetalol	0795

Roper Hospital	2/24/2013	19131706	$	2.50	furosemide	0795
Roper Hospital	2/24/2013	19144668	$	2.50	metolazone	0795
Roper Hospital	2/24/2013	19144668	$	2.50	metolazone	0795
Roper Hospital	2/24/2013	19165317	$	2.50	warfarin sodium	0795
Roper Hospital	2/24/2013	19165319	$	38.90	lidocaine hcl	0795
Roper Hospital	2/24/2013	19177259	$	4.50	temazepam	0795
Lowe's	2/25/2013	22893503	$	248.58	medical equipment	0037
Roper Hospital	2/25/2013	420	$	532.00	adl training	0801
Roper Hospital	2/25/2013	421	$	266.00	ther exer 15 min	0801
Roper Hospital	2/25/2013	422	$	532.00	adl training	0800
Roper Hospital	2/25/2013	423	$	266.00	ther exer 15 min	0800
Roper Hospital	2/25/2013	429	$	139.00	pt	0799
Roper Hospital	2/25/2013	430	$	36.00	venipuncture	0799
Roper Hospital	2/25/2013	461	$	1,542.00	room 3907	0789
Roper Hospital	2/25/2013	19088973	$	2.50	tamsulosin	0795
Roper Hospital	2/25/2013	19088983	$	4.50	hydrocodone	0796
Roper Hospital	2/25/2013	19088984	$	2.50	diltiazem	0795
Roper Hospital	2/25/2013	19088987	$	2.50	carvedilol	0796
Roper Hospital	2/25/2013	19088987	$	2.50	carvedilol	0796
Roper Hospital	2/25/2013	19088992	$	2.50	folic acid	0796
Roper Hospital	2/25/2013	19089041	$	2.50	insulin lispro	0796
Roper Hospital	2/25/2013	19089041	$	2.50	insulin lispro	0796
Roper Hospital	2/25/2013	19100195	$	2.50	labetalol	0795
Roper Hospital	2/25/2013	19100195	$	2.50	labetalol	0795
Roper Hospital	2/25/2013	19131706	$	2.50	furosemide	0796
Roper Hospital	2/25/2013	19144668	$	2.50	metolazone	0796
Roper Hospital	2/25/2013	19144668	$	2.50	metolazone	0796
Roper Hospital	2/25/2013	19165319	$	38.90	lidocaine hcl	0796
Roper Hospital	2/25/2013	19177259	$	4.50	temazepam	0796
Roper Hospital	2/25/2013	19182645	$	2.50	warfarin sodium	0795
Roper Hospital	2/25/2013	19182645	$	5.00	warfarin sodium	0795
JLK Enterprises Inc.	2/26/2013		$	239.19	installation of equipment	0038
Roper Hospital	2/26/2013	463	$	532.00	adl training	0801
Roper Hospital	2/26/2013	464	$	266.00	ther exer 15 min	0801
Roper Hospital	2/26/2013	466	$	798.00	adl training	0800
Roper Hospital	2/26/2013	470	$	139.00	pt	0799
Roper Hospital	2/26/2013	471	$	36.00	venipuncture	0799

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Roper Hospital	2/26/2013	507	$ 1,542.00	room 3907	0789
Roper Hospital	2/26/2013	19088973	$ 2.50	tamsulosin	0796
Roper Hospital	2/26/2013	19088983	$ 4.50	hydrocodone	0796
Roper Hospital	2/26/2013	19088983	$ 4.50	hydrocodone	0796
Roper Hospital	2/26/2013	19088984	$ 2.50	diltiazem	0796
Roper Hospital	2/26/2013	19088987	$ 2.50	carvedilol	0796
Roper Hospital	2/26/2013	19088987	$ 2.50	carvedilol	0796
Roper Hospital	2/26/2013	19088992	$ 2.50	folic acid	0797
Roper Hospital	2/26/2013	19089041	$ 2.50	insulin lispro	0796
Roper Hospital	2/26/2013	19100195	$ 2.50	labetalol	0796
Roper Hospital	2/26/2013	19100195	$ 2.50	labetalol	0796
Roper Hospital	2/26/2013	19131706	$ 2.50	furosemide	0797
Roper Hospital	2/26/2013	19144668	$ 2.50	metolazone	0797
Roper Hospital	2/26/2013	19144668	$ 2.50	metolazone	0797
Roper Hospital	2/26/2013	19165319	$ 38.90	lidocaine hcl	0796
Roper Hospital	2/26/2013	19177259	$ 4.50	temazepam	0796
Roper Hospital	2/26/2013	19190113	$ 5.00	warfarin sodium	0796
Roper Hospital	2/26/2013	19190128	$ 5.00	warfarin sodium	0796
Family Medical Supply	2/27/2013	483381	$ 375.00	heavy duty transport chair	0029
Family Medical Supply	2/27/2013	483381	$ 56.57	bathing seat w/ back	0029
Family Medical Supply	2/27/2013	483381	$ 26.68	side sleeper pillow	0029
Roper Hospital	2/27/2013	510	$ 798.00	adl training	0800
Roper Hospital	2/27/2013	511	$ 133.00	adl training	0801
Roper Hospital	2/27/2013	512	$ 133.00	functional trng 15 min	0801
Roper Hospital	2/27/2013	513	$ 532.00	ther exer 15 min	0801
Roper Hospital	2/27/2013	514	$ 139.00	pt	0799
Roper Hospital	2/27/2013	515	$ 36.00	venipuncture	0799
Roper Hospital	2/27/2013	548	$ 1,542.00	room 3907	0789
Roper Hospital	2/27/2013	19088973	$ 2.50	tamsulosin	0797
Roper Hospital	2/27/2013	19088983	$ 4.50	hydrocodone	0797
Roper Hospital	2/27/2013	19088983	$ 4.50	hydrocodone	0797
Roper Hospital	2/27/2013	19088984	$ 2.50	diltiazem	0797
Roper Hospital	2/27/2013	19088987	$ 2.50	carvedilol	0797
Roper Hospital	2/27/2013	19088987	$ 2.50	carvedilol	0797
Roper Hospital	2/27/2013	19088992	$ 2.50	folic acid	0797
Roper Hospital	2/27/2013	19089041	$ 2.50	insulin lispro	0797
Roper Hospital	2/27/2013	19100195	$ 2.50	labetalol	0797

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Roper Hospital	2/27/2013	19100195	$	2.50	labetalol	0797
Roper Hospital	2/27/2013	19131706	$	2.50	furosemide	0797
Roper Hospital	2/27/2013	19144668	$	2.50	metolazone	0797
Roper Hospital	2/27/2013	19144668	$	2.50	metolazone	0797
Roper Hospital	2/27/2013	19165319	$	38.90	lidocaine hcl	0797
Roper Hospital	2/27/2013	19177259	$	4.50	temazepam	0797
Roper Hospital	2/27/2013	19203498	$	10.00	warfarin sodium	0797
Roper Hospital	2/27/2013	19203583	$	15.95	triamcinolone	0797
Roper Hospital	2/28/2013	549	$	266.00	ther exer 15 min	0801
Roper Hospital	2/28/2013	550	$	532.00	ther exer 15 min	0801
Roper Hospital	2/28/2013	551	$	133.00	gait training	0800
Roper Hospital	2/28/2013	552	$	399.00	ther exer 15 min	0800
Roper Hospital	2/28/2013	553	$	266.00	gait training	0800
Roper Hospital	2/28/2013	561	$	139.00	pt	0800
Roper Hospital	2/28/2013	562	$	36.00	venipuncture	0800
Roper Hospital	2/28/2013	594	$	1,542.00	room 3907	0789
Roper Hospital	2/28/2013	19088973	$	2.50	tamsulosin	0798
Roper Hospital	2/28/2013	19088983	$	4.50	hydrocodone	0798
Roper Hospital	2/28/2013	19088983	$	4.50	hydrocodone	0798
Roper Hospital	2/28/2013	19088984	$	2.50	diltiazem	0798
Roper Hospital	2/28/2013	19088987	$	2.50	carvedilol	0798
Roper Hospital	2/28/2013	19088987	$	2.50	carvedilol	0798
Roper Hospital	2/28/2013	19088992	$	2.50	folic acid	0798
Roper Hospital	2/28/2013	19089041	$	2.50	insulin lispro	0798
Roper Hospital	2/28/2013	19100195	$	2.50	labetalol	0798
Roper Hospital	2/28/2013	19100195	$	2.50	labetalol	0798
Roper Hospital	2/28/2013	19131706	$	2.50	furosemide	0798
Roper Hospital	2/28/2013	19144668	$	2.50	metolazone	0798
Roper Hospital	2/28/2013	19144668	$	2.50	metolazone	0798
Roper Hospital	2/28/2013	19165319	$	38.90	lidocaine hcl	0798
Roper Hospital	2/28/2013	19177259	$	4.50	temazepam	0798
Roper Hospital	2/28/2013	19215898	$	7.50	warfarin sodium	0798
Family Medical Supply	3/1/2013	484698	$	52.99	quick change crutch	0031
Roper Hospital	3/1/2013	598	$	133.00	ther exer 15 min	0801
Roper Hospital	3/1/2013	599	$	133.00	functional trng 15 min	0801
Roper Hospital	3/1/2013	600	$	266.00	adl training	0801
Roper Hospital	3/1/2013	601	$	266.00	ther exer 15 min	0801

Roper Hospital	3/1/2013	604	$	133.00	ther exer 15 min	0800
Roper Hospital	3/1/2013	605	$	399.00	adl training	0800
Roper Hospital	3/1/2013	606	$	266.00	adl training	0800
Roper Hospital	3/1/2013	608	$	139.00	pt	0800
Roper Hospital	3/1/2013	609	$	36.00	venipuncture	0800
Roper Hospital	3/1/2013	648	$	1,542.00	room 3907	0789
Roper Hospital	3/1/2013	19088973	$	2.50	tamsulosin	0798
Roper Hospital	3/1/2013	19088983	$	4.50	hydrocodone	0799
Roper Hospital	3/1/2013	19088984	$	2.50	diltiazem	0798
Roper Hospital	3/1/2013	19088987	$	2.50	carvedilol	0798
Roper Hospital	3/1/2013	19088987	$	2.50	carvedilol	0799
Roper Hospital	3/1/2013	19088992	$	2.50	folic acid	0799
Roper Hospital	3/1/2013	19089041	$	2.50	insulin lispro	0799
Roper Hospital	3/1/2013	19100195	$	2.50	labetalol	0798
Roper Hospital	3/1/2013	19131706	$	5.00	furosemide	0799
Roper Hospital	3/1/2013	19144668	$	5.00	metolazone	0799
Roper Hospital	3/1/2013	19144668	$	2.50	metolazone	0799
Roper Hospital	3/1/2013	19165319	$	38.90	lidocaine hcl	0798
Roper Hospital	3/1/2013	19177259	$	4.50	temazepam	0798
Roper Hospital	3/1/2013	19223611	$	2.50	warfarin sodium	0798
Roper Hospital	3/1/2013	19223622	$	2.50	metolazone	0799
Roper Hospital	3/1/2013	19223625	$	2.50	lisinopril	0799
Roper Hospital	3/1/2013	19226394	$	4.50	hydrocodone	0799
Roper Hospital	3/2/2013	655	$	139.00	pt	0800
Roper Hospital	3/2/2013	656	$	36.00	venipuncture	0800
Roper Hospital	3/2/2013	19088973	$	2.50	tamsulosin	0799
Roper Hospital	3/2/2013	19088987	$	2.50	carvedilol	0799
Roper Hospital	3/2/2013	19100195	$	2.50	labetalol	0799
Roper Hospital	3/2/2013	19131706	$	2.50	furosemide	0799
Roper Hospital	3/2/2013	19144668	$	2.50	metolazone	0799
Roper Hospital	3/2/2013	19165319	$	38.90	lidocaine hcl	0799
Roper Hospital	3/2/2013	19226394	$	4.50	hydrocodone	0799
Wilson County Home Health	3/4/2013	PT2	$	112.00	pt eval	2519
Wilson County Home Health	3/4/2013	SN02	$	106.00	sn eval	2519
Wilson County Home Health	3/5/2013	PT1	$	112.00	pt routine visit	2519
Duke South	3/6/2013	200763	$	7.00	parking	0080
Wilson County Home Health	3/6/2013	SN01	$	106.00	sn routine visit	2519

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Wilson County Home Health	3/7/2013	OT2	$ 112.00	ot eval	2519
Wilson County Home Health	3/7/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	3/11/2013	PT1	$ 112.00	pt routine visit	2519
Duke South	3/12/2013	201578	$ 7.00	parking	0080
Hooper & Burnette Internal Medicine	3/12/2013	3554791	$ 149.24	office/outp	2467
Hooper & Burnette Internal Medicine	3/12/2013	3554791	$ 20.60	cxr tech c	2467
Hooper & Burnette Internal Medicine	3/12/2013	3554791	$ 11.20	cxr prof c	2467
Hooper & Burnette Internal Medicine	3/12/2013	3554791	$ 3.01	measurment	2467
Hooper & Burnette Internal Medicine	3/12/2013	3554791	$ 7.52	prothrombin	2467
Hooper & Burnette Internal Medicine	3/12/2013	3564591	$ 3.00	routine ven	2465
Wilson County Home Health	3/13/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	3/14/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	3/18/2013	PT1	$ 112.00	pt routine visit	2519
Hooper & Burnette Internal Medicine	3/20/2013	3569931	$ 45.40	office/outp	2465
Hooper & Burnette Internal Medicine	3/20/2013	3569931	$ 7.52	prothrombin	2465
Hooper & Burnette Internal Medicine	3/20/2013	3569931	$ 3.00	routine ven	2465
Wilson County Home Health	3/20/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	3/21/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	3/22/2013	SN01	$ 106.00	sn routine visit	2519
Wilson County Home Health	3/25/2013	PT1	$ 112.00	pt routine visit	2519
Hooper & Burnette Internal Medicine	3/27/2013	3564571	$ 111.40	atheroscler	2465
Hooper & Burnette Internal Medicine	3/27/2013	3576111	$ 7.52	prothrombin	2469
Hooper & Burnette Internal Medicine	3/27/2013	3576111	$ 3.00	routine ven	2469
Wilson County Home Health	3/27/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	3/28/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	4/1/2013	PT1	$ 112.00	pt routine visit	2519
Private Diagnostic Clinic	4/2/2013	03103796142	$ 42.00	depo-medrol	2470
Private Diagnostic Clinic	4/2/2013	03103796142	$ 182.00	inject/drain joint	2470
Private Diagnostic Clinic	4/2/2013	03103796142	$ 274.00	office visit (extensive)	2470
Private Diagnostic Clinic	4/2/2013	03103796142	$ 288.00	x-ray knee	2470
Wilson County Home Health	4/3/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	4/4/2013	PT1	$ 112.00	pt routine visit	2519
Family Medical Supply	4/5/2013	495033	$ 36.28	jobst stocking donner	0036
Wilson County Home Health	4/8/2013	PT1	$ 112.00	pt routine visit	2519
Family Medical Supply	4/10/2013	496330	$ 72.58	arthritis knee brace	0034
Wilson County Home Health	4/10/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	4/11/2013	PT1	$ 112.00	pt routine visit	2519

Wilson County Home Health	4/17/2013	PT1	$ 112.00	pt routine visit	2519
Wilson County Home Health	4/19/2013	PT1	$ 112.00	pt routine visit	2519
Hooper & Burnette Internal Medicine	4/24/2013	3592531	$ 111.40	office/outp	2469
Private Diagnostic Clinic	5/28/2013	03105928903	$ 182.00	inject/drain joint	2470
Private Diagnostic Clinic	5/28/2013	03105928903	$ 132.00	x-ray both knees	2470
Private Diagnostic Clinic	5/28/2013	03105928903	$ 204.00	office visit (complex)	2470
Carolina Joint and Spine	6/6/2013		$ 7,875.00	program costs	2575
Carolina Joint and Spine	6/12/2013		$ 250.00	99203	2545
Carolina Joint and Spine	6/12/2013		$ 125.00	73560	2545
Carolina Joint and Spine	6/12/2013		$ 295.00	J7321	2545
Carolina Joint and Spine	6/12/2013		$ 475.00	73580	2545
Carolina Joint and Spine	6/12/2013		$ 550.00	27370	2545
Carolina Joint and Spine	6/12/2013		$ 10.00	Q9967	2545
Carolina Joint and Spine	6/12/2013		$ 100.00	97001	2546
Carolina Joint and Spine	6/17/2013		$ 45.00	97150	2544
Carolina Joint and Spine	6/17/2013		$ 85.00	97110	2544
Carolina Joint and Spine	6/19/2013		$ 295.00	J7321	2543
Carolina Joint and Spine	6/19/2013		$ 475.00	77002	2543
Carolina Joint and Spine	6/19/2013		$ 550.00	27370	2543
Carolina Joint and Spine	6/19/2013		$ 10.00	Q9967	2543
Carolina Joint and Spine	6/19/2013		$ 150.00	99212	2543
Carolina Joint and Spine	6/19/2013		$ 45.00	97150	2543
Carolina Joint and Spine	6/27/2013		$ 295.00	J7321	2542
Carolina Joint and Spine	6/27/2013		$ 475.00	77002	2542
Carolina Joint and Spine	6/27/2013		$ 550.00	27370	2542
Carolina Joint and Spine	6/27/2013		$ 10.00	Q9967	2542
Carolina Joint and Spine	6/27/2013		$ 150.00	99212	2542
Carolina Joint and Spine	6/27/2013		$ 85.00	97110	2542
Carolina Joint and Spine	7/1/2013		$ 45.00	97150	2551
Carolina Joint and Spine	7/3/2013		$ 295.00	J7321	2550
Carolina Joint and Spine	7/3/2013		$ 475.00	77002	2550
Carolina Joint and Spine	7/3/2013		$ 550.00	27370	2550
Carolina Joint and Spine	7/3/2013		$ 10.00	Q9967	2550
Carolina Joint and Spine	7/3/2013		$ 150.00	99212	2550
Carolina Joint and Spine	7/3/2013		$ 85.00	97110	2550
Carolina Joint and Spine	7/8/2013		$ 85.00	97110	2549
Carolina Joint and Spine	7/10/2013		$ 295.00	J7321	2548

Carolina Joint and Spine	7/10/2013		$ 475.00	73580	2548
Carolina Joint and Spine	7/10/2013		$ 550.00	27370	2548
Carolina Joint and Spine	7/10/2013		$ 10.00	Q9967	2548
Carolina Joint and Spine	7/10/2013		$ 150.00	99212	2548
Carolina Joint and Spine	7/10/2013		$ 45.00	97150	2548
Carolina Joint and Spine	7/15/2013		$ 85.00	97110	2547
Department of Health and Human Services		EO627	$ 337.32	seat lift mechanism	0032
DukeMedicine	8/27/2014	131423900421	$ 4,756.10	multiple services	4118
DukeMedicine	8/27/2014	131423900421	$ 5,645.44	multiple services	4119
DukeMedicine	8/30/2014	131423900421	$ 5,642.92	multiple services	4120
DukeMedicine	9/1/2014	131423900421	$ 9,250.22	multiple services	4121
DukeMedicine	9/1/2014	131423900421	$ 2,842.00	multiple services	4122
DukeMedicine	9/1/2014	131423900421	$ 1,071.85	multiple services	4123
DukeMedicine	9/1/2014	131423900421	$ 6,078.38	multiple services	4124
DukeMedicine	9/1/2014	131423900421	$ 9,554.43	multiple services	4125
DukeMedicine	9/1/2014	131423900421	$ 6,030.35	multiple services	4126
DukeMedicine	9/1/2014	131423900421	$ 929.37	multiple services	4128
DukeMedicine	9/1/2014	131423900421	$ 3,812.76	multiple services	4129
DukeMedicine	9/1/2014	131423900421	$ 26,110.39	multiple services	4130
DukeMedicine	9/1/2014	131423900421	$ 23,104.54	multiple services	4131
DukeMedicine	9/1/2014	131423900421	$ 7,712.22	multiple services	4132
DukeMedicine	9/1/2014	131423900421	$ 7,854.35	multiple services	4133
DukeMedicine	9/1/2014	131423900421	$ 5,587.49	multiple services	4134
DukeMedicine	9/1/2014	131423900421	$ 4,871.42	multiple services	4135
DukeMedicine	9/1/2014	131423900421	$ 3,225.24	multiple services	4136
DukeMedicine	9/1/2014	131423900421	$ 5,449.44	multiple services	4137
DukeMedicine	9/2/2014	131423900421	$ 3,434.58	multiple services	4138
			$ 299,460.93		

1044

Medical University of South Carolina
Charleston, SC
843-792-2123

Transfer Summary

Patient: BURKE, ROBERT
MRN: [redacted]
Attending:
Date: 1/28/13 12:00 AM
Status: INITIAL

PATIENT NAME: [redacted]
MRN: 005502246
PATCOM: 860183706
ADMITTED: 01/25/2013
DISCHARGED: 01/28/2013
SERVICE: STICU
ATTENDING: Joseph Sakran, MD
REFERRING: SELF REFERRAL
PRIMARY CARE PHYSICIAN: PATIENT, NONE PER
DATE OF TRANSFER: 01/28/2013.
BRIEF HISTORY: A 67-year-old male with a history of AFib admitted status post fall with active bleeding and enlarging thigh hematoma secondary to supratherapeutic INR (3.35). He tripped over a kerb onto concrete.
PAST MEDICAL HISTORY:
1. Diabetes.
2. Coronary artery disease.
3. Atrial fibrillation.
4. Basal cell carcinoma of bilateral lower extremities status post radiation.
5. Chronic renal insufficiency.

INJURY COMPLEX:
1. Right thigh hematoma.
2. Right chest contusion.
3. Right arm contusion/skin tears.
4. Acute kidney injury versus chronic renal insufficiency.
5. Anemia.

OPERATIVE PROCEDURES: None.
CONSULTS: None.
BRIEF ICU COURSE: 01/25: Admitted to STICU for close monitoring and serial labs given expanding hematoma of his thigh in setting of coagulopathy (INR 3.25). Received 4 units FFP, 2 units PRBC; INR corrected to 1.5. On 01/26, the patient's hemoglobin was stable, his thigh was tender to palpation, he did complain of right knee pain, which led to x-rays of that joint which were negative. The following day on 01/27, the patient's hematoma of his thigh was stable, but his hemoglobin continued to drop, presumably secondary to acute blood loss anemia. The patient received 3 units of PRBCs on that day and his hemoglobin went from 6.4 to 8.5. On 01/28, the patient's condition appeared to have destabilized and the decision was made to transfer

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Printed by: SIMMONS, FLORENCE

Medical University of South Carolina
Charleston, SC
843-792-2123

Transfer Summary

Patient: BURKE, ROBERT
Attending:

MRN: [redacted]
Date: 1/28/13 12:00 AM
Status: INITIAL

the patient to the floor. His hemoglobin did not respond appropriately on his q.12 hour repeat CBC later on that day however. So, we kept until the next day for further observation. On 01/29, his hemoglobin dropped again, so we repeated the CT of his abdomen and pelvis, as well as his right thigh. None of these showed the formation of any new hematoma or the expansion of any old hematomas. Since 01/29, we have kept him for observation and daily CBCs. Hemoglobin has been stable since 01/29 at 8.0 on 01/30 and 7.9 on 01/31. Skin tears and avulsions of his right and left upper extremities are stable and appeared to be healing. His creatinine is stable at 1.6 and he has been tolerating a regular carb-counting diet well. We have him on Lantus and sliding scale insulin. PT and OT had been by to see him. We now feel that he is stable enough to go to the floor.

Dictated by: Michael Warren Boone II, MD

Michael Warren Boone II, MD

Joseph Sakran, MD
Attending
549212014/medq/
JOB: 1104013
DD: 01/31/2013 19:39:27
DT: 01/31/2013 20:30:28

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no lo[Burke 0011]

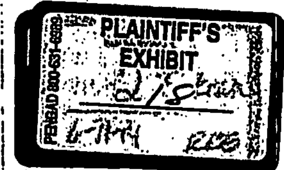
Printed by: SIMMONS, FLORENCE
Date Printed: 02/01/2013

Medical University of South Carolina
Charleston, SC
843-792-2123

Discharge Summary

Patient: BURKE, ROBERT
MRN: [redacted]
Attending:
Date: 2/13/13 12:00 AM
Status: INITIAL

PATIENT NAME: BURKE, ROBERT
MRN: [redacted]
PATCOM: [redacted]
ADMITTED: 01/25/2013
DISCHARGED: 02/13/2013
SERVICE: Trauma Surgery.
ATTENDING: Stephanie Montgomery-Idema, MD
REFERRING: SELF REFERRAL
PRIMARY CARE PHYSICIAN: PATIENT, NONE PER
HISTORY AND PHYSICAL EXAM: Please refer to H and P in chart. Briefly, this is a 67-year-old Caucasian gentleman who presented to MUSC. This was a trauma consult. The patient reportedly was visiting from his home state of North Carolina. He tripped over a curb onto concrete, landed on his right thigh, and was brought to MUSC with bleeding and right thigh pain. He is currently anticoagulated on Coumadin for atrial fibrillation and was noted to have a supratherapeutic INR upon admission which was 3.25. Trauma Surgery Service was consulted for management of the thigh hematoma. The patient had images in the Trauma Bay including a right femur x-ray that was negative, bilateral hand x-ray was negative, right elbow x-ray was negative. Chest x-ray showed cardiomegaly, no other abnormalities. Brain CT showed no evidence of acute trauma, showed remote infarction of the posterior right cerebellum and scattered subcortical white matter hypodensities, most likely representing chronic microangiopathic disease. CT of the chest, abdomen, and pelvis showed no evidence of acute trauma, showed a small right knee effusion and small right pleural effusion with an incidental liver cyst and a renal stone. Right knee x-ray was negative and left knee x-ray was negative. The patient was admitted to the STICU. Please refer to previously dictated ICU transfer summary to highlight the course in the unit. The patient did not have any active extravasation with thigh hematoma, however, did have acute blood loss anemia requiring blood transfusion and FFP to reverse the Coumadin. The patient's Coumadin was not restarted during his hospital course due to the bleeding. The patient had an elevated creatinine of 1.8 with a history of chronic renal insufficiency. Nephrology was consulted for management of that and recommended restarting his home medication except for the lisinopril, the Lasix, and the metolazone due to his renal failure and that was continued to be monitored. The patient had a prolonged hospital course. He was finally stabilized in the ICU and



This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Medical University of South Carolina
Charleston, SC
843-792-2123

Discharge Summary

Patient: BURKE, ROBERT
Attending:

MRN: [redacted]
Date: 2/13/13 12:00 AM
Status: INITIAL

transferred out on 01/28/2013. On 01/29, he had a repeat abdominal CT that was unchanged from previous with decrease in size of the right pleural effusion. He had labs as recommended by the Renal Team. Renal ultrasound showed no evidence of obstruction and an echocardiogram was done which showed an ejection fraction of 60% with normal left ventricular systolic function, indeterminate diastolic function, severe peak systolic pulmonary hypertension, dilated and hypokinetic right ventricle with elevated right atrial pressure. The remainder of the patient's home medications were restarted again with the exception of Coumadin, lisinopril, aspirin, Lasix, and metolazone. He was placed on heparin for DVT prophylaxis post Lovenox due to his renal impairment. He had worked with Physical Therapy and Occupational Therapy. The patient had severe deconditioning, malnutrition and was determined to require rehab placement once he was stable. He had issues with acute urinary retention and failed voiding trial x2. Therefore, Foley catheter was replaced, Lovenox was initiated, and the decision was made to send him to rehab with the Foley catheter. He had loose stools. C. diff was ordered and that was negative. Imodium was ordered for loose stools; however, the patient improved without medication. The patient also was noted to have bilateral lower extremity wounds. He had previous basal cell carcinoma in bilateral lower extremity status post radiation and received wound care for Unna boots in bilateral lower extremity, and he has had a skin tear in his right upper extremity. The patient had a stable hemoglobin and hematocrit level, and was determined to be stable for discharge to rehab on 02/13/2013. Upon discharge, his hemoglobin was 8.2 and hematocrit was 25.8. His creatinine upon discharge was 1.2, which had trended down. The patient's electrolytes were stable. His blood pressure and pulse were stable. He remained in atrial fibrillation.
HOSPITAL COURSE: His hyperglycemia was managed with Lantus insulin and sliding scale. His p.o. intake improved. The decision was made by the trauma attending surgeons that the Coumadin would not be restarted in this setting due to the risk stratification and the fact that the risk of him developing a stroke from his atrial fibrillation was much lower than the risks of him falling again and sustaining acute hemorrhage. Therefore, we will elect to have him follow up with his primary care physician to determine if the Coumadin will be reinitiated in the future.
DISCHARGE PHYSICAL EXAM: VITAL SIGNS: Stable.

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MUSC Health

Medical University of South Carolina
Charleston, SC
843-792-2123

Discharge Summary

Patient: BURKE, ROBERT
Attending:

MRN: [redacted]
Date: 2/13/13 12:00 AM
Status: INITIAL

GENERAL: The patient is alert and oriented x3.
LUNGS: Clear to auscultation bilaterally.
HEART: Irregularly regular rhythm with a rate of 84 with atrial fibrillation.
ABDOMEN: Obese, soft, nontender, and nondistended.
EXTREMITIES: The patient moves all 4 extremities. He has a skin tear in his right forearm with Allevyn dressing in place, and he has bilateral lower extremity Unna boots in place.
NEUROLOGIC: No gross neurologic deficits.
DISCHARGE DIAGNOSES: Include status post fall with supratherapeutic INR upon admission secondary to Coumadin and anticoagulation for atrial fibrillation, right thigh hematoma, right knee effusion, right pleural effusion, right chest contusion, atrial fibrillation, acute blood loss anemia, acute kidney injury, hyperglycemia, acute urinary retention, malnutrition, history of chronic kidney disease, atrial fibrillation on Coumadin, hypertension, type 2 diabetes, coronary artery disease, and basal cell carcinoma of bilateral lower extremity, status post radiation.
PROCEDURES: No surgical procedures were done during this hospitalization. The patient did have an echocardiogram done on February 5th, which showed an ejection fraction of 60%. Incidental findings of a right liver cyst and a left kidney stone.
DISPOSITION: The patient will be discharged to Roper Rehab in stable condition.
ACTIVITY: Includes perform breathing exercise, incentive spirometer every 2 hours while awake, walk with assistance or device, do not drive or operate machinery when taking narcotic medication.
WEIGHTBEARING STATUS: No restriction.
DIET: Diabetic diet.
WOUND CARE: The patient has bilateral leg wounds. He is to have the Unna boot dressing to be changed 1-2 times per week, and a right arm skin tear and that can be changed daily with Allevyn dressing.
DISCHARGE INSTRUCTIONS: The patient was consulted by Nephrology attending, Dr. Kadian, and he will follow up in the Nephrology Clinic upon rehab discharge if the patient desires. Otherwise, he can have his primary care physician in North Carolina refer him to a nephrologist if indicated. Otherwise, we do recommend that he follow up with his primary care physician in North Carolina immediately upon rehab discharge to discuss management of his atrial fibrillation with or without Coumadin to continue to manage his hypertension, diabetes,

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Medical University of South Carolina
Charleston, SC
843-792-2123

Discharge Summary

Patient: BURKE, ROBERT
Attending:

MRN: [redacted]
Date: 2/13/13 12:00 AM
Status: INITIAL

and his chronic kidney disease and also to discuss the incidental findings of the renal stone and the liver cyst. The patient does not need to follow up in the Trauma Clinic. The patient is advised to call for the following; temperature greater than 101.5, diarrhea or constipation for more than 2 days, numbness or tingling, any increased drainage from the wound, nausea or vomiting, shortness of breath, lasting greater than 5 minutes, pain not controlled by pain medications, dizziness or lightheadedness. The patient will be discharged from 6-West. Discharge phone number is 252-532-0624. Of note, the patient will be discharged to rehab with a Foley catheter secondary to acute urinary retention. The patient may have that Foley catheter discontinued at physician discretion at the rehab with a void check. Otherwise, if he fails or if they decide to leave the Foley catheter in, he can follow up with the Urology Clinic at MUSC with Joe Turner, nurse practitioner, upon rehab discharge or his primary care physician can follow for the urinary retention.
DISCHARGE MEDICATIONS: He will be discharged to rehab on the following medications; carvedilol 25 mg by mouth twice a day for atrial fibrillation, diltiazem 120 mg by mouth daily for atrial fibrillation, ferrous gluconate 324 mg by mouth 3 times a day for iron deficiency, tamsulosin Flomax 0.4 mg by mouth daily for urinary retention, heparin 5000 units subcutaneous q.8 hours for DVT prophylaxis, Lortab 5/500 one tablet p.o. q.4 hours p.r.n. pain, Lantus insulin 26 units subcu q.h.s. for diabetes. NovoLog insulin sliding scale as follows; fingerstick blood sugar 141-170 equals 3 units of insulin, fingerstick blood sugar 171-220 equals 6 units of insulin, fingerstick blood sugar 221-270 equals 9 units of insulin, fingerstick blood sugar 271-320 equals 12 units of insulin, and greater than 320 equals 15 units of insulin. The patient will have the remainder of his home medications held. The Coumadin 5 mg daily for atrial fibrillation will be held due to bleeding risk, the aspirin 81 mg by mouth daily for CAD will be held due to bleeding risk, the lisinopril 10 mg daily for hypertension is going to be held due to renal insufficiency per Nephrology, the Lasix 40 mg by mouth daily for hypertension will be held due to renal insufficiency per nephrology, and the metolazone 5 mg daily for hypertension will be held due to renal insufficiency. All those medications will be held until the patient sees his primary care physician.
Dictated by: Brandi Aquino, PA

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Printed by: SIMMONS, FLORENCE
Date Printed: 02/13/2013

Medical University of South Carolina
Charleston, SC
843-792-2123

Discharge Summary

Patient: BURKE, ROBERT
Attending:

MRN: [redacted]
Date: 2/13/13 12:00 AM
Status: INITIAL

Brandi Aquino, PA

Stephanie Montgomery-Idema, MD
Attending
[redacted]
JOB: 1106474
DD: 02/13/2013 11:00:23
DT: 02/13/2013 12:29:18

[signature] 15910 2/13/13 1320

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient Name: BURKE, ROBERT MR #: [REDACTED] PAT #: 860183706

Sex: M
Birthdate: [REDACTED]
Age at Admit: [REDACTED]
Attending Phys: 003503 MONTGOMERY-IDEM

Admitted: 1/25/13
Discharged: 2/13/13
LOS: 19 FC: MC
UB82 Disp: 62

Current DRG: 604 - TRMA SKN, SBCT TIS & BRST W M CODER ID: mem39
APR-DRG 384 APR-SOI 4 APR-ROM 3

	Diagnoses	M1	M2	Description
1.	924.00	Y		CONTUSION OF THIGH
2.	262	Y		OTH SEVERE MALNUTRITION
3.	584.9	Y		ACUTE RENAL FAILURE USP
4.	511.9	Y		PLEURAL EFFUSION NOS
5.	286.9	Y		COAGULAT DEFECT NEC/NOS
6.	427.31	Y		ATRIAL FIBRILLATION
7.	416.8	Y		CHR PULMON HEART DIS NEC
8.	285.1	Y		AC POSTHEMORRHAG ANEMIA
9.	E885.9	Y		FALL,OT SLIP/TRIP/STUMBLE
10.	E849.9	E		ACCIDENT IN PLACE NOS
11.	429.3	Y		CARDIOMEGALY
12.	719.06	Y		JOINT EFFUSION-L/LEG
13.	573.8	Y		LIVER DISORDERS NEC
14.	592.0	Y		CALCULUS OF KIDNEY
15.	403.90	Y		HCRD, UNSP W CRD STG I-IV
16.	585.9	Y		CHRONIC KIDNEY DIS NOS
17.	922.1	Y		CONTUSION OF CHEST WALL
18.	788.20	N		RETENTION,URINE,UNSPEC
19.	250.00	Y		DMII wo cmp nt st uncntr
20.	414.00	Y		COR ATH UNSP VSL NTV/GFT
21.	923.10	Y		CONTUSION OF FOREARM
22.	V58.66	E		LT (CURRENT) USE OF ASPIR
23.	V58.61	E		LG TRM(CUR)USE ANTICOAGS

	Date	Proc	Description
1.	01/25/13	99.04	PACKED CELL TRANSFUSION
2.	01/25/13	99.07	SERUM TRANSFUSION NEC

PHYSICIAN SIGNATURE AND DATE

CANCER STAGING: ______T ______N ______M __________STAGING

The
OOPS!
CATALOG CLOTHI
RESERVED
PARKING
ONLY
RESERVED
NANCYS

DEFENDANT'S
EXHIBIT

JOSEPH P. RILEY, JR.
Mayor

STEPHEN BEDARD
Chief Financial Officer

ROBERT MIRACLE
Deputy Chief Financial Officer

GARY COOPER
Procurement Director

City of Charleston
South Carolina
Department of Budget, Finance & Revenue Collections

Procurement Division

ROBIN BARRETT-ROBINSON
Senior Buyer

CHENETTE SINGLETON
Buyer

SCOTT MAXIE
Contracts Coordinator

MARJORIE HENDRIKS
Project Assistant

June 19, 2013

Mr. Dwight Potter
Republic Parking System
401C King Street
Charleston, SC 29406

Dear Mr. Potter:

An inspection of the George-Society Street Parking Lot was held on June 18, 2013 at 4:20 PM. The results of the inspection and the discrepancies that need immediate attention by Republic Parking are listed below. Please call me at [redacted] or e-mail me at maxies@charleston-sc.gov with any questions or comments.

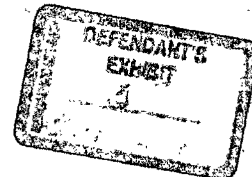
George-Society Street Parking Lot:
1. No concerns noted during inspection.

Thank you in advance for your assistance in this manner.

Sincerely,

Scott Maxie
Contracts Coordinator

[illegible] Charleston, South Carolina 29401 (843) 724-7312 (843) 720-3872 (Fax)



JOSEPH P. RILEY, JR.
Mayor

STEPHEN BEDARD
Chief Financial Officer

ROBERT MIRACLE
Deputy Chief Financial Officer

GARY COOPER
Procurement Director

City of Charleston
South Carolina
Department of Budget, Finance
& Revenue Collections

Procurement Division

ROBIN D. BARRETT
Senior Buyer

CHENETTE SINGLETON
Buyer

SCOTT MAXIE
Contracts Coordinator

MARJORIE HENDRIKS
Project Assistant

January 4, 2013

Mr. Dwight Potter
Republic Parking System
401C King Street
Charleston, SC 29403

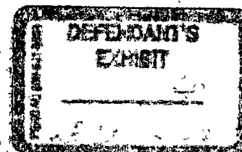
Dear Mr. Potter:

An inspection of the **George-Society Street Parking Lot** was held on January 4, 2013 at 10:25 AM. The results of the inspection and the discrepancies that need immediate attention by Republic Parking are listed below. Please call me at 965-4184 or e-mail me at maxies@charleston-sc.gov with any questions or comments.

George-Society Street Parking Lot:
Noted improvements in leaf and trash debris from previous inspection. No discrepancies found during inspection.

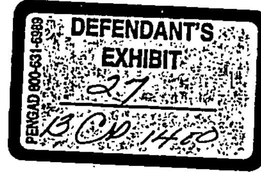
Thank you in advance for your assistance in this matter.

Sincerely,



Scott Maxie
Contracts Coordinator

104 King Street, Ste 134 Charleston, South Carolina [illegible] ([illegible]) 724-7312 (843) 720-3872 (Fax)



Robert Burke
5/10/07

New complete examination on this 61 year old married male, recently relocated back to NC from Portland, Oregon.

He had not lived in NC for a number of years but now has moved back to be closer to his mother-in-law.

He is accompanied by records from his physician, Dr. Peterson in Portland and from Dr. Beard, Endocrinologist, also from Portland.

Problem List:

1. Atrial fibrillation, chronic. Intolerant to Coumadin therapy due to anemia.
2. DM, Type II, diagnosed in 2000 with complications of retinopathy, neuropathy, sexual dysfunction and microalbuminuria.
3. History of hypertension
4. Right knee pain
5. Esophagitis, diagnosed on esopha/gastro/duodenoscopy in 2003.
6. History of recent cataract extraction
7. History of ____________ previously.
8. History of cholecystectomy

Mr. Burke is also followed at DUMC by endocrinologist, Dr. Jelesoff.

Medications at the current time include:

1. Diltiazem XR 240 mg daily
2. Digoxin 1.25 mg daily
3. Avalide 300/12.5 daily
4. Furosemide 80 mg PO BID
5. Benzopril 20 mg PO daily.
6. Avandia daily
7. Lantus - currently 14 units
8. Amaryl 2 mg 2 BID
9. ASA 325 mg daily

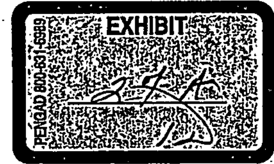
His Diabetic medications are being managed by his Endocrinologist. He has recently had some increased BS's and they are working to help control these. Diabetes is not well controlled at the current time with HGB A1C in range of 9.3 with fasting sugar in the high 100's to 200 range.

Mr. Burke is a non-smoker. Uses no ETOH or illicit drugs. Current weight is 237. H: 6'1". He is a scout for the Portland Trail Blazers and also helps as a coach. Currently married and has two children.

ALLERGY TO CODEINE.

FAXED 12-17-07 WMC Cardio Rehab

HOOP0099



Most recently he has had cataract extraction by Dr. Putnam, Wilson. He has seen his doctor at DUMC for endocrinology in the week. He travels with his job and will not be back in this area until early 7/07.

He denies any chest pain, tightness or angina equivalents. He has decreased sensation in the lower extremities secondary to his diabetes. He states he does rest well at night and states he does get up once per night to urinate. H e is up to date on colonoscopy and also had gastro duodenoscopy because of anemia.

His records from Portland are reviewed with him. We have discussed the fact that is not on Coumadin and he is aware of the fact that he is at a high risk of embolic stroke because of this however he had tried Coumadin and was unable to take this because of anemia.

His FH is positive for heart failure in his father who died at age 60. Mother died at age 83 and has had siblings with heart failure and diabetes.

He is apparently been on statin therapy in past but is unsure why this was DC'd. He does not recall any difficulty taking the medication.

Currently BS 172 and cholesterol 156 with LDL of 110 and HDL 35. We have elected, because of history of diabetes, to place him on Lipitor 20 mg daily. He is counseled re: possible side effects and will retirn and have lipid liver panel in 7/07 when he returns to the area and will DC medication should he have side effects in the interim.

Remainder of labs were remarkable for micro albumin of 150 and HGB is 11 with HCT of 32, white count 8000.

On Examination: well developed, well nourished male in no acute distress currently. He has recently had cataract surgery. No scleral icterus. No carotid bruits. Neck supple. Thyroid is not enlarged. Chest clear to A&P and heart sounds reveal atrial fibrillation with controlled rate. No gallop or murmur. Abdomen remarkable for cholecystectomy scar and no organomegaly and no bruits. Normal male genitalia, prostate of normal size and stool negative for occult blood. Extremities: 1+ to 2+ edema with some discoloration secondary to diabetic changes. Pulses present but diminished in the posterior tibial and dorsalis pedis area.

Have discussed number of issues with him and elected to place on Statin Therapy and will continue his medications and also FU with endocrinologist at DUMC hopefully for better control of diabetes. There is some concern regarding the use of Avandia due to continuing edema.

We are going to see him back here in 7/07 on return to the area following the NBA Draft. He will need a rest and stress echo in the next year or so and consideration of additional colonoscopy or esophagoscopy if anemia worsens.

2/3 FAXED 12-17-07 MB
WMC Cardio Rehab

Robert Burke, cont
PAGE 3 5/10/07

He remains at increased risk because of the history of diabetes, hypertension and neuropathy.
Thomas E. Hooper, M. D., F. A. C. P./pct

3/3

FAXED 12-17-07 WMC Cardio Rehab

7-3-07 pt. DNS for L/L. CO
9-12-07 pt. CX his appt. on 9-13-07. CO

HOOP0101

Robert Burke
7/1/2011

Mr. Burke came in for a pro-time today however his pro-time today however his pro-time which was appropriate at last visit is now 54. He has had no spontaneous bleeding but did fall in the bath tub approximately 2 weeks ago and has a largely ecchymosis over his left leg. I spoke with his wife and we are going to have him take 10 mg of Vitamin K today. He will hold his Coumadin for three days and then will have his Coumadin rechecked.

He is traveling to Charleston. HGB 10 which is unchanged from previous HGB and he is given the appropriate cautions for bleeding however do not want to restart his Coumadin at a regular dosage until we have pro-time rechecked. His wife is agreeable to this.

Thomas E. Hooper, M. D., F. A. C. P./pct

Patient: Robert Burke
Date: 7-11-11 MR#: 34385

Face to Face instructions given for Coumadin Therapy.
Patient also given appointment for follow-up pro-time.

Thomas E. Hooper, M.D., F.A.C.P./

Patient: Robert Burke
Date: 8-12-11 MR#: 34385

Face to Face instructions given for Coumadin Therapy.
Patient also given appointment for follow-up pro-time.

Thomas E. Hooper, M.D., F.A.C.P./

HOOP0049

MUHA Rehab Services Charting Report

Name: BURKE, ROBERT ROOM: 006W:D655	MRN: [redacted] PAT: [redacted]

Date/Time: 02/07/2013 5:45 PM

Orders Completed:

Documentation:
Medical University Hospital Authority
Occupational Therapy Charting Report for 2/7/2013

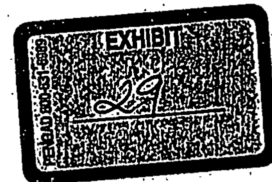
Patient:ROBERT BURKE
MRN
PAT:
DOB:
AGE:67 years

Attending Provider: MONTGOMERY-IDEM, STEPHANIE
Referring Provider: REFERRAL, SELF
Location of Treatment: Bedside
Date Therapy Plan Established (17): 2/7/2013
Date Patient First Became Aware of Symptoms (11): 01/25/2013
Date Service Initiated by Billing Provider (44): 2/7/2013
Funding: MEDICARE A B
Primary Diagnosis: Fall from car, R LE hematoma, AKI
Treatment Diagnosis: Decreased level of independence in ADL

History of Present Illness:Pt is a 67 y/o male admitted s/p trip and fall out of the car. Pt sustained multiple skin tears and R LE hematoma while on coumadin. Hospital course significant for ICU stay and AKI secondary to elevated Cr.
Past Medical History:DM, CAD, MI, A-fib, hyperlipidemia, self reports peripheral neuropathy
Past Surgical History:CABG x 4, defibrillator placement after episode of VTACH with 7 minutes of unresponsiveness (self reported by pt)
Social History
-Marital status: Married
- Prior level of function:Pt ambulated with no AD and completed basic and instrumental ADL prior to fall. Reports some memory deficits since previous hospital admission for VTACH. Reports several near misses in regards to prior fall.
- Occupation/Work status:Pt reports that he was a basketball coach prior to cardiac issues.
- Living situation: Lives with family 4 hours north of here in North Carolina. One story home with 2-3 steps to enter.
Equipment at home: No DME
Allergies:Please refer to medical record.
Precautions:fall risk , IV at risk for further skin breakdown
Activity Status: OOB with Assistance

SUBJECTIVE
Pain (Average pain over the last 24 hours):6 /10 (0=no pain to 10=E.R.)

Patient's Goals:To return to prior level of function



Robert Burke
7/6/2010

Mr. Burke is seen as work-in today. He has had a number of issues, many of which relate around the fact that he is working on some plans for trying to increase his physical fitness while realizing the fact that he is limited by a number of physical issues including his significant cardiovascular symptomatology.

He is status post cardiac arrest and anoxic episode followed by an emergency bypass.

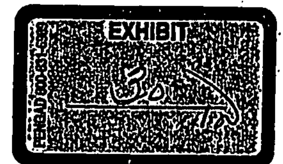
He has some short term memory issues and this is very difficult for him to deal with. He is functioning at a very high level of intelligence and has been give lectures, etc., for motivation in basketball strategy.

His atrial fibrillation is currently rate controlled and he is on Coumadin. He is bruising easily and also had significant swelling of ankles particularly when he is up. Most recent problem included some plantar fasciitis and heel pain on the right. Will get Dr. Blackwell to see him regarding this.

His BP is doing well and ankle swelling is really about the same. Renal function is stable with mild renal insufficiency at creatinine of 1.7 and BUN 47. Previous creatinine in 2/2010 was 1.7 with BUN 53. His pro-time is 1.6. We are going to have him continue current dosage but repeat in 2 weeks. He has previously been at this level and without change has increased and do not want to increase him at this point but he will certainly need to be up to a more therapeutic level if he remains under 2 to 2.5.

See him back here on the 19th and spent approximately 45 minutes discussing his other concerns. He has had some arthritic problems with his knee and trying to decide what to do as far as moving forward with disability planning. Also has significant Dupreytens Contracture, most prominently in the 4th finger of the left hand but also to a lesser extent of the 3rd and 4th fingers of the right hand. I will see him back on the 19th or sooner prn.

Thomas E. Hooper, M. D., F. A. C. P./pct



HOOP0059

Forest Hills Immediate Care

A Division of Hooper & Burnette Internal Medicine

Name Robert Burke Date 3/21/14 MR# 34385

DOB [redacted] Age 68 **Primary Care Provider** Hooper

Allergies Codeine

T 96.9 P 70 R 14 BP 90/50

LMP NA WT 235 HT 6'1"

Immunizations UTD Y / N
Appetite WNL Y / N
Tobacco Y / N
Alcohol Y / N
Drugs Y / N
(Answers are per pt)

MEDS:

1) See Med sheet (Same) no change 2) 3)
4) 5) 6)

CC: (Rt) knee pain - needs cortisol shot
Had injury 2 years ago - (He will tell you story)

SUBJECTIVE: Robert returns to office today with sudden onset of knee pain. Patient has a long-standing history of knee pain. Patients had multiple injections of both prednisone and hyaluronic acid in said right knee. Patient is been informed he may need a knee replacement several years ago. Patients Main concerns these had a sudden onset of pain in the past two days. Is now ambulating with a walker. Patient denies any acute trauma to said knee.

PAST MEDICAL HISTORY: noncontributory. **Allergies: NKND**

OBJECTIVE:

General: healthy 68-year-old male gnocchi distress.

chest: Respirations are regular and nonlabored.

Lungs: clear to auscultation bilaterally.

Extremity: mild warmth to the right knee lateral aspect crepitus noted. Significant decreased range of motion with the extension flexion.

Skin: venous insufficiency noted bilateral lower extremity...

LABORATORY: I and R4 .4

radiology: complete loss of joint space with the right knee. Calcifications of the popliteal artery noted.

A/P: Osteoarthritis right knee

1. Vicodin 5/325Q6 hours PRN pain.
2. Due to his INR felt uncomfortable about injection of right knee.
3. Will hold Coumadin tell Monday and have him return with possible injection at that time.
4. Encourage ice and heat alternating to area.
5. If no improvement return to practice standard warnings provided

Mark Randolph PA-C

HOOP0005

Robert Burke
7/6/2010

Mr. Burke is seen as work-in today. He has had a number of issues, many of which relate around the fact that he is working on some plans for trying to increase his physical fitness while realizing the fact that he is limited by a number of physical issues including his significant cardiovascular symptomatology.

He is status post cardiac arrest and anoxic episode followed by an emergency bypass.

He has some short term memory issues and this is very difficult for him to deal with. He is functioning at a very high level of intelligence and has been give lectures, etc., for motivation in basketball strategy.

His atrial fibrillation is currently rate controlled and he is on Coumadin. He is bruising easily and also had significant swelling of ankles particularly when he is up. Most recent problem included some plantar fasciitis and heel pain on the right. Will get Dr. Blackwell to see him regarding this.

His BP is doing well and ankle swelling is really about the same. Renal function is stable with mild renal insufficiency at creatinine of 1.7 and BUN 47. Previous creatinine in 2/2010 was 1.7 with BUN 53. His pro-time is 1.6. We are going to have him continue current dosage but repeat in 2 weeks. He has previously been at this level and without change has increased and do not want to increase him at this point but he will certainly need to be up to a more therapeutic level if he remains under 2 to 2.5.

See him back here on the 19th and spent approximately 45 minutes discussing his other concerns. He has had some arthritic problems with his knee and trying to decide what to do as far as moving forward with disability planning. Also has significant Dupreytens Contracture, most prominently in the 4th finger of the left hand but also to a lesser extent of the 3rd and 4th fingers of the right hand. I will see him back on the 19th or sooner prn.

Thomas E. Hooper, M. D., F. A. C. P./pct

Patient Information

Patient Name	Sex	DOB	SSN
Burke, Robert	Male	[redacted]	[redacted]

Consult NW signed by Stephanie Carol Montgomery- Idema, MD at 1/25/2013 2:19 AM

Author:	Stephanie Carol Montgomery-Idema, MD	Service:	Trauma	Author Type:	Physician
Filed:	1/25/2013 2:19 AM	Note Time:	1/25/2013 1:15 AM		
Related Notes:	Original Note by Alicia Lenora Patterson, MD filed at 1/25/2013 1:26 AM				

ED CONSULTATION

Robert Burke is a 68 y.o. male.
MRN: [redacted]

Consulting Service: Trauma

CHIEF COMPLAINT/REASON FOR CONSULT: Bleeding

68 to male coming to town to visit and tripped over a curb onto the concrete. He is now bleeding from several areas of his left and right arms and also has an enlarging right thigh hematoma. He has atrial fibrillation for which he takes coumadin, and currently his INR is 3.25.

He denies dizziness, confusion, or other mental status changes. He is having pain and throbbing over areas of abrasions and in right thigh and leg.

Past Medical History

Diagnosis	Date
• Diabetes mellitus	
• Coronary artery disease	
• MI (myocardial infarction)	

Past Surgical History

Procedure	Date
• Cardiac surgery	

History

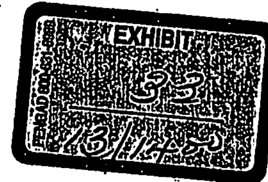
Social History

• Marital Status:	Single
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

Occupational History
• Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Not on file
• Alcohol Use:	No



- Drug Use: No
- Sexually Active:

Other Topics Concern
- Not on file

Social History Narrative
- No narrative on file

Allergies

Allergen	Reactions
• Codeine	

History reviewed. No pertinent family history.

Current facility-administered medications:sodium chloride 0.9 % bolus 1,000 mL, 1,000 mL, Intravenous, Once, Jacob Ian Fulkerson, MD, Last Rate: 500 mL/hr at 01/25/13 0030, 1,000 mL at 01/25/13 0030
Current outpatient prescriptions:furosemide (LASIX) 20 MG tablet, Take 20 mg by mouth 2 (two) times daily. , Disp: , Rfl: ; insulin glargine (LANTUS) 100 unit/mL injection, Inject into the skin nightly. , Disp: , Rfl: ; insulin lispro (HUMALOG) 100 unit/mL injection, Inject into the skin 3 (three) times daily before meals. , Disp: , Rfl: ; warfarin (COUMADIN) 1 MG tablet, Take 1 mg by mouth as directed. , Disp: , Rfl:

REVIEW OF SYSTEMS:
Review of Systems
Constitutional: Negative.
HENT: Negative.
Eyes: Negative.
Respiratory: Negative.
Cardiovascular:
[Previous MI
Gastrointestinal: Negative.
Genitourinary: Negative.
Musculoskeletal:
[B/L leg Mohs procedure, knee arthritis, multiple abrasions with bleeding and thigh hematoma
Neurological: Negative.
Hematological:
[anticoagulated

PHYSICAL EXAM:
Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed. No distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes: EOM are normal.
Neck: Normal range of motion.
Cardiovascular: Normal rate,
Irregularly Irregular
Pulmonary/Chest: Effort normal.
Abdominal: Soft. There is no tenderness. There is no rebound.
Musculoskeletal:
Multiple superficial abrasions to B/L upper extremities with active bleeding, enlarging

Roper Hospital Imaging Services

Name: BURKE, ROBERT
Exam Date: 02/20/13 1635
Ord. Phy.: TSAI-MD, NANCEY T

MR#: [redacted]
DOB: 01/21/40
Pt. Phone#: [redacted]
Ord. Phy.#: [redacted]
Phy. Fax #: [redacted]

TSAI-MD, NANCEY T
96 JONATHAN LUCAS ST
CHARLESTON SC 29425

Acct_Nbr : [redacted]
Pat_Type : RIA

Chk-in #	Order	Exam	
3269151	0209	30226	XR KNEE 3 VIEWS*R Ord Diag: PAINFUL

Right knee AP, crosstable lateral and sunrise: 02/20/13

INDICATION: "PAINFUL".

COMPARISON: None

FINDINGS: Peripheral vascular cavitation present. No discrete effusion or lipohemarthrosis. There is tricompartmental degenerative change with minor osteophytes. There is complete joint space loss medial compartment.

IMPRESSION:
Degenerative changes, negative for fracture or aggressive lesion.

Transcriptionist- MATTHEW J BRADY-MD
Reading Radiologist- MATTHEW J BRADY-MD
Releasing Radiologist- MATTHEW J BRADY-MD
Released Date Time- 02/20/13 1706

Notes (continued)

Providers Only (continued)

Gait	Antalgic	
	Right	Left
Weightbearing		
Inspection	Swelling	Swelling
Alignment	Varus	Varus
Palpation		
Tenderness	Medial condyle	No tenderness
Crepitus	Moderate	None
Swelling	Moderate	None
Effusion	2+	None
Range of Motion		
Flexion (passive)	135	135
Flexion (active)	135	135
Extension (passive)	0	0
Extension (active)	0	0
Meniscus Exam		
Popliteal Cyst	Negative	Negative
McMurray's - Lateral	Not assessed	Not assessed
McMurray's - Medial	Not assessed	Not assessed
Ligament Exam		
Lachman	Negative	Negative
Anterior Drawer	Negative	Negative
Valgus at 20	Negative	Negative
Varus at 20	Negative	Negative
Posterior Drawer	Negative	Negative
Patella Exam		
Apprehension	Negative	Negative
Patella Position	intermediate	intermediate
Vascular/Lymphatic Exam		
Edema	None	None
Venous Stasis Changes	None	None
Distal Circulation	Normal	Normal
Neurologic		
Light Touch Sensation	Intact	Intact

Imaging both knees:
X-rays: 4 views of the knee demonstrate severe medial joint space narrowing and subchondral sclerosis on the right. Minimal involvement on the left.

Assessment/Plan:
The history and examination are consistent with right end-stage knee osteoarthritis. The findings and pathology are discussed with the patient. The initial approach includes the use of analgesics and/or anti-inflammatories (if tolerated), weight control, avoidance of impact exercise, and a strengthening program. The possibility of injections for symptomatic relief and eventual arthroplasty surgery on right are discussed. He

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT
STATE OF SOUTH CAROLINA
CHARLESTON COUNTY

DEPOSITION OF JACK SKELTON

ROBERT J. BURKE and JANE B. BURKE,

Plaintiffs,

vs. Case No.: 2013-CP-10-1400

INDIGO REALTY COMPANY, LLC, REPUBLIC PARKING SYSTEM, INC., and the CITY OF CHARLESTON,

Defendants.

DEPONENT: JACK SKELTON

DATE: MAY 21, 2014

TIME: 9:58 A.M.

LOCATION: McCULLOUGH KHAN, LLC

REPORTED BY: ROLAYNE M. VOLPE, CCR, RPR
CLARK & ASSOCIATES, INC.
P.O. Box 73129
Charleston, SC 29415
(843) 762-6294
www.clark-associates.com
Rolayne@clark-associates.com

A P P E A R A N C E S

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ANDREW L. DINKELACKER
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P.O. Box 13177
Charleston, South Carolina 29422
(843) 762-4567
adinkelacker@wilsonheyward.com
for Indigo Realty Company, LLC

1 I N D E X

DESCRIPTION PAGE

2

DEPONENT: SANDRA LIPTON

3 Examination by Mr. Kahn 4

Examination by Ms. Reynolds 55

4 Examination by Mr. Dinkelacker 86

Examination by Mr. Darling 89

5 Further Examination by Mr. Kahn 92

Further Examination by Ms. Reynolds 92

6 Further Examination by Mr. Dinkelacker 99

7

REPORTER'S CERTIFICATE 101

8

9

10

E X H I B I T S

11 DESCRIPTION PAGE

12 Exhibit No. 1 10

Second Notice of Deposition of Republic Parking

13 System, Inc., 30(b)(6)

14 Exhibit No. 2 31

City of Charleston, Parking Garage Management

15 Agreement, May 1, 2008

16 Exhibit No. 3 45

Republic Parking System, Self-Inspection

17 Checklist

18 Exhibit No. 4 51

Hand Written Note, Kenneth Lee

19

20

21

22

23

24

25

1 JACK SKELTON,
2 having been first duly sworn by the Court Reporter to
3 tell the truth, the whole truth, and nothing but the
4 truth, was examined and testified upon his oath as
5 follows:
6 EXAMINATION
7 BY MR. KAHN:
8 Q Good morning. We met momentarily off the
9 record. Would you please state your full name for the
10 record.
11 A Jack Skelton.
12 Q Thank you, Mr. Skelton. I'm Jamie Khan, and
13 our firm represents the Plaintiffs in an action that
14 was brought here in Charleston County. I'm going to go
15 over a few general rules of depositions. I'm unsure if
16 you've given one prior.
17 First, it's important that we do not talk over
18 each other. There's a court reporter here today that's
19 writing down everything I say and you say and anyone
20 else says in the room. Therefore, it's important, for
21 clarity in the transcript, that I give you a full
22 opportunity to answer the question; and at the same
23 time, you give me a full opportunity to get out my
24 question, even though you may anticipate what I'm
25 asking. Do you understand that?

1 A Yes.

2 Q Okay. The second one is that we must give
3 verbal answers, for purposes of the record, versus
4 uh-huhs and shaking of the head, just for clarity. I
5 think you understand that.

6 Third, it's my understanding, at least, that
7 you work for Republic Parking Systems, Incorporated,
8 and that Mr. Darling is here representing you today.
9 If you have a question about any question I ask, it's
10 important that you direct that question back to me, and
11 I will clarify that for you. This is not a trick
12 contest, and I'm not hiding the ball. I'm simply here
13 to find out what you know about the issues in this
14 case. Do you understand that?

15 A Yes.

16 Q At a certain point -- I don't know that we
17 will get into it too much, but you may hear an
18 objection to what we call the form of the question.
19 That's an issue for us and for the record. If you hear
20 one of those, you should proceed as normal, unless
21 you're instructed not to answer the question, which I
22 don't think we'll get into today. Okay?

23 Having gone over those, Mr. Skelton, do you
24 have any questions for me before we begin?

25 A No, sir.

1 Q Okay. Where do you work, Mr. Skelton?
2 A I work for Republic Parking Systems.
3 Q Okay. And what is your position?
4 A I'm a regional vice president.
5 Q Where are you based out of?
6 A Chattanooga, Tennessee, which is our corporate
7 office.
8 Q Which region are you responsible for?
9 A The eastern half of the United States.
10 Q And how long have you had that position,
11 roughly?
12 A Seven, eight years.
13 Q Okay. Prior to becoming the regional VP for
14 the eastern half of the U.S., did you hold another
15 position with Republic?
16 A Yes. I was a general manager in Houston,
17 Texas.
18 Q Would that be a manager of the parking
19 facilities that Republic had under contract in the
20 Houston area?
21 A Yes.
22 Q Prior to that, did you hold another position
23 with Republic?
24 A No.
25 Q How long were you the general manager in the

1 Houston area?
2 A Approximately two years.
3 Q Okay. By doing the math, is it safe to say
4 that you've worked for Republic for roughly ten years?
5 A Yes.
6 Q Prior to joining Republic, where did you work?
7 A I worked for Central Parking.
8 Q Okay. Did you go to college?
9 A I did.
10 Q Where did you attend?
11 A University of Minnesota.
12 Q Okay. Have you been in the parking industry,
13 so to speak, since graduating from college?
14 A No.
15 Q How long have you been in the parking
16 industry, to include your time at Republic and Central
17 Parking?
18 A Since 1995.
19 Q Okay. Based on your earlier answer, where you
20 gave me a brief description of your duties as regional
21 VP, is there a tier of management below you responsible
22 for a more defined specific region of the southeast or
23 South Carolina or some other type of region as well?
24 A We have district managers that oversee
25 multiple cities within my region.

1 Q So below you, for this general area, there's a
2 district manager; correct?
3 A Correct.
4 Q And what district would that manager oversee?
5 A Presently his name is Wally Bice, and he
6 oversees, basically, Maryland down to Florida.
7 Q Okay. You mentioned an individual's name,
8 Wally. I didn't catch the last name. And can you
9 spell that for us?
10 A Bice, B-i-c-e.
11 Q And how long has Mr. Ice [sic] been the
12 district manager for that region?
13 A He's been employed as a district manager for
14 about four years. He just recently took on the
15 responsibility of additional states, including South
16 Carolina.
17 Q Below that level of management, is there a
18 manager for the State of South Carolina?
19 A No.
20 Q Below Mr. Ice, would the next level of
21 management be a management level position for a
22 particular city or town?
23 A Typically, a general manager is what we would
24 call him.
25 Q Okay. It's my understanding that Republic, at

1 the moment, does not have a contract with the City of
2 Charleston to manage parking; is that correct?
3 A Correct.
4 Q When it did, did it have a GM, general
5 manager, specifically for the City of Charleston?
6 A Yes, sir.
7 Q Who was that?
8 A At what time?
9 Q Okay. Changes -- changes often?
10 A No, it didn't. I was just curious what time.
11 Q Okay. Well, let's -- why don't we just say
12 January of 2013, if you know.
13 A Dwight Potter.
14 Q Dwight Potter?
15 A P-o-t-t-e-r.
16 Q Do you know if Mr. Potter is still employed by
17 Republic?
18 A He is not.
19 Q Who is Scott Titmus?
20 A It's pronounced Titmus.
21 Q Okay.
22 A He is the president.
23 Q Of Republic Parking Systems?
24 A Yes.
25 Q At one point, did he hold your job or another

1 executive vice president job, to your knowledge?
2 A Previous to being president he was executive
3 vice president.
4 Q Okay. And do you report to the executive vice
5 president currently?
6 A There is no executive vice president at this
7 time.
8 Q Okay.
9 (Exhibit Number 1 is marked for
10 identification.)
11 Q Mr. Skelton, I am handing you what has been
12 marked as Exhibit 1. Have you seen that document?
13 A Yes, sir.
14 Q Okay. Have you given a deposition before?
15 A Yes, sir.
16 Q Okay. This is a deposition taken in
17 accordance with a specific rule of the South Carolina
18 Rules of Civil Procedure, and that rule is what we call
19 30(b)(6). And what that allows a party to do is
20 designate general topics they would like to speak to
21 someone about at an entity or a company where we
22 designate the general topics. And then it's generally
23 incumbent upon that company to identify someone that
24 has the knowledge to answer those questions.
25 I'll represent to you that's what we've done

1 here. You've indicated that you have seen this notice.
2 Have you reviewed the general topics that were attached
3 to it?
4 A Yes, sir.
5 Q By your presence here -- I assume that I know
6 the answer to my own question. But by your presence
7 here, I assume that, for Republic Parking Systems,
8 Incorporated, you are the most knowledgeable person to
9 testify on those subjects.
10 A Yes, sir.
11 MR. DARLING: I'm not objecting, but I don't
12 think the rule requires that you provide the person
13 most knowledgeable, but a knowledgeable person about
14 those things.
15 MR. KAHN: That's fair enough.
16 MR. DARLING: I'm not objecting --
17 Q You have the general knowledge to talk about
18 what we want to talk about today?
19 A Yes, sir.
20 Q Okay. Before we get a little more specific, I
21 want to get more of an idea of why you're that person.
22 And I think to get there, I need to discuss your role a
23 little more with Republic. As the regional VP for the
24 area you've described, are you involved with assessing
25 parking lots which Republic is taking under management?

1 A Yes.

2 Q Is there written protocol or written rules for
3 Republic when it comes to undertaking management of
4 particular lots?

5 A Yes.

6 Q That's a broad question. But are those
7 written policies of Republic?

8 A Yes.

9 Q Okay. And is this some form of policy manual
10 of Republic which discusses topics of what Republic
11 does when it's taking over management of lots?

12 A In general, yes.

13 Q Is there a protocol which Republic follows
14 when they are asked to manage a particular lot or a
15 number of lots for a specific entity or government
16 entity?

17 A It depends. It depends often on the client's
18 desires and wishes, since they are the landowner.

19 Q Okay. Were you involved specifically with the
20 assessment of the City of Charleston facilities when
21 Republic undertook the management of those?

22 A Yes.

23 Q Do you know, in that instance, if the City of
24 Charleston reached out to Republic to manage these lots
25 or did they request proposals or how they went about

1 that?
2 A They issued an RFP.
3 Q Were you involved with the response to the
4 RFP?
5 A Yes, sir.
6 Q Is that document available in Republic?
7 A I'm not sure.
8 Q Okay. Who was the primary drafter of the
9 response for the proposal?
10 A Myself.
11 Q As part of the response, did you come to
12 Charleston to conduct assessment or site visits of the
13 facilities?
14 A Yes, sir.
15 Q How many times?
16 A Relative to what?
17 Q To the response of the RFP.
18 A Once.
19 Q Okay. Did you tour the facilities?
20 A Yes, sir.
21 Q Did you tour the parking lot at issue in this
22 case, which I'm going to call the George Street lot?
23 A Yes, sir.
24 Q Just to make sure we understand, I think you
25 know, but that's the lot that has rough borders of

1 George Street, King Street, and Society Street,
2 downtown Charleston?
3 A Yes.
4 Q Okay. When you conducted those site -- that
5 site visit to the City of Charleston, are there any
6 written procedures that Republic uses to evaluate those
7 specific sites?
8 A No.
9 Q And I've seen the agreement. I recognize
10 there are surface lots, there are parking decks, there
11 are a variety of different types of parking locations
12 in this city; correct?
13 A Correct.
14 Q And Republic managed many of those; correct?
15 A Correct.
16 Q Earlier we were talking about specific
17 policies that Republic may have when it comes to
18 management or assessment. And that's where I -- that's
19 what I would like to learn a little more about. When
20 Republic's coming in to a contract, or a management
21 agreement, does it evaluate the facilities against any
22 criteria that Republic may have?
23 A Operationally, we assess the current operation
24 and make recommendations for possible improvements to
25 the client -- to the city.

1 Q And what can that range from? Can that range
2 from making additional cashier stations, or -- or what?
3 A That would be one option. Use of technology;
4 relaying out the lot to gain additional space; better
5 traffic flow.
6 Q Do you know if there were any specific
7 recommendations by Republic made for the George Street
8 lot?
9 A Not that I can recall.
10 Q Prior to May, 2008, which is the date of the
11 management agreement between Republic and the City of
12 Charleston, prior to that date, do you know if a
13 different company managed that particular lot?
14 A They did not. It's been Republic since 1998.
15 Q Okay. Prior to Republic managing it, do you
16 know if another outside company managed it for the
17 City?
18 A They did not. It was run internally by the
19 City.
20 Q Okay. What year, if you know, did you conduct
21 the RFP and your site visit?
22 A 1997.
23 Q Do you know, at that time, if the attendant
24 station and gate arms were in place at the George
25 Street lot?

1 A I believe they were.
2 Q Do you know if Republic ever recommended
3 placing additional parking spaces in the George Street
4 lot?
5 A Not to my knowledge.
6 Q Do you know if Republic actually placed
7 additional parking spaces in the George Street lot?
8 A Not to my knowledge.
9 MR. KAHN: We can go off the record.
10 (A discussion is held off the record.)
11 Q (By Mr. Kahn) I think you may have answered
12 this. If I asked it, I apologize. But you do not
13 recall if Republic made any specific site
14 recommendations with respect to the George Street lot?
15 A Not that I recall.
16 Q Would there be any documents in Republic's
17 files had you done that?
18 A The proposal itself would have contained any
19 recommendations we had come to.
20 Q When you say "proposal," is that the response
21 to the RFP?
22 A Yes, sir.
23 Q Okay. So it was that specific, where Republic
24 actually made site specific recommendations on how they
25 could improve or manage the particular lots?

1 A That would be typical.
2 Q Okay. Do you remember addressing the George
3 Street lot in the RFP?
4 A No, sir.
5 Q Is that something we can flag, the RFP
6 response, that we can see if we can get our hands on?
7 A It should be a City document.
8 Q Okay. Does Republic generally keep their
9 responses to the RFPs as well?
10 A For a period of time.
11 Q Okay. As part of the evaluation process, and
12 in this case, the RFP, but more generally, does
13 Republic assess lots and decks from the standpoint of
14 safety as well?
15 A Yes.
16 Q I've read the management agreement, and we'll
17 talk more specifically about it shortly. But there are
18 certain requirements on Republic when they manage a
19 lot; correct?
20 A Contractually.
21 Q Why would Republic evaluate particular lots
22 from the standpoint of safety and hazardous conditions?
23 A It's part of our duty to the client. We also
24 provide the insurance and name the clients, typically,
25 as an additional insurer. So it's in our best interest

1 to minimize any risk.
2 Q Do you know if Republic obtained insurance on
3 behalf of the City of Charleston for these specific
4 lots?
5 A Yes.
6 Q When you evaluate a particular lot for safety
7 and potential dangerous conditions, what would that
8 evaluation include?
9 A Surface conditions, possible trip hazards,
10 lighting, drainage, signage, vegetation.
11 Q Those topics you just mentioned, were
12 those topics evaluated with respect to the City of
13 Charleston?
14 A I would expect they were, but I can't recall
15 for sure.
16 Q Next question was specifically the George
17 Street lot. Do you know if those general evaluation
18 subjects were evaluated at the George Street lot?
19 A It would be typical of our course of doing
20 business.
21 Q Okay. I recognize you're probably one of many
22 that participate in that evaluation process and RFP.
23 Are there specific individuals within Republic whose
24 duty it is to do those things you mentioned?
25 A Yes.

1 Q Are those engineers or field operations
2 personnel?
3 A Not engineers. They're operational managers.
4 Q Okay. Did one of those individuals accompany
5 you on the trip to Charleston?
6 A Yes.
7 Q Okay. Do you know who that was?
8 A Scott Titmus, Eric Teter, and there was one
9 other gentleman. I can't recall his name at the
10 moment.
11 Q Okay. Scott Titmus we talked about before.
12 He's now the president of Republic; correct?
13 A Yes.
14 Q Okay. What was his part in that trip?
15 A Helping in preparation of the proposal.
16 Q And Eric Teter, you mentioned, what was his
17 involvement?
18 A Same.
19 Q Okay. Was Mr. Teter one of the field
20 operations people you described?
21 A At the time, he was the vice president.
22 Q Okay. Was he also one of the folks that you
23 described as to evaluate those subjects you mentioned?
24 A Yes.
25 Q You mentioned there was a third -- I guess,

1 fourth individual. I know you can't recall his name,
2 but what aspect of this did he have?
3 A We all filled a common role of evaluating the
4 operations.
5 Q You indicated surface issues, trip hazards,
6 lighting, drainage, signage, vegetation. Would you
7 four who came on that trip been the ones to evaluate
8 that?
9 A Yes.
10 Q Were any other individuals with further
11 expertise in those particular areas consulted with
12 respect to the George Street lot?
13 A No.
14 Q Did you -- how long did you stay in Charleston
15 during that trip?
16 A I believe it was two days.
17 Q Okay. Did you evaluate the facilities both
18 during the day and at night?
19 A I cannot recall.
20 Q Okay. What is your general practice when you
21 go on a site visit?
22 A There is no general practice.
23 Q Okay. Do you recall ever having evaluated
24 parking lots both during the day and at night?
25 A Yes, sir.

1 Q Why would you do that?
2 A Mostly for traffic, parking demand studies.
3 Q And when you say parking demand studies, do
4 you actually perform any data collection yourself on
5 those visits?
6 A Yes.
7 Q Okay. Is that with particular devices to
8 measure counts?
9 A Eyeballs.
10 Q Okay. Fair enough. And that is -- I don't
11 do what you do, so I may not know. But is that
12 essentially eyeballing the lot, roughly counting the
13 amount of vehicles in it, and the traffic going in and
14 out type of operation?
15 A Typically, yes.
16 Q If you do it a different way, I'd like for you
17 to explain how you do that.
18 A There's a number of methods. One, you can
19 actually videotape the operation and go back and
20 monitor that later. Two, you can buy a ticket at a
21 certain time, come back at a later time, buy another
22 ticket; and the tickets are sequentially numbered, so
23 you can extrapolate how many vehicles entered the lot
24 during a set period of time.
25 Q I see. So this particular visit that you four

1 gentlemen came on, was that a visit coordinated with
2 the City of Charleston, or was that the visit that you
3 came on your own to gather information?
4 A It was on our own to gather information.
5 Q So in this particular instance, this RFP visit
6 to Charleston, did the City even know that you were
7 here?
8 A No.
9 Q I've responded to RFPs before myself, and I
10 understand they're voluminous, and you need to enter a
11 lot of data, especially if you want to be competitive,
12 correct, in the actual process?
13 A Each RFP lays out what they want included in
14 the submittal. So typically we're restricted by what
15 the potential client is asking for.
16 Q There's a -- there was a fair amount of City
17 of Charleston facilities managed by Republic under your
18 agreement; correct?
19 A Yes, sir.
20 Q How does that relate generally to a
21 municipality agreement that Republic -- agreements that
22 Republic enters into?
23 A They range widely.
24 Q Obviously, when you're in Houston, I'm sure
25 the City of Houston has a large amount of parking

1 facilities; correct?
2 A Yes, sir.
3 Q Would you say that the amount of facilities
4 managed for the City of Charleston was a fair amount?
5 A If you're measuring by number of facilities,
6 it's one of the larger ones.
7 Q Okay. One of the larger management agreements
8 that Republic had at the time?
9 A Yes.
10 Q We talked about the methods that Republic
11 employed for attempting to gather data on traffic
12 and -- I forgot the word you used, but, I guess,
13 volume. Did you do that at multiple lots, that you
14 can recall?
15 A I can't recall the specifics from 1997,
16 but. . .
17 Q Okay. You mentioned one point of evaluation
18 was trip hazards, and you also mentioned lighting. How
19 did you four gentlemen assess the George Street lot for
20 trip hazards and lighting?
21 A I can't recall specifically about that
22 particular lot.
23 Q Do you recall how you did that specifically
24 for any of the lots at the City of Charleston when you
25 came to visit?

1 A I can only comment typically what we would do.
2 Q What would be a typical evaluation of those
3 two items?
4 A Lighting, we would want to make sure that
5 it was sufficient to see your pathway and also for
6 the lot to be visible for cars to enter the lot.
7 Marketing-wise: On the trip hazards, we would look for
8 uneven pavement, potholes, conduits, overgrowth of
9 vegetation.
10 Q As to the trip hazard general evaluation,
11 would you also look at placement of parking spaces?
12 A Potentially.
13 Q Okay. Those two topics you discussed, the
14 lighting and the trip hazards, I understand that to be
15 generally what you would do; correct?
16 A Yes.
17 Q As you sit here today, do you know if you
18 performed those two functions here at the City of
19 Charleston during your site visit?
20 A I can't recall specifically during that visit.
21 Q And I think the same answer exists
22 specifically as to the George Street lot?
23 A Yes, sir.
24 Q Okay. I know it's going back to 1997, but
25 when you viewed the George Street lot, do you know if

1 you viewed it during the daytime or at nighttime?
2 A I do not recall.
3 Q Okay. Do you recall if anything remarkable
4 stood out to you as to the George Street lot?
5 A No.
6 Q That was in 1997. Did you ever come back to
7 the City of Charleston to evaluate the facilities --
8 A Yes.
9 Q -- since -- I'm sorry. Go ahead.
10 A Yes.
11 Q Okay. Question, going back to the lighting,
12 you indicated that generally you would evaluate it to
13 see if there was sufficient lighting, to see pathways,
14 and for folks to see the lot for marketing purposes?
15 A Correct.
16 Q How do you make the determination whether or
17 not the light or lighting is sufficient?
18 A Eyeball.
19 Q Do you have any specific training in measuring
20 ambient lighting?
21 A No, sir.
22 Q Do you or Republic generally use light meters
23 or any other devices to measure light?
24 A No, sir.
25 Q You've been with Republic for quite some time;

1 correct?
2 A Yes.
3 Q And do you roughly know how many individual
4 parking locations are under your management?
5 A Mine specifically?
6 Q Correct. Roughly.
7 A 350.
8 Q Okay. Based on your experience with Republic,
9 has there ever been an issue where Republic questioned
10 the sufficiency of a lighting in a parking lot?
11 A Yes.
12 Q Was that in the City of Charleston, or outside
13 the City of Charleston?
14 A I don't recall any issues in Charleston, but I
15 do recall other issues outside of Charleston.
16 Q Has Republic ever had a lot or parking
17 facility tested for sufficiency of illumination?
18 A I'm sure we have, but I can't recall any
19 specifics.
20 Q Okay. Based on that, I assume from your
21 answers that -- well, I'll just ask. Has Republic ever
22 tested the sufficiency of the lighting at the George
23 Street lot location?
24 A Not that I'm aware of.
25 Q The incident that you recall, where there was

1 sufficiency illumination at issue, can you briefly tell
2 me what the issue was in that instance?
3 A We've had a lot in Houston, Texas, that was in
4 a bar district, and we recommended to the owner that
5 they put additional lights on the lot to make it more
6 visible to the public, and also to make it appear
7 safety-wise to be better to the public.
8 Q Was there an incident that occurred which led
9 to that recommendation?
10 A No.
11 Q Is the sufficiency of illumination or lighting
12 related to safety within the lot?
13 MR. DARLING: Object to the form.
14 A No. For that specific instance?
15 Q No, I'm just asking. Is illumination related
16 to safety in a particular lot?
17 MR. DARLING: Object to the form.
18 A Typically it is.
19 Q Why would that be?
20 A Common sense. People need to be able to see
21 where they are walking, see their vehicles.
22 Q You indicated that there -- you, at least, had
23 one subsequent visit to Charleston after your site
24 visit in 1997. Did you routinely make trips to various
25 facilities under management in your region?

1 A Yes.
2 Q Did you make it a practice to come to the City
3 at various specific intervals, or did you come when
4 needed?
5 A A mixture of both.
6 Q We talked about a group of four coming in 1997
7 to evaluate the facilities in response to the RFP.
8 Based on that evaluation and based on your submittal,
9 did Republic win the agreement under that submission?
10 A Yes.
11 Q Subsequent to that, did you or this particular
12 team or any other team come to evaluate the specific
13 facilities further?
14 A Yes.
15 Q Why would you have done that?
16 A Course of our management obligation to the
17 company.
18 Q And would that have been under the same
19 subject matter as the first visit, as far as assessment
20 of these particular lots, or was that -- did that have
21 a different subject matter?
22 A It would be of the same mind-set.
23 Q Okay. Was that in the mind-set of, how do we
24 improve these particular lots for purposes of revenue,
25 improvements, and things of that nature?

1 A Yes.
2 Q Okay. I assume Republic put certain things in
3 the RFP that they would do to improve the parking
4 facilities, if they are the company that is hired to do
5 so; correct?
6 MR. DARLING: Object to the form.
7 A Yes. We made very specific recommendations to
8 improve the operations.
9 Q Were those subsequent site visits to
10 coordinate with the City of Charleston on those
11 recommendations?
12 A Yes, sir.
13 Q Okay. We're not going to sit here today
14 and go through your memory of all the specific
15 recommendations that you made. But do you recall any
16 specifically related to the George Street lot?
17 A No, sir.
18 Q Okay. Do you recall any implementation of any
19 changes to the George Street lot after Republic took
20 over management?
21 A No, sir. In fact, it looks very similar to
22 what it did back in 1997.
23 Q Okay. Do you know if any of the
24 recommendations for the City of Charleston, under the
25 management agreement, included any illumination

1 matters?
2 A Not that I recall.
3 Q Can you give me an example of some of the
4 recommendations made -- maybe three -- that were
5 implemented under the agreement with the City of
6 Charleston?
7 A If I recall correctly, the City was very
8 reluctant to change much operationally. The primary
9 changes were done on the back end auditing and revenue
10 control of the existing operation.
11 Q So physically speaking, you can't -- can you
12 recall any physical adjustments made to any of the
13 particular lots?
14 A No.
15 Q Does that mean that they didn't occur, or you
16 just can't recall them?
17 A I can't recall any.
18 Q Had there been any modifications, would you
19 have known about them?
20 A Yes.
21 Q After Republic -- I use the term "won," but I
22 don't know what the right term is -- was awarded the
23 agreement -- the management agreement based on the RFP,
24 did you personally have any input on the management
25 agreement that was eventually agreed to with the City?

1 A Yes.
2 Q Do you know who drafted this agreement?
3 A If memory serves me, it was Lottie, and I
4 cannot recall her last name. She worked for the mayor
5 at the time.
6 Q Okay. So the City of Charleston provided the
7 initial document?
8 A That, I'm not sure. We may have given them a
9 sample of another contact. I can't say for sure.
10 Q Like any agreement, do you recall if there was
11 revisions back and forth between the City and Republic?
12 A Not specifically.
13 Q Okay.
14 (Exhibit Number 2 is marked for
15 identification.)
16 Q Mr. Skelton, I'm handing you what's been
17 marked as Exhibit 2. I know we've been talking about
18 the, quote, agreement. Do you recognize that document
19 in Exhibit 2?
20 A Yes.
21 Q Is this a copy of an agreement between the
22 City and Republic for management of its parking?
23 A Yes, sir.
24 Q Do you know if that agreement covers the lot
25 at issue in this case, the George Street location?

1 A Yes, it does.

2 Q We were talking about the evolution of the

3 written agreement. Did you have any input on the

4 language in this particular agreement that's in

5 Exhibit 2?

6 A No, sir.

7 Q Okay. Why would you have not had any input on

8 that agreement?

9 A At the time of signing this agreement, I was

10 not responsible for this territory.

11 Q Okay. Was your responsibility for this

12 territory postdated, the date of this agreement?

13 A Technically before and after.

14 Q Okay.

15 A Yes.

16 Q Before 2008 -- I'm not a math person, but,

17 roughly, it appeared that you may have been in the

18 Houston market. But did you have responsibility for

19 South Carolina at one time, and then did your

20 responsibility change?

21 A Yes.

22 Q Okay. When you had responsibility for the

23 Charleston market, let's call it -- I assume that's,

24 roughly, in 1997, because you were involved in this

25 process; correct?

1 A I assisted with the RFP preparation before I
2 was responsible for the territory.
3 Q And you're currently responsible for the
4 territory; correct?
5 A Yes, sir.
6 Q Okay. Are you aware of any issues or
7 complaints related to lighting at the George Street lot
8 location?
9 A No.
10 Q Based on your answer, I assume, during the
11 entire time you were responsible for this territory,
12 that issue never came up?
13 A Correct.
14 Q Besides lighting, are you aware of any other
15 complaints as to any -- what we'll call hazardous
16 conditions at the George Street lot?
17 A Not that I'm aware of.
18 Q Do you know if the lights that are currently
19 in the George Street lot existed in the same form when
20 Republic took over management of the facility?
21 A I couldn't say for sure.
22 Q I don't want to know any discussions you may
23 have had with Mr. Darling, but have you made a site
24 visit to this particular lot -- the George Street lot
25 recently?

1 A Not physically.
2 Q When you say not physically, how did you make
3 that?
4 A Google.
5 Q Okay. So you viewed the lot on Google Earth?
6 A Yes, sir.
7 Q Or some form of map; correct?
8 A Yes. Great tool.
9 Q Do you know the last time you actually visited
10 the site physically?
11 A Approximately 2000.
12 Q The year 2000?
13 A Yes.
14 Q Why would it have been at that particular
15 year?
16 A I was responsible for Charleston about that
17 time.
18 Q What was your position within Republic at that
19 time?
20 A Regional manager.
21 Q Okay. Approximately what years were you the
22 regional manager with Republic for the City of
23 Charleston?
24 A 1998, and then again in 2000, 2001,
25 approximately.

1 Q And you were the regional manager for what
2 area?
3 A Would have been the southeast.
4 Q Okay. And I'm sorry, I'm just confused. It's
5 nothing you've done. But did you then go to Houston
6 after last performing the regional management duties
7 for the southeast?
8 A I had two stints in Houston.
9 Q Okay.
10 A Two separate stints.
11 Q Okay. When you left regional management of
12 the southeast the last time, roughly, when was that?
13 A It would have been, if I recall correctly,
14 2001.
15 Q Okay. Did you go to Houston then?
16 A I went to South America.
17 Q For Republic?
18 A Yes.
19 Q Okay. Where did you next go then?
20 A Houston.
21 Q Roughly, in what year?
22 A Now you're making me do math.
23 MR. DARLING: I object to the form.
24 A 2001, 2002, approximately.
25 Q Okay. And just to clarify again, you're now

1 the regional vice president for Republic Parking;
2 correct?
3 A Yes.
4 Q And that is essentially the eastern seaboard
5 -- or excuse me, the eastern half of the United States;
6 correct?
7 A Correct.
8 Q And you've held that particular position for
9 how long?
10 A For seven years.
11 Q Okay. So roughly, 2007?
12 A Yes.
13 Q But just to go back to the question again. So
14 the last time physically you were on the George Street
15 lot was roughly the year 2000?
16 A I believe so.
17 Q Do you know why you were there at that point?
18 A Can't recall specifically why.
19 Q Okay. Earlier we talked about the due
20 diligence generally performed by Republic when taking
21 over management of a lot; correct?
22 A Yes.
23 Q And I asked you why Republic might do that.
24 I'm not going to put words in your mouth, but you
25 indicated that was some form of duty to your client;

1 correct?
2 MR. DARLING: Object to the form. You did put
3 words in his mouth.
4 Q I'll just ask it again. Why does Republic do
5 the evaluation that you mentioned generally for surface
6 conditions, trip hazards, lighting, drainage, signage,
7 and vegetation?
8 A To perform our duties to the client, live up
9 to the contractual obligations, minimize our own risk
10 exposure on our insurance that we're required to carry.
11 Q When Republic manages a facility, is Republic
12 responsible to keep the facility free from hazardous
13 condition?
14 MR. DARLING: Object to the form.
15 A Not necessarily.
16 Q Would that be a function of the contract
17 between the parties?
18 A Yes.
19 Q Okay. I am going to point you to Article III
20 of Exhibit 2, which begins on the fourth page of the
21 document. Did you locate that Article III?
22 A Yes.
23 Q Okay. I'm sorry. I'm going to take you to
24 Article IV. Article IV, Section 4.1, by my reading, is
25 styled, Maintenance of the Parking Facility; correct?

1 A Yes.
2 Q 4.1(a) is titled General Upkeep; correct?
3 A Correct.
4 Q 4.1(a)(1)(b) states: Republic shall, as part
5 of the Operating Advance, perform the following: Keep
6 the facilities in a properly maintained state, free
7 from hazardous condition and deterioration, normal wear
8 and tear excepted.
9 Did I read that correctly?
10 A Yes.
11 Q My question before, as to responsibility to
12 keep the facilities free from hazardous condition, you
13 answered that with, that depends; correct?
14 A Yes.
15 Q Okay. And we then discussed that that
16 probably depended on the contract between the parties;
17 correct?
18 A Correct.
19 Q What we just read here in Article IV of
20 Exhibit 2, under this agreement, did Republic have the
21 obligation to keep the facilities free from hazardous
22 conditions?
23 A Correct, in the context of the remaining
24 provisions of the agreement.
25 Q Understood. And when you indicate in the

1 context of the remaining provisions, what do you
2 specifically mean by that?
3 A Some areas, the City's control of the budget,
4 the City's obligations spelled out within the
5 agreement, and the City's control of our operating
6 practices.
7 Q Does Republic ever, as a matter of course, for
8 the facilities it has under management, monitor
9 specifically lighting conditions at those facilities?
10 A Can you repeat that?
11 Q Sure. Does Republic, as a matter of course,
12 for the facilities it has under management, monitor
13 lighting conditions at those facilities?
14 A Yes.
15 Q How is that done?
16 A Visual inspection.
17 Q Is that a visual inspection of the employees
18 that are on-site?
19 A In part.
20 Q Okay. What would the other part be?
21 A Someone like myself visiting the city and
22 touring the facilities to be aware of lighting.
23 Q We'll talk briefly in a moment. We won't go
24 through all of them. But I've seen in this case some
25 inspection checklists as to the facilities. Are you

1 aware of those documents?
2 A Yes, sir.
3 MR. DARLING: I don't mean to interrupt.
4 MR. KAHN: Sure.
5 MR. DARLING: By that you mean the quarterly
6 inspections that Republic did?
7 MR. KAHN: Yes, sir.
8 Q The quarterly inspection checklist?
9 A Yes, that's what I was referring to.
10 Q Okay. Is that a document that is used by
11 Republic nationwide to do its quarterly inspections of
12 the lots?
13 A Yes.
14 Q Who are those inspections performed by, on
15 that specific document?
16 A Typically it would be the senior management
17 team within each city.
18 Q Okay. In January of 2013, I think you
19 mentioned the GM was Dwight Potter; correct?
20 A Yes.
21 Q In that time frame, generally, would he be
22 expected to be the one to have completed those forms?
23 A He or his designees.
24 Q Okay. To your knowledge, has Republic ever
25 faced a situation where it had a lot under management,

1 and Republic deemed the lighting to be insufficient at
2 that facility?
3 MR. DARLING: Object to the form.
4 A Yes.
5 Q Is there a specific instance that you recall,
6 based on that answer?
7 A One I can recall is the Houston example I had
8 given you previously.
9 Q Okay. In that scenario, what was the issue?
10 Were there not enough lights? Were the lights too dim?
11 What do you recall about that?
12 A In that particular case, there was not enough
13 light fixtures.
14 Q And was that a facility you had under
15 management for the City of Houston?
16 A No, sir.
17 Q You managed it for a private company?
18 A Yes.
19 Q What did Republic do in that instance?
20 A If I recall correctly, we invested in the
21 property to improve the pavement and add additional
22 light fixtures on behalf of the client.
23 Q The insufficiency of the lighting, was that
24 something Republic noticed on its own?
25 A Yes.

1 Q Okay. Did Republic then bring that to the
2 attention of the property owner?
3 A Yes.
4 Q I guess, based on those discussions, the
5 lighting was improved?
6 A Yes.
7 Q In that instance, who paid for the
8 improvements?
9 A If I recall correctly, we fronted the capital
10 investment, but it was worked out in the terms of
11 -- the financial terms of the contract itself.
12 Q You're the regional vice president for half
13 the nation. And as I understand your testimony, the
14 inspections of the facility are generally performed by
15 the local general manager or his designee; correct?
16 A You're referring to the quarterly inspections?
17 Q Yes, sir.
18 A Yes.
19 Q If a condition is not noted to be deficient on
20 a quarterly inspection report, higher level management
21 would probably not know of an issue; correct?
22 A That would depend on the circumstances.
23 Q Okay. You clarified the quarterly inspection
24 report with me when I asked that question. Is there an
25 additional layer of inspections that are done in

1 addition to the quarterly inspections?
2 A Inspections are ongoing as part of our course
3 of management by all layers of employees.
4 Q Okay. Above the GM level, Mr. Potter, as it
5 relates to the City of Charleston, are there any
6 written required inspections that would have been
7 performed on these facilities?
8 A Our operations manual has guidelines for what
9 you should observe in a parking operation.
10 Q Okay. This operations manual, is that
11 something someone in the position of Mr. Potter has at
12 his disposal?
13 A Yes.
14 Q What is the title of the operations manual, to
15 your knowledge?
16 A Typically it's operations manual.
17 Q Okay. So there is a Republic Parking
18 operations manual that exists?
19 A We have a template which is customized for
20 each specific operation.
21 Q For each client?
22 A Typically it's for each client.
23 Q Okay. So is there one that exists for
24 fulfillment of the City of Charleston agreement?
25 A I believe so.

1 Q Does that operations manual speak to lighting
2 requirements?
3 A I would have to reference the specific
4 document to answer that question.
5 Q Okay. And what I'm just trying to clarify is,
6 I know there's quarterly inspection reports. I know
7 that you told me that you haven't been on-site since
8 2000. Are there any writings which document
9 inspections of the George Street lot besides the
10 quarterly inspection reports we have?
11 A There should be maintenance checklists, but I
12 couldn't say for sure if they exist or not.
13 Q Okay. Do you know if the George Street lot
14 was initially to be only used as a day lot?
15 MR. DARLING: You talking about before
16 Republic got involved?
17 MR. KAHN: I don't know.
18 MR. DARLING: I object to the form of the
19 question.
20 A I'm not sure.
21 Q Do you know if George Street, at the time
22 Republic managed it, was a 24-hour lot?
23 A I believe it was.
24 Q Okay. How would Republic know if a lot is
25 simply too dark, which would give rise to safety

1 issues?

2 A Visual inspections.

3 Q And by that, do you mean the quarterly visual

4 inspections?

5 A No. It would be every employee is obligated

6 to note any safety hazards, any lighting issues on the

7 lot.

8 Q And based on that, would that be the

9 subjective interpretation of that -- of those

10 employees?

11 A Yes. We employ no engineers in that regard.

12 (Exhibit Number 3 is marked for

13 identification.)

14 Q Mr. Skelton, I've marked Exhibit 3. Do you

15 recognize that type of document?

16 A Yes.

17 Q Okay. What generally is that?

18 A This is a quarterly self-inspection checklist.

19 Q And we've talked a little bit about these, but

20 are these documents -- these form documents in the

21 files of the general manager of a particular vicinity

22 that's under management?

23 A They should be.

24 Q And is the general manager required to

25 complete these by a specific date per year or per

1 quarter?
2 A Yes.
3 Q And when a general manager completes one of
4 these, what does he then do with it?
5 A It's sent to our corporate insurance
6 department.
7 Q Is that at the same location where you
8 currently work out of?
9 A Yes. a different suite, but the same
10 building.
11 Q You said insurance department. Tell me a
12 little more about that department. Is it insurance or
13 is it operations or is it both?
14 A The insurance department is -- primarily deals
15 with liability insurance, health insurance, workers'
16 comp.
17 Q Okay. Does this document, Exhibit 3, one of
18 these quarterly inspections, does it come up the chain
19 at all to the district manager of the region?
20 A If there's an issue noted.
21 Q Okay. Would it ever -- would one ever rise to
22 your level, the regional vice president?
23 A Possibly.
24 Q Okay. If I'm Dwight Potter, I complete one of
25 these, and in this case on July 27th, 2012; correct?

1 A This particular one, yes.
2 Q And how does he transmit it to this insurance
3 department?
4 A I couldn't say for sure how it was
5 transmitted, but it likely was sent via FedEx.
6 Q If an issue is noted, is there any protocol
7 from there with the insurance department?
8 A Protocol would be for them to follow up with
9 the on-site manager to make sure it was resolved.
10 Q When would a district manager have an
11 opportunity to view that under that scenario?
12 A It would be at the discretion of our
13 insurance department to evaluate it.
14 Q So it goes to the general manager to the
15 insurance department, and then the insurance department
16 would get the district manager involved, if necessary?
17 A Yes.
18 Q Okay. As to Exhibit 3, on the front face of
19 it, the first area in Section A is identified and says,
20 Parking areas well illuminated with designated
21 entrances, exits, and directional signs; correct?
22 A Yes, it does.
23 Q In this particular instance, there's a
24 checkmark for yes; correct?
25 A Correct.

1 Q Is there any training given to the folks
2 completing these to determine what is well illuminated
3 and what is not?
4 A No.
5 Q Based on this, Exhibit 3 --
6 I can't tell who completed this.
7 -- is there anything on here that would give
8 you an indication of who filled this out?
9 A Not that I see.
10 Q On the bottom, it says -- there's a space that
11 says: CO, slash, lot number, and in it is written 440;
12 correct?
13 A Correct.
14 Q Is that a numerical given by Republic to that
15 particular lot?
16 A Yes. It's the account number.
17 Q Okay.
18 A The lot number.
19 Q Is this the same self-inspection checklist
20 that is used by Republic nationally?
21 A Yes.
22 Q Is this the same document that's still used
23 today?
24 A Yes.
25 Q Other than Exhibit 3, are you aware of any

1 other checklist document that Republic uses that
2 touches on lighting or illumination?
3 A The only other document would be a maintenance
4 checklist, which should be done regularly by the
5 general manager.
6 Q Okay. Mr. Skelton, when did you learn,
7 approximately, of the incident that we're here for
8 today?
9 A A few months back.
10 Q Are you the nonlegal representative of
11 Republic that's responsible at all for this claim?
12 A Yes, I've been designated as such.
13 Q Okay. Are you aware if the City of Charleston
14 has requested Republic to indemnify it in this case?
15 A I'm not aware of the details of that.
16 Q Are you aware at all of it?
17 A Of what?
18 Q Well, I asked a question, and you said, I'm
19 not aware of the details of that. And I said, are you
20 aware at all of it?
21 A That the City has formally requested
22 indemnification?
23 Q Right.
24 A No, I'm not.
25 Q So you have no knowledge as to whether they

1 have or have not?
2 A I couldn't say for sure, no.
3 Q Okay. Does Republic have a form document
4 that's used for any incidents or injuries which takes
5 place on a facility that it has under management?
6 A Yes, sir.
7 Q Who has those form documents? Is that the
8 general manager?
9 A Are you referring to blank forms?
10 Q Correct.
11 A Yes.
12 Q Is there a protocol that's in place for the
13 completion or documentation of any incidents on your
14 facilities?
15 A Yes.
16 Q The general manager does not work 24/7;
17 correct?
18 A That is correct.
19 Q What does your operations manual, or any
20 other policy you have, say about employees reporting
21 incidents?
22 A They're supposed to promptly report them,
23 based on the incident itself, to the different
24 entities, whether it be the police, fire, ambulance, a
25 client.

1 Q What about internally to their superiors at
2 Republic?
3 A It's typically after the incident has been
4 dealt with, they are to notify the corporate office of
5 an incident.
6 Q Is that done on a particular document?
7 A Yes.
8 Q And is that something that's entitled, like,
9 Republic Incident Report or something of that nature?
10 A I think you nailed it.
11 Q Do you know if one of those has been completed
12 in this particular case?
13 A I would expect it has.
14 Q Have you seen one that's been completed?
15 A Not that I recall.
16 Q Should one have been completed?
17 MR. DARLING: Object to the form.
18 A It depends when we were alerted of the
19 incident.
20 Q Okay. Do you have a policy that requires
21 employees to document an incident where someone is
22 injured on a lot you manage?
23 A Yes.
24 (Exhibit Number 4 is marked for
25 identification.)

1 Q I'm going to hand you what's been marked
2 as Exhibit 4. Have you ever seen that before,
3 Mr. Skelton, before now?
4 A Not that I recall.
5 Q Okay. Have you personally talked with any
6 employees of Republic that were either a witness to
7 this incident or had knowledge of it?
8 MR. DARLING: I'm going to object. That goes
9 beyond the scope of the 30(b)(6) deposition. I'm going
10 to let him answer, but I'm not going to let you go too
11 far.
12 MR. KAHN: Understood.
13 MR. DARLING: Okay. Thanks.
14 A Other than our insurance department, no.
15 Q Do you know a Kenneth Lee, by any chance?
16 A No.
17 Q What I've marked as Exhibit 4 appears to be a
18 statement on a lined piece of paper; correct?
19 A It appears to be.
20 Q Would you expect that there be further
21 documentation of an incident than what's been marked on
22 Exhibit 4?
23 MR. DARLING: Object to the form.
24 A Typically there should be.
25 Q Do you have any knowledge of the City's

1 involvement -- the City of Charleston's involvement in
2 inspecting these particular facilities that were under
3 management?
4 A No.
5 Q Are you aware of any City of Charleston
6 performed repairs or modifications to the George Street
7 facility during the time Republic had it under
8 management?
9 A Not specifically.
10 Q Do you know what the gross revenues from the
11 George Street lot were by year?
12 MR. DARLING: I'm going to object to the form
13 of that question and reserve and preserve my objection
14 to the financial information. Subject to that
15 objection, I'm going to allow him to answer that
16 question, however. Because I know you asked about it
17 in your 30(b)(6).
18 MR. KAHN: And your objection is, the
19 financial --
20 MR. DARLING: -- is irrelevant.
21 MR. KAHN: Right. And you probably dealt with
22 that with Clay in written discovery?
23 MR. DARLING: I have.
24 Q (By Mr. Kahn) As you sit here today, do you
25 know the gross revenues for the George Street location

1 for any particular year?
2 A Prior to coming to the deposition, I reviewed
3 the 2012 financials, and it was approximately $660,000
4 in gross revenue?
5 Q From George Street?
6 A Yes.
7 Q Did you review any other year besides 2012?
8 A The previous year, and they were about the
9 same, a slight increase in the latter year.
10 Q I asked about gross revenues, and that's, I
11 believe, the answer you gave me; correct?
12 A Yes.
13 Q Do you know what the net profit, after
14 operating expense, is as to the George Street location
15 for the year 2012?
16 A Net profit to the City?
17 Q I assume that's how it would have been done,
18 based on the way the management fees were calculated.
19 A It would be -- according to the financial
20 reporting that we provide to the City, it would be
21 under 100,000 a year.
22 Q Okay. Do you know where Dwight Potter is
23 employed at this current time?
24 A I believe he's employed by our predecessor.
25 MR. DARLING: Successor?

1 A Yeah, you are right.
2 Q Who is the successor?
3 A ABM.
4 Q Do you know if he's still a district -- or a
5 general manager? Excuse me.
6 A I believe so.
7 MR. KAHN: Okay. I think that's all I have.
8 MR. DINKELACKER: I'll pass on to you.
9 MR. DARLING: Do you need a short break?
10 MS. REYNOLDS: Yeah, if we could. Can we get
11 a quick break?
12 MR. KAHN: Real quick. Mr. Skelton, I just
13 want to say, because the deposition is ongoing, you
14 can't discuss your testimony with anyone during the
15 break.
16 THE DEPONENT: Understood.
17 (A break is taken from 11:26 a.m. until
18 11:32 a.m.)
19 EXAMINATION
20 BY MS. REYNOLDS:
21 Q Mr. Skelton, my name is Lisa Reynolds, and I'm
22 here on behalf of the City of Charleston. I've got a
23 couple of follow-up questions. And I apologize if I
24 sort of jump around a little bit, but I'm going to
25 really try hard not to replow any ground that's already

1 been done.
2 Can you briefly give your education for me?
3 A Education?
4 Q (Moves head up and down.)
5 A Received a Bachelor of Arts from the
6 University of Minnesota and a J.D. from Hamline
7 University.
8 Q What was your Bachelor of Arts in?
9 A Political science and sociology.
10 Q And what year did you get that?
11 A It would have been 1990.
12 Q And you said you got your J.D. from Hamline
13 University?
14 A Yes, ma'am.
15 Q What year did you graduate from Hamline?
16 A 1993.
17 Q Did you sit for the bar?
18 A I did.
19 Q Have you sat for more than one bar?
20 A No.
21 Q What state did you take the bar for?
22 A Minnesota.
23 Q Did you practice in Minnesota?
24 A I did.
25 Q How long?

1 A Less than two years.
2 Q And what did you practice?
3 A Anything that people would hire me to do, as
4 you young lawyers know.
5 Q Are you a member of any civic organizations or
6 national organizations?
7 A The IPI, International Parking Institute.
8 Q Okay. After you got the J.D. from Hamline,
9 you practiced for about two years. So we're probably
10 up to about 1995. And that's when you went into the
11 parking business; am I correct?
12 A Yes, ma'am.
13 Q It has nothing to do with it, but how did you
14 transition from lawyer to parking?
15 A See, this is my old joke. I moved one ladder
16 up the food chain. Sorry.
17 Q That's okay.
18 MR. DARLING: That's good.
19 Q We're like cops. Everybody has something bad
20 to say about us until they need us.
21 A Uh-huh.
22 Q After your graduation from Hamline, did you
23 receive any additional educational training in any. . .
24 A Couple of CLE classes.
25 Q Any training or education -- formal training

1 or education in, say, parking or business management?
2 Anything after?
3 A No.
4 Q In 1995 -- if you can, and just in overall
5 details, take me from 1995 to when you joined Republic
6 Parking Services, in your work history.
7 A I'll do the best I can.
8 Q Yes, sir.
9 A I began with Central Parking System for a
10 couple of years in Houston, and then went to work for
11 Republic for about two years in Houston. And then from
12 there, moved to Cincinnati, Ohio, for a short stint;
13 Chattanooga, Tennessee, with Republic; Santiago, Chile,
14 with Republic; Houston, Texas, with Republic; and then
15 I left for five years and went to work for Ace Parking
16 Management in Dallas; and then about seven years ago, I
17 returned to Republic in the corporate office in
18 Chattanooga.
19 Q So when you were in Houston the first time was
20 with Central Parking?
21 A Correct.
22 Q You didn't travel anywhere with Central
23 Parking?
24 A No.
25 Q And then you went through several places:

1 Houston, Chattanooga -- I'm not sure Chattanooga, but
2 Chile. All those were when you were still with
3 Republic; is that correct?
4 A Correct. Except for the time I was with Ace
5 Parking.
6 Q When did you go to Ace Parking? I understand
7 it's an approximate.
8 A About 11 years ago.
9 Q And where did you go with Ace Parking?
10 A I was based in Dallas, Texas.
11 Q And you left Ace Parking and went back to
12 Republic?
13 A Yes, ma'am.
14 Q How long were you with Ace?
15 A About four years.
16 Q And why did you leave Ace?
17 A I was -- long story short. I left Republic
18 because they hired the wrong guy to be president, and
19 when he got fired, they offered for me to come back.
20 So. . .
21 Q This may seem like an odd question, but I
22 really -- there is a reason for it. I'm not just being
23 nosey. Do you have any relatives over the age of 18
24 that reside in Charleston County, whether related by
25 blood or marriage?

1 A Not that I'm aware of.
2 Q And I'll just tell you, the reason we do that
3 is if -- when this case goes to trial, we don't want to
4 seat anybody on the jury that's related to anybody who
5 will be testifying as witnesses.
6 Who was the district manager in January of
7 2013?
8 A Technically there was not a district manager.
9 The gentleman in charge of Charleston at that time
10 would have been Michael Shille.
11 Q What was his position at the time?
12 A His title was regional vice president.
13 Q And how long did he hold that position?
14 A I believe Mike was with the company for about
15 nine years.
16 Q Was there no position as a district manager at
17 that time, and that position was ultimately developed
18 later, or there just wasn't anybody in that position
19 at -- in January, 2013, so Michael took over the
20 responsibilities?
21 A At that time, there was not justification to
22 have a district manager in that area.
23 Q Do you know when a district manager was
24 -- that position was developed for this area?
25 A It coincided with Michael Shille's leaving the

1 company. It would have been earlier this year.
2 February, I believe.
3 Q You were asked about the RFP, and I understand
4 you said that would be a City document. Does Republic
5 still have a copy of that RFP?
6 A We may.
7 MR. DARLING: Just for clarification, you said
8 the RFP. You mean the RFP, or the response to the RFP?
9 MS. REYNOLDS: I'm sorry. The response to the
10 RFP. I apologize. Thank you.
11 A Same answer. We may.
12 Q In answer to some questions from Mr. Kahn, you
13 said that you have come back to Charleston to evaluate
14 the lots and the garages and all here since 1997. Do
15 you know how many times and when?
16 A I could tell you in 1998, when we opened on
17 New Year's Eve, as the fireworks were going off over
18 the harbor, I spent the better part of the next three
19 months here.
20 Q Okay. Any other times that you have come back
21 to Charleston to evaluate the -- whether the garages or
22 the lots?
23 A After that initial transition, I would say it
24 was probably once a month until I moved.
25 Q Until you moved to what?

1 A Until I moved positions.
2 Q And when did you move positions?
3 A I couldn't say exactly. It's when I went to
4 Santiago.
5 Q Okay. And when you would come, approximately
6 once a month, would you do the same -- would you do an
7 evaluation of the lots and the garages that were under
8 contract with the City?
9 A Typically, I would.
10 Q And would those evaluations encompass the same
11 issues that you have discussed regarding the original
12 assessment and subsequent evaluation, such as,
13 lighting, safety, vegetation, signage, trip hazards,
14 those sort of things?
15 A Yes.
16 Q When you would come approximately once a month
17 or so, would you fill out any checklists or paperwork?
18 A No.
19 Q Would you go back and write any reports or
20 make any notation in any file that you had made that
21 visit?
22 A I may have made notes, but I wouldn't have
23 filed any reports, per se.
24 Q Other than the general management team that
25 was here, or that is located here, who else from

1 Republic would come, whether on an as-needed basis or
2 on an interval basis?
3 A In general, come to Charleston?
4 Q Yes, sir.
5 A On a quarterly basis, our HR department would
6 travel to Charleston to perform employee training
7 sessions.
8 Q Okay. Anything else? Anybody else?
9 A I couldn't say specifically, but I'm sure in
10 the subsequent RFPs, there may have been additional
11 executives that visited the city.
12 Q Okay. In 1997, you were a district manager;
13 is that correct? No. Yeah. I'm trying to remember.
14 A In '97, I was a regional manager.
15 Q Regional manager. Do you know who was the
16 regional manager in 2013? That was you again, was it
17 not?
18 A Over this market?
19 Q Yes, sir.
20 A Mike Shille.
21 Q Did Mr. Shille also do an, approximately,
22 once-a-month inspection or evaluation of these
23 properties the way you did?
24 A I can't say for sure if he did or not.
25 Q Is that part of his duties and

1 responsibilities as a regional manager with Republic?
2 A To make regular inspections, yes.
3 Q Did they -- did Republic say how often they
4 wanted -- or they determined regular inspections, or
5 that was up to the person who was filling that person,
6 what regulated meant?
7 A Most of the time it was dictated by the client
8 relationship. Some clients want to see you more often;
9 others don't want to be bothered.
10 Q Other than the regional manager or an HR
11 person, anybody else or any other position with
12 Republic that would be coming to the Charleston area
13 for evaluations and/or assessments or training
14 regarding any of the lots or garages that were under
15 contract between the City and Republic?
16 A Not that I'm aware of.
17 Q Okay. Do you know if Michael Shille kept any
18 notes or checklists or anything regarding his routine
19 or regular inspections during his time as regional
20 manager?
21 A I'm not aware if he has any.
22 Q Do you know where Mr. Shille is --
23 A I believe --
24 Q -- currently?
25 A I believe he still resides in Jacksonville,

1 Florida.

2 Q He no longer works for Republic?

3 A That's correct.

4 Q Do you know when he left?

5 A Earlier this year.

6 Q That's right. You said that. I apologize.

7 And this is going to replow a little bit. And
8 I do apologize. I kind of got lost. Can you sort of
9 walk me through the timeline of the times that you were
10 responsible for this area, or this territory?

11 A Would have been when we were awarded the
12 contract up until I went to Chile. I can't recall for
13 sure, but there was a second time when I was involved.
14 Approximately 2000, 2001 area.

15 Q And how long during that second time?

16 A I couldn't say for sure.

17 Q And as the regional vice president for the
18 eastern half of the United States, you're still
19 responsible for this territory; is that correct?

20 A As of approximately August of 2013.

21 Q What happened in August of 2013?

22 A Mike Shille was designated to report to me
23 instead of directly to the president.

24 Q Okay.

25 A It was a restructure.

1 Q But prior to that, he would report directly to
2 the president?
3 A Yes, ma'am.
4 Q Okay. But in August of 2013, you were still
5 the regional vice president for the eastern half of the
6 United States; correct?
7 A Yes. My responsibilities were just expanded.
8 Q Okay. And this territory is within the
9 eastern half of the United States; correct?
10 A Correct.
11 Q If you could for me, in your understanding,
12 what were -- what were Republic's duties to the City of
13 Charleston under this contract?
14 MR. DARLING: Object to the form of the
15 question.
16 A I would refer to the contract document itself.
17 Q Okay. You've testified a couple of times
18 about some things that y'all would do, and you said
19 whether it was -- for the duties to the client were
20 contractual obligations or to minimize risk regarding
21 the insurance that you carry. What is incorporated in
22 that? What did you think that Republic was responsible
23 to do in order to meet those obligations?
24 A Which obligations specifically?
25 Q Any of them. Start with duties to the client.

1 A As far as to the client, I would refer to the
2 contract document.
3 Q Have you reviewed that document?
4 A Yes, ma'am.
5 Q Okay. From your review of that document, what
6 is your understanding of -- or what is your opinion
7 regarding Republic's duties to the City of Charleston?
8 MR. DARLING: Object to the form.
9 A To manage the parking facilities according to
10 the terms of the agreement.
11 Q And how do you define "manage"?
12 MR. DARLING: Same objection.
13 A Oversee the operational aspects on behalf of
14 the City.
15 Q And what do you mean by the terms of the
16 agreement?
17 MR. DARLING: Object to the form.
18 A The actual wording of the document itself.
19 Q Okay. Under the agreement, Republic was -- or
20 one of their responsibilities or obligations was to
21 operate and manage the lots and/or garages controlled
22 by that contract. Is that correct?
23 A Correct.
24 Q And that would include the George Street
25 surface lot that we have been talking about here?

1 A Yes, ma'am.

2 Q Under the contract, Republic was responsible
3 to prepare a report quarterly with operating budget
4 proposals that included making recommendations for the
5 improvement of services? Is that correct?

6 A Yes.

7 Q And did Republic do that?

8 A I couldn't say specifically if that obligation
9 was fulfilled or not.

10 Q Republic was responsible to operate, manage,
11 and maintain the facilities and collect parking meter
12 revenue whenever that -- wherein efficient, economical,
13 and professional delivery of services is a primary
14 consideration. Is that correct?

15 A Where are you referring to in the document?

16 Q If you look under -- I wrote it down, but,
17 apparently, I didn't bother to put where exactly I got
18 it from.

19 A Are you referring to Exhibit B?

20 Q Exhibit 2 would be the report.

21 MR. DARLING: I think he was talking about
22 Exhibit B, Scope of Services, the last page of that
23 Exhibit 2.

24 Q That may be. And I apologize for not having
25 that right where I needed it.

1 Yes, sir.
2 A That is what the contract says, yes.
3 Q And were those obligations provided to the
4 City?
5 A As far as I'm aware, yes.
6 Q Republic was required -- responsible to
7 operate the lot as a first-class commercial parking
8 facility with energy, fidelity, and diligence
9 respectful of the culture it serves and in compliance
10 with all terms and conditions contained in the
11 agreement. Is that correct?
12 A That's what it says, yes.
13 Q With the principle objective of the overall
14 excellence of the City's total parking services
15 program. Correct?
16 A Yes.
17 Q As a part of Republic's responsibilities
18 for -- under the Operating Advance section of this
19 contract, Republic was responsible for regular and
20 frequent inspections to determine whether maintenance,
21 repair, and/or replacement of the facilities was
22 required; is that correct?
23 A What paragraph?
24 MR. DARLING: Where are you referring to? I'm
25 sorry.

1 Q If you go to 4.1(a) 1(a): Republic shall make
2 regular and frequent inspections to determine whether
3 maintenance, repair, and/or replacement of the parking
4 facilities is required.
5 ~~A That's what it says, yes.~~
6 Q And did Republic perform those duties?
7 A To the best of my knowledge, yes.
8 Q When Republic performed those duties, if they
9 identified anything that required maintenance, repair,
10 or replacement, would Republic alert the City?
11 A Yes, ma'am.
12 Q Okay. How would they alert the City?
13 A Could be a phone call; could be an E-mail.
14 Q When they made these regular and frequent
15 inspections, were their any checklists or forms that
16 were filled out to document that these inspections were
17 completed?
18 A Some of them, yes.
19 Q If an issue was raised to the City, whether by
20 phone call, E-mail, or however Republic would raise
21 that issue, if it was not resolved, what would Republic
22 do?
23 A It depends on the circumstances.
24 Q Would they make any notations or reports?
25 A There's not a standard protocol.

1 Q Are you aware of any issues that were raised
2 to the City regarding the Georgetown/Society Street
3 parking lot?
4 MR. DARLING: George Street.
5 Q I'm sorry. The George Street parking lot?
6 A I'm not aware of any, no.
7 Q Are you aware of any time that any issue was
8 raised by Republic regarding the physical conditions of
9 the lots and/or garages themselves that the City
10 refused to respond to or failed to respond to?
11 A It would be stretching my memory to say so.
12 Q And you don't remember if there was, or you
13 don't recall anything specific?
14 A I don't recall anything specific.
15 Q Republic was responsible to keep the parking
16 facilities in a properly maintained state, free from
17 hazardous conditions and deterioration, normal wear and
18 tear excepted. Correct?
19 A That's what it says.
20 Q Do you consider illuminations a hazardous
21 condition or possible hazardous condition?
22 MR. DARLING: Object to the form.
23 A Depends on the state of illumination.
24 Q Would you consider insufficient illumination a
25 hazardous condition?

1 MR. DARLING: Object to the form.
2 A Being a subjective term, "insufficient,"
3 it's -- it's tough to answer that question.
4 Q In the times that you would come down, when
5 you were responsible for this territory, if you came
6 down and thought the lighting was bad, would you
7 consider that a hazardous condition?
8 A Yes, ma'am.
9 Q And would you have reported it or identified
10 it?
11 A I would have identified it.
12 Q Okay. And you would have identified it or
13 reported it to the City?
14 A Possible.
15 Q If you didn't, what would you do with it? If
16 you identified it, but --
17 A Depends on the causation.
18 Q Okay. Well --
19 A If the light bulb was out, I would probably
20 instruct someone to have it replaced.
21 Q And if it wasn't the light bulb, if you
22 thought there were too little lights?
23 A Then I would definitely make sure the City was
24 aware of it.
25 Q Would there be any notes or memos or any kind

1 of written account on behalf of Republic that that
2 issue was raised to the property owner?
3 A In this specific location, the property
4 owner?
5 Q Under y'all's general contracts, if you find
6 an issue like that and you think there's insufficient
7 lighting, like you told us in Texas, you bring that to
8 the property's owner attention; correct?
9 A Typically, yes.
10 Q Okay. Is there any notation or report or
11 memo in Republic's file to say, hey, we've raised this
12 issue -- we think there's insufficient lighting here,
13 and we've raised the issue with the owner?
14 A Possible. There's no standard protocol,
15 though.
16 Q And you don't recall that being an issue with
17 the George Street parking lot; is that correct?
18 A I do not recall.
19 Q You don't recall whether it was or wasn't, or
20 you don't recall that it was?
21 A Both.
22 Q Republic was required to maintain the parking
23 facilities in a clean and neat fashion, ensuring that
24 all trash, bottles, and papers, and other dirt and
25 debris are routinely removed and disposed of in a legal

1 manner; empty all waste receptacles for off-site
2 disposal; and perform all tasks as defined and directed
3 by the City. Is that correct?
4 A That's what the document says, yes.
5 Q They were responsible for all reasonable
6 improvements in cleaning and/or maintenance methods as
7 deemed necessary to meet the requirements of the City
8 and all the contractual obligations contained in the
9 agreement?
10 A That's what the document says, yes.
11 Q And do you know if those obligations were
12 upheld?
13 A To the best of my understanding, yes.
14 Q Republic was responsible to furnish the
15 supplies and housekeeping equipment needed to operate,
16 clean, and maintain the parking facilities, including,
17 but not limited to, spare parts for the parking control
18 equipment. Is that correct?
19 A Yes.
20 Q Okay. And they were -- Republic was
21 responsible to perform minor repairs to the parking
22 facilities, including, but not limited to, relamping
23 and minor electrical repairs, which its staff is
24 capable of performing in a safe and efficient manner.
25 Is that correct?

1 A That's what it says, yes.
2 Q And they were responsible to maintain all
3 garage parcels and surface lot landscaping and
4 hardscaped areas associated with the parking facilities
5 to City specifications. Is that correct?
6 A Correct.
7 Q Okay. And you see in the next section, it
8 says: City shall make periodic and routine inspection
9 of the parking facilities?
10 A Correct.
11 Q I believe you were asked some questions by
12 Mr. Kahn about, if you had any knowledge regarding the
13 City -- the City's involvement in inspecting these lots
14 or the lots that were under management. And I believe
15 you testified you were not aware of any; is that
16 correct?
17 A You're referring to specific inspections?
18 Q Were you -- any inspection. Are you aware of
19 the City being involved in any inspections of the lots
20 that were under management by Republic?
21 A None that I can specifically recall.
22 Q According to -- we're back on the same page of
23 the agreement, Exhibit 2, (b)(1): The physical
24 facilities provided to Republic for the term of the
25 agreement shall become the responsibility of Republic.

1 Is that correct?
2 A Yes.
3 Q Okay. And Republic was responsible for
4 preventative maintenance and repair of all parking
5 facilities.
6 A You're referring to where?
7 Q To (a): Be responsible for preventative
8 maintenance and repair of all the parking facilities
9 under this agreement.
10 A Yes, that's what the document says.
11 Q And Republic was responsible to promptly
12 inform the City of any need for major repairs,
13 replacements, elevator repair, painting, or patching
14 for the parking facilities?
15 A That's what it says, yes.
16 Q Do you believe that that section would include
17 an obligation by Republic to let the City know if they
18 felt like there was insufficient or poor lighting --
19 MR. DARLING: Object to the form.
20 Q -- at this lot?
21 MR. DARLING: Object to the form.
22 A Which section are you referring to?
23 Q At (b)(1)(b).
24 A It would depend on the situation.
25 Q Under your reading of this contract, do you

1 believe, under any provision, that Republic was
2 responsible to alert the City whether they thought
3 -- to alert the City if they thought the lighting was
4 poor or insufficient?
5 MR. DARLING: Object to the form.
6 A You're asking for my opinion?
7 Q Yes, sir. From your review of this contract.
8 A It would depend on the situation.
9 Q In what situation would Republic -- do you
10 believe Republic would be responsible to alert the
11 City?
12 MR. DARLING: Object to the form.
13 A If a light fixture was damaged, knocked down
14 by weather, vehicle, something along those lines.
15 Q And in what situation do you believe Republic
16 would not be responsible?
17 A My opinion would be, if the deciding entity
18 felt the design of the lot was insufficiently laid out,
19 that would not be our responsibility.
20 Q If the designing entity felt the layout was
21 insufficient?
22 A In deciding --
23 Q I'm sorry. Go ahead.
24 A Somebody ultimately makes a determination
25 who's right and who's wrong. I assume the Court will

1 in this case.
2 Q Okay. Under this contract, there's a hold.
3 Do you believe -- tell me what situation would Republic
4 not have been responsible to alert the City that they
5 believed that the lighting was either poor or
6 insufficient at this lot?
7 A If we believed it was poor and insufficient,
8 then, yes, we are obligated to notify the City.
9 Q At any time, do you recall Republic believing
10 that the lighting at this lot was poor or insufficient?
11 A No.
12 Q When you were answering some questions for
13 Mr. Kahn, y'all had looked at 4.1, Subsection
14 (a)(1)(b), which was: Keeping free of hazardous
15 conditions. And you -- I believe, you testified -- if
16 I understood your testimony correctly -- and please
17 tell me if I'm wrong -- that you agreed that Republic
18 was responsible to keep the lot free of hazardous
19 conditions in the context of the remaining provisions;
20 correct?
21 A That sounds correct.
22 Q And when you were asked, what do you mean by
23 that, you talked about the City being -- the City being
24 responsible or in control of the budget, the City's
25 obligations in the contract, and the City's control of

1 operating practices; correct?
2 A Correct.
3 Q What do you mean by the "budget"?
4 A This is a cost-plus management agreement,
5 which allows the City to set the budget, which the
6 operator of Republic Parking could not exceed without
7 permission from the City to do so.
8 Q Are you aware of any time that Republic
9 requests to exceed the budget in the maintenance or --
10 excuse me -- in performing their obligations under this
11 contract?
12 A Not specifically, no.
13 Q Okay. What do you understand would be the
14 City's obligation under the contract?
15 MR. DARLING: Object to the form of the
16 question.
17 A I would refer to the document.
18 Q Okay. And you said, the City's control of
19 operating practices. Can you tell me what you meant by
20 that?
21 A Ultimately they set the policies and
22 procedures.
23 Q Such as?
24 A How much to charge, what hours of operation
25 to be open, different validation programs, different

1 staffing levels.

2 Q Okay. You talked about an operations manual

3 for what Republic's employees should observe in the

4 garages or lots or the areas that they're managing

5 under agreements. Do you remember that testimony?

6 A Yes.

7 Q And you said you sort of had a template that

8 was customized for each operation. Typically, more

9 generally for each client; is that correct?

10 A That is correct.

11 Q And you said you believe there was one for the

12 City of Charleston?

13 A Yes.

14 Q Do you know if Republic would still have a

15 copy of that?

16 A I'm not sure we do or not, but I know a copy

17 was provided to the City.

18 Q Do you know when?

19 A It would have been in '98.

20 Q Who prepares that template or modifies that

21 template to be customized?

22 A At the time, it would have been our general

23 manager or myself.

24 Q And do you know when that was created -- that

25 was created for these lots in 1997, 1998?

1 A '98, yes. And it's something that's modified
2 over time.
3 Q Do you know or do you recall any modifications
4 to the template for this?
5 A Not specifically.
6 Q Thanks. You talked about the maintenance
7 checklist is done regularly by a general manager. And
8 you said that would deal -- that would also deal with
9 lighting, maintenance checklists? Did I understand
10 that testimony correct?
11 A Yes.
12 Q Is that maintenance checklist transmitted to
13 corporate?
14 A No.
15 Q Like the quarterly self-inspection checklists?
16 A No, ma'am.
17 Q Where are those maintenance checklists
18 maintained?
19 A On-site, in the facilities.
20 Q If you could look at what was marked as
21 Defendant's Exhibit 3 to your deposition. I believe
22 that was the quarterly checklist form; is that correct?
23 Self-inspection checklist. I apologize.
24 The checklist discusses Republic's loss
25 control program. Can you tell me what that program

1 is?
2 A In general, it's an assessment of how we
3 can limit the risk of claims occurring in the field.
4 Q Is there any written policies or procedures or
5 standards, manuals, whatever, for anything regarding
6 that loss control program?
7 A Not that I am specifically aware of.
8 Q Okay. Who were the top management that
9 reviewed the self-inspection checklists to monitor the
10 loss control program?
11 A Depends on the report itself. If there was no
12 issues, it probably never went beyond our insurance
13 department.
14 Q Okay. If there were issues, then it would go
15 to your insurance department. And I believe you
16 testified that they were responsible for following up
17 to make sure it was completed?
18 A Yes.
19 Q And it was up to them as to whether or not
20 they felt the issue needed to be raised to a level
21 above them; is that correct?
22 A That's correct.
23 Q These self-inspection checklists also discuss
24 safety committee. Can you tell me who was on the
25 safety committee?

1 A I could not.
2 Q Was there a safety committee with Republic?
3 A I think it's more loosely referring to the
4 executives who discuss such things.
5 Q Okay. On the last page, it says: The safety
6 committee meets monthly or quarterly in compliance with
7 state or corporate requirements. And there's a
8 checkmark in the yes block. Do you see that?
9 A What page are you on?
10 Q The very last page of Exhibit 3.
11 A Yes.
12 Q Do you know whether the Republic safety
13 committee met monthly or quarterly?
14 A This would have been on-site. So it probably
15 would have been -- really, it's an everyday occurrence,
16 but at least quarterly.
17 Q Do you know if there were any policies,
18 procedures, or standards that were promulgated by that
19 committee?
20 A It's a conglomeration of things, such as the
21 operations manual and checklists such as this.
22 Q The checklist talks about a regular monthly,
23 or more frequently, meetings are held with all
24 employees. Was that done?
25 A Couldn't say for sure, but the report says it

1 was.
2 Q Do you know who would attend those meetings?
3 A I would assume it would be the on-site
4 management team and staff.
5 Q The on-site management team would have been
6 the one that would have called those meetings?
7 A Yes.
8 Q Do you know if they kept any sign-in sheets or
9 anything regarding who attended those meetings?
10 A Not that I'm aware of.
11 Q The self-inspection checklist required
12 Republic to be responsible to conduct thorough employee
13 and customer accident investigations and have
14 corrective actions documented. Do you see that?
15 A Where are you referring to?
16 Q If you look at the very last page, over on the
17 right hand -- no. I'm sorry. In the left-hand column,
18 second to the last.
19 A Okay.
20 Q Thorough employee and customer accident
21 investigations conducted and corrective actions are
22 documented, and it's checked yes; is that correct?
23 A Yes.
24 Q Do you know whether there was any accident
25 investigation regarding the incident we're here about

1 today?

2 A Not specifically.

3 Q Do you know if there was any corrective

4 actions recommended or deemed necessary as a result of

5 any inspection following the accident we're here about

6 today?

7 A Not that I'm aware of, no.

8 Q Who would know whether or not there was an

9 investigation regarding this incident?

10 A It would have been our insurance department.

11 Q Who was the Republic management individual who

12 was assigned responsibility for inspections, meetings,

13 investigations, and employee training?

14 A Ultimately, it would have been our general

15 manager on-site, Dwight Potter.

16 Q And the Republic manager on duty performs

17 daily inspections?

18 A Yes.

19 Q Do you know if there were any checklists or

20 notes regarding those daily inspections?

21 A Not specifically.

22 (Pause in proceedings.)

23 MS. REYNOLDS: Sir, I apologize. I'm just

24 looking over my notes. I believe that's all I have.

25 I'm going to pass on. Double-check.

1 EXAMINATION
2 BY MR. DINKELACKER:
3 Q Mr. Skelton, my name is Andy Dinkelacker. I
4 represent Indigo Realty. During your dealings with the
5 City of Charleston related to this lot, were you ever
6 made aware of the existence of Indigo Realty?
7 A Yes.
8 Q Can you tell me how?
9 A I was told by the client that y'all own the
10 lot.
11 Q And when would that have been?
12 A When we took over.
13 Q Okay. Did you ever speak with anyone
14 associated with Indigo Realty at any time?
15 A I know I did. I can't recall specific.
16 Q Okay. And do you know when that might have
17 been?
18 A 1998.
19 Q And do you have any general remembrances about
20 the conversations and what you talked about?
21 A No.
22 Q Looking at the parking agreement in Exhibit 2,
23 4(a)(1)(g), the surface lot landscaping that y'all were
24 to maintain at the George Street lot, what did that
25 consist of?

1 A I can't recall specifically.
2 Q And it says: Associated with the parking
3 facilities to City's specifications. Do you know if
4 y'all were ever provided with any specifications for
5 landscaping at that lot?
6 A Not specifically, no.
7 Q Would that, to the best of your knowledge,
8 just have been whatever you were told to do, or was
9 there any typical program Republic maintained for
10 landscaping purposes?
11 A I'm sure it was a combination of both, our
12 standards and the City's approved standards.
13 Q And what were your normal standards for
14 landscaping?
15 A Good aesthetic visual, presence, obstruction
16 -- visual obstructions would be taken care of, limbs,
17 things like that.
18 Q And who would have been responsible for
19 determining those visual obstructions?
20 A It would have been our entire staff.
21 Q Would that have ever been documented or noted
22 somewhere if there was something discovered?
23 A Possibly.
24 Q Were you aware or did you ever see anything
25 noted or discovered for visual obstructions at the lot?

1 A No.
2 Q Did y'all typically contract out landscaping
3 services, or would that be something Republic would
4 provide themselves?
5 A It depends. Some contracts, we do it
6 ourselves; some we hire people to do it.
7 Q Do you know how the George Street lot, in this
8 case, was handled?
9 A Not at the time of the incident. I believe
10 when we took over originally, we did the work
11 ourselves, or most of it.
12 Q Did y'all have on hand, then, your own
13 equipment for that?
14 A Yes.
15 Q Do you know what that -- what the equipment
16 you had for this lot was?
17 A You're stretching my memory, but I'm sure it's
18 around the nature of a rake and a weed eater and a lawn
19 mower and such.
20 Q Okay. And would that have been documented
21 whenever landscaping work had been done?
22 A Most likely. For sure, if there was
23 expenditures, it would have been included in our report
24 to the City.
25 Q Okay. That was something y'all would provide

1 to the City?
2 A Yes. Every month we provide documentation of
3 all of our expenses.
4 Q And what would that be in the form of?
5 A Receipts, invoices, quotes.
6 Q Does Republic maintain copies of that?
7 A We do. I'm not sure how far back our records
8 go, though. Typically we keep them six years.
9 MR. DINKELACKER: Okay. That's all I have.
10 Thanks.
11 EXAMINATION
12 BY MR. DARLING:
13 Q I've got just a very few number of questions.
14 Mr. Skelton, I believe you testified that Republic
15 entered a contract to manage this lot beginning in
16 1998; is that correct?
17 A Yes, I believe so.
18 Q Okay. And before that, Republic was not
19 involved with the lot?
20 A Correct.
21 Q Did Republic design or build the George Street
22 parking lot?
23 A No, sir.
24 Q It was already designed and built by the time
25 Republic took over the management group, or entered the

1 management group?
2 A Yes, that's correct.
3 Q Is it your understanding that the City of
4 Charleston or one of its contractors designed the
5 parking lot?
6 A Yes.
7 Q Is it your understanding that the City of
8 Charleston or one of its contractors, other than
9 Republic, constructed the parking lot?
10 A Yes.
11 Q And included in that design or construction
12 were the lights or lamp posts where lights were in the
13 parking lot or around the parking lot; is that correct?
14 A Yes.
15 Q That's not something that Republic did?
16 A That's correct.
17 Q Okay. And is the same -- does the same hold
18 true for the islands or curbing in and around the
19 parking lot? That's not something that Republic
20 designed or built; is that correct?
21 A That is correct.
22 Q That would be something that the City or its
23 contractors designed or built; is that correct?
24 A Yes, sir.
25 Q And, specifically, the curbing or raised area

1 near the entrance to the parking lot, are you familiar
2 with that?
3 A Yes.
4 Q Okay. Is that something that Republic
5 designed or built?
6 A No, sir.
7 Q Would that have been designed or built by the
8 City or its contractors, other than Republic?
9 A Yes.
10 Q While Republic managed the lot, are you aware
11 of any other falls, other than Mr. Burke's, that
12 occurred in the area near that curb or area near the
13 entrance to the parking lot?
14 A None that I'm aware of.
15 Q And when the management agreement, in
16 Article IV, talks about relamping, does that mean put
17 new light bulb in the light fixtures?
18 A Yes, sir, that's exactly what it refers to.
19 Q And, to your knowledge, were there any reports
20 that the lights in -- the lamps in the lights at the
21 parking lot were in full repair or not in place at the
22 time of Mr. Burke's fall in January of 2013?
23 A None that I'm aware of.
24 Q No complaints about that?
25 A No, sir.

1 MR. DARLING: Okay. That's all I have. Thank
2 you.
3 MR. KAHN: I just have one follow-up, Steve,
4 to that.
5 FURTHER EXAMINATION
6 BY MR. KAHN:
7 Q Mr. Skelton, irrespective of whether -- or
8 whoever built or designed this lot, you would agree
9 with me that when Republic came in and agreed to manage
10 this particular lot, it was still responsible to keep
11 the lot free from hazardous conditions, in accordance
12 with the agreement; correct?
13 MR. DARLING: Object to the form.
14 A That's what the contract says, yes.
15 Q As you sit here today, you don't know what the
16 particular design called for, as far as lighting and
17 curbing, with respect to the George Street lot, do you?
18 A No, I do not.
19 MR. KAHN: That's all I have.
20 MS. REYNOLDS: I just have a few follow-ups.
21 FURTHER EXAMINATION
22 BY MS. REYNOLDS:
23 Q Republic Parking Systems is in the business of
24 operating and managing parking garages and parking
25 lots, basically parking systems; is that correct?

1 A Yes.
2 Q And do you believe Republic Parking Systems,
3 Inc., has, whether through training, education, or
4 experience, a better understanding or knowledge of the
5 requirements of a properly operating or properly
6 -- I'll just say of a proper parking system?
7 MR. DARLING: Object to the form.
8 A I believe we have expertise in that area, but,
9 obviously, it's an opinion.
10 Q Do you believe that Republic had a better
11 understanding or expertise of these applicable
12 standards required of parking lots and/or garages than
13 the City of Charleston?
14 MR. DARLING: Object to the form.
15 A Better understanding, no.
16 Q Okay. And I believe, in the agreement, it
17 was -- once the agreement was signed, the physical
18 facilities became the responsibility of Republic; is
19 that correct?
20 MR. DARLING: Object to the form.
21 A That's what the contract states, yes.
22 Q Okay. And that would include the lighting; is
23 that correct?
24 MR. DARLING: Object to the form.
25 A If that's what the contract states, yes.

1 Q And you testified earlier that Republic,
2 pursuant to their duties and obligations, whether to
3 themselves, their client, or their -- to minimize risk,
4 did assessments -- precontractual assessments, as well
5 as postcontractual evaluations of these lots and/or
6 garages; is that correct?
7 A That's correct.
8 Q Which included their opinion or evaluation of
9 lighting; is that correct?
10 A Yes.
11 Q Whether sufficient -- whether it was or wasn't
12 sufficient or insufficient; is that correct?
13 A Subjective, yes.
14 Q Okay. And that was a duty that was undertaken
15 by Republic; is that correct?
16 MR. DARLING: Object to the form.
17 A That's what the contract calls for, yes.
18 Q The contract requires Republic to carry the
19 insurance for this facility; is that correct?
20 MR. DARLING: Object to the form.
21 A Yes, ma'am.
22 Q And that's to cover any type of claim or
23 liability, losses, or suits; is that correct?
24 MR. DARLING: Object to the form.
25 A I'd refer to the terms of the agreement.

1 Q Okay. Instead of beating around the bush, I'm
2 just going to flat-out ask you. The Plaintiff in this
3 case indicates or alleges that the lighting at this lot
4 was insufficient or poor, and that was the proximate
5 cause of him falling.
6 A Okay.
7 Q From your inspections, and the times you've
8 ever seen the lot and what you have seen as far as
9 reviewing any documents from Republic, do you believe
10 that Republic ever believed that this lot was
11 insufficiently lit?
12 A From my personal knowledge, no.
13 Q Okay. Under the agreements, as we've
14 gone through the agreement here today regarding
15 responsibilities and obligations, do you believe that
16 it was Republic's responsibility or obligation to alert
17 the City if they believed that there was -- that this
18 lot was insufficiently lit?
19 MR. DARLING: Object to the form.
20 A Yes. If we believed it was insufficiently
21 lit, we should have notified the City.
22 Q And the only business Republic is in is
23 operating and/or managing parking systems; is that
24 correct?
25 A No.

1 Q What other businesses are they in?
2 A We provide shuttle, taxi/charter services,
3 consulting services, wheelchair assistance. All kinds
4 of areas of -- related to parking and transportation.
5 Q But it's related to parking or transportation?
6 A Typically.
7 Q That's Republic's bailiwick. This is their
8 specialty?
9 A It's in our name.
10 Q That's what they do?
11 Do you believe it's unreasonable for
12 Republic's clients to rely upon Republic's knowledge
13 and expertise in these areas?
14 MR. DARLING: Object to the form.
15 A In my opinion, it's not unreasonable for them
16 to rely upon our expertise, no.
17 Q Okay. In this case, if -- where the Plaintiff
18 alleges that the lighting at the George Street lot was
19 insufficient, whose responsibility do you believe that
20 was?
21 MR. DARLING: Object to the form.
22 Q The City's or Republic's?
23 MR. DARLING: Object to the form.
24 A It depends on the nature of the causation.
25 Q I believe it's insufficient lighting.

1 MR. DARLING: Is that a question?
2 Q They believe it is insufficient lighting.
3 That's the situation. That's the condition. Whose
4 responsibility do you believe it is?
5 MR. DARLING: Object to the form.
6 A It depends on the causation.
7 Q What do you mean by "causation"?
8 A If it is determined that there was
9 insufficient lighting, what is the reason for the
10 insufficient lighting.
11 Q Such as?
12 A A burnt out light bulb.
13 Q That would be Republic's responsibility?
14 A Yes, ma'am.
15 MR. DARLING: Object to the form.
16 Q How about whether or not there are or are not
17 enough light fixtures?
18 A Depends -- well -- that would be the City's
19 responsibility as a capital project.
20 Q Okay. Once they're alerted that there -- let
21 me back up. They would be responsible to pay for it?
22 A Authorize the work, yes.
23 Q Okay. Who is responsible for identifying that
24 the work is needed?
25 MR. DARLING: Object to the form.

1 A I would say it's a combination of both the
2 operator and the landowner.
3 Q And what of the landowner? What's the
4 obligation of the landowner?
5 A The City writes the building codes and
6 standards, makes the laws. They own the property.
7 Q Okay. What if the City doesn't own the
8 property?
9 A Well, they have the legal right to the
10 property.
11 Q So it's a combination because the City writes
12 the codes?
13 A In part, yes.
14 Q Okay. And Republic or the management company
15 is the one operating and managing the facility; is that
16 correct?
17 A If there was a standard that wasn't met
18 according to city code, clearly it should have been on
19 the City to establish the lot and proper code
20 compliance.
21 Q Do you know whether this lot was established
22 in a proper code compliance?
23 A No.
24 Q Do you know when this lot was established?
25 A No.

1 Q Okay. But when Republic came in in 1997 and
2 assessed this lot, they believed it was in compliance
3 with applicable codes and standards; correct?
4 A To the best of my knowledge, yes.
5 Q And as we've stated before, this is their --
6 this is their specialty. This is their bailiwick;
7 correct?
8 A Yes. We're a parking management company, yes.
9 MS. REYNOLDS: That's all I have. I
10 appreciate it. Thank you, sir.
11 FURTHER EXAMINATION
12 BY MR. DINKELACKER:
13 Q Mr. Skelton, just real briefly. When you
14 initially talked with Indigo and found out that they
15 were the landowner at the time, were you made aware of
16 or were you ever shown any of the leases they had with
17 the City of Charleston?
18 A Can't say for sure if I was or not.
19 Q What was your understanding of their
20 relationship with the City of Charleston at the time
21 y'all came in?
22 A That the City had a land lease for the parking
23 lot or part of the parking lot. I'm not sure if it was
24 the entire lot.
25 Q Were you ever told who constructed the lot?

1 A No.
2 MR. DINKELACKER: Okay. That's all I have.
3 MR. KAHN: We're done.
4 MR. DARLING: Jack, you've got a right to read
5 and sign the deposition. You don't have to do that.
6 You can't make any changes, unless you said something
7 wrong or meant to say something differently. It's okay
8 with me for you to waive that right. Most people do,
9 but it's your choice. What would you care to do?
10 THE DEPONENT: I would rather review the
11 transcript.
12 MR. DARLING: Yes. That's fine.
13 (The deposition concludes at 12:29 p.m., on
14 May 21, 2014.)
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1 R E P O R T E R' S C E R T I F I C A T E

2

STATE OF SOUTH CAROLINA)
3) ss.
COUNTY OF BERKELEY)
4

5 I, ROLAYNE M. VOLPE, Certified Court Reporter, CCR, and Registered Professional Reporter, RPR, do
6 hereby certify that the transcript of the foregoing proceedings accurately reflects the events that
7 occurred before me to the best of my ability at the time and place set out on the caption hereto; that the
8 witness was by me duly cautioned and sworn, or affirmed, to tell the truth, the whole truth, and
9 nothing but the truth; that the testimony of the witness and all objections made at the time of the
10 examination were recorded stenographically by me and were thereafter transcribed by computer-aided
11 transcription; and that the witness was given an opportunity to read and correct said deposition and to
12 subscribe the same.

13

14 Should the signature of the witness not be affixed to the deposition, the witness shall not have availed himself or herself of the opportunity to sign
15 or the signature has been waived.

16

17 I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken or to
18 any attorney or counsel employed by the parties hereto, nor financially interested, directly or indirectly, in
19 the outcome of this action.

20

21 CERTIFIED AND SIGNED on this 3rd day of June, 2014.

22

23

24 ROLAYNE M. VOLPE, CCR, RPR
Certified Court Reporter and
Registered Professional Reporter
25 Commission Expires: 8-30-2021

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT
STATE OF SOUTH CAROLINA
CHARLESTON COUNTY

DEPOSITION OF JACK SKELTON

ROBERT J. BURKE and JANE B. BURKE,
Plaintiffs,
vs. Case No.: 2013-CP-10-1400
INDIGO REALTY COMPANY, LLC, REPUBLIC PARKING SYSTEM, INC., and the CITY OF CHARLESTON,
Defendants.

DEPONENT: JACK SKELTON
DATE: MAY 21, 2014
TIME: 9:58 A.M.
LOCATION: McCULLOUGH KHAN, LLC
REPORTED BY: ROLAYNE M. VOLPE, CCR, RPR
CLARK & ASSOCIATES, INC.
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EXHIBITS

11 DESCRIPTION PAGE
12 Exhibit No. 1 10
13 Second Notice of Deposition of Republic Parking System, Inc., 30(b)(6)
14 Exhibit No. 2 31
15 City of Charleston, Parking Garage Management Agreement, May 1, 2008
16 Exhibit No. 3 45
17 Republic Parking System, Self-Inspection Checklist
18 Exhibit No. 4 51
19 Hand Written Note, Kenneth Lee

20
21
22
23
24
25

1 JACK SKELTON,
2 having been first duly sworn by the Court Reporter to
3 tell the truth, the whole truth, and nothing but the
4 truth, was examined and testified upon his oath as
5 follows:
6 EXAMINATION
7 BY MR. KAHN:
8 Q Good morning. We met momentarily off the
9 record. Would you please state your full name for the
10 record.
11 A Jack Skelton.
12

Page 5

Page 7

Page 6

1 Q Okay. Where do you work, Mr. Skelton?
2 A I work for Republic Parking Systems.
3 Q Okay. And what is your position?
4 A I'm a regional vice president.
5 Q Where are you based out of?
6 A Chattanooga, Tennessee, which is our corporate
7 office.
8 Q Which region are you responsible for?
9 A The eastern half of the United States.
10 Q And how long have you had that position,
11 roughly?
12 A Seven, eight years.

Page 8

1 Q So below you, for this general area, there's a
2 district manager; correct?
3 A Correct.
4 Q And what district would that manager oversee?
5 A Presently his name is Wally Bice, and he
6 oversees, basically, Maryland down to Florida.

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Page 11

1 here. You've indicated that you have seen this notice.
2 Have you reviewed the general topics that were attached
3 to it?
4 A Yes, sir.
5 Q By your presence here -- I assume that I know
6 the answer to my own question. But by your presence
7 here, I assume that, for Republic Parking Systems,
8 Incorporated, you are the most knowledgeable person to
9 testify on those subjects.
10 A Yes, sir.

t?

Page 10

11 Q Mr. Skelton, I am handing you what has been
12 marked as Exhibit 1. Have you seen that document?
13 A Yes, sir.
14 Q Okay. Have you given a deposition before?
15 A Yes, sir.
16 Q Okay. This is a deposition taken in
17 accordance with a specific rule of the South Carolina
18 Rules of Civil Procedure, and that rule is what we call
19 30(b)(6). And what that allows a party to do is
20 designate general topics they would like to speak to
21 someone about at an entity or a company where we
22 designate the general topics. And then it's generally
23 incumbent upon that company to identify someone that
24 has the knowledge to answer those questions.
25 I'll represent to you that's what we've done

Page 12

19 Q Okay. Were you involved specifically with the
20 assessment of the City of Charleston facilities when
21 Republic undertook the management of those?
22 A Yes.
23 Q Do you know, in that instance, if the City of
24 Charleston reached out to Republic to manage these lots
25 or did they request proposals or how they went about

Page 13

1 that?
2 A They issued an RFP.
3 Q Were you involved with the response to the
4 RFP?
5 A Yes, sir.
6 Q Is that document available in Republic?
7 A I'm not sure.
8 Q Okay. Who was the primary drafter of the
9 response for the proposal?
10 A Myself.
11 Q As part of the response, did you come to
12 Charleston to conduct assessment or site visits of the
13 facilities?
14 A Yes, sir.
15 Q How many times?
16 A Relative to what?
17 Q To the response of the RFP.
18 A Once.
19 Q Okay. Did you tour the facilities?
20 A Yes, sir.
21 Q Did you tour the parking lot at issue in this
22 case, which I'm going to call the George Street lot?
23 A Yes, sir.
24 Q Just to make sure we understand, I think you
25 know, but that's the lot that has rough borders of

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1 George Street, King Street, and Society Street,
2 downtown Charleston?
3 A Yes.
4 Q Okay. When you conducted those site -- that
5 site visit to the City of Charleston, are there any
6 written procedures that Republic uses to evaluate those
7 specific sites?
8 A No.

Page 15

Page 16

11 Q Okay. As part of the evaluation process, and
12 in this case, the RFP, but more generally, does
13 Republic assess lots and decks from the standpoint of
14 safety as well?
15 A Yes.
16 Q I've read the management agreement, and we'll
17 talk more specifically about it shortly. But there are
18 certain requirements on Republic when they manage a
19 lot; correct?
20 A Contractually.
21 Q Why would Republic evaluate particular lots
22 from the standpoint of safety and hazardous conditions?
23 A It's part of our duty to the client. We also
24 provide the [redacted] and name the clients, typically,
25 as an additional [redacted]. So it's in our best interest

1 to minimize any risk.

6 Q When you evaluate a particular lot for safety
7 and potential dangerous conditions, what would that
8 evaluation include?
9 A Surface conditions, possible trip hazards,
10 lighting, drainage, signage, vegetation.
11 Q Those topics you just mentioned, were
12 those topics evaluated with respect to the City of
13 Charleston?
14 A I would expect they were, but I can't recall
15 for sure.
16 Q Next question was specifically the George
17 Street lot. Do you know if those general evaluation
18 subjects were evaluated at the George Street lot?
19 A It would be typical of our course of doing
20 business.
21 Q Okay. I recognize you're probably one of many
22 that participate in that evaluation process and RFP.
23 Are there specific individuals within Republic whose
24 duty it is to do those things you mentioned?
25 A Yes.

1 Q Are those engineers or field operations
2 personnel?
3 A Not engineers. They're operational managers.
4 Q Okay. Did one of those individuals accompany
5 you on the trip to Charleston?
6 A Yes.
7 Q Okay. Do you know who that was?
8 A Scott Titmus, Eric Teter, and there was one
9 other gentleman. I can't recall his name at the
10 moment.
11 Q Okay. Scott Titmus we talked about before.
12 He's now the president of Republic; correct?
13 A Yes.
14 Q Okay. What was his part in that trip?
15 A Helping in preparation of the proposal.
16 Q And Eric Teter, you mentioned, what was his
17 involvement?
18 A Same.
19 Q Okay. Was Mr. Teter one of the field
20 operations people you described?
21 A At the time, he was the vice president.
22 Q Okay. Was he also one of the folks that you
23 described as to evaluate those subjects you mentioned?
24 A Yes.
25 Q You mentioned there was a third -- I guess,

1 fourth individual. I know you can't recall his name,
2 but what aspect of this did he have?
3 A We all filled a common role of evaluating the
4 operations.
5 Q You indicated surface issues, trip hazards,
6 lighting, drainage, signage, vegetation. Would you
7 four who came on that trip been the ones to evaluate
8 that?
9 A Yes.
10 Q Were any other individuals with further
11 expertise in those particular areas consulted with
12 respect to the George Street lot?
13 A No.
14 Q Did you -- how long did you stay in Charleston
15 during that trip?
16 A I believe it was two days.
17 Q Okay. Did you evaluate the facilities both
18 during the day and at night?
19 A I cannot recall.
20 Q Okay. What is your general practice when you
21 go on a site visit?
22 A There is no general practice.

3 Q And when you say parking demand studies, do
4 you actually perform any data collection yourself on
5 those visits?
6 A Yes.
7 Q Okay. Is that with particular devices to
8 measure counts?
9 A Eyeballs.
10 Q Okay. Fair enough. And that is -- I don't
11 do what you do, so I may not know. But is that
12 essentially eyeballing the lot, roughly counting the
13 amount of vehicles in it, and the traffic going in and
14 out type of operation?
15 A Typically, yes.

5 Q So in this particular instance, this RFP visit
6 to Charleston, did the City even know that you were
7 here?
8 A No.

3 Q Would you say that the amount of facilities
4 managed for the City of Charleston was a fair amount?
5 A If you're measuring by number of facilities,
6 it's one of the larger ones.
7 Q Okay. One of the larger management agreements
8 that Republic had at the time?
9 A Yes.

17 Q Okay. You mentioned one point of evaluation
18 was trip hazards, and you also mentioned lighting. How
19 did you four gentlemen assess the George Street lot for
20 trip hazards and lighting?
21 A I can't recall specifically about that
22 particular lot.
23 Q Do you recall how you did that specifically
24 for any of the lots at the City of Charleston when you
25 came to visit?

1 A I can only comment typically what we would do.
2 Q What would be a typical evaluation of those
3 two items?
4 A Lighting, we would want to make sure that
5 it was sufficient to see your pathway and also for
6 the lot to be visible for cars to enter the lot.
7 Marketing-wise: On the trip hazards, we would look for
8 uneven pavement, potholes, conduits, overgrowth of
9 vegetation.
10 Q As to the trip hazard general evaluation,
11 would you also look at placement of parking spaces?
12 A Potentially.
13 Q Okay. Those two topics you discussed, the
14 lighting and the trip hazards, I understand that to be
15 generally what you would do; correct?
16 A Yes.
17 Q As you sit here today, do you know if you
18 performed those two functions here at the City of
19 Charleston during your site visit?
20 A I can't recall specifically during that visit.
21 Q And I think the same answer exists
22 specifically as to the George Street lot?
23 A Yes, sir.
24 Q Okay. I know it's going back to 1997, but
25 when you viewed the George Street lot, do you know if

1 you viewed it during the daytime or at nighttime?
2 A I do not recall.

11 Q Okay. Question, going back to the lighting,
12 you indicated that generally you would evaluate it to
13 see if there was sufficient lighting, to see pathways,
14 and for folks to see the lot for marketing purposes?
15 A Correct.
16 Q How do you make the determination whether or
17 not the light or lighting is sufficient?
18 A Eyeball.
19 Q Do you have any specific training in measuring
20 ambient lighting?
21 A No, sir.
22 Q Do you or Republic generally use light meters
23 or any other devices to measure light?
24 A No, sir.
25 Q You've been with Republic for quite some time;

1 correct?
2 A Yes.
3 Q And do you roughly know how many individual
4 parking locations are under your management?
5 A Mine specifically?
6 Q Correct. Roughly.
7 A 350.
8 Q Okay. Based on your experience with Republic,
9 has there ever been an issue where Republic questioned
10 the sufficiency of a lighting in a parking lot?
11 A Yes.
12 Q Was that in the City of Charleston, or outside
13 the City of Charleston?
14 A I don't recall any issues in Charleston, but I
15 do recall other issues outside of Charleston.
16 Q Has Republic ever had a lot or parking
17 facility tested for sufficiency of illumination?
18 A I'm sure we have, but I can't recall any
19 specifics.

15 Q No, I'm just asking. Is illumination related
16 to safety in a particular lot?
18 A Typically it is.
19 Q Why would that be?
20 A Common sense. People need to be able to see
21 where they are walking, see their vehicles.

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21 Q After Republic -- I use the term "won," but I
22 don't know what the right term is -- was awarded the
23 agreement -- the management agreement based on the RFP,
24 did you personally have any input on the management
25 agreement that was eventually agreed to with the City?

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1 A Yes.

16 Q Mr. Skelton, I'm handing you what's been
17 marked as Exhibit 2. I know we've been talking about
18 the, quote, agreement. Do you recognize that document
19 in Exhibit 2?
20 A Yes.
21 Q Is this a copy of an agreement between the
22 City and Republic for management of its parking?
23 A Yes, sir.
24 Q Do you know if that agreement covers the lot
25 at issue in this case, the George Street location?

Page 32

1 A Yes, it does.

Page 33

Page 35

Page 34

9 Q Do you know the last time you actually visited
10 the site physically?
11 A Approximately 2000.
12 Q The year 2000?
13 A Yes.

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4 Q I'll just ask it again. Why does Republic do
5 the evaluation that you mentioned generally for surface
6 conditions, trip hazards, lighting, drainage, signage,
7 and vegetation?
8 A To perform our duties to the client, live up
9 to the contractual obligations, minimize our own risk
10 exposure on our [redacted] that we're required to carry.
11 Q When Republic manages a facility, is Republic
12 responsible to keep the facility free from hazardous
13 condition?
15 A Not necessarily.
16 Q Would that be a function of the contract
17 between the parties?
18 A Yes.
19 Q Okay. I am going to point you to Article III
20 of Exhibit 2, which begins on the fourth page of the
21 document. Did you locate that Article III?
22 A Yes.
23 Q Okay. I'm sorry. I'm going to take you to
24 Article IV. Article IV, Section 4.1, by my reading, is
25 styled, Maintenance of the Parking Facility; correct?

1 A Yes.
2 Q 4.1(a) is titled General Upkeep; correct?
3 A Correct.
4 Q 4.1(a)(1)(b) states: Republic shall, as part
5 of the Operating Advance, perform the following: Keep
6 the facilities in a properly maintained state, free
7 from hazardous condition and deterioration, normal wear
8 and tear excepted.
9 Did I read that correctly?
10 A Yes.
11 Q My question before, as to responsibility to
12 keep the facilities free from hazardous condition, you
13 answered that with, that depends; correct?
14 A Yes.
15 Q Okay. And we then discussed that that
16 probably depended on the contract between the parties;
17 correct?
18 A Correct.
19 Q What we just read here in Article IV of
20 Exhibit 2, under this agreement, did Republic have the
21 obligation to keep the facilities free from hazardous
22 conditions?
23 A Correct, in the context of the remaining
24 provisions of the agreement.
25 Q Understood. And when you indicate in the

1 context of the remaining provisions, what do you
2 specifically mean by that?
3 A Some areas, the City's control of the budget,
4 the City's obligations spelled out within the
5 agreement, and the City's control of our operating
6 practices.
7 Q Does Republic ever, as a matter of course, for
8 the facilities it has under management, monitor
9 specifically lighting conditions at those facilities?
10 A Can you repeat that?
11 Q Sure. Does Republic, as a matter of course,
12 for the facilities it has under management, monitor
13 lighting conditions at those facilities?
14 A Yes.
15 Q How is that done?
16 A Visual inspection.
17 Q Is that a visual inspection of the employees
18 that are on-site?
19 A In part.
20 Q Okay. What would the other part be?
21 A Someone like myself visiting the city and
22 touring the facilities to be aware of lighting.
23 Q We'll talk briefly in a moment. We won't go
24 through all of them. But I've seen in this case some
25 inspection checklists as to the facilities. Are you

1 aware of those documents?
2 A Yes, sir.
8 Q The quarterly inspection checklist?
9 A Yes, that's what I was referring to.
10 Q Okay. Is that a document that is used by
11 Republic nationwide to do its quarterly inspections of
12 the lots?
13 A Yes.
24 Q Okay. To your knowledge, has Republic ever
25 faced a situation where it had a lot under management,

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1 and Republic deemed the lighting to be insufficient at
2 that facility?

4 A Yes.
5 Q Is there a specific instance that you recall,
6 based on that answer?
7 A One I can recall is the Houston example I had
8 given you previously.
9 Q Okay. In that scenario, what was the issue?
10 Were there not enough lights? Were the lights too dim?
11 What do you recall about that?
12 A In that particular case, there was not enough
13 light fixtures.

23 Q The insufficiency of the lighting, was that
24 something Republic noticed on its own?
25 A Yes.

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1 Q Okay. Did Republic then bring that to the
2 attention of the property owner?
3 A Yes.
4 Q I guess, based on those discussions, the
5 lighting was improved?

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5 Q Okay. And what I'm just trying to clarify is,
6 I know there's quarterly inspection reports. I know
7 that you told me that you haven't been on-site since
8 2000. Are there any writings which document
9 inspections of the George Street lot besides the
10 quarterly inspection reports we have?
11 A There should be maintenance checklists, but I
12 couldn't say for sure if they exist or not.

21 Q Do you know if George Street, at the time
22 Republic managed it, was a 24-hour lot?
23 A I believe it was.
24 Q Okay. How would Republic know if a lot is
25 simply too dark, which would give rise to safety

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1 issues?
2 A Visual inspections.
3 Q And by that, do you mean the quarterly visual
4 inspections?
5 A No. It would be every employee is obligated
6 to note any safety hazards, any lighting issues on the
7 lot.
8 Q And based on that, would that be the
9 subjective interpretation of that -- of those
10 employees?
11 A Yes. We employ no engineers in that regard.
14 Q Mr. Skelton, I've marked Exhibit 3. Do you
15 recognize that type of document?
16 A Yes.
17 Q Okay. What generally is that?
18 A This is a quarterly self-inspection checklist.
19 Q And we've talked a little bit about these, but
20 are these documents -- these form documents in the
21 files of the general manager of a particular vicinity
22 that's under management?
23 A They should be.
24 Q And is the general manager required to
25 complete these by a specific date per year or per

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1 quarter?
2 A Yes.
3 Q And when a general manager completes one of
4 these, what does he then do with it?
5 A It's sent to our corporate [redacted]
6 department.
7 Q Is that at the same location where you
8 currently work out of?
9 A Yes. a different suite, but the same
10 building.
11 Q You said [redacted] department. Tell me a
12 little more about that department. Is it [redacted] or
13 is it operations or is it both?
14 A The [redacted]e department is -- primarily deals
15 with liability [redacted], health [redacted], workers'
16 comp.
17 Q Okay. Does this document, Exhibit 3, one of
18 these quarterly inspections, does it come up the chain
19 at all to the district manager of the region?
20 A If there's an issue noted.
21 Q Okay. Would it ever -- would one ever rise to
22 your level, the regional vice president?
23 A Possibly.
24 Q Okay. If I'm Dwight Potter, I complete one of
25 these, and in this case on July 27th, 2012; correct?

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1 A This particular one, yes.
2 Q And how does he transmit it to this [redacted]
3 department?
4 A I couldn't say for sure how it was
5 transmitted, but it likely was sent via FedEx.
6 Q If an issue is noted, is there any protocol
7 from there with the [redacted] department?
8 A Protocol would be for them to follow up with
9 the on-site manager to make sure it was resolved.
10 Q When would a district manager have an
11 opportunity to view that under that scenario?
12 A It would be at the discretion of our
13 [redacted] department to evaluate it.
14 Q So it goes to the general manager to the
15 [redacted] department, and then the [redacted] department
16 would get the district manager involved, if necessary?
17 A Yes.
18 Q Okay. As to Exhibit 3, on the front face of
19 it, the first area in Section A is identified and says,
20 Parking areas well illuminated with designated
21 entrances, exits, and directional signs; correct?
22 A Yes, it does.
23 Q In this particular instance, there's a
24 checkmark for yes; correct?
25 A Correct.

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1 Q Is there any training given to the folks
2 completing these to determine what is well illuminated
3 and what is not?
4 A No.
5 Q Based on this, Exhibit 3 --
6 I can't tell who completed this.
7 -- is there anything on here that would give
8 you an indication of who filled this out?
9 A Not that I see.
10 Q On the bottom, it says -- there's a space that
11 says: CO, slash, lot number, and in it is written 440;
12 correct?
13 A Correct.
14 Q Is that a numerical given by Republic to that
15 particular lot?
16 A Yes. It's the account number.
17 Q Okay.
18 A The lot number.
19 Q Is this the same self-inspection checklist
20 that is used by Republic nationally?
21 A Yes.

6 Q Okay. Mr. Skelton, when did you learn,
7 approximately, of the incident that we're here for
8 today?
9 A A few months back.
10 Q Are you the nonlegal representative of
11 Republic that's responsible at all for this claim?
12 A Yes, I've been designated as such.

3 Q Okay. Does Republic have a form document
4 that's used for any incidents or injuries which takes
5 place on a facility that it has under management?
6 A Yes, sir.
7 Q Who has those form documents? Is that the
8 general manager?
9 A Are you referring to blank forms?
10 Q Correct.
11 A Yes.
12 Q Is there a protocol that's in place for the
13 completion or documentation of any incidents on your
14 facilities?
15 A Yes.
16 Q The general manager does not work 24/7;
17 correct?
18 A That is correct.
19 Q What does your operations manual, or any
20 other policy you have, say about employees reporting
21 incidents?
22 A They're supposed to promptly report them,
23 based on the incident itself, to the different
24 entities, whether it be the police, fire, ambulance, a
25 client.

1 Q What about internally to their superiors at
2 Republic?
3 A It's typically after the incident has been
4 dealt with, they are to notify the corporate office of
5 an incident.
6 Q Is that done on a particular document?
7 A Yes.
8 Q And is that something that's entitled, like,
9 Republic Incident Report or something of that nature?
10 A I think you nailed it.
11 Q Do you know if one of those has been completed
12 in this particular case?
13 A I would expect it has.
14 Q Have you seen one that's been completed?
15 A Not that I recall.
16 Q Should one have been completed?

18 A It depends when we were alerted of the
19 incident.
20 Q Okay. Do you have a policy that requires
21 employees to document an incident where someone is
22 injured on a lot you manage?
23 A Yes.

1 Q I'm going to hand you what's been marked
2 as Exhibit 4. Have you ever seen that before,
3 Mr. Skelton, before now?
4 A Not that I recall.
5 Q Okay. Have you personally talked with any
6 employees of Republic that were either a witness to
7 this incident or had knowledge of it?

15 Q Do you know a Kenneth Lee, by any chance?
16 A No.
17 Q What I've marked as Exhibit 4 appears to be a
18 statement on a lined piece of paper; correct?
19 A It appears to be.
20 Q Would you expect that there be further
21 documentation of an incident than what's been marked on
22 Exhibit 4?

24 A Typically there should be.

24 Q (By Mr. Kahn) As you sit here today, do you
25 know the gross revenues for the George Street location

1 for any particular year?
2 A Prior to coming to the deposition, I reviewed
3 the 2012 financials, and it was approximately $660,000
4 in gross revenue?
5 Q From George Street?
6 A Yes.
7 Q Did you review any other year besides 2012?
8 A The previous year, and they were about the
9 same, a slight increase in the latter year.
10 Q I asked about gross revenues, and that's, I
11 believe, the answer you gave me; correct?
12 A Yes.

2 Can you briefly give your education for me?
3 A Education?
4 Q (Moves head up and down.)
5 A Received a Bachelor of Arts from the
6 University of Minnesota and a J.D. from Hamline
7 University.
8 Q What was your Bachelor of Arts in?
9 A Political science and sociology.
10 Q And what year did you get that?
11 A It would have been 1990.
12 Q And you said you got your J.D. from Hamline
13 University?
14 A Yes, ma'am.

17 Q Did you sit for the bar?
18 A I did.
19 Q Have you sat for more than one bar?
20 A No.
21 Q What state did you take the bar for?
22 A Minnesota.
23 Q Did you practice in Minnesota?
24 A I did.
25 Q How long?

1 A Less than two years.

17 Q Okay. You've testified a couple of times
18 about some things that y'all would do, and you said
19 whether it was -- for the duties to the client were
20 contractual obligations or to minimize risk regarding
21 the [redacted] that you carry. What is incorporated in
22 that? What did you think that Republic was responsible
23 to do in order to meet those obligations?
24 A Which obligations specifically?
25 Q Any of them. Start with duties to the client.

1 A As far as to the client, I would refer to the
2 contract document.
3 Q Have you reviewed that document?
4 A Yes, ma'am.
5 Q Okay. From your review of that document, what
6 is your understanding of -- or what is your opinion
7 regarding Republic's duties to the City of Charleston?

9 A To manage the parking facilities according to
10 the terms of the agreement.
11 Q And how do you define "manage"?

13 A Oversee the operational aspects on behalf of
14 the City.
15 Q And what do you mean by the terms of the
16 agreement?
17
18 A The actual wording of the document itself.
19 Q Okay. Under the agreement, Republic was -- or
20 one of their responsibilities or obligations was to
21 operate and manage the lots and/or garages controlled
22 by that contract. Is that correct?
23 A Correct.

17 Q As a part of Republic's responsibilities
18 for -- under the Operating Advance section of this
19 contract, Republic was responsible for regular and
20 frequent inspections to determine whether maintenance,
21 repair, and/or replacement of the facilities was
22 required; is that correct?
23 A What paragraph?

1 Q If you go to 4.1(a) 1(a): Republic shall make
2 regular and frequent inspections to determine whether
3 maintenance, repair, and/or replacement of the parking
4 facilities is required.
5 A That's what it says, yes.

8 Q When Republic performed those duties, if they
9 identified anything that required maintenance, repair,
10 or replacement, would Republic alert the City?
11 A Yes, ma'am.

15 Q Republic was responsible to keep the parking
16 facilities in a properly maintained state, free from
17 hazardous conditions and deterioration, normal wear and
18 tear excepted. Correct?
19 A That's what it says.
20 Q Do you consider illuminations a hazardous
21 condition or possible hazardous condition?

23 A Depends on the state of illumination.
24 Q Would you consider insufficient illumination a
25 hazardous condition?

4 Q In the times that you would come down, when
5 you were responsible for this territory, if you came
6 down and thought the lighting was bad, would you
7 consider that a hazardous condition?
8 A Yes, ma'am.
9 Q And would you have reported it or identified
10 it?
11 A I would have identified it.
12 Q Okay. And you would have identified it or
13 reported it to the City?
14 A Possible.

18 Q Okay. Well --
19 A If the light bulb was out, I would probably
20 instruct someone to have it replaced.
21 Q And if it wasn't the light bulb, if you
22 thought there were too little lights?
23 A Then I would definitely make sure the City was
24 aware of it.

5 Q Under y'all's general contracts, if you find
6 an issue like that and you think there's insufficient
7 lighting, like you told us in Texas, you bring that to
8 the property's owner attention; correct?
9 A Typically, yes.
10 Q Okay. Is there any notation or report or
11 memo in Republic's file to say, hey, we've raised this
12 issue -- we think there's insufficient lighting here,
13 and we've raised the issue with the owner?
14 A Possible. There's no standard protocol,
15 though.
16 Q And you don't recall that being an issue with
17 the George Street parking lot; is that correct?
18 A I do not recall.

7 Q To (a): Be responsible for preventative
8 maintenance and repair of all the parking facilities
9 under this agreement.
10 A Yes, that's what the document says.

16 Q Do you believe that that section would include
17 an obligation by Republic to let the City know if they
18 felt like there was insufficient or poor lighting --

20 Q -- at this lot?

22 A Which section are you referring to?
23 Q At (b)(1)(b).
24 A It would depend on the situation.

Page 77

Page 79

Page 78

2 Q Okay. Under this contract, there's a hold.
3 Do you believe -- tell me what situation would Republic
4 not have been responsible to alert the City that they
5 believed that the lighting was either poor or
6 insufficient at this lot?
7 A If we believed it was poor and insufficient,
8 then, yes, we are obligated to notify the City.
9 Q At any time, do you recall Republic believing
10 that the lighting at this lot was poor or insufficient?
11 A No.

Page 80

Page 89

Page 91

Page 90

Page 92

7 Q Mr. Skelton irrespective of whether -- or
8 whoever built or designed this lot, you would agree
9 with me that when Republic came in and agreed to manage
10 this particular lot, it was still responsible to keep
11 the lot free from hazardous conditions, in accordance
12 with the agreement; correct?

14 A That's what the contract says, yes.
15 Q As you sit here today, you don't know what the
16 particular design called for, as far as lighting and
17 curbing, with respect to the George Street lot, do you?
18 A No, I do not.

23 Q Republic Parking Systems is in the business of
24 operating and managing parking garages and parking
25 lots, basically parking systems; is that correct?

1 A Yes.
2 Q And do you believe Republic Parking Systems,
3 Inc., has, whether through training, education, or
4 experience, a better understanding or knowledge of the
5 requirements of a properly operating or properly
6 -- I'll just say of a proper parking system?

16 Q Okay. And I believe, in the agreement, it
17 was -- once the agreement was signed, the physical
18 facilities became the responsibility of Republic; is
19 that correct?
21 A That's what the contract states, yes.
22 Q Okay. And that would include the lighting; is
23 that correct?
25 A If that's what the contract states, yes.

1 Q And you testified earlier that Republic,
2 pursuant to their duties and obligations, whether to
3 themselves, their client, or their -- to minimize risk,
4 did assessments -- precontractual assessments, as well
5 as postcontractual evaluations of these lots and/or
6 garages; is that correct?
7 A That's correct.
8 Q Which included their opinion or evaluation of
9 lighting; is that correct?
10 A Yes.
11 Q Whether sufficient -- whether it was or wasn't
12 sufficient or insufficient; is that correct?
13 A Subjective, yes.
14 Q Okay. And that was a duty that was undertaken
15 by Republic; is that correct?
17 A That's what the contract calls for, yes.

7 Q From your inspections, and the times you've
8 ever seen the lot and what you have seen as far as
9 reviewing any documents from Republic, do you believe
10 that Republic ever believed that this lot was
11 insufficiently lit?
12 A From my personal knowledge, no.
13 Q Okay. Under the agreements, as we've
14 gone through the agreement here today regarding
15 responsibilities and obligations, do you believe that
16 it was Republic's responsibility or obligation to alert
17 the City if they believed that there was -- that this
18 lot was insufficiently lit?
20 A Yes. If we believed it was insufficiently
21 lit, we should have notified the City.
22 Q And the only business Republic is in is
23 operating and/or managing parking systems; is that
24 correct?
25 A No.

1 Q What other businesses are they in?
2 A We provide shuttle, taxi/charter services,
3 consulting services, wheelchair assistance. All kinds
4 of areas of -- related to parking and transportation.
5 Q But it's related to parking or transportation?
6 A Typically.
7 Q That's Republic's bailiwick. This is their
8 specialty?
9 A It's in our name.
10 Q That's what they do?
11 Do you believe it's unreasonable for
12 Republic's clients to rely upon Republic's knowledge
13 and expertise in these areas?
15 A In my opinion, it's not unreasonable for them
16 to rely upon our expertise, no.

2 Q They believe it is insufficient lighting.
3 That's the situation. That's the condition. Whose
4 responsibility do you believe it is?

6 A It depends on the causation.
7 Q What do you mean by "causation"?
8 A If it is determined that there was
9 insufficient lighting, what is the reason for the
10 insufficient lighting.
11 Q Such as?
12 A A burnt out light bulb.
13 Q That would be Republic's responsibility?
14 A Yes, ma'am.

16 Q How about whether or not there are or are not
17 enough light fixtures?
18 A Depends -- well -- that would be the City's
19 responsibility as a capital project.
20 Q Okay. Once they're alerted that there -- let
21 me back up. They would be responsible to pay for it?
22 A Authorize the work, yes.
23 Q Okay. Who is responsible for identifying that
24 the work is needed?

1 A I would say it's a combination of both the
2 operator and the landowner.

1 REPORTER'S CERTIFICATE
2
3 STATE OF SOUTH CAROLINA)
) ss
4 COUNTY OF BERKELEY)

5 I, ROLAYNE M. VOLPE, Certified Court Reporter,
CCR, and Registered Professional Reporter, RPR, do
6 hereby certify that the transcript of the foregoing
proceedings accurately reflects the events that
7 occurred before me to the best of my ability at the
time and place set out on the caption hereto; that the
8 witness was by me duly cautioned and sworn, or
affirmed, to tell the truth, the whole truth, and
9 nothing but the truth; that the testimony of the
witness and all objections made at the time of the
10 examination were recorded stenographically by me and
were thereafter transcribed by computer-aided
11 transcription; and that the witness was given an
opportunity to read and correct said deposition and to
12 subscribe the same.
13
Should the signature of the witness not be
14 affixed to the deposition, the witness shall not have
availed himself or herself of the opportunity to sign
15 or the signature has been waived.
16
I further certify that I am neither counsel
17 for, related to, nor employed by any of the parties to
the action in which these proceedings were taken or to
18 any attorney or counsel employed by the parties hereto,
nor financially interested, directly or indirectly, in
19 the outcome of this action.
20
CERTIFIED AND SIGNED on this 3rd day of June,
21 2014.
22
23
ROLAYNE M. VOLPE, CCR, RPR
24 Certified Court Reporter and
Registered Professional Reporter
25 Commission Expires: 8-30-2021

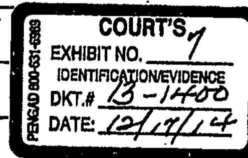
PREPARED BY

DATE

Judge,

We would feel more comfortable having a copy of what you just read to us as far as the specific laws we just heard and need to understand. Can you provide a written copy of it?

Anna Bronkowitz Juror #28



27

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Charge requested Ct's #7

Under our constitution, and under our laws, you, and only you, can make the findings of fact in this case. To determine the facts in this case, you will have to evaluate the credibility and believability of each witness. The fact that testimony is not contradicted directly does not necessarily render it undisputed. There remains the question of the inherent probability of the testimony and the credibility of a witness which you of course are to decide. In deciding these issues, you may consider what was the manner and appearance of the witness who testified -- was he or she straightforward, or hesitant in answering? Was the testimony of a witness consistent -- or inconsistent? How did the witness come to know the facts that he or she testified to? - - or what was his ability to know these facts? Is there some reason a witness would want to give testimony which would help -- or hurt -- one side or the other? In other words, was the witness biased or prejudiced? Was the testimony of a witness strengthened -- or weakened -- by other testimony or evidence?

Our law allows you certain very broad discretions in deciding truth. You have the right to believe one witness and disbelieve another; you can believe a part of what a witness tells you and can disbelieve the rest; you can believe one witness against many or many witnesses against one. These considerations you do not exercise arbitrarily, but if, in your good judgment there is a sound reason in the record of this case for so doing, you do have that prerogative. During this process you do not determine the truth merely by counting the number of witnesses presented by each side. Your objective, ladies and gentlemen, is to find the truth, regardless of the source of evidence.

It is also your duty to accept the law from the court, regardless of what you personally believe the law is, or ought to be. You are to apply the law to the facts and in this way decide the case. The order in which the instructions are given to you has no significance as a whole, and you should not place undue emphasis on any particular instruction or part of an instruction.

The evidence you are to consider consists of the testimony of the witnesses and the exhibits that have offered and received during the trial. The remarks of the attorneys are not evidence. Their statements and their arguments are intended to help you understand the evidence and apply the law. You should disregard any remark, statement or argument which is not supported by the evidence or the law

Rdg (1)

as given to you by the court. The law does not permit me to comment on the evidence. If it appears to you that i have so commented, during either the trial or the giving of these instructions, you must disregard such comment entirely. You are the judges of the facts and i cannot interfere with that responsibility.

The rules of evidence ordinarily do not permit witnesses to testify to opinions or conclusions. An exception to this rule exists for witnesses we call expert witnesses. A witness who, by education and experience, has become expert in some art, science, or profession, may give an opinion as to the subject the witness claims to be an expert in, and may also give the reasons for the opinion. You should consider any expert opinion given by a witness and, like any other evidence, give it the weight you think it deserves. If you decide that an expert witness' opinion is not based on sufficient education and experience, or if you decide that the reasons given in support of the opinion are not sound, or that the opinion is outweighed by other evidence, you may disregard the opinion entirely.an expert witness' testimony is to be given no greater weight than that of other witnesses simply because the witness is an expert, and you do not have to accept an expert's opinion, even though it is not contradicted.

There are two kinds of evidence recognized by our laws. Evidence may be either direct or circumstantial. These two kinds of evidence apply to the parties alike, the plaintiff and the defendant, and both are equally good in the law. The law makes absolutely no distinction between the weight or value to be given to either direct or circumstantial evidence. Nor is a greater degree of certainty required of circumstantial evidence than of direct evidence. You should weigh all the evidence in the case. On a particular factual point, you may have direct evidence, circumstantial evidence or a combination of these kinds of evidence.

Direct evidence proves a fact without an inference and if true, conclusively establishes that fact. Direct evidence is testimony of a person who has perceived certain facts by means of his senses and comes in to testify what he perceived. If you, the jury, believe the evidence to which he testifies, that evidence will conclusively establish a particular fact.

Circumantial evidence proves a fact from which an inference of the existence of another fact may be drawn. An inference is a deduction of fact that may logically

RAP (2)

and reasonably be drawn from another fact or group of facts. In other words, you may infer that a particular event that occurred based on proof of circumstances warranting such an inference. The proof as to circumstantial evidence is sufficient if shown by the preponderance of the evidence or the greater weight of the evidence. The conclusion reached in the minds of you, the jury, must be the most probable and reasonable one. In a civil case such as this, every other reasonable conclusion need not be excluded. If there are several reasonable inferences that may be drawn from all the circumstances and evidence, it is for you, the jury, to say which is established by the greater weight of the evidence.

In every civil action, the burden is on the plaintiff to prove every essential element of the claim by a measure of proof called the preponderance or the greater weight of the evidence. To "establish by a preponderance of the evidence" does not mean to prove something to an absolute certainty. Rather, it means to prove that something is more likely so than not so. In other words, a preponderance of the evidence means the evidence, when considered and compared to the evidence opposed to it, which has more convincing force and produces in your mind's belief that what plaintiff seeks to prove is more likely true than not true. Proof cannot rest on conjecture and mere possibility to meet plaintiff's burden of proof. Also the he defendant does not have the burden of proving that the negligence of another caused the injuries or damages; instead the burden is upon the plaintiff to prove that the defendant was negligent is some manner and the negligence was at least one of the reason he sustained some injury or damage.

With respect to the Defendant's affirmative defense of comparative negligence the Defendant has the same burden of prove as to each of the elements of that defense. That is the Defendant has to prove those elements by the preponderance of the evidence and the same restrictions indicated above as to Plaintiff's claim would likewise apply to the Defendant's defense.

Negligence

Negligence means that a person did not use the same amount of care that a person of ordinary reason and prudence would exercise in the same circumstances. The party claiming injury as a result of the negligence of another must establish a duty, which generally is defined as the obligation to conform to a particular

RWP (3)

standard of conduct toward another. The party claiming negligence must also prove a breach of that duty and that some damage or injury as a result of that breach. The word "careless" means the same thing.

It can be said that a negligent person has done something that a reasonable person would not have done, if faced with the same situation; or, on the other hand, that he has failed to do something that a reasonable person would have done -- or both.

To determine whether a particular act is negligent, you should compare that act with the manner in which a person of ordinary reason and prudence would have acted in similar circumstances. When a business adopts internal policies or self-imposed rules, then violates those policies or rules, you may consider such violations as evidence of negligence if they proximately cause injuries or damages.

The mere fact that an injury has been sustained or that an accident occurs is not, in and of itself, sufficient to prove negligence. The foundation of liability is actionable negligence. Negligence may be proved by circumstantial evidence, the facts and circumstances shown are to be evaluated in the light of ordinary experience, and conclusions should be reached about these facts and circumstances based on common sense.

The plaintiff claims that the Defendant not only was careless but also that the defendant acted was grossly negligent, recklessness, willful and wanton. These words are used to describe a conscious failure to use reasonable care. In other words, while a negligent person or entity is one who acts carelessly, a person or entity whose behavior is grossly negligent, reckless, willful and wanton is not only careless in his actions, but also is aware that he is careless. Conduct is willful, wanton or reckless when it is committed with a deliberate intention under such circumstances that a person of ordinary prudence would be conscious of it as an invasion of another's rights.

Plaintiff has the burden of proving grossly negligent, willful, wanton or reckless conduct by a standard that is greater than that required for negligence. If you will recall that standard for negligence is by the preponderance or greater weight of the evidence. The clear and convincing standard is greater than the probability standard for negligence. The clear and convincing evidence standard is defined as

RAJ (4)

that measure or degree of proof which will produce in the mind of the jury a firm belief or conviction as to the truth of the allegations sought to be established. Clear and convincing proof leaves no substantial doubt in your mind. It means that the evidence is not ambiguous, doubtful, equivocal or contradictory. Clear and convincing proof establishes in your mind, not only that the fact is probable, but that it is highly probable.

PREMISES LIABILITY

An invitee is a person who enters upon the premises of another at the express or implied invitation of the occupant for a purpose for which the premises are held open to the public or for a purpose connected with the business of the occupier that does or may result in their mutual economic benefit. The term "invitee" includes patrons upon the premises of any business open to the public and business visitors. One who controls the use of property has a duty of care not to harm others by its use. Conversely, one who has no control owes no duty of care.

The plaintiff claims that an unsafe condition on the defendant's premises caused him injury. In order to prevail the plaintiff must first prove by a preponderance, or greater weight, of the evidence that an unsafe condition existed on the defendant's premises. Next, the plaintiff must show that the unsafe condition was caused the defendant or that the defendant had actual or constructive notice of the unsafe condition. Constructive notice may be proven by showing that the unsafe condition had existed for a long enough time for the defendant to have discovered and fixed it. Just because an unsafe condition existed, standing alone is not enough to show that the defendant had notice of the unsafe condition. In that regard I charge you that a principal is affected with constructive knowledge of all material facts of which his agent receives notice while acting within the scope of his authority.

A occupier owes an invitee the duty of exercising reasonable or ordinary care for his or her safety and is liable for any injury resulting from the breach of this duty. This degree of care must be commensurate with the particular circumstances involved including the age and capacity of the invitee. This duty is an active or affirmative duty. It includes refraining from any act which may make the invitee's use of the premises dangerous or result in injury. The occupier of the premises

Bnl (5)

further owes an invitee the affirmative duty to use reasonable care to discover any unreasonably dangerous conditions on the premises and then to either put the premises in a reasonably safe condition for use in a manner consistent with the purpose of the invitation or to warn the invitee of the danger.

The precise manner in which the injuries might have occurred does not have to be foreseeable. It is sufficient that there is a greater than ordinary danger of injury of which the occupier knew or should have discovered by the use of ordinary care. The precise nature in which injuries are sustained does not have to be foreseeable to the occupier; it is sufficient that there is a reasonable generalized gamut of greater than ordinary dangers of injury and that the sustaining of the injury was within this range. An invitee is entitled to expect that the owner will take reasonable care to know the actual condition prevailing at the time the invitee is on the premises and either make those conditions safe or warn the invitee of the dangerous conditions.

The occupier is not an insurer of the safety of invitees. The duty is only to exercise reasonable care. An occupier is not required to maintain the premises in such condition that no accident could happen to a patron using the premises The plaintiff has the burden of showing that with the exercise of due care the defendant could have discovered the defect and remedied the situation. Therefore if a reasonable person would not have been aware of the risk or if the risk was not unreasonable, there is no liability.

An occupier of is not liable to his invitees for physical harm caused to them by any activity or condition on the land whose danger is known or obvious to the invitee, unless the owner/occupier should anticipate the harm despite such knowledge or obviousness. An invitee or customer is expected to use reasonable care for his or her own safety and avoid obvious dangers but the occupier may be liable for injuries to an invitee, despite an open and obvious defect, if the owner should have anticipated that the invitee would nevertheless encounter the condition, or that the invitee was likely to be distracted.

RM (6)

Comparative Negligence

One of the defenses interposed by the defendant is what is known as comparative negligence. You will recall that I have already defined the word "negligence" to you as the lack of due or ordinary care. "Comparative negligence" is negligence on the part of one party which is greater in degree of fault than that of the other party and which combines and concurs with the negligence of the other party to act as a proximate cause of the accident and without which the accident would not have happened. In other words, it required the fault of each of us for the accident to have happened, but the other party was more at fault than I was. As I have said, with respect to the complaint, the plaintiff has the burden of proving the negligence and fault, if any, of the defendant. For the purposes of this defense, the defendant has the burden of proving the negligence and fault, if any, of the plaintiff and the degree of such.

Where negligence has been established on the part of both the defendant and the plaintiff, then you must weigh or compare the respective contributions of each person to the occurrence. Considering the conduct of each person involved as a whole, you must determine whether one made a larger contribution than the other.

In making such an allocation of fault, you may consider:

1. Whether the conduct was mere inadvertence or whether the party was aware of the danger involved, or reasonably should have been aware of the danger involved;

2. The seriousness of the risk created by this conduct, including the number of persons endangered and the potential seriousness of the injury;

3. The nature of the goal the party was seeking to attain by her conduct and the need to achieve the goal in this manner

4. The party's superior or inferior aptitude or capacity, and his ability to realize and eliminate the risk involved;

5. The particular circumstances confronting the party at the time his conduct occurred;

6. The relative closeness of the causal relationship of the negligent conduct of the defendant(s) and the harm to the plaintiff; and

7. The conscious failure to observe due care or conscious indifference with respect to the rights and safety of others.

8. Any other facts and circumstances in the case which you find are appropriate.

Comparative negligence will defeat a recovery by a party only if the fault of that party was greater than that of the other party. Another way of saying this is to say that a party can recover only if his fault, if any, is equal to or less than that of the other party. If you find some negligence by the plaintiff that was not greater than that of the defendant, while it will not prevent recovery by the plaintiff but it will have an effect on the amount of the plaintiff's recovery.

Now, your verdict in this case should do one thing. It should speak the truth of this controversy as you twelve folks see that to be. You have got no friends to reward. You have got no enemies to punish. That is evidence. You should not be motivated by or consider in any passion, prejudice, caprice, or arbitrary whim should be involved in this process. Neither should you be motivated by sympathy, for either side in reaching your decision. You should conscientiously adhere to your oath, take the law as I've given it to you, examine these facts as you see them to be, the documents that you'll have with you and reach a decision which speaks the truth. No one will then have any right to criticize your verdict if you conscientiously apply your oath.

PREPARED BY

DATE

COURT'S EXHIBIT NO. 8
IDENTIFICATION/EVIDENCE
DKT.# 13-1400
DATE 12/17/15

Judge,

Can you clarify for us the definition of proving a "preponderance of the evidence" with regards to circumstantial evidence? We are struggling with knowing how much evidence is sufficient to reach a "preponderance of the evidence" (see pg. 3, 1st paragraph) → based on inference. We need clarification –

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PREPARED BY

DATE

Judge,

Can we judge/deem "negligence" after the incident/injury occured as described on page 3 + 4 of the charge you gave us? Can you clarify this for us?

A Brad[illegible]

Juror #28

COURT'S EXHIBIT NO. 10
IDENTIFICATION/EVIDENCE
DKT.# 13/400
DATE: 12/07/15

PENGAD 800-631-6989

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25
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1 IN THE COURT OF COMMON PLEAS
FOR THE STATE OF SOUTH CAROLINA
2 CHARLESTON COUNTY
FOR THE NINTH JUDICIAL CIRCUIT
3
4 DEPOSITION OF TODD A. SHUMAN, MD
5 ROBERT J. BURKE AND
JANE B. BURKE,
6
Plaintiffs,
7
vs. CASE NO. 2013-CP-10-1400
8
INDIGO REALTY COMPANY,
9 LLC, REPUBLIC PARKING
SYSTEM, INC., AND CITY
10 OF CHARLESTON,
11 Defendants.

12
DEPONENT: TODD A. SHUMAN, MD
13
14 DATE: AUGUST 4, 2014
15
TIME: 3:00 PM
16
17 LOCATION: ANDERSON REYNOLDS & STEPHENS, LLC
CHARLESTON, SOUTH CAROLINA
18
19
20
REPORTED BY: CHERIE J. ANDERSON, RPR, CRR
21 CLARK & ASSOCIATES, INC.
P.O. Box 73129
22 Charleston, SC 29415
843-762-6294
23 WWW.CLARK-ASSOCIATES.COM
24
25

1 A P P E A R A N C E S

2

ON BEHALF OF PLAINTIFFS

3

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ON BEHALF OF DEFENDANT INDIGO REALTY COMPANY

7

WILSON & HEYWARD, LLC
8 BY: JEANETTE HEYWARD
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ON BEHALF OF DEFENDANT REPUBLIC PARKING SYSTEMS

11

HAYNSWORTH SINKLER BOYD
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13 Charleston, SC 29402

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ON BEHALF OF DEFENDANT CITY OF CHARLESTON

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ANDERSON REYNOLDS & STEPHENS, LLC
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17 Charleston, SC 29401

18

19

20

21

22

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1 I N D E X

2 - - -

3 TODD A. SHUMAN, MD

		PAGE
4	EXAMINATION	PAGE
5	BY MR. McCULLOUGH	4
6	BY MR. DARLING	68
7	BY MS. REYNOLDS	79

8

9

10 EXHIBITS

	EXHIBIT NO.		PAGE
12	Exhibit No. 01	Curriculum Vitae	5
13	Exhibit No. 02	Potential Expert Witnesses	20
14	Exhibit No. 03	5/5/14 Letter/Subpoena	22
15	Exhibit No. 04	Handwritten Notes	24
16	Exhibit No. 05	Handwritten Notes/Diagnoses	64
17			
18	Sakran Exhibit No. 01 (prior exhibit)		90

19

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23

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25

1 TODD A. SHUMAN, MD
2 having been first duly sworn, was examined and
3 testified as follows:
4 EXAMINATION
5 BY MR. McCULLOUGH:
6 Q Good afternoon. My name is Clay McCullough.
7 We met just a second ago. And I'm here on behalf of
8 the Burkes in a lawsuit that's been brought.
9 And it's my understanding that you have been
10 disclosed as an expert witness by the City of
11 Charleston. Are you aware of that?
12 A Yes, I am.
13 Q Great. And have you been deposed before?
14 A I have been.
15 Q You know the ground rules: I'm going to ask
16 ask you some questions. You do your best to answer
17 those questions. If I ask you a question that does
18 not make sense, stop me. I'll do my best to explain
19 it.
20 If you want to take a break, just let me know.
21 Okay?
22 A Yes, sir.
23 Q What's your full name?
24 A Todd Alan Shuman.
25 Q Where are you from originally?

1 A I was born in Lawton, Oklahoma. But my dad
2 was in the military, so we moved around a lot.
3 Q Lisa emailed me a CV. And we can save some
4 time. I'm going to hand you what I'm going to mark
5 as Exhibit Number 1, and if you would flip through it
6 and tell me if this is, if not the most updated, a
7 reasonably updated CV.
8 (Exhibit No. 01 was marked for
9 identification.)
10 A Except for one error, this looks up to date.
11 Q And just so we're clear, what is that error?
12 A So I wasn't re-certified in surgery in 2010.
13 So I'm just going to mark through that for you.
14 Q So everything else is accurate?
15 A It looks to be accurate. Yes, sir.
16 Q Tell me -- and again, we don't need to go
17 through every detail, but just walk me through
18 generally your educational background, please.
19 A So I graduated from the University of Colorado
20 with a degree in physics, and after that, I went to
21 medical school at the Vanderbilt University School of
22 Medicine, which is in Nashville, Tennessee, and
23 graduated from Vanderbilt medical school in 1983.
24 I stayed at Vanderbilt and did a residency in
25 general surgery, and after completing a general

1 surgery residency, I went to Barnes Hospital, which
2 is Washington University in St. Louis, Missouri, and
3 did a three-year cardiac -- we call it residency;
4 some people would call it fellowship.
5 And then I returned to Nashville and was in
6 practice for about 18-and-a-half years doing cardiac
7 surgery -- cardiac and thoracic surgery.
8 Q When did you move to Charleston?
9 A The beginning of -- end of 2009/beginning of
10 2010.
11 Q What have you done professionally since you
12 moved here?
13 A So I moved here to start an intensive-care-
14 unit program at the Roper St. Francis Hospitals.
15 They didn't have an intensivist program at the time.
16 And after starting that, they asked me to be the
17 chief quality officer for the system.
18 And subsequently, now I'm the vice president
19 of quality for the Roper St. Francis Healthcare
20 System.
21 Q And are you actually a Roper employee?
22 A I am.
23 Q Do you have any private practice or just --
24 A No, sir.
25 Q And have you testified as an expert witness

1 before?
2 A I have, once.
3 Q One other time?
4 A Uh-huh.
5 Q And tell me about that.
6 A It was a case in Memphis, Tennessee. To be
7 honest, it's a number of years ago. I don't remember
8 all of the details about it. Right now I'm blanking
9 on it totally, but I can get you the information
10 about it. But I really -- I'll just make this
11 comment: I mean, in general, I don't do expert
12 testimony.
13 Several years ago, our society -- which is
14 called the Society of Thoracic Surgeons -- asked for
15 people to sign up for an expert witness sort of
16 registry that had certain conditions, testifying for
17 either plaintiffs or defendants, having your
18 testimony reviewed and so forth, and sort of a call
19 to an advocate for the profession, so to speak. And
20 so I felt that, you know, probably it was important
21 to do that, and so I agreed to do it intermittently.
22 I really don't have the time to do it, to be
23 honest, but if an occasional case comes along, I do
24 it.
25 Q What's the name of that registry?

1 A Society of Thoracic Surgeons Expert Witness
2 Registry.
3 Q And I may have gotten the question right or I
4 might have been too specific. I think I asked you if
5 you ever testified as an expert. Have you served as
6 an expert witness without testifying in other
7 matters?
8 A I have seen other cases. I certainly have,
9 yes, sir.
10 Q And to your knowledge, have you been disclosed
11 as an expert witness in other cases?
12 A I would say yes.
13 Q And tell me about how many times you've been
14 either hired or disclosed as an expert.
15 A Five, six, at the most. Not very often.
16 Q And have those five to six been since you've
17 been in South Carolina?
18 A No. I've never testified in South Carolina.
19 Q And again, let's get away from testimony --
20 A I've never been deposed. I've never given
21 testimony. I've never reviewed a case in
22 South Carolina. Sorry to interrupt you.
23 Q And when were you first contacted in this
24 case?
25 A It's going to be a roundabout guess, but I'm

1 going to say about six weeks ago.
2 Q And how were you --
3 A Let me take that back, because I originally
4 got a request for a deposition in June, so -- which
5 was very soon after I found out about the case. So
6 I'm going to say it was around the end of May/first
7 of June. And now it's August, so two months, maybe
8 two months and a week, something like that.
9 Q First of all, who actually hired you to serve
10 as an expert?
11 A So it was sort of a roundabout way. This case
12 was actually given to me by a urologist. The
13 urologist asked if I would be interested in expert
14 testimony that involved ICU care. And I said, you
15 know, usually I don't do that. And he said, well, I
16 would appreciate it if you would do it. And he gave
17 me, actually, the discs.
18 About the second day after I got the discs, I
19 got a letter actually from you or from your paralegal
20 saying you have been subpoenaed. And actually, I
21 called and said, you know, I'm not even sure I've
22 agreed to be part of this testimony. And I thought,
23 actually, the person I was talking to was the person
24 who hired me, but it was actually your office.
25 Q Okay.

1 A And only then they said, well, you're an
2 expert. You've been mentioned as an expert for the
3 City; you need to contact Ms. Reynolds.
4 So that's the way the case came to me, sort of
5 a roundabout way.
6 Q Who was the urologist?
7 A Bill Carter.
8 Q And do you know why he had the -- when you say
9 the DVD, are those Mr. Burke's medical records?
10 A Yes, and deposition. Deposition of him, his
11 wife, and the physician at MUSC.
12 Q And you said you have that --
13 A I do. I should have brought that. It's
14 probably in my car. I'll be glad to get it on break.
15 Q Let's just do this. The medical records and
16 what else was on the --
17 A And the depositions.
18 Q And which depos?
19 A The deposition of Mr. Burke, his wife, and
20 what I believe to be the first deposition of
21 Dr. Sakran.
22 Q And do you know him?
23 A I do not. No, sir.
24 Q And so you received these from Dr. Carter?
25 A Correct.

1 Q And do you know why he had those materials?
2 A I mean, what he told me is I've been asked
3 about this case; I think it's a more appropriate case
4 for somebody with a specialist in intensive care;
5 would you review it.
6 Q And at that time did you have any conversation
7 with Ms. Reynolds or anybody for this law firm, or
8 did you just receive the materials from --
9 A I just received materials. Actually, if I can
10 interrupt you, I had this -- this is probably why I
11 don't review very many cases. I had this policy
12 where I came from where I signed up for the expert
13 registry that I wouldn't talk to any lawyers before I
14 reviewed the case, and I would ask for the case to be
15 totally removed from, you know, any of these
16 letterheads that had lawyers' names. And so I had
17 asked for the records just purely to review, I'd
18 write a summary, and my assistant would send it to
19 the lawyer, and I thought it was the best way for me
20 to be blinded to whether it was a plaintiff or a
21 defendant case and therefore I wouldn't be biased
22 and, you know, I'd be able to give, you know, an
23 honest testimony.
24 I feel like I can give an honest testimony,
25 anyway, but it absolutely -- I thought -- raised the

1 credibility. But often lawyers want to talk to you
2 before they send you the case, so I think in general,
3 it's been an effective technique for not having to
4 review very many cases, actually.
5 Q So when do you believe you received the DVD
6 from Dr. Carter?
7 A Again, as I mentioned, I think it was right
8 towards the end of May.
9 Q And what did you do with those materials?
10 A So I looked at them on the -- on my laptop --
11 or my desktop, actually.
12 Q Had you started to review them prior to my
13 office harassing you?
14 A No. No. I mean, it was -- literally, it was
15 within a couple of days. I got this, and I called
16 your office to say -- and they did not harass me.
17 But I called your office --
18 Q I was being facetious.
19 A -- to say, you know, this seems a short period
20 of time. You know, I barely had the materials, and I
21 had looked at the disc enough to know that one of the
22 materials was 790 pages long. So I said, I need a
23 little time to review this, and they effectively
24 said, you're talking to the wrong person.
25 Q And tell me about what you did after that.

1 You called Ms. Reynolds at that point, or did you go
2 back to --
3 A So I started reviewing it, and then I called
4 her. I don't -- I'm going to say I may not have been
5 completely done, but I was completely done before I
6 ever talked to her.
7 Q And you mentioned a policy of writing a
8 summary, sending it to the attorney. Did you do that
9 in this case?
10 A I didn't.
11 Q And why is that?
12 A Again, I didn't know what -- you know, what
13 the -- I had never testified in South Carolina, I'll
14 say, so I didn't know what the policy was here. I
15 sort of had an idea, you know, in Tennessee. But in
16 this particular case, I just thought I'll just review
17 the materials, call, you know, the responsible party,
18 and sort of figure out how to proceed.
19 Q And in this case, you were asked to review the
20 medical records with an eye towards what?
21 A Well, initially, you know, I didn't know
22 exactly towards what, because Dr. Carter said this
23 patient had a fall, this gentleman had a fall -- and
24 the question is what was the cause of his fall --
25 and had some injuries related to that fall,

1 effectively.
2 He may or may not, to be quite honest, have
3 mentioned who had contacted him. He would be a
4 better judge of that. But it was sort of a cursory
5 conversation on the phone, and he actually left the
6 materials in my office, you know, next to my
7 computer.
8 Q Does he work with you at Roper?
9 A He's an independent physician. You know, he's
10 not employed by Roper, but as the vice president of
11 quality, I pretty much have contact with every
12 physician who practices at Roper because we're
13 talking about, you know, their outcomes.
14 Q Right. And Mr. Burke was a patient in Roper
15 as well; is that right?
16 A He was. And -- well, in Roper Rehab Hospital,
17 so not in the acute care hospital, but the -- it's
18 call an inpatient rehab hospital. So the post-acute
19 care hospital.
20 Q And is that affiliated with the Roper acute
21 care hospital?
22 A I mean, it's part of the healthcare system,
23 yes, sir.
24 Q And you understand that -- we haven't heard
25 your testimony yet, but the City is adverse to

1 Mr. Burke. They are a defendant; we're a plaintiff.
2 You understand that?
3 A I do, yes, sir.
4 Q And you've been disclosed as an expert witness
5 on behalf of the City, one of the defendants.
6 A I understand.
7 Q And is there a policy with regards to Roper
8 physicians testifying adverse to -- in cases where
9 they were a Roper patient?
10 A I will have to ask that. Should we stop and I
11 find that out before I testify?
12 Q No, sir. It occurs to me that -- did you
13 review the Roper medical records?
14 A Only if they were in this. I didn't go on our
15 internal records to review any records. Only records
16 that were sent to me.
17 Q And I have not reviewed what's in front of
18 you. If I understand it, he was in Roper Rehab for
19 approximately three weeks. Have you, to the best of
20 your knowledge, reviewed records of his stay at
21 Roper?
22 A I've reviewed part of those records. I would
23 say that is not a record that I reviewed in detail,
24 but I certainly reviewed the history and physical
25 when he came to Roper Rehab, when he was transferred

1 from MUSC to Roper Rehab Hospital.
2 Q I wrote this down, but I want to make sure I
3 got it right: The message that you received on the
4 phone was to review these medical records with an eye
5 towards what may have caused Mr. Burke's fall and
6 then his injuries related to the fall?
7 MS. REYNOLDS: Objection.
8 A I'm not going to say those are the exact words
9 that were said to me, so I'm not going to testify,
10 you know, that those were the exact words.
11 Q Sure.
12 A But what I recall -- and again, what I recall
13 is that Dr. Carter said, I reviewed a case about a
14 patient who had a fall, and I'm sure he said
15 something about in the intensive care unit, and I
16 think somebody who has intensive care unit experience
17 would be the best person to review this case.
18 Q So you reviewed these materials and --
19 A Hold on just a second.
20 Q Please.
21 A Can I talk to my attorney about -- should I
22 actually ask somebody at Roper about am I allowed to
23 testify? Can I ask -- can I ask the opinion?
24 MR. McCULLOUGH: We can go off the record.
25 (A recess was taken.)

1 Q So we're back on the record. So tell me, your
2 first conversation with an attorney on behalf of the
3 City, was that Ms. Reynolds?
4 A Yes. Yes, sir.
5 Q And tell me about the contents of that
6 conversation.
7 A So I just sort of gave her an overview of the
8 records that I had reviewed and just to sort of
9 discuss, you know, my thoughts about the plaintiff,
10 the patient.
11 Q And have you formed opinions in this case?
12 A I have.
13 Q And when did you form those opinions?
14 A Upon reviewing the record.
15 Q Which would have been in June?
16 A Yes, sir. Approximately, I would say.
17 Q I know you had gotten -- we described the
18 conversation with the referring doctor or the doctor
19 that gave you the DVD. What did Ms. Reynolds ask you
20 to do specifically?
21 A So the first time I actually talked to
22 Ms. Reynolds was, I'm going to say, the day before or
23 maybe two days before the videotaped deposition of
24 Dr. Sakran. And so she explained to me that she was
25 going to be taking the -- she was going -- you were

1 going to be taking the testimony, I think, of
2 Dr. Sakran, and she wanted to know my opinion of the
3 case.
4 Q And did you provide that to her?
5 A So -- yes.
6 Q And did you provide questions that she should
7 ask?
8 A I told her there were some things that I was
9 curious about. I'm not saying I gave her
10 word-for-word questions, but there were some things
11 that I thought were inconsistent between reading the
12 depositions that I had previously looked at and
13 reviewing the records.
14 Q Did you email her or mail her any documents to
15 review in anticipation of that deposition?
16 A To the best of my knowledge, no. I don't
17 remember emailing her anything.
18 Q After the deposition, when was the next time
19 you actually spoke to Ms. Reynolds about this case?
20 A I'm going to say about ten days ago.
21 Q Tell me about that conversation.
22 A So she sort of wanted to go over again my
23 formulation of what I had decided after reviewing the
24 record.
25 Q Now, from what I'm gathering, you had a

1 conversation with Ms. Reynolds when you found out
2 about the deposition that we had scheduled, there was
3 a conversation shortly before the video deposition of
4 the MUSC treating physician, and then a conversation
5 about ten days ago?
6 A No. So there were two conversations. The
7 first conversation was right before the videotaped
8 deposition of Dr. Sakran, and the second was ten days
9 ago.
10 Q When you were speaking with her prior to the
11 video deposition, had you already formulated opinions
12 in this case?
13 A By opinions, I would say that I thought there
14 were several reasons that the patient could have
15 fallen. I thought that there were -- that the result
16 of his fall and recovery was greatly influenced by
17 his comorbidities, and I thought that the extent of
18 his injuries may not be as great as were initially
19 stated in the first deposition of the physician. And
20 I relayed that information to her.
21 Q Have you ever worked for anybody in this law
22 firm prior to being retained in this case?
23 A No, sir.
24 Q And same question for the City of Charleston?
25 A No, sir.

1 (Exhibit No. 02 was marked for
2 identification.)
3 Q I'm going to hand you a document that I'm
4 going to mark as Exhibit Number 2 and ask you to take
5 a look at that.
6 A Thank you.
7 Q Do you see that?
8 A Yes, sir.
9 Q And would you agree with me this is an expert
10 witness designation by the City of Charleston?
11 A I'm not an expert in that, but if you say it
12 is, it appears that it is.
13 Q And you're Dr. Todd A. Shuman at 316 Calhoun
14 Street. Would you agree with that?
15 A Yes.
16 Q And would you agree with me that this document
17 signed by Ms. Reynolds is dated May 1st, 2014?
18 A Correct.
19 Q Do you know how the City had already
20 determined you would be an expert testifying on their
21 behalf against my client before you had ever even
22 reviewed any documentation in this case?
23 A I don't.
24 MS. REYNOLDS: Objection.
25 A I mean, I don't. I could be wrong on the

1 dates, number one -- slightly off. But I suspect
2 that there must have been -- I was supposing -- I
3 would expect there was some conversation between
4 Dr. Carter and the City before he talked to me.
5 Q And we can go through the documents if need
6 be.
7 A And let me back up just a second. So I talked
8 to Dr. Carter before he gave me the records. So he
9 called me and said, would you be willing to be an
10 expert, you know, for -- I'm not sure he said expert.
11 Would you be willing to testify, you know, in a case
12 that has information about the ICU. And when he
13 asked me that and when I got the records, I'm not
14 sure.
15 Q Let's do it this way: You testified
16 previously when you got the subpoena from my office,
17 at that point you had not seen these records.
18 Correct?
19 A I'm going to say that the envelope containing
20 the disc had potentially been dropped off to me, I
21 think is what I testified. What I said was I called
22 and I said, you know, it's a short period of time to
23 review records I've just received.
24 Q And at the time that you received that
25 subpoena, had you reviewed that DVD?

1 A No, I don't believe so.
2 Q And the phone call to my office basically was,
3 what is this about?
4 A Correct. I had not talked to any attorney at
5 that point, so I thought, actually, you were the
6 attorney. And so I called to say, I want to talk to
7 so-and-so, and they said -- and I read the subpoena,
8 and they said, well, you know, you've been deposed
9 [sic] as an expert on behalf of the City; you need to
10 talk to Lisa Reynolds.
11 (Exhibit No. 03 was marked for
12 identification.)
13 Q And I'll hand you what we'll mark as
14 Exhibit 3, which is the cover letter enclosing the
15 subpoena in this case.
16 Would you agree with me the letter is dated
17 May 5?
18 A I do.
19 Q And I'll tell you that we checked and it
20 appeared that you called my office on May the 12th,
21 shortly after receiving the subpoena, to say, what is
22 this about? Does that sound about correct?
23 A Again, I looked at the subpoena thinking you
24 might ask me about the dates, and I think there was a
25 second subpoena for a deposition in June.

1 Q Yes, sir.
2 A And so when I looked at that, then I sort of
3 backtracked and said, well, I called about, you know,
4 ten days before the subpoena and, you know, so I
5 thought, well, this says -- as I looked through it --
6 June the 12th or June the -- I don't remember the
7 exact -- in June and put that together.
8 But you've produced something where it was
9 earlier, and I stand corrected.
10 Q So let's circle back to my original question:
11 Do you know how it is that the City felt comfortable
12 disclosing you as an expert witness prior to you ever
13 reviewing any of the materials in this case?
14 MS. REYNOLDS: Objection.
15 A I do not.
16 Q Other than the documents that we've described
17 that were contained on the DVD, did you review
18 anything else in anticipation of providing opinions
19 in this case?
20 A And these additional documents I showed you
21 earlier today.
22 Q This stack of medical records?
23 A Some of these are duplicates of what was on
24 the DVD, but there are some additions.
25 Q Who provided you with the materials in front

1 of you?
2 A All the paper materials were provided by
3 Ms. Reynolds. All the DVDs were provided by
4 Dr. Carter.
5 Q How much time have you spent on this case?
6 A Before I talked to her the first time, I spent
7 about six-and-a-half hours, and knowing this
8 deposition was -- and then a conversation -- two
9 conversations with her the time period of that, and
10 then within the last three days, again, about
11 six-and-a-half to seven more hours.
12 Q And do you keep billing records?
13 A I keep the time I spend, uh-huh.
14 Q And do you have that with you here today, by
15 chance?
16 A No.
17 Q I'm going to ask if you would just forward to
18 your attorney the most recent, after today, billing
19 record of time that you've spent in this case. Okay?
20 A Yes, sir.
21 (This page contains requested information.)
22 Q Thank you. Let's go through. I'm going to
23 mark this packet as Exhibit Number 4.
24 MR. McCULLOUGH: And I believe -- does
25 everybody have a copy of all of these?

1 (Exhibit No. 04 was marked for
2 identification.)
3 Q And I truly do not want to belabor this. What
4 I'd like to do is, as quickly as possible, just have
5 you go through your notes to tell us what these --
6 first of all, what was the purpose of you taking
7 these notes?
8 A They're just notes to myself after I review
9 the records, viewing thousands of pages, and don't
10 want to go back through those thousands of pages to
11 try to get an idea of what happened to the patient.
12 Q And what is your understanding, in summary
13 fashion, of what happened to Mr. Burke on the evening
14 in question?
15 A So he fell or he said tripped trying to step
16 over a curb, is the way he described it, at least
17 according to the records.
18 Q And if you would just pull out the handwritten
19 notes that we've marked as Exhibit 4, and we can go
20 through them. And I'd like for you just to walk us
21 through what the notes state, starting with, I
22 believe, this page, page 1. And it says Duke Medical
23 at the top.
24 These records appear to be -- why don't you
25 tell me what medical records correspond to page 1.

1 A These records right here.
2 Q And these are from the North Carolina
3 Orthopaedic Clinic, Bates stamped -- I don't believe
4 they're Bates stamped, but anyway, these are from the
5 North Carolina Orthopaedic, which contain Duke
6 medical records. Is that correct?
7 A The sticker says North Carolina Clinic. The
8 designation looked like it's Duke.
9 Q Right. Okay. And the pages that you have
10 folded, are those pages where you had made notations?
11 A Or made notations here. One or the other.
12 Q And why don't you do this. I hate to ask you
13 to do this, but let's just go through these as
14 quickly as we can and tell me what it says and why
15 you felt it was significant, starting with the
16 7/9/2012.
17 A Do you want me to look at the records or do
18 you want me to look at this?
19 Q Let's start with the notes.
20 A So it says Duke Med. It says July
21 the 9th -- or 7/9/2012. Fatigues easily.
22 4/2/2013, Depo-Medrol injection, right knee.
23 Bilateral knee pain. Right end-stage knee
24 osteoarthritis.
25 5/28/2013, repeat Depo-Medrol injection.

1 Significantly improved symptoms after 4/2, but
2 recurred. Right end-stage knee osteoarthritis or
3 could have been blood in his knee from his Coumadin.
4 Q Tell me, do you have any opinions or do you
5 plan on offering any testimony as it relates to your
6 review of this portion of the medical records?
7 A So I'm not an orthopaedist, but when you say
8 end-stage knee osteoarthritis and are getting
9 Depo-Medrol injections, that would worry me about a
10 chronic problem, not an acute problem.
11 Q Meaning that this would not have been caused
12 by the fall?
13 A Meaning that it wouldn't have occurred within
14 the last few months.
15 Q Could it have occurred a year before or year
16 and a half before?
17 A I think there's other evidence that he had had
18 knee pain for quite some time, so I think that he had
19 had knee pain for a while.
20 Q Why don't we do this: Before we get into the
21 weeds, let's step back, and after your review of the
22 medical records, tell me generally your opinions in
23 this case.
24 A So I thought there was a discrepancy between
25 the deposition of the patient and how active he is

1 and at least the comorbidities that were present and
2 what he appeared from the records to be in terms of
3 being able to do.
4 I thought that there were a lot of reasons,
5 when you review it, that you would consider the
6 patient to be what we would call a fall risk and that
7 he had demonstrated previous falls. So it made me
8 concerned that there may be other reasons than just
9 light to be a reason for his fall.
10 In addition, I think that his inability to
11 recover quickly was really related to his underlying
12 disease, and there was some radiologic or x-ray
13 evidence that his injuries, again, weren't quite as
14 severe as at least outlined in the deposition that
15 the physician offered.
16 Q Anything else?
17 A No, sir.
18 Q And again, before we get really in the weeds,
19 I just want to go back through these, and I want you
20 to correct me if I state these wrong. But the first
21 one I've got generally is that the activities
22 Mr. Burke testified he was able to do before the fall
23 were overstated. Did I get that right?
24 A And I don't know Mr. Burke, but I would say
25 that what he stated in the deposition and, again,

1 what it appears that the records indicate -- there is
2 a discrepancy, which can often happen with patients.
3 Often patients compensate very well and think they're
4 doing very well, but at least his evaluation by the
5 physicians would not indicate that he was quite as
6 active as it appeared in his deposition.
7 Q And the physician records you're referring to,
8 are those ones before or after the accident?
9 A Before.
10 Q And would those records be in the Duke medical
11 records or other records that we haven't gotten to
12 yet?
13 A Other records.
14 Q Go ahead. And have you --
15 A Just a second, please.
16 Q Please.
17 A So I'll stand corrected. So all of his visits
18 at Duke were after the accident except for one visit,
19 and that one visit has some relation to his
20 debilitation.
21 Q And what was the date of that visit?
22 A July the 9th, 2012.
23 Q What other records have you reviewed that
24 occurred before the fall?
25 A So he first visited Dr. Hooper, who -- I don't

1 know Dr. Hooper, but he first visited Dr. Hooper in
2 May of 2007. So Dr. Hooper is -- are the records
3 that I know that it was his primary care doctor and
4 followed him for years before this incident.
5 Q Now, as far as his level of activities before
6 his fall, you've read Mr. Burke's testimony. Did you
7 also read Jane Burke's testimony?
8 A I did.
9 Q And I'm going to assume this, but I'll ask:
10 You haven't spoken to any of Mr. Burke's friends or
11 family or acquaintances, have you?
12 A No, sir.
13 Q And would you rely on the medical records that
14 you have reviewed, or would you rely on the testimony
15 of the patient and friends and family with regards to
16 a person's pre-accident condition?
17 A By condition, if you mean level of activity,
18 what he can actually do, I would say obviously the
19 patient has a better idea. If by condition you mean
20 what his medical illnesses are and how those medical
21 illnesses manifest, I would say the record is a
22 better judge.
23 Q And I believe you testified previously that
24 you were focused on the activities prior to the fall.
25 Is that correct?

1 A Maybe activities is a bad word. But I would
2 say -- let's back up and say I was focused on his
3 comorbidity and events which occurred which should
4 have an effect on what he can do.
5 Q And are those events outlined in Dr. Hooper's
6 records?
7 A And in some of MUSC records.
8 Q And tell me about the previous falls. You
9 testified about previous falls.
10 A So there is a record from July the 1st of
11 2011 from Dr. Hooper which says he did fall in the
12 bathtub approximately two weeks ago. It talks about
13 his injuries from that.
14 There's a physical therapy note from the MUSC
15 records. Reports several near-miss in regards to
16 prior falls, is the quote.
17 Q Anything else with regards to activities prior
18 to, or previous falls prior to, the incident that
19 we're here about today?
20 And again, we'll get into your notes. I'm
21 just trying to big-picture it.
22 A I'm struggling to answer because maybe we're
23 defining activity differently, but if you mean, you
24 know, what he -- that I would visually see him do, I
25 don't have any other.

1 Q You testified that one of your opinions you
2 had formed was other reasons Mr. Burke fell other
3 than the lighting condition; is that correct?
4 A Correct.
5 Q Tell me about that opinion.
6 A So he has a number of comorbidities. And the
7 first is diabetes. And in various places in the
8 chart it talks about how long he's had diabetes, but
9 probably the most accurate seems to be since 1982.
10 In several records, but certainly in the first visit
11 with Dr. Hooper in May of 2007, as a result of his
12 diabetes, he has retinopathy, neuropathy,
13 nephropathy, and sexual dysfunction.
14 So of those things -- both retinopathy, for
15 which he had operations on his eye, and neuropathy,
16 which is a lack of feeling, in the feet can certainly
17 cause patients to have difficulty with balance or
18 potentially fall.
19 In addition, he had bad venous insufficiency,
20 had actually been seen at Duke and was wearing Unna
21 boots, which is a treatment for venous insufficiency,
22 had significant swelling, which had been measured in
23 the records, and can make neuropathy, or the feeling
24 in your feet, worse.
25 He had also driven a long period of time prior

1 to the time he got there, which, again, makes the
2 swelling usually more marked, makes the feeling in
3 your feet, again, worse.
4 So patients with retinopathy often don't
5 respond as well to light that's there. So often in
6 patients with retinopathy, they may not see as well.
7 But, again, also his neuropathy.
8 Q Anything else with regards to that opinion?
9 A His first CT scan from MUSC noted that he had
10 anasarca, which is massive swelling of his lower
11 extremities, again leading to difficulty with what we
12 would call proprioception, the ability to sort of
13 feel for things being at the right height.
14 And then, lastly, he had had a CT scan at
15 MUSC, which I understand, from looking through the
16 depositions from the patient, or it may have been
17 wife -- I'm not sure which -- showed that he had an
18 old stroke on the CT scan. And the old stroke was in
19 the cerebellar region. The cerebellum of the brain
20 is responsible for balance.
21 So you've got, you know, an old stroke,
22 potentially. How it affected him, I don't know,
23 since I've never examined the patient. Again,
24 neuropathy, retinopathy, massive swelling, long car
25 ride. So that's what I mean when I said to you, it

1 seems like there's a number of reasons, potentially,
2 other than light, that he could have fell.
3 Q Now, the massive swelling, it's not your
4 testimony he had massive swelling before the fall?
5 A It's what the CT scan shows.
6 Q Before his fall?
7 A When he arrived, you know, within a few hours
8 of the admission to MUSC.
9 Q Several hours after the fall, he had massive
10 swelling is what the CT scan shows?
11 A That's what the CT scan shows. Correct.
12 Q Opinion number 3, the inability to heal is
13 related to the underlying medical condition. Tell me
14 about that.
15 A So again, diabetes -- by heal, I mean bounce
16 back, return to whatever normal function or previous
17 function he had. So all of these problems that he
18 has, which are, again, diabetes, anemia, underlying
19 heart disease -- I'm sure you know that he had, you
20 know, an arrest in 2007, was on a support for his
21 heart, the most advanced support we have, you know,
22 ventricular assist device -- severe pulmonary
23 hypertension. You know, those things are things
24 which cause people to have great difficulty, even
25 from a minor injury, being able to bounce back.

1 Q And then number 4, MUSC overstated his
2 injuries. Tell me about that.
3 A I think what I said was that the injuries that
4 were reported did not agree with the records. If I
5 said MUSC overstated his injuries, I misspoke. What
6 I said I think was that the records and what was in
7 the deposition were two different things.
8 Q When you say injuries that were reported, are
9 you saying when the doctor was deposed, he overstated
10 the injuries?
11 A Yeah.
12 Q Where were they overstated?
13 A So what I'm saying is there's a difference
14 between the record and what was in the deposition in
15 terms of the severity of the injuries as I would
16 interpret the record.
17 Q But the man who was being deposed was the
18 physician actually providing the care, right?
19 A Correct.
20 Q And do you know of any reason why he would
21 have provided untruthful testimony?
22 A I didn't say he provided untruthful testimony.
23 Q Well, overstated --
24 A Yeah. So what his interpretation -- so
25 medicine is a little bit art, little bit science. So

1 the way some people might interpret the data might be
2 different than the way the other people interpret the
3 data. And I'm sure we'll get into the weeds about
4 that.
5 But, for instance, when you say massive
6 bleeding, I might look at the same data and not
7 believe that there's massive bleeding. I may have an
8 alternative explanation.
9 So I would -- I would caution you to say
10 different than what I said. I did not say he
11 provided untruthful testimony. I believe what I said
12 was there was a discrepancy, and I think that's a
13 major difference.
14 Q In that he overstated the injuries? I believe
15 that was your testimony.
16 A Again, what I would correct that to say is
17 there was a discrepancy between how he interpreted
18 the injuries and how I would interpret the injuries
19 based on the record.
20 Q And he had the benefit of treating Mr. Burke
21 for several weeks whereas you have to go off of dry
22 records that were provided to you, correct?
23 A Overall, that's true. Whether he was treating
24 him every day was very difficult to see from the
25 records, and I think he testified that they rotated

1 off quite frequently.
2 Q Correct. Any other opinions, in general
3 fashion, that I didn't just go back over with you?
4 A No, sir.
5 Q Let's go to the Hooper records. Exhibit 4,
6 page 1. Walk us through your note from Dr. Hooper's
7 records, please.
8 A So I'm going to go back to the Duke records
9 for just a second, because you asked me about that.
10 Q Sure.
11 A And so just so that we're thorough, there's
12 this one exhibit that I mentioned to you which was
13 beforehand, and it talks about evaluation of
14 bilateral leg ulcers. And it talks about severe
15 venous insufficiency and recurring venous ulcers. It
16 also talks about that he fatigues easily and that he
17 has a lot of swelling of his lower legs and recurring
18 leg ulcers.
19 So I think, again, that's one of the things I
20 mentioned as a comorbidity.
21 And then starting with the Hooper records on
22 this sheet, his first visit was in May the 10th of
23 2007, and it says, number 1, atrial fib, chronic,
24 1985.
25 The second line, 1982, question mark.

1 Number 2, diabetes mellitus, type II, 2000.
2 Retinopathy, neuropathy, sexual dysfunction,
3 nephropathy. On insulin.
4 Number 3, right knee pain.
5 Number 4 -- no, not number 4. Next line,
6 diabetes mellitus, poorly controlled. Hemoglobin
7 A1C, 9.3 percent.
8 Number 4, anemia, EGD.
9 Next, hematocrit, 32 percent.
10 Next, 1-2 plus edema.
11 Next, canceled appointment 7/3/07 and 9/12/07.
12 Second visit, 12/11/07. Seen following
13 cardiac arrest when giving motivation speech in
14 California, 9/15/07. CAB times 4. Limited maze.
15 ICD.
16 Third visit, 12/20/07. Leg swelling.
17 3-4 plus edema of lower extremities. Lasix 80 plus
18 Zaroxalyn. BUN/creatinine 47/1.7.
19 Q And tell me -- maybe I put them in wrong
20 order. Okay. I got it.
21 A Next visit, 1/23/08. INR, 3.3. Creatinine,
22 1.5.
23 4/23/08. INR, 1.6.
24 10/08. Hemoglobin A1C, 8.1 percent.
25 BUN/creatinine 32/1.4.

1 Visit, 4/13/09. Wound of lower leg.
2 Visit 5/18/2010, hemoglobin decreased to 10.
3 7/6/2010, short-term memory issues, 47/1.7.
4 Quote, arthritic problems with knee, end quote.
5 7/1/2011, quote, did fall in the bathtub
6 approximately two weeks ago. INR, 5.4.
7 3/8/12, right leg painful.
8 4/26/12, INR, 3.8.
9 Hemoglobin, 10, 2007. 12/2007, 61, 1.7,
10 BUN/creatinine. 2/2010, 53/1.7.
11 9/10/2012, BUN/creatinine, 50/2.
12 4/2012, 9/26.
13 4/21/2012, small right effusion.
14 Q Have you spoken to Dr. Hooper about his care
15 of Mr. Burke?
16 A No, sir.
17 Q Have you consulted with any specialists at
18 Roper or elsewhere about Mr. Burke?
19 A No, sir.
20 Q Have you spoken to anybody who has ever
21 treated Mr. Burke?
22 A No, sir.
23 Q What's the next page of notes that you've got?
24 A Is there anything in this stack you want to
25 review?

1 Q No, sir.
2 A So MUSC records?
3 Q Okay. And is this -- go ahead. Sorry.
4 A So these are limited notes. I don't know how
5 you have this marked, but these are limited notes
6 from this paper, and the other legal pad is, you
7 know, extensive notes from the discs.
8 Q Let's do this. This is the third page of
9 Exhibit Number 4, and then we're just going to go
10 through your legal pad in order. Okay.
11 A Can I see that to make sure we're looking at
12 the same thing?
13 Q That's what you copied for us.
14 A Yes, sir. Okay.
15 So it says BUN/creatinine, 48/1.8.
16 Hematocrit, 29.2. Hemoglobin, 9.2.
17 Off to the right it says nephrology consult
18 not until -- I originally wrote 2/14 -- because that
19 was what the date was on the record -- but, actually,
20 when you look at it, it was on 2/4. So that's that
21 correction there.
22 Q Okay.
23 A The record is wrong.
24 Q And do you have any quarrel or comment or
25 criticism of MUSC's treatment of Mr. Burke?

1 A No, sir.
2 Q Okay. Go ahead.
3 A 1/25, 4 units FFP. INR, 1.9. Hemoglobin,
4 6.2. 2 units packed red blood cells. Quote, left,
5 end quote, thigh hematoma is what's written in the
6 chart. It was actually a right thigh hematoma, but
7 that's what's written.
8 1/26, 4575/2175. Hemoglobin stable at 7.6.
9 D/C serial hemoglobin.
10 1/27, thigh hematoma. Stable on exam.
11 Hemoglobin with a downward arrow, parentheses, 6.4.
12 Creatinine, 2.1. Transfused 2 units packed red blood
13 cells.
14 I think -- I believe that's supposed to say
15 1/28. I can't read my own writing. Will follow up
16 next. Hematocrit/hemoglobin if stable transfer.
17 Tertiary survey. Quote, thigh hematoma swollen but
18 soft, end quote.
19 1/29, 2 units packed red blood cells.
20 1/31, patient stable. Decrease creatinine.
21 Continue PT/OT. Transfer to floor.
22 This is not written, but off -- so that's just
23 my summary of the daily notes by MUSC of what they
24 did, effectively, without having to go back and look
25 through every note.

1 Below that is x-rays, just in my mind to see
2 what x-rays they did. So it says CT scan brain,
3 1/25. Remote infarct. Knee, 1/26 and 1/28. Chest
4 x-ray, 1/24. Right elbow 1/24 negative. Hands,
5 1/24. Soft tissue otherwise negative. CT, 1/25,
6 anasarca.
7 Out to the right, right femur, 1/24. Chest
8 x-ray, 1/29. CT, 1/29.
9 Q And let's get to the records and in the packet
10 here that Ms. Reynolds had sent over previously, and
11 some of these are just -- well, I'm going to try to
12 skip some of them, but let's go through and tell me
13 what this -- I've got copies of your legal pad.
14 These were notes that you made while reviewing the
15 DVD?
16 A Yes, sir.
17 Q Will you turn to the second page. We have a
18 black piece on there. I just wanted to make sure we
19 weren't missing anything. I'm trying to figure out
20 what I can't read so I can get you to talk about it.
21 Start at 1/29, repeat CT scan, and start
22 reading that for me. This is on the first page.
23 A 1/29, repeat CT scan. Right pleural effusion,
24 decreased. Otherwise unchanged. Echo EF,
25 60 percent. Normal LV function. Severe systolic

1 pulmonary hypertension. Dilated hypokinetic RV.
2 Elevated RA pressure.
3 Q Is the purpose of you going through these
4 records and detailing this information to ascertain
5 his condition while at MUSC, or is this to ascertain
6 his condition prior to the fall with an eye towards
7 figuring out other ways or manners he could have
8 fallen other than poor lighting?
9 A I don't know exactly how to answer that, but
10 this is the only way I know to deal with medical
11 records, and it's not -- doesn't have anything to do
12 with legal testimony. It has to do with the way I
13 approach a patient who appears to me.
14 So for me to be able to treat a patient, I
15 have to figure out what's wrong with the patient
16 chronically, because that will have an effect how I
17 treat them acutely. So the only way I know -- it may
18 not be the best legal way. The only way I know to
19 deal with records that are sent to me, whether it be
20 a lawyer sent them to me, whether it be a friend sent
21 them to me to review, or whether it be a patient
22 presented to me, is just to begin reviewing the
23 records and try to build a picture in my mind of who
24 this patient is medically, not socially, and then be
25 able to craft a treatment plan based on who the

1 patient is medically.
2 So this is an attempt to try to -- because you
3 said very accurately, I've never seen Mr. Burke. I
4 don't know Mr. Burke. It's for me to try to get a
5 flavor of who the patient is and then understand what
6 his injuries might be and, if I were taking care of
7 him, what I might do.
8 Q Have you been to this parking lot at night
9 after you received these medical records?
10 A That's a very good question, and actually, I
11 asked Ms. Reynolds that. I said should I go to this
12 parking lot to try to help with my judgment? And she
13 said you're testifying to his medical condition, not
14 to the lighting of the parking lot; you don't want
15 to -- I don't know -- she probably didn't say, you
16 don't want to be. I mean, she would say you're
17 not -- you know, you're not testifying to the quality
18 of lighting. That's not your area of expertise.
19 Please restrict, you know, effectively to what you
20 do.
21 So I thought about doing that. I thought
22 about -- I did this: looked up on the internet and
23 said was there a full moon that night, for instance,
24 just out of purely personal interest, but I don't
25 remember what it said. But I -- out of purely sort

1 of investigation.

2 But I'm not testifying to those things.

3 Q And as we sit here today, you don't know what

4 caused Bob Burke to fall that night?

5 MR. DARLING: Object to the form.

6 A Correct.

7 Q We're down to -- help me out here -- this is

8 terrible for the record. I think we're on page 4,

9 Exhibit 4, where you've got a bracket with an arrow.

10 Tell me what this is intending to show and detail.

11 A So they had mentioned some diagnoses above,

12 and then there was an interruption, and so I'm

13 linking those diagnoses to the other diagnoses. So

14 it says, other problems.

15 And again, just so the record is clear, so my

16 note says this is in the MUSC discharge summary. So

17 this is all in the MUSC discharge summary.

18 So under that it says urinary retention.

19 Bilateral lower extremity wounds, status post basal

20 cell CA -- cancer -- in bilateral lower extremities.

21 Status post RT and received wound care with Unna

22 boots.

23 Q What is this fourth one under the bracket? I

24 can't read.

25 A Severe deconditioning.

1 Q Let's turn the page. And now we're on page 5
2 of the packet, page 2 of those materials from your
3 notebook. And these are just the list from the
4 discharge?
5 A Nothing more than copying from the discharge
6 summary down so that I didn't have to -- again, I
7 just want to go back. So these are on a DVD, and
8 they're one of 700-something pages or something. So
9 I didn't want to have to keep going back to the DVD
10 to try to learn who the patient is. So I just wrote
11 to myself, these are the diagnoses they assigned to
12 him, and put it down.
13 If I had paper and could have put that to the
14 top, you know, I might not have written it, but since
15 I didn't have that, I just didn't want to keep going
16 through the DVD.
17 Q Understood. Let's go to II. Tell me about
18 this.
19 A So that's the only thing I reviewed from Roper
20 Rehab. It's in just that short paragraph. So it
21 says Roper Rehab H & P. Debility with coagulopathy
22 and cardiac dysrhythmia after a fall. History of --
23 that's number 1. Excuse me.
24 Number 2, history of malignancy in bilateral
25 lower extremities. Status post procedure/RT/HBO at

1 Duke.
2 Number 3, diabetes mellitus.
3 Number 4, hypertension.
4 Number 5, benign prostatic hypertrophy.
5 Q Now, is this the only tab that relates to
6 anything with Roper?
7 A From there down to after social history. So
8 it says, quote, admitted to evaluate syncope, end
9 quote, possibly. And it says social history: Lives
10 in two-level home but never goes upstairs. About
11 three steps to enter home.
12 Q And is that the only notation that you have
13 for Roper?
14 A Yes, sir.
15 Q Did you obtain the Roper Rehab records?
16 A Yes, sir.
17 Q And so you reviewed those several weeks' worth
18 of care Roper provided?
19 A Yeah. And I went through every page that was
20 provided to me, and I can supply to you exactly what
21 pages they were. But the answer is yes.
22 Q And every page that was provided to you, not
23 necessarily every page of his medical record, right?
24 Correct?
25 A Correct.

1 Q Is there any reason that there's so much
2 information -- I don't want to -- there's this level
3 of information on the MUSC treatment and so little on
4 Roper?
5 A Again, by that time he had gone to rehab
6 and -- let me back up. In general, notes of acute
7 care facility are markedly more extensive than notes
8 from a rehab facility, just by what we do. So in an
9 acute care facility, you've got multiple consultants,
10 multiple people seeing patients, and the number of
11 records are quite extensive.
12 In addition to that, the acuity of care,
13 particularly when somebody first comes in, has a lot
14 more documentation. Once you're at the rehab level,
15 it's markedly more things. Has the patient exercised
16 twice today or patient walked X number of feet today
17 or patient did Y?
18 And so I wasn't, you know, looking to testify
19 of what he could do at the time he left; what I was
20 testifying was is what happened to him with his acute
21 injury.
22 Q But one of your opinions also relates to the
23 slowness of his recovery related to preexisting
24 conditions; is that fair?
25 A Yes.

1 Q Let's go to the next page. Again, everything
2 on III is information taken from the MUSC ICU
3 transfer summary?
4 A Yes, sir.
5 Q Anything that you've added that I can't find
6 on the transfer summary itself?
7 A So I'm going to say no. I can't be
8 100 percent sure except for a couple things. The
9 question mark under the next-to-the-last line where
10 it says anemia, parentheses, question mark, I'm sure
11 it was my question mark. I'm sure they didn't put a
12 question mark next to anemia.
13 And the quotations, destabilized -- the
14 quotations, I'm sure, were not in there, and the word
15 wrong was not in there. But I think the testimony
16 was that it was incorrect -- it should have been
17 stabilized, not destabilized -- in the deposition
18 that previously occurred, so --
19 Q What about the question mark? Why do you have
20 the question mark?
21 A So I'm sure we'll get into this, but I was
22 wondering if really his anemia was due to acute blood
23 loss.
24 Q And if not acute blood loss, what would the
25 other reason for the anemia be?

1 A So fluid. Effectively, fluid shifts.
2 Q What's the next Roman numeral?
3 A So it looks like that's something from an
4 orthopaedic clinic, which I think is the records from
5 Duke, I believe, because that looks like the date.
6 But again, this is on disc, so you know, it had some
7 things on disc, some things that were subsequently
8 supplied to me. But it looks like this was part of
9 the records on disc.
10 And it says, orthopaedic clinic, 4/2/2013.
11 Lists Warfarin. I guess you have to understand my
12 thinking, you know, going through here as I was
13 reviewing the records from MUSC. It says, we're not
14 going to send him home on Warfarin; we're going to
15 let his primary care doctor decide that. And so this
16 is the first record I've come on after the incident
17 in which he's back on Warfarin.
18 So I'm thinking, you know, who started him on
19 Warfarin when MUSC said his risk of fall is greater
20 than his risk of stroke and so we're not going to put
21 him on Coumadin. So it's a note to me to say
22 sometime between the middle of February to the first
23 of April, somebody started him on Coumadin.
24 It says injected knee with Depo-Medrol.
25 Q V, tell me about that.

1 A So this begins all the records that I would
2 say are not summary records, necessarily, of MUSC.
3 So I say MUSC record, 709 pages. And that says,
4 page 5, rehab services, primary diagnoses, fall from
5 car. Again, that's their writing, not mine.
6 Treatment diagnosis, decreased level of independence
7 in ADL.
8 Q What's ADL stand for?
9 A Activities of daily living.
10 Q And all of these are from -- is this page 5?
11 A It is. Again, it's on the disc, but I can
12 show it to you in paper.
13 Q That's fine. And then let's go down. Is that
14 this stack right here?
15 A It's right here.
16 Q Can I have that while we go through this?
17 A Sure.
18 Q Maybe save some time.
19 What's the next one? That's page 9?
20 A In about ten minutes, I'm going to have to go
21 feed the meter.
22 Q Okay. And when you say page 9 -- I see. It's
23 just down here, MUSC page 9 of --
24 A No. I don't know that. Again, these are
25 pages that came up, you know, on the disc. So

1 they're listed 1 to 705 pages, so I'm looking up --
2 like you would -- in the top of my screen. Right.
3 It's the disc has been loaded for 709 pages, and I'm
4 looking up at the toolbar, and it says page 9. Then
5 I'm just writing down page 9.
6 So if I could go back to the disc, I could
7 find where it is. So it's not a reference to
8 anything in the record per se. It's a reference to
9 my computer.
10 Q What I'm trying to avoid doing is going
11 through all of this and all of this.
12 A I have that outlined pretty well, so if you
13 want me to look at anything, I can find it among
14 those papers.
15 Q For instance, where it says -- you've circled
16 in the radiology, volume overload clinically, do you
17 know what that means? And I can --
18 A I do. I think it's actually in the renal
19 consult. I don't think it's in the radiology. But
20 the renal consult is -- and when they saw him, they
21 thought he was volume overloaded clinically, meaning
22 he had too much fluid.
23 Q And that's what I think you referred to a
24 moment ago, his fluid shifts?
25 A It is. And again, your client mentioned in

1 his deposition that he had gained 45 pounds during
2 the hospitalization.
3 Q Let's turn the page. And what does this say
4 at the top? I can't -- flow sheet? What's it say
5 past that?
6 A So -- and this is just to give me an idea of
7 trying to organize 709 pages. So initially there
8 were rehab services sheets, and then the next thing
9 is there's what we call flow sheets, which would
10 be -- you know, could be anything from vital signs
11 to -- I didn't find fluids, but they're things like
12 that, so --
13 Q And then down here, VI, is that Roper records?
14 Are we back into Roper with admin/admission records?
15 A Must be. So there must have been a separate
16 thing. It says page 14. I can produce that for you.
17 So sometimes in the disc it would have the records
18 and then it would have a discharge summary. So
19 again, this says, you know, admit 2/13 to 3/2, Roper
20 Rehab, so it may have been a discharge summary.
21 Q Now, let's go into the next page where you
22 have depositions. Did you ever print off or make
23 notes on the deposition transcripts?
24 A No.
25 Q And we're on this top one for the MUSC

1 physician, page 19, explanation of INR. Do you know
2 the doctor's explanation of -- I assume we're talking
3 about the elevated INR readings when he or Mr. Burke
4 arrived at MUSC?
5 A Yes. So that's a note to me, I'm sure, that
6 says, you know, the way I would -- if you asked me
7 this question, the way I would explain INR is
8 different than the way he explained INR. So often I
9 do that to say that -- particularly if you're talking
10 to people, it's a little bit different than what is
11 described.
12 Q What does this say? Would you read page 23
13 and page 27? I can't read those. Would you read
14 those to me?
15 A So page 23, diabetes would not have aggravated
16 his injury.
17 Page 27, CKG. Chronic kidney disease is what
18 that stands for. Did it play a problem, question.
19 This is a note to me: Look at the creatinine rise
20 and fall. Nephrology consult. Page 58, knee.
21 Q I assume this was the doctor's testimony, not
22 your thoughts. Is that correct?
23 A The -- I can't testify for sure, but where it
24 says look at creatinine rise and fall, I suspect
25 that's my note that I need to look at the creatinine

1 rise and fall. None of these are his, I don't think,
2 exact testimony.
3 Q Understood.
4 A So they're all notes to me. So it's page 19,
5 he's saying something about INR, and I say,
6 explanation of INR. That's my note, not his note.
7 And he may have said diabetes would have not
8 aggravated his injury. I would say that's probably
9 him. Page 27, chronic kidney disease -- I can't tell
10 you if that's me or him, but I would say it's
11 probably me -- did it play a problem?
12 Q Do you plan on offering any opinion or
13 testimony as to whether or not the fall either caused
14 or possibly exacerbated Mr. Burke's right knee
15 issues?
16 A I think what I can -- I think what I can
17 testify to that is that he had a problem with his
18 knee beforehand. I can't testify more than that.
19 Q There's some small writing on the right-hand
20 side over here, starting -- it says, look at x-rays,
21 echo, wound care, EMT record. What's that last?
22 A Nephrology.
23 Q Did you look at all of those materials?
24 A So I looked at the x-ray reports. I asked
25 Ms. Reynolds to get me the copies of, actually, the

1 x-rays so I could look at the x-rays myself. I do
2 not have a copy of the echo, but I've looked at the
3 echo report.
4 Q Have you gotten a copy of the x-rays yet?
5 A I got them earlier today. I've not looked at
6 them.
7 Q All right.
8 A The wound care would be obviously looking at
9 notes. I can't look at the wound. EMT record, I
10 cannot find an EMT record, and there's some -- it
11 seems like to me -- and you've studied this record
12 more than me, but it seems like there was some
13 discrepancy whether he was brought by EMT or not, and
14 I couldn't quite figure that out. And I certainly
15 couldn't find an EMT record. The only EMT record I
16 could find is the transfer EMT record, actually, from
17 MUSC Roper. I did find that.
18 And then the nephrology quote is the fact that
19 up to that point, even though Dr. Sakran said there
20 was a nephrology consult, I had not seen the
21 nephrology consult, and I wanted to know what they
22 said about his kidneys.
23 Q And did you find that?
24 A I did, yes, sir.
25 Q And in reviewing any of that information, did

1 that help form your opinion that you've offered here
2 today?
3 A So I had known that he had this cardiac arrest
4 when he was giving the speech in California, so I
5 wanted to know what the echo was, so that helped with
6 some valuable information.
7 I had seen that he had a lot of swelling of
8 his legs and that he wore those Unna boots, and so I
9 wanted to figure out about the echo and see if the
10 echo played any part in that.
11 Q And do you think it did?
12 A Yes. I mean, the echo didn't, but the
13 findings on the echo gave some delineation for why he
14 may have had the swelling.
15 Q Now let's go to the UNC records. What does
16 that say? Second?
17 A Second disc. So now I'm on to the second disc
18 of the numerous records that -- to review, and so
19 that says UNC records. These are records, obviously,
20 that are -- the initial records are post discharge
21 because it's 3/11/2013, and those were the diagnoses
22 assigned to him, again, by the UNC records.
23 So I wanted to look at that and make sure
24 there was no chronic problems that had not been
25 delineated by other caregivers up until that time.

1 Q And were you provided the second disc at a
2 later time?
3 A No, same time. It was all in the same
4 envelope.
5 Q And just because I can't read it all, go
6 through 1 through 9 for me, please.
7 A Diabetes mellitus diagnosed 1985. Retinopathy
8 status post laser, status post vitrectomy.
9 Neuropathy. Microalbuminia [sic]. Hypertension.
10 Hyperlipidemia. Coronary artery disease.
11 Asymptomatic CVA. Anemia.
12 Q Anything in the UNC records that was different
13 or addition to the things that were contained in the
14 MUSC records?
15 A So I didn't know how long he had had diabetes,
16 and again, it says here he had -- at least since
17 1985. There was no note that I recall from MUSC
18 about that he had actually had an operation on his
19 eyes, you know, so that he had fairly severe
20 retinopathy. I don't recall them mentioning
21 hyperlipidemia even though that didn't really have an
22 effect on his disease.
23 Anemia was sort of a new diagnosis, at least
24 if that meant he had anemia before his fall. At this
25 point when I was reviewing the records, I didn't have

1 Dr. Hooper's records at that point.
2 Q Turn the page. These are Hooper's notes. Are
3 these additional notes relating back to Hooper's
4 records that we've already gone over?
5 A So -- well, so this was -- there were,
6 again -- I don't know how lawyers get records, but
7 there were very cursory records from Dr. Hooper, you
8 know. So this was markedly less records than the
9 paper records I subsequently got. So again, this is
10 all on the disc; these are the records I had from
11 Dr. Hooper, and they were quite short. They were
12 markedly less than the paper records.
13 Q And let's go to Duke ortho. Tell me your
14 understanding of the treatment -- let's go this
15 route --
16 A Can I go --
17 Q Yes, please.
18 (A recess was taken.)
19 Q You've reviewed the treatment Mr. Burke
20 received to his right knee following his discharge
21 from Roper, correct?
22 A I don't know if this is all the treatment, but
23 I've reviewed the treatment that's been provided to
24 me.
25 Q And you agree he has undergone a series of

1 more conservative treatments short of a full surgery
2 to his right knee?
3 A So I have notes from Carolina Joint and Spine
4 where it looks like he had five treatments.
5 Q And those included injections and various
6 procedures short of actually knee replacement
7 surgery?
8 A So those five treatments included -- were
9 halogen treatments, which, you know, I have no
10 expertise in whatsoever. Prior to that, he had had
11 two knee injections.
12 Q And do you plan on offering any testimony
13 about whether or not Mr. Burke needed to have -- he's
14 having knee surgery this month. Do you have any
15 testimony or do you plan on offering any opinion as
16 to whether or not Mr. Burke actually needed that
17 surgery?
18 A No, I'm not an orthopaedist.
19 Q What was the purpose of your reviewing the
20 orthopaedic records?
21 A I would answer that the same way I answered
22 before: Every record that's sent to me by any
23 patient that I'm going to take care of, I review the
24 records. Often there will be something in the
25 records which only one doctor will have asked, so

1 even though you may be thinking they're being treated
2 for orthopaedic disease, it may be the only time they
3 mentioned something that may be pertinent to your
4 care.
5 Q If you turn the page to -- at the top there's
6 a V, and then it looks like North Carolina
7 Orthopaedic Center. That's struck out, and it says
8 x-rays. Tell me what this page -- what is this
9 information?
10 A So V must have been that I reviewed the
11 North Carolina Orthopaedic Clinic and that there was
12 really nothing really that -- one way or the other I
13 thought was worth notation.
14 And then x-rays, these are back -- I think you
15 asked me to read that little printout on the side,
16 and one of the things I said was review the x-rays.
17 So I've gotten to that now. This is further in those
18 708 pages, and in those 708 pages, these are the
19 x-ray reports from MUSC.
20 Q And are these -- everything on here -- tell me
21 what's yours and tell me what you've just written
22 down that was in the records.
23 A Well, if you really want me to do that, I'm
24 going to have to pull up those records and then go
25 through line by line. So I would be glad to do that.

1 Q I don't want to do that. Read through this.
2 I just wanted to know if you're commenting on
3 something or this is something that appears to be,
4 just as you stated earlier, jotting down information
5 from a vast amount of medical records so you wouldn't
6 have to keep flipping through.
7 A So under 1/25, all the comments from small
8 right pleural effusion through anasarca are directly
9 taken from the record.
10 Under CT of the head, all of those are
11 directly, you know, taken from the record.
12 Q What about this first -- it says page 646. Do
13 you know where that -- what date that is?
14 A So that's a renal ultrasound, and it says 2/4
15 was when the renal ultrasound was done, and that says
16 right, 10.5 -- which is the length of the kidney --
17 left, 11.9 -- which is the length of the kidney --
18 and no obstruction. And that's definitely taken
19 right from the record.
20 And then under that is a CT of the lower
21 extremity which was done on 1/29.
22 Q And then on this next page, on 1/24, what does
23 that say? I can't read that. I apologize.
24 A It's an x-ray of the femur, and it says, joint
25 space narrowing of the medial tibiofemoral

1 compartment.

2 Q And then you don't need to read it. This is

3 on page 664, 2/5 is another echo?

4 A That's the only echo he had.

5 Q Now, tell me what all of these remainder --

6 appear to be dates with figures. Tell me what this

7 represents.

8 A So it's in reverse order. So if you start

9 down here at the bottom, again, 1/24 is the day he

10 presented, and that's 2115 hours. The left column

11 are his BUN and creatinines that you can track. The

12 right column are his hemoglobins and hematocrits that

13 you can track.

14 Q And then when you've written notations further

15 out to the right, what are those?

16 A Can you show me? Those are just other -- let

17 me just make sure. So those are just other labs

18 that, you know, I thought were important to look at.

19 They're related to his kidney function.

20 Q Are these all of the notes that you've taken

21 in this case?

22 A I didn't give you this. This is a list of

23 diagnoses. That's the only other thing.

24 Q And where did that list come from?

25 A I made it up in my mind just before I came

1 over here just so I had it -- think to myself.
2 Q So we're complete, let's make copies of that
3 and just add it to the stack, please. Actually,
4 we'll do that as a separate exhibit.
5 MR. McCULLOUGH: So if we could make copies,
6 please.
7 (A recess was taken.)
8 (Exhibit No. 05 was marked for
9 identification.)
10 Q We have got a copy here marked as Exhibit 5.
11 Tell us -- you've got the original, so walk us
12 through what this document --
13 A So just before I came over, just sort of in
14 preparing myself to think what are Mr. Burke's
15 various diseases that I sort of thought -- and again,
16 this is not anything but from my memory and just
17 wrote down, you know, the list of things that are
18 potential diagnoses of his.
19 Q And let's go through them really quickly.
20 Number 1?
21 A Atrial fib, chronic, 1985.
22 Number 2, diabetes mellitus, type II, 1982.
23 Retinopathy, neuropathy, nephropathy, sexual
24 dysfunction.
25 Number 3, right knee pain.

1 Number 4, cardiac disease. Status post CAB
2 after arrest. Questionable limited maze. IABP, VAD.
3 Number 5, ICD-V-fib.
4 Number 6, pulmonary hypertension. RV
5 dilatation. RV decreased function. IVC dilatation.
6 Number 7, CKD, chronic kidney disease.
7 Q I don't want to interrupt, but when you use
8 acronyms, do you mind filling in the gaps, like
9 number 5, ICD, HTN, CKD, would you spell those out
10 for me?
11 A Sure. Let's go back to number 4. So status
12 post CAB is coronary artery bypass after arrest.
13 Questionable limited maze. IABP is intra-aortic
14 balloon pump. VAD is ventricular assist device.
15 Number 5 is ICD, which is internal cardiac
16 defibrillator. V fib is ventricular fibrillation.
17 The next is pulmonary HTN, hypertension. RV,
18 which is right ventricular dilatation. Again, RV,
19 which is right ventricular decreased function. The
20 next is IVC, which is inferior vena cava dilatation.
21 The next is CKD, which is chronic kidney
22 disease.
23 Then I think this is where I was. So venous
24 stasis with stasis ulcers-Unna boots.
25 Number 9 is chronic anticoagulation.

1 Number 10 is possible right pleural effusion.
2 Number 11 is history of urinary retention.
3 Number 12 is hypertension.
4 Number 13 is basal cell carcinoma.
5 Number 14 is anemia.
6 Q And you put this together this morning or
7 today just summarizing your understanding of
8 Mr. Burke's medical condition?
9 A Right. So sometimes when you get asked a lot
10 of questions you can sort of get discombobulated a
11 little bit, so I just wanted to get my thoughts clear
12 about all the potential chronic diagnoses that I at
13 least was thinking about as I reviewed his records.
14 Q Do you have any opinion or do you plan on
15 offering an opinion as to Mr. Burke being on
16 Coumadin, how that impacted his condition before the
17 fall and how that may have impacted his injuries?
18 A I don't really have an idea about how it
19 necessarily impacted him before the fall. It's the
20 standard of treatment for atrial fibrillation in
21 general. Certainly somebody that is on an
22 anticoagulant, if they have any sort of trauma, will
23 have a tendency to bleed more than somebody who is
24 not on an anticoagulant.
25 Q Do you plan on offering any testimony about

1 Mr. Burke's INR levels either pre- or post-fall?
2 A If I'm asked questions about his INR, I would
3 certainly respond to the questions about the INR.
4 Q Do you have an opinion as to whether or not
5 that impacted Mr. Burke's condition at the time of
6 his fall?
7 A I think I answered that. Patients on
8 anticoagulation -- so anticoagulants are going to
9 have a tendency to bleed, certainly more than people
10 that aren't on anticoagulants.
11 Q You've described for me the basis for your
12 opinion as to other possible reasons Mr. Burke fell.
13 Have we covered everything?
14 A Other than, you know, the right knee and the
15 comment and Dr. Hooper's notes about him talking
16 about disability, I don't think there's anything
17 else, per se.
18 Q Tell me what you mean about his note talking
19 about disability. What do you mean by that?
20 A It may take me a second to find. So this is
21 from a note from 7/6/2010, so I guess that about two
22 and a half years before the incident. And
23 Dr. Hooper's conclusion is he has had some arthritic
24 problems with his knee and trying to decide what to
25 do as far as moving forward with disability planning.

1 Q Thank you.
2 A So, as I said, so only in the sense that I
3 don't know if he had some disability related to his
4 right knee by that note that could have an effect on
5 balance or could have an effect on walking.
6 Q Anything else?
7 A I can't recall anything right now.
8 MR. McCULLOUGH: That's all the questions
9 I've got. They may have some questions for you.
10 MS. HEYWARD: I don't have any questions.
11 EXAMINATION
12 BY MR. DARLING:
13 Q Dr. Shuman, I've just got a few. I'm Steve
14 Darling. I represent Republic Parking Systems.
15 And you've been very thorough, so I don't have
16 to ask many, but one thing I was curious about is you
17 talked about Dr. Sakran describing the INR and that
18 you would testify a little bit different about how to
19 describe the INR.
20 What do you mean by that?
21 A So I think -- I think he says things like a
22 normal INR is 1 to 2 and, you know, that he was
23 higher than a normal INR. So I think it's just
24 important to understand what INR means. So it used
25 to be years ago that we would send patients to get

1 their blood checked and it would come back with a
2 certain number of seconds of how -- what we would say
3 "how thin their blood is."
4 By that, I mean that it would take, if you
5 weren't on -- if you had normal clotting, let's say,
6 and the lab said it would take, for a normal, 12
7 seconds, it may take 18 seconds.
8 And the problem with that was that different
9 labs use different reagents, and so you sent it one
10 place, it may come back one way and one place going
11 another way.
12 And so several years ago -- in a sense, I'll
13 use the term "lab community" got together and decided
14 to standardize that. And what INR means is
15 international normalized ratio. Right. So that
16 means internationally, no matter where you go, it's a
17 normal ratio between how thin your blood is compared
18 to a normal standard.
19 So it doesn't matter if I send the patient,
20 you know, someplace in Charleston or they go on
21 vacation in Hickory, North Carolina and they get
22 their blood drawn. I can have reliability that their
23 thinness of blood is the same.
24 So normal is pretty close to 1. Right.
25 You're not on anything. You ought to clot just like,

1 you know, the reagent. And you know, there's a
2 little bit of error, but not much, so it's really
3 right around 1.
4 And so then you make a decision about what you
5 want the INR to be dependent on what the patient's
6 condition is you're trying to treat, and so that's --
7 you know, by studies which say, if I keep the INR X,
8 this patient's chance of having -- let's use atrial
9 fibrillation -- this patient's chance of having a
10 stroke from atrial fibrillation is less than his
11 bleeding.
12 So medicine is all about risk/benefit. You
13 know, what's the risk? What's the benefit? So
14 you're making a decision, effectively, I'm going to
15 put somebody on, in this case, Coumadin or Warfarin,
16 and what I'm trying to do is get their blood thin
17 enough they won't have a stroke but not so thin that
18 they will bleed what we call spontaneously, right,
19 they'll just bleed without any fall. And that's a
20 risk from taking Coumadin.
21 So as time has gone on, this INR has decreased
22 some for what we're trying to keep it, and in
23 general, as was said in some of the testimony, we try
24 to keep the INR, for this particular indication --
25 atrial fibrillation -- between about 2 and 3.

1 If you look at Dr. Hooper's records, you know,
2 his went up and down consistently. I mean, there
3 were times where -- one time here where, you know,
4 Mr. Burke had an INR of greater than 5. That's the
5 time I mentioned to you when he fell in the bathtub.
6 So it's not as if you can just take a pill and it's
7 necessarily stable. So you need to monitor it.
8 Q You've got to test it?
9 A You have to test it.
10 Q You've got to give blood samples?
11 A Yes, you do.
12 Q And it has to be read?
13 A You mean read by -- somebody has to interpret
14 it?
15 Q Exactly.
16 A Yes, sir.
17 Q And you want to try to keep it, with his
18 condition, between 2 and 3?
19 A Correct.
20 Q At the time he went to MUSC, his INR was 3.25,
21 which is too high --
22 A Right.
23 Q -- which means he had too much Coumadin in his
24 system and his blood was too thin?
25 MR. McCULLOUGH: Object to the form.

1 A So, again, it's -- it's -- Coumadin works
2 against vitamin K. So you could say he had too much
3 Coumadin or he had too little vitamin K compared to
4 what you're trying to keep it at.
5 But again, it's not something -- again, sort
6 of -- you see these commercials all the time on TV
7 right now about take this pill; this pill, you don't
8 have to have your blood monitored; it's approved for
9 X.
10 I mean, you see that all the time.
11 Q Like Xarelto?
12 A Exactly.
13 Q But he was on Coumadin?
14 A Yes, he was.
15 Q So he's got to monitor his blood --
16 A He does.
17 Q -- to make sure he's in a proper level so he
18 doesn't have complications?
19 A Correct.
20 Q And one of the complications is to have it too
21 high?
22 A Correct.
23 Q Which means you might bleed more?
24 A Correct.
25 Q Or you might fall like he did when he had the

1 5.4 back in 2011?
2 A Again, I wouldn't say necessarily the Coumadin
3 made him fall, but if he fell, the chance that he's
4 going to bleed significantly is markedly greater if
5 it's 5.4 compared to if it's between 2 and 3.
6 Q And patients who are on Coumadin are told by
7 the doctors, you've got to watch out for this because
8 if you get out of whack, even too high or too low,
9 you're going to have complications?
10 MR. McCULLOUGH: Object to the form.
11 A Again, too low, your risk is higher of having
12 a stroke. Too high, your risk is higher of having a
13 bleed.
14 Q Now, you mentioned some other things that he
15 had as well. You talked about diabetes?
16 A Yes, sir.
17 Q He had that before his fall?
18 A Yes, sir.
19 Q He had retinopathy, a condition of the eye,
20 before his fall?
21 A Yes, sir.
22 Q And retinopathy makes your vision not as good
23 as a normal person; is that correct?
24 A That's correct.
25 Q In layman's terms, what is retinopathy?

1 A So diabetes is a disease in general which
2 affects small blood vessels, and by that, I mean
3 causes damage to small blood vessels. So anywhere
4 sort of the end of the blood vessels, it causes
5 problems. So you have very small blood vessels -- as
6 you can imagine -- going to your eye, so you get
7 disease of those small blood vessels, and that's the
8 term retinopathy. Pathy means pathology, or disease,
9 of the retina. But it's really, again, the blood
10 vessels going to the eye.
11 Same thing: small blood vessels going to the
12 kidney. Right? So you get this problem with chronic
13 kidney disease, as he has.
14 Small blood vessel go into the feet, which are
15 supplied by the nerves, and you get this nephropathy,
16 and that nephropathy leads people to not having good
17 sensation in their feet.
18 And what usually happens --
19 Q That's neuropathy.
20 A Neuropathy.
21 Q That's right.
22 THE COURT REPORTER: I'm sorry. Can we just
23 have one person at a time, please.
24 A I misspoke. It was my fault.
25 So neuropathy, and so it's disease of the

1 small blood vessels going to the foot. And what
2 often happens is you don't have good feeling, you get
3 ulcers, and that's the reason diabetics end up with
4 amputation.
5 So again, neuropathy, nephropathy,
6 retinopathy, again, sexual dysfunction. Those are
7 common things with diabetes.
8 Q And one of the problems with, first of all,
9 the retinopathy is that it lessens one's ability to
10 see at nighttime. Is that correct?
11 A That's correct.
12 Q And with neuropathy -- that's the problem with
13 the feet -- it lessens one's ability to feel their
14 their feet as they ambulate or walk?
15 A Correct.
16 Q And gives them problems in stepping up and
17 down on things from time to time?
18 A Again, the feeling of -- the feeling of moving
19 up, it may give them problems. Uh-huh.
20 Q Those conditions we've been talking about are
21 things that Mr. Burke had before his fall in the
22 parking lot?
23 A Correct. Yes, sir.
24 Q One thing that you also talked about was his
25 driving for a long time. He had driven from Wilson,

1 North Carolina down to Charleston?
2 A Yes, sir.
3 Q What effect would that long drive have on his
4 retinopathy and neuropathy?
5 MR. McCULLOUGH: Object to the form.
6 A Again, the biggest thing, I think, is -- you
7 know, was he had these Unna boots on and he had had
8 them on for a long time. By long time, I don't know
9 how long he had that particular set of Unna boots,
10 but he had been treated with Unna boots for a long
11 time.
12 Q A chronic condition?
13 A Yes, a chronic condition.
14 And Unna boots are basically used for what we
15 call venous insufficiency, which means that the blood
16 pools in the legs. And because of that blood pooling
17 in the legs, it increases the pressure in the legs
18 and causes you to have breakdown of the skin so you
19 have these ulcers and use the Unna boots to try to
20 heal the ulcers.
21 So when your legs are dependent, like driving,
22 the swelling gets worse; and when the swelling is
23 worse like that, then the chance that your neuropathy
24 is going to be worse.
25 So again, all of those things sort of play

1 into my opinion that there are other reasons that he
2 could have potentially fell.
3 Q Now, you mentioned one other medical term,
4 anasara [phonetic]; am I pronouncing that right?
5 A Anasarca.
6 Q Anasarca. I'm sorry. And that's, I believe,
7 massive swelling of the legs?
8 A Yes. So it's massive swelling in general, but
9 it's most common in the legs.
10 Q What was the cause of that condition in him?
11 A So again, I think he had it two different --
12 he had it probably exacerbated, but as I mentioned,
13 it says it in the first CT when he gets to MUSC. And
14 so then it's related to his right-sided heart
15 failure.
16 So you probably know this, but the right side
17 of the heart pumps blood out to the lungs, and the
18 left side of the heart pumps blood to the body. So
19 if the right side of the heart doesn't work right and
20 can't pump blood to the lungs, then the blood builds
21 back up in the body, which would be in the legs.
22 And so that's what he had, was he had -- the
23 right side of his heart did not work well; the
24 pressures in his lungs were high, which made it hard
25 for him to put the blood out to his lungs; and so it

1 built back up in his body and caused the swelling.
2 So the anasarca is the accumulation of that
3 fluid from effectively right heart failure.
4 Now, he got -- I suspect -- I could never find
5 this in the records, but the usual situation when
6 somebody comes in with trauma is they get a lot of
7 fluid. And one of the reasons -- again, you know,
8 during the period when he was trying to walk that he
9 couldn't walk, that they may -- is that he's got even
10 such bad edema that he has scrotal edema. So he has
11 edema up, you know, where his testicles are, he's so
12 swollen down below.
13 And that's a combination of trying to give so
14 much -- give fluid to resuscitate him, and that
15 additional fluid your right heart can't handle, and
16 that builds up.
17 So I think he had anasarca when he came in,
18 and then he had a 45-pound weight gain while he was
19 in the -- at least according to him, a 45-pound
20 weight gain while he was in the hospital.
21 Q The anasarca that he had when he came in you
22 mentioned would cause difficulty with walking or
23 ambulating or dealing with steps, could you describe
24 that for me.
25 A Yes. So if your legs are that swollen --

1 again, first thing is -- what you mentioned to me
2 before, I mean, your neuropathy is worse. But
3 secondly, just your mobility is markedly diminished.
4 MR. DARLING: That's all I have. Thank you.
5 EXAMINATION
6 BY MS. REYNOLDS:
7 Q I just have a few follow-ups, Doctor, if I
8 could. You were asked whether or not you had treated
9 Mr. Burke; is that correct?
10 A Correct.
11 Q And you said you had not, right?
12 A No, I've never seen Mr. Burke.
13 Q In your experience as a doctor, if you're
14 dealing with chronic versus acute illnesses or
15 diseases or chronic versus acute causes of injuries
16 or damages, is it important that you review prior
17 medical records or records from other doctors when
18 determining whether it's acute or chronic versus
19 looking at a single snapshot?
20 A So you know, again, there's two different time
21 periods here. I mean, if somebody comes into the ED
22 and your message is this patient's bleeding a lot
23 and, you know, I'm thinking -- I'm a trauma -- you
24 know, somebody specialized in trauma -- my idea is
25 let's get that patient resuscitated.

1 But once I know the pulse is okay, blood
2 pressure is okay, no evidence of bleeding by a number
3 of x-rays -- like in this case, there was no evidence
4 of significant bleeding by any x-ray -- you know,
5 then I'm sort of thinking, okay, I've got a stable
6 patient; what I really need to be thinking about is,
7 you know, what could cause him to be having problems
8 while he's in the hospital, and then I need to be
9 treating those chronic diseases.
10 So you know, in the rush of the moment, I
11 think it's reasonable not to be taking a complete
12 history -- particularly in a patient like this -- and
13 finding out, you know, 14 diagnoses. But once you
14 know the patient is stable, it's imperative to find
15 that, because, you know -- again, let's say the
16 patient makes no urine. Right. Let's say their
17 kidneys are completely shut down. You don't want to
18 be giving that person a lot of fluid.
19 So you need to know that other than -- every
20 patient is different. You have to treat every
21 patient differently. And that's what the chronic
22 disease tell you.
23 So I think you've got to separate it. I
24 certainly wouldn't have any problems, if you were
25 worried, quickly treating the patient. But then you

1 need to step back -- thoughtful pause, you know --
2 what are we treating here?
3 Q I have noticed that in some of your notes you
4 note that records are taken of end-stage
5 osteoarthritis of the right knee.
6 How long does that take to develop?
7 MR. McCULLOUGH: Object to the form.
8 A Again, my notes for that were more of the
9 idea -- this has been something -- again, I can't say
10 that because I'm not an orthopaedist, but that's been
11 going on for a long time. I mean, it's not an acute
12 problem.
13 And so, again, as I tried to testify before, I
14 mean, if you look at that, say, what is chronic? I
15 go back and say, well, the first time Dr. Hooper saw
16 him in 2007 he was complaining of knee pain. And
17 then I say, you know, here is he talking about knee
18 pain related to disability, which I can't remember
19 if -- it was in 2010, I think.
20 And so there's other times that he's had knee
21 pain that have been documented in the record. So I
22 can't tell you exactly the amount of time, but it
23 would worry me that that knee pain was already the
24 degenerative arthritis that you would normally see.
25 Q I noticed in Exhibit Number 4, the last

1 section, the last couple of pages there seems to
2 be like charts, flow charts, for lack of a better
3 term, where you had the date, the time, the BUN, and
4 creatinine.
5 Can you tell me why you tracked those?
6 A So there was the idea, number 1 -- you know,
7 in one -- in the records from the beginning -- I
8 think it was on the transfer summary, and if you need
9 me, I can look at that. But there's a notation which
10 effectively says -- I don't remember how it's worded,
11 but it's sort of unsure if acute or unsure if chronic
12 kidney problems.
13 And so the first thing I did was say, well,
14 what was his creatinine when he first got to the
15 emergency room. And creatinine is a measure of
16 kidney function. The higher it is, the worse the
17 kidney function. And so his creatinine when he came
18 in was 1.9, which is already elevated. So he's got
19 chronic kidney disease.
20 And then I went back and looked at
21 Dr. Hooper's notes and saw he's really had that level
22 of creatinine for, you know, quite a few years, and
23 there's actually a note from the UNC records which
24 says creatinine 2, when last checked in September;
25 creatinine 3.3 after cath in September of 2007.

1 So he's actually had some underlying kidney
2 disease for years.
3 And so I was trying to figure out -- again,
4 knowing he had chronic kidney disease and they're
5 saying he had acute kidney injury, what was the cause
6 of the acute kidney injury? And if you look at that,
7 his creatinine didn't really elevate from the 24th
8 until the 4th, and so that's a difference of 11 days.
9 So a difference of 11 days is not really due to, you
10 know, blood loss or hypovolemia or low blood
11 pressure, which, again, I can't find any
12 documentation that his blood pressure was low when he
13 arrived to the emergency room.
14 But it's not really that; it's something
15 that's happened to him, in a sense, while he's in the
16 hospital.
17 Q So you don't -- I'm sorry. Go ahead.
18 A And you know, again, I would say that's due to
19 the extra fluid. The extra fluid that he has is
20 what's caused his, you know, creatinine to elevate or
21 his kidney to not function as well a long time into
22 his hospital course.
23 Q So it would be your opinion that the injury or
24 damage to his kidney is a result of the chronic
25 kidney disease and not as an acute injury?

1 MR. McCULLOUGH: Object to the form.
2 A Right. So he had underlying chronic kidney
3 disease. I would say that, you know, some of the
4 management, you know, contributed to that, but it
5 wasn't the fall, per se. It wasn't blood loss, per
6 se, that caused him to have the acute kidney injury.
7 Q And I believe you said you looked at the
8 records from MUSC and you didn't see any notice of
9 bleeding or blood loss. Is that correct?
10 A So again, if we go back to what the CT scan
11 showed, so -- you know, again, he gets -- he gets
12 basically scanned twice. He gets scanned when he
13 first comes to the emergency room, and the only
14 positive findings there are a small right pleural
15 effusion. And this is the quote: The surgical
16 changes are noted within right medial thigh with
17 extensive venous collaterals, anasarca.
18 So it doesn't mention that there's a large
19 thigh hematoma. So the evidence of the large thigh
20 hematoma is in exam, and my concern is is that how --
21 and I think it was asked in the deposition -- how
22 large was the hematoma. And Dr. Sakran said he
23 didn't measure it or -- I may -- I'm not quoting him
24 exactly, but something to the effect that we didn't
25 measure it.

1 When he goes for his second scan, there is a
2 mention that this hematoma is softer -- quote,
3 unquote, his hematoma is softer -- and the scan,
4 which is now three-and-a-half days later, says --
5 this is the quote -- no evidence of soft tissue
6 hematoma.
7 So you know, again, maybe the amount of
8 bleeding is -- in his leg doesn't look as bad because
9 of all of the swelling, but there's no evidence on
10 CT scan that he's got a big hematoma, and there's no
11 evidence anywhere that he's bled into his belly.
12 Right. And there's -- and the thing he has is a
13 small right pleural effusion, which Dr. Hooper
14 actually notes previously.
15 And when he gets the scan three-and-a-half
16 days later, it says the pleural effusion has
17 decreased in size.
18 So when I mentioned to the other lawyer, you
19 know, that's what -- you know, I can't quite say how
20 much bleeding there was when you find no bleeding in
21 the belly, no bleeding significantly in the chest,
22 and no obvious large amount of bleeding in the
23 extremities.
24 So -- and that's why I wrote all those
25 hematocrits down. Those hematocrits and hemoglobin

1 is trying to find out how much bleeding is there.
2 Q And what do the hemoglobins or hematocrits
3 tell you if you're trying to figure that out?
4 A So, again, you've got to -- there's no --
5 there's no time -- and again, we can try to get these
6 records. I can't find them. There's no time where
7 you find out how much fluid he actually gets. The
8 only evidence of that you have, again, is a -- his
9 description of a 45-pound weight gain. And two
10 weights that I can find in the chart, one weight,
11 which is 118, and one weight, which is 141 kilograms,
12 which is the difference of 23 kilograms, at
13 2.2 pounds per kilograms, is about 50 pounds. So
14 it's about a 45- to 50-pound weight difference.
15 So what it makes you concerned about is -- let
16 me back up just a second and say, what hematocrit
17 means is the percent of red blood cells versus
18 everything in your blood. So there's what we call
19 plasma, which doesn't have any red blood cells, and
20 what you do is you take a blood sample and you spin
21 it down and it packs the red blood cells down and you
22 measure that compared to the whole thing. So it's a
23 percentage.
24 So when it says 28, that means it's 28 percent
25 of the total amount. And the first thing is,

1 normally for a gentleman, your normal blood count is
2 around 42 to 45. And his blood count in Dr. Hooper's
3 records was 29, and so he's already anemic.
4 And when he comes to the ER, his first
5 hematocrit is 29. So it's exactly the same
6 hematocrit as he had before. Again, you can have
7 that, but that makes you worry about how much
8 bleeding he really had, because it's the same
9 hematocrit that he had. So how much red blood cell
10 loss did he have?
11 And then, like I said, you don't know how much
12 fluid he gets except one note says running fluids at
13 500 ccs per hour, and that's a lot of fluid, and
14 that's in the trauma notes.
15 So if he gets that much fluid, then a lot of
16 this may be dilutional, that is, the amount of blood
17 above the red cells is greater. And again, my
18 testimony would be that that's why when they
19 rescanned him on the 29th they didn't find any
20 bleeding, is because the decrease in his hematocrit
21 was not due to blood loss but was due to the shifting
22 of fluid that he had been given and caused him to --
23 what we call dilutional anemia.
24 Q In your opinion and your experience, if you're
25 going to make a determination of whether or not an

1 injury or damage is caused from an acute reason
2 versus a chronic reason, it's important to review
3 these prior records to determine what these
4 elevations or levels were; is that correct?
5 A Again, with the caveat that you may not be
6 able to do it in the first period of time if you
7 think the person is unstable and want to treat them.
8 But after that, when you're in the intensive care
9 unit for a number of days, it's really important to
10 try to figure out what is the baseline level of --
11 you know, in this case, anemia, cardiac function.
12 And again, this is a fellow who, you know, by
13 most standards, is lucky to be alive. I mean, he's
14 suffered an arrest that usually would kill most
15 people. Again, I don't have those records from 2007.
16 I would be really interested in reviewing them.
17 But he's somebody who's on a ventricular
18 assist device after an operation -- after an arrest.
19 So those kind of things are really -- you
20 know, you know he has a cardiac history. It's really
21 important to know what his cardiac function is now,
22 how am I going to treat his cardiac function? What
23 medicines should he be on for cardiac function?
24 And you know, the first thing when the --
25 again, the kidney doctors came by is they said, stop

1 these medicines. So again, looking at his chronic
2 problems, you know, let's put -- not have him on
3 these medicines, which, again, is the -- as the
4 kidney doctors say, can make his kidney function
5 worse.
6 Q So I understand that when you're making the
7 initial determination of treatment like when he
8 presented in the ER, you make the determination on
9 what you've got right there in front of you?
10 A Yes, ma'am.
11 Q But if you're then going to try to determine
12 whether, subsequent to treatment, was the cause acute
13 versus chronic, it would be important to look back at
14 those prior records to determine what those levels
15 were; is that correct?
16 A Yes, ma'am.
17 MR. McCULLOUGH: Object to the form.
18 Q You talked about the anasarca that appeared on
19 the CT scan on the day he arrived at the ER?
20 A Yes, ma'am.
21 Q How long does it take for anasarca to develop?
22 A I would say that's variable, but usually it
23 doesn't occur when the person first arrives to the
24 emergency room. I mean, again, to get -- to get
25 fluid out in the tissues is a reflection of sometimes

1 how sick you are. For instance, if somebody comes in
2 with almost no blood pressure and you put a lot of
3 fluid into them, they will definitely not be able to
4 hold that fluid in the blood vessels.
5 But for somebody that seems to be what I would
6 call hemodynamically stable like this, you wouldn't
7 expect them to have a lot of leakage out to the
8 tissue.
9 So I would say that's a chronic problem. And
10 again, we know that he has chronic swelling or he
11 wouldn't be wearing the Unna boots.
12 Q I'm going to show you what was marked as
13 Defendant's Exhibit 1 to Dr. Sakran's deposition.
14 Have you had a chance to see that?
15 A I have.
16 Q Do you see the list of diagnoses that he's got
17 here?
18 Can you tell me what of those you believe are
19 chronic versus acute?
20 MR. McCULLOUGH: Object to the form.
21 A So --
22 Q In your review of the records. I apologize.
23 A So from my review of the records, under past
24 medical history, he certainly had diabetes.
25 He certainly had coronary disease -- to be

1 honest, I can't say specifically he has coronary
2 artery disease. I mean, you can suffer a cardiac
3 arrest and not have it, but he did have CAB -- now
4 that I think about it -- so he had CAB times 4, so he
5 must have coronary artery disease.
6 He does have atrial fibrillation.
7 He has basal cell carcinoma of bilateral lower
8 extremities status post radiation.
9 He does have chronic renal insufficiency.
10 Then it says injury complex. It says right
11 thigh hematoma. Again, the physical exam by the
12 doctors say that he had a right thigh hematoma.
13 Again, sometimes not picked up, marked -- you know,
14 small on a CT so --
15 Right chest contusion. Again, that's a
16 physical exam, so he couldn't tell that from the
17 records.
18 Right arm contusion/skin tears. Again, that's
19 a physical examination. It is documented by the
20 examiner.
21 Then it says, acute kidney injury versus
22 chronic renal insufficiency, which would mean to me
23 that they don't know which it is. But if we look and
24 his creatinine was 1.9 when he came in and when he
25 left the intensive care unit -- which is when this

1 is -- his creatinine was not different. So this
2 particular transfer summary was definitely chronic
3 renal insufficiency. There was no acute kidney
4 injury during this part of his stay.
5 And then anemia. Again, I'm not sure if they
6 mean he had anemia -- it says as part of his injury
7 complex, so they're just talking about his blood
8 count was low during the injury complex. We know it
9 was low chronically in addition. So he had some
10 element of anemia, probably related to bleeding.
11 Obviously a lot of his anemia is due to chronic
12 disease.
13 Q From your review of the medical records that
14 you've seen both following this accident and before
15 this accident, have you formed any opinion regarding
16 whether or not the majority of the treatment or what
17 percentage of the treatment at MUSC was for issues
18 that were chronic versus acute?
19 MR. McCULLOUGH: Object to the form.
20 A That's hard for me to say. I mean, the
21 biggest reason I would say he was initially in the
22 ICU, at least by reviewing the records, were that,
23 you know, they were following his hematocrit. I
24 can't tell that there was any instability. I mean,
25 there's never a mention where his blood pressure is

1 low, his pulse rate is high, you know, X.
2 So he's not in the intensive care unit for,
3 you know, necessarily instability. By that, I mean,
4 you know, we're doing something. He needs to be on
5 the ventilator. He needs to be on medicines to keep
6 his blood pressure up.
7 What we're doing is thinking that he may have
8 internal bleeding or he may have bleeding and his
9 hematocrits look like they're going down, and so we
10 better keep him here for observation. We want more
11 intense observation. So that sort of -- it looks
12 like the reason they kept him in the intensive care
13 unit.
14 And then there's a question of how mobile he
15 is. And you know, again, his mobility is related to
16 PT, but again, there's no reason he can't get PT out
17 of the intensive care unit. So from what I can do by
18 reviewing the records is say he's sort of in the
19 intensive care unit for cautionary reasons, not for
20 what I would call critically ill reasons.
21 Q And you believe that his hematocrit level was
22 falling as a result of the shifting of fluid versus a
23 bleed?
24 A I think that's the majority of it, just,
25 again, based on looking at the x-rays and, you know,

1 looking at the time course.

2 MS. REYNOLDS: Thank you, Doctor. That's all

3 I have.

4 MR. McCULLOUGH: I don't have any questions.

5 Thank you.

6 THE WITNESS: Thank you.

7 (The deposition concluded at 5:51 PM.)

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1 IN THE COURT OF COMMON PLEAS
FOR THE STATE OF SOUTH CAROLINA
2 CHARLESTON COUNTY
3
VIDEOTAPE DEPOSITION OF JOSEPH V. SAKRAN, MD
4
5 ROBERT J. BURKE and JANE B. BURKE,
6 Plaintiffs,
7 vs. CASE NO. 2013-CP-10-1400
8 INDIGO REALTY COMPANY, LLC; REPUBLIC PARKING
SYSTEM, INC.; AND THE CITY OF CHARLESTON,
9
Defendants.
10
11 DEPONENT: JOSEPH V. SAKRAN, MD
12 DATE: JUNE 11, 2014
13 TIME: 3:07 P.M.
14 LOCATION: MUSC CLINICAL SCIENCE BUILDING
CHARLESTON, SOUTH CAROLINA
15
REPORTED RONDA K. BLANTON, RPR
16 BY: NCRA REGISTERED PROFESSIONAL
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18 PRESENT: Michael Beish
Videographer
19 - - -
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24
25

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1 P R O C E E D I N G S
2 VIDEOGRAPHER: We are on the record
3 in the videotape deposition of Dr. Joseph V.
4 Sakran in the State of South Carolina, Court
5 of Common Pleas, County of Charleston. This
6 is the case of Robert J. Burke and Jane B.
7 Burke versus Indigo Realty Company, LLC, et
8 al. Case number is 2013-CP-10-1400.
9 Today's date is Wednesday, June 11,
10 2013. Time now is 3:07 p.m. We're located
11 at the Medical University of South Carolina
12 in the Clinical Science Building at 96
13 Jonathan Lucas Street, Charleston, South
14 Carolina. Court reporter is Ronda Blanton.
15 My name is Michael Beish. I'm the
16 videographer with Clark & Associates.
17 Can everyone identify themselves for the
18 record, please?
19 MR. MCCULLOUGH: Clay McCullough on
20 behalf of Jane and Bob Burke.
21 MR. DINKELACKER: Andrew Dinkelacker
22 on behalf of Indigo Realty.
23 MS. REYNOLDS: Lisa Reynolds on
24 behalf of the City of Charleston.
25 MR. DARLING: I'm Steve Darling. I

1 represent Republic Parking Systems.
2 VIDEOGRAPHER: Thank you. Ronda,
3 can you please swear in the doctor.
4 JOSEPH V. SAKRAN, MD,
5 having been first duly sworn, was examined
6 and testified as follows:
7 THE REPORTER: Thank you.
8
9 DIRECT EXAMINATION
10 BY MR. MCCULLOUGH:
11 Q. Good afternoon, Doctor. Would you
12 please introduce yourself to the jury.
13 A. My name is Dr. Joseph Sakran. I'm
14 an assistant professor of surgery here at the
15 Medical University of South Carolina. I'm in
16 the Division of General Surgery, and also the
17 director of Global Health and Disaster
18 Preparedness.
19 Q. Thank you. And did you have -- do
20 you know the plaintiff in this case, Bob
21 Burke?
22 A. I do.
23 Q. And did you have an opportunity to
24 treat Mr. Burke while he was here at MUSC?
25 A. I did.

1 Q. Are you a licensed and practicing
2 physician in the State of South Carolina?
3 A. I am.
4 Q. What is your area of specialty, or
5 do you specialize in a particular area of
6 medicine?
7 A. So I specialize in general surgery,
8 emergency general surgery, trauma, and
9 surgical critical care.
10 Q. And you are -- and you mentioned
11 this at the beginning; but, again, who is
12 your current employer?
13 A. The current employer is the Medical
14 University of South Carolina.
15 Q. And what do you do at MUSC?
16 A. I am one of the attending surgeons
17 within the Division of General Surgery. So I
18 operate on general surgery patients. I take
19 care of patients with emergency general
20 surgery issues. I take care of trauma
21 patients, and I also take care of patients in
22 the Surgical Trauma ICU.
23 Q. And would you walk the jury through
24 your educational background, please.
25 A. So I went to four years of undergrad

1 at George Mason University. I then -- I went
2 to medical school at a program between Ben
3 Gurion and Columbia University.
4 In between my second and third year, I
5 spent a year doing a Master's in public
6 health at the Johns Hopkins Bloomberg School
7 of Public Health, and I then spent five years
8 at Inova Fairfax Hospital doing a general
9 surgery residency.
10 I then spent two years at the University
11 of Pennsylvania doing trauma, critical care,
12 and emergency general surgery; and then I got
13 recruited down to the Medical University of
14 South Carolina.
15 Q. And are you currently board
16 certified?
17 A. I am board certified by the American
18 Board of Surgery, and I also have a special
19 certification in surgical critical care also
20 through the American Board of Surgery.
21 Q. So you're board certified in general
22 surgery and critical -- critical care?
23 A. Yes.
24 MR. MCCULLOUGH: For the purposes of
25 the record, I tender Dr. Sakran as an expert

1 in the field of general surgery, surgical
2 critical care, and emergency general surgery.
3 Any objection?
4 MS. REYNOLDS: One more time.
5 You're qualifying him for which ones?
6 General surgery?
7 MR. MCCULLOUGH: I'm sorry?
8 MS. REYNOLDS: Which ones? General
9 surgery?
10 MR. MCCULLOUGH: General surgery,
11 surgical critical care, and emergency general
12 surgery.
13 MS. REYNOLDS: Thanks.
14 THE WITNESS: And trauma, obviously.
15 Q. And trauma?
16 A. Right.
17 Q. Okay.
18 A. That's --
19 Q. And tell me about the last one. How
20 would you describe your expertise in trauma
21 care?
22 A. Well, I mean, that was my
23 fellowship. In surgical critical care, all
24 trauma surgeons are pretty much now board
25 certified in surgical critical care. So they

1 kind of go hand-in-hand because trauma
2 patients are so sick so --
3 MR. MCCULLOUGH: All right. And so
4 for the purpose of the record, I'll add that
5 to the list, trauma care.
6 A. Okay.
7 Q. All right. Now, how did you first
8 come to meet Bob and Jane Burke?
9 A. He was a trauma patient at the
10 Medical University of South Carolina.
11 Q. Okay. And how -- do you recall how
12 he was brought to this hospital?
13 A. He was brought by EMS, I believe,
14 although it's been -- I'm sure the records
15 state it, but I believe he was brought by EMS
16 or -- or I'm not 100 percent sure; but he
17 came through the ED, through the trauma bay.
18 Q. And do you recall, aside from
19 looking at medical records and things of that
20 nature, do you actually recall Bob Burke?
21 A. I do, yeah.
22 Q. Why do recall Mr. Burke?
23 A. I recall him because he was a
24 memorable individual since he was a former
25 basketball coach, and so he kind of stuck out

1 in my head. The other reason is, is that he
2 was in our ICU for quite a long time as well
3 as the ward; and so we took care of him for a
4 while. So those patients that you typically
5 take care of for a long time, they, you know,
6 kind of stick in the back of your mind.
7 Q. And as part of your treatment of --
8 well, first of all, did you treat Mr. Burke?
9 A. I did.
10 Q. And as part of your treatment, did
11 you become familiar with his past medical
12 history?
13 A. I did.
14 Q. And was -- was Bob hospitalized at
15 MUSC from January 25 until February the 13?
16 A. Yes. Those dates --
17 Q. That sound about right?
18 A. Yeah.
19 Q. And approximately three weeks?
20 A. Yes.
21 Q. And during that time -- and I
22 believe you mentioned this -- Mr. Burke was
23 in intensive care for a -- a pretty
24 significant period of time?
25 A. Yes, he was.

1 Q. All right. And the records will
2 bear this out in a minute; but is it about
3 from January 25 to February 1, total of eight
4 days?
5 A. Right.
6 Q. What's the difference or what causes
7 a patient to be admitted into the Intensive
8 Care Unit versus the regular hospital?
9 A. Well, you know, the Intensive Care
10 Unit is part of the regular hospital.
11 Patients that go to the ICU versus the ward
12 are typically critically ill; and so they
13 have, you know, either problems with
14 bleeding, problems with, you know,
15 respiratory function.
16 So there's a whole slew of potential
17 problems that could arise that would, you
18 know, require someone to be in the Intensive
19 Care Unit. They typically require more high-
20 level monitoring from a nursing staff, from a
21 respiratory staff, and from a physician
22 standpoint.
23 Q. All right. And -- and the Intensive
24 Care Unit provides a higher level of
25 monitoring than the -- than the traditional

1 ward?
2 A. Yes.
3 Q. And he was -- Bob was in ICU for
4 eight days?
5 A. Yeah. Approximately eight days, as
6 best as I can recollect.
7 Q. And during that time what was your
8 involvement during those eight days when
9 Mr. Burke was admitted into the ICU?
10 A. So I was one of the Surgical Trauma
11 ICU attendings. You know, we have eight
12 other different partners so there's a total
13 of nine of us; and we rotate through the
14 Surgical Trauma ICU on a week-by-week basis.
15 And, you know, I spent, you know, time taking
16 care of him as one of the ICU attendings that
17 week.
18 Q. And were you one of the decision
19 makers that held Bob in ICU for those eight
20 days?
21 A. Yeah, for a portion of the time. We
22 have people that, you know, take call at
23 night. So we're not here 24 hours a day,
24 seven days a week. So, you know, our --
25 between myself and my other partners, we go

1 back and forth as to, you know, who's here
2 and who's not depending upon the time.
3 Q. Okay. And tell me your
4 understanding of what brought Bob Burke here
5 on the evening of the 25th.
6 A. My understanding was that he tripped
7 over a -- a curb and ended up falling
8 primarily on his right side, which resulted
9 in significant pain, bruising, contusions;
10 and then he was brought to the hospital where
11 he was worked up.
12 Q. All right. And did you discuss this
13 with Mr. Burke at some point in your
14 treatment of him?
15 A. I did.
16 Q. All right. And do you recall any
17 other specifics about what caused him to
18 fall?
19 A. Yes. So one of the things that I
20 was asking -- I wanted to know whether or not
21 this was an episode where he had passed out
22 from, you know, what we call a sinkable
23 episode; and he said he didn't. He said that
24 the lighting was poor and it -- he felt like
25 it was just a, you know, a typical trip. It

1 wasn't due to, you know, him blacking out or
2 some other condition.
3 Q. Describe his condition when he was
4 first admitted to the hospital, his injuries.
5 A. So when he was first admitted to the
6 hospital, he had a -- a significant thigh --
7 right thigh hematoma, meaning he had blood
8 within the thigh tissue. He also had
9 significant abrasions and contusions over
10 that lower extremity as well as some
11 contusions along his right side. He had a
12 small right-sided hemothorax, and I believe
13 he had also a small liver laceration.
14 Q. And as his injuries -- as you
15 continued to treat him, walk the jury through
16 those first day or two of the progression of
17 his injuries.
18 A. So initially, you know, he was --
19 the first thing that we were really concerned
20 with was that his hemoglobin counts were
21 dropping; and so, you know, when you have
22 extensive amount of blood that's seeping into
23 the tissues, you have to watch that very
24 closely because it can expand significantly
25 and result in compromise of the extremity.

1 He had a complicating factor, which was
2 that his INR, which is a -- a marker of how
3 thin the blood is -- was high. He was on a
4 medication called Coumadin which thins out
5 the blood; and his level was around 3.25,
6 more or less. And so that, you know,
7 obviously played a role in this because after
8 he, you know, had the injury from falling, he
9 bled a significant amount.
10 Q. All right. And the fact that he was
11 on blood thinners, what impact did that have
12 on his injuries?
13 A. Well, it probably caused him to
14 bleed more than, you know, someone who
15 wouldn't be on blood thinners.
16 Q. Okay. And just so I'm clear, was
17 Bob bleeding both externally from cuts and
18 abrasions and internally from internal
19 contusions or bruising?
20 A. Yes. So he had bruising on the
21 outside, as I described; but he also had
22 within his thigh compartments some bruising,
23 and he also had a -- what appeared to be a
24 small right-sided hemothorax in his right
25 chest.

1 Q. And explain to the jury what that
2 is.
3 A. That's just some blood that can
4 layer into the chest.
5 Q. What's the impact of somebody with
6 Bob's -- how old was Bob about this time?
7 A. He was -- I want to say -- gosh, I
8 don't remember off the top of my head. I
9 want to say like in his late 60s, more or
10 less.
11 Q. Okay.
12 A. Maybe like --
13 Q. Mid to late 60s.
14 A. -- 67, 68, something like that.
15 Q. Okay.
16 A. I can't remember off the top of my
17 head. I'm sorry.
18 Q. And if for a 60s -- mid 60s, late
19 60-year-old man, what -- tell the jury what
20 some of the impacts are to somebody who
21 suffers from significant internal bleeding.
22 A. Well, you know, as -- as we get
23 older, you know, especially in someone like
24 Bob who had other comorbidities, the ability
25 to, you know, you know, get back after a

1 significant trauma like this is a lot harder.
2 The morbidity, you know, and mortality
3 rate in this population when you're elderly
4 is increased; and so, you know, I think
5 that's typically the main difference if
6 you're asking me to describe the difference
7 between someone who's older and someone who
8 is younger.
9 Q. All right. And what -- other than
10 the actual areas themselves, the thigh and
11 the chest, where you -- you saw this internal
12 bleeding, what organs can be impacted? Or
13 more importantly, with Bob, were impacted as
14 a result of the internal bleeding?
15 A. Well, he had some atrial
16 fibrillation, which was not new. This was
17 old, which was why he was on the Coumadin.
18 So, you know, there can always be an impact
19 to your -- to your cardiac status when you're
20 having low levels of -- of hemoglobin
21 secondary to bleeding.
22 The other -- the other impact can be
23 your kidneys. He had base line chronic renal
24 insufficiency; but that can be exacerbated if
25 the, you know, perfusion to the kidneys is

1 lower because your blood volume is less.
2 Q. Is it normal for somebody to spend
3 eight days in the ICU after a trip and fall,
4 in your experience?
5 A. It -- it just depends on what their
6 injury complex is.
7 Q. All right. I want to make sure the
8 jury understands. You're describing internal
9 bleeding and bruising and things of that
10 nature.
11 Would -- how would you describe his
12 condition at that time his first day, two,
13 three days post fall?
14 A. Well, by definition, if they're in
15 the ICU, they're -- they're critically ill.
16 We wouldn't have someone in the ICU that
17 wasn't critically ill. So by definition, you
18 know, they would be critical.
19 Q. Doctor, based on your treatment
20 of -- of Bob Burke together with your
21 communications with Mr. Burke, to a
22 reasonable degree of medical certainty most
23 probably, what caused Mr. Burke's injuries?
24 A. Well, I mean, what caused his
25 injuries were the fall.

1 Q. All right. And same question to a
2 reasonable degree of most certain -- of
3 medical certainty most probably, what impact
4 did the blood thinner have on Bob's injuries?
5 A. It exacerbated the bleeding.
6 Q. Doctor, I want to hand you a
7 document that's been previously marked as
8 Exhibit No. 1 --
9 A. Okay.
10 Q. -- titled "Transfer Summary." Do
11 you see that?
12 A. Yes, sir.
13 Q. All right. Explain to the jury --
14 VIDEOGRAPHER: Off.
15 MR. DARLING: We object to
16 Exhibit 1, the Transfer Summary; and while
17 we're on (SIC) the record, I might as well go
18 ahead and object to all three of these
19 exhibits: The Transfer Summary, Discharge
20 Summary, and another record called Diagnosis
21 and Procedure Summary.
22 These are all -- these documents all
23 contain hearsay, plus they are cumulative.
24 The doctor can testify orally and describe
25 things that he did or things that he treated

1 or diagnosed; but these all attempt to
2 bolster the plaintiff's case, are cumulative,
3 and contain hearsay. Therefore, we do not
4 believe they're admissible.
5 MR. MCCULLOUGH: Okay.
6 VIDEOGRAPHER: Back on.
7 BY MR. MCCULLOUGH:
8 Q. All right. Doctor, again, what is
9 this document?
10 A. So the Transfer Summary is a
11 document that we do in order to document the
12 hospital course of a patient. So sometimes
13 these patients can be in the hospital for,
14 you know, weeks, months. And it's -- we --
15 we find it more accurate to be able to
16 immediately dictate a summary when they go
17 from one level of care to the next.
18 So this Transfer Summary appears to be a
19 Transfer Summary of when Mr. Burke left the
20 Intensive Care Unit and went to the ward so
21 it documents the status in the ICU.
22 Q. And this basically describes the
23 picture as to the treatment he was provided
24 and his condition for the eight days he was
25 in the Intensive Care Unit?

1 A. Yeah. It's -- it's a -- it's a
2 brief report. Clearly, you know, we can't
3 list every little thing; but it is a brief
4 report of the overall course.
5 Q. And is this kept in the normal
6 course at MUSC as far as treating its
7 patients?
8 A. Yes. In the Surgical Trauma ICU,
9 yes.
10 Q. And is this information something
11 that both you and other physicians should and
12 do rely on as far as providing important
13 medical information about your patients?
14 A. Yeah. 'Cause, you know, sometimes
15 it's -- it's hard to recall everything that
16 happened, especially when, you know, you see
17 a patient later on in follow-up. So we use
18 this to kind of refresh our memory as to the
19 hospital course and what took place.
20 Q. Are you confident that this contains
21 accurate information about Mr. Burke's
22 condition and the treatment of Mr. Burke
23 while in the care of MUSC physicians?
24 A. I am.
25 MR. MCCULLOUGH: At this time I

1 would like to admit Exhibit No. 1 into
2 evidence noting the objection.
3 MR. DARLING: Noted. This will be
4 on the record, rather than me going back and
5 forth, we reserve all objections throughout
6 this deposition exhibits; correct?
7 MR. MCCULLOUGH: Okay.
8 MR. DARLING: Okay. Thank you.
9 VIDEOGRAPHER: We're back on.
10 BY MR. MCCULLOUGH:
11 Q. All right. Let's refer to the
12 Transfer Summary, Exhibit No. 1. This date
13 is 1-28-13; is that correct?
14 A. Yes. You're talking about the --
15 the date that's listed up here at the top?
16 Q. Yes, sir.
17 A. Yes.
18 Q. All right. And -- and you are
19 listed as the attending physician on this
20 Transfer Summary. Is that accurate?
21 A. Yes.
22 Q. All right.
23 A. There's, you know, there's two
24 main -- there's myself and I think
25 Dr. Montgomery is another attending on the

1 discharge.
2 Q. Okay. And did you work together
3 with Dr. Montgomery with Mr. Burke?
4 A. Well, we work with all -- again,
5 there's eight -- there's a total of nine of
6 us; and so, you know, if someone is on call,
7 we all cover for each other. We all know
8 each other's patients. So, yes, we work very
9 closely together.
10 Q. And did you discuss Mr. Burke's
11 treatment with not only Dr. Montgomery but
12 the other attendings?
13 A. The treatment of every patient on
14 our service is discussed in the morning and
15 at night.
16 Q. And is that --
17 A. We have a morning report and a --
18 and a signout at night that's done seven days
19 a week, 365 days a year.
20 Q. And is that one of the reasons that
21 you have Exhibit No. 1, so that you can help
22 share information amongst the physicians and
23 other staff folks at MUSC?
24 A. Sure. I mean, yeah. Anyone can use
25 this to -- to find out information.

1 Q. And -- and you as the attending
2 physician rely on it and expect others to
3 rely on its -- the information contained
4 therein?
5 A. Yes, sir.
6 Q. All right. Again, under the brief
7 history, it -- it lists Bob, a 67-year-old
8 male. Is that basically what you had said
9 previously?
10 A. Yes, sir. I couldn't remember the
11 exact date, but it appears here he was 67 at
12 the time.
13 Q. All right. And it says, "Admitted
14 status post fall with active bleeding,
15 enlarging thigh hematoma secondary to
16 therapeutic INR 3.35." Said, "He tripped
17 over a curb onto concrete."
18 And does that jive with your
19 recollection of your communications with Bob?
20 A. Yes.
21 Q. I want to -- there's a list here of
22 past medical history. How did you obtain
23 that information?
24 A. By asking the patient.
25 Q. And where -- and did you also

1 communicate with Bob's wife Jane?
2 A. I did. I communicated with his wife
3 and the rest of his family. He has a son
4 that I spoke to as well.
5 Q. And were they helpful in providing
6 the information you needed to help your
7 treatment of Mr. Burke?
8 A. Absolutely. They were there, I
9 mean, almost 24 hours a day the whole time he
10 was in the hospital, you know, plus or minus.
11 Q. All right.
12 A. Very involved.
13 Q. Now, walk me through -- you had
14 mentioned the atrial fibrillation.
15 A. Uh-huh.
16 Q. Tell me what your understanding
17 of -- of what happened with Bob previously
18 with regards to that.
19 A. Well, I don't know at what point he
20 was diagnosed; but many patients with atrial
21 fibrillation are started on a blood thinner
22 in order to help prevent their risk of having
23 a stroke. And so that -- my understanding
24 from him was he was diagnosed with atrial
25 fibrillation, and his physician started him

1 on a blood thinner.
2 Q. And -- and Coumadin's a brand name
3 for the blood thinner?
4 A. Coumadin is, yes, exactly.
5 Q. And what is "INR"?
6 A. So "INR" is a way that one can
7 measure how thin the blood is. So it's a lab
8 test that we use to -- to determine --
9 Q. What's the normal range?
10 A. Typically from two to three --
11 Q. All right.
12 A. -- is typically where most people
13 are.
14 Q. And I believe in other documents
15 it's -- his INR was 3.25. Here it's 3.35.
16 A. Right.
17 Q. What's your -- I guess how would you
18 describe somebody that comes in with 3.25
19 INR?
20 A. We would call that, as listed here,
21 it's a supratherapeutic meaning it's above
22 the level. It's, you know. So -- so it's
23 slightly above the level of three that we
24 typically would like.
25 Q. All right. But your -- your

1 description of that is "slightly above"
2 meaning, is that something that while you
3 wouldn't ignore -- is that leaps and bounds
4 outside the norm?
5 VIDEOGRAPHER: Off.
6 MR. DARLING: Object to the form of
7 the question. Leading the witness.
8 VIDEOGRAPHER: Back on.
9 BY MR. MCCULLOUGH:
10 Q. You can answer the question.
11 A. Sorry. Can you repeat the question?
12 Q. Sure. I believe your description
13 was "slightly above."
14 A. Uh-huh.
15 Q. What is your reaction to as -- as a
16 trauma surgeon to finding somebody with a
17 3.25 INR?
18 A. Well, in the -- in the setting of
19 trauma, clearly that's an abnormal, you know,
20 level. It would be abnormal even if it was
21 2-and-a-half; and so we like to get them
22 lower in order to prevent them from, you
23 know, further bleeding. And so I would
24 simply call this an abnormal level of INR, if
25 that makes any sense.

1 Q. Let's go through the injury complex.
2 Walk me through these five separately listed
3 items and just describe for the jury what
4 they are, please.
5 A. So "right thigh hematoma" means that
6 there is blood within the compartment of the
7 thigh.
8 "Right chest contusion" means there's
9 almost like a bruise over the chest. Had a
10 right arm contusion and some skin tears as
11 well.
12 "Acute kidney injury" versus "chronic
13 renal insufficiency" so Bob had some base
14 line chronic renal insufficiency, but the
15 level was above his base line so that's why
16 that's listed there.
17 And "anemia" means that the blood levels
18 are lower than normal, and that's listed
19 there 'cause he bled.
20 Q. And Bob described intense swelling.
21 Do you recall Bob being swollen in areas?
22 A. Yes. Particularly the thigh.
23 Q. All right. I want to walk through.
24 Down here at the bottom where it says "brief
25 ICU course," what is this information

1 intended to do?
2 A. So this is intended to describe --
3 it's a brief description of the ICU course.
4 Q. And --
5 A. So, again, it's not every little
6 detail; but it's intended to give whoever's
7 reading this an idea of what happened
8 throughout this part of the hospital stay.
9 Q. And the treatment provided while in
10 the ICU either came from you or a team member
11 with your input?
12 A. Yes.
13 Q. So this is information you would
14 have known at the time it was performed
15 because you were either a participant or were
16 made aware of the treatment to your patient?
17 A. Yes.
18 Q. All right. On January 25 it says,
19 "Admitted to STICU for close monitoring and
20 serial labs given expanding hematoma of his
21 thigh and setting of" -- what's that word?
22 A. Coagulopathy.
23 Q. "INR 3.25. Received four units."
24 What's "FFP" stand for?
25 A. Fresh frozen plasma.

1 Q. All right.
2 A. So it's a product that we give to
3 correct the really thin blood, essentially.
4 Q. "Two units PRCB"?
5 A. Yeah. Packed red blood cells so
6 that's blood transfusion.
7 Q. All right. And then, "INR corrected
8 to 1.5." What does that mean? You got the
9 INR straight?
10 A. Yeah. So we -- we corrected the INR
11 so it was, you know, 3 point -- I guess here
12 at 3.35, and we gave blood products in order
13 to get it down to a level where he's less
14 likely at risk for bleeding.
15 Q. All right. And it says "expanding
16 hematoma." Is that getting worse while he
17 was there?
18 A. Yeah. So that means that, you know,
19 he comes in with a certain size thigh; and
20 then that gets bigger over time. So it's
21 expanding.
22 Q. And then on the next day, he's still
23 in the ICU; right? Is that right?
24 A. Yes, he was.
25 Q. And on the 26th, it says, "The

1 patient's hemoglobin was stable. His thigh
2 was tender to palpation. He did complain of
3 right knee pain which led to X rays of that
4 joint which were negative."
5 Tell me what you recall about the right
6 knee pain.
7 A. Well, he had, you know. We do
8 what's called a tertiary exam the day after a
9 trauma where we examine all parts of the body
10 to make sure there's nothing that was
11 potentially missed; and during that exam, he
12 was tender to palpation. And so, you know,
13 we would routinely check an X ray to make
14 sure that there wasn't a -- a fracture or
15 something else going on.
16 Q. And he had -- it's your recollection
17 he had fallen on his side?
18 A. Well, it appeared, you know. I
19 don't know how he fell; but it appeared based
20 on his injuries that he fell on his right
21 side 'cause he had the right chest contusion,
22 the right thigh hematoma, and, you know, the
23 bruising and stuff there.
24 Q. Now, on the next day, the 27th, it
25 says, "The patient's hematoma of his thigh

1 was stable; but his hemoglobin continued to
2 drop presumably secondary to acute blood
3 loss, anemia. The patient received three
4 units of PRBCs on that day, and his
5 hemoglobin went from 6.4 to 8.5."
6 A. Uh-huh.
7 Q. Tell the jury what all that means.
8 A. So essentially, clinically we
9 weren't seeing the thigh continue to expand
10 but the levels of his -- his blood count
11 levels, which is a more objective sign, was
12 decreasing, which told us he was still oozing
13 and -- which resulted in him getting blood.
14 Q. And so he's still bleeding somewhere
15 several days after the accident?
16 A. Well, part of it is that he's still
17 oozing; and part of it is, is that after you
18 bleed, it takes a little bit of time for your
19 blood volumes to equilibrate.
20 Q. And then on the next day, the 28th,
21 "The patient's condition appeared to have
22 destabilized, and the decision was made to
23 transfer the patient to the floor. His
24 hemoglobin did not respond appropriately on
25 his Q.12-hour repeat CBC later on that day,

1 however, so we kept until the next day for
2 further observation."
3 Explain to the jury what that means,
4 please.
5 A. So I think -- I think what this
6 should say is that the patient's condition
7 appears to have stabilized --
8 Q. Okay.
9 A. -- because we wouldn't transfer a
10 patient out to the floor.
11 Q. That was a question I have.
12 A. All right. So I think that's a
13 typo. But essentially that means that he
14 appeared to us that he was getting better,
15 and the plan was to send him to the floor.
16 Many times when we do this, we'll check
17 a hemoglobin to make sure that he doesn't
18 continue to drop. And so his hemoglobin had
19 not responded appropriately when we checked
20 that hemoglobin before we were going to send
21 him out; and so, therefore, he was kept in
22 the ICU.
23 Q. Then on the next day, the 29th, his
24 hemoglobin dropped again. So we repeated the
25 CT of his abdomen and pelvis as well as his

1 right thigh.
2 A. Uh-huh.
3 Q. None of these showed the formation
4 of any new hematoma or the expansion of any
5 old hematomas.
6 Explain what that means, please.
7 A. So we were concerned because he was
8 still continuing to drop his hemoglobin
9 level, and so we wanted to make sure he
10 didn't have any other sources of bleeding in
11 his abdomen or any continued active bleeding
12 in his thigh.
13 So those images were performed in order
14 to more objectively evaluate it. They turned
15 out to be pretty much stable; and so at that
16 point, you know, we were pretty comfortable
17 with the fact that there wasn't something
18 that we were missing.
19 Q. All right. And then on the 31st,
20 "Skin tears of his right and left upper
21 extremities are stable and appear to be
22 healing. His creatinine is stable of 1.6,
23 and he has been tolerating a regular carb-
24 counting diet well."
25 It goes on, "We now feel he's stable

1 enough to go to the floor."
2 Is -- tell me -- tell the jury what this
3 means, essentially.
4 A. So that means so now we -- we see
5 that he's not -- he doesn't appear that he's
6 actively bleeding. He's actually able to
7 tolerate some sort of nutritional, you know,
8 intake.
9 We've gotten his diabetes a little bit
10 under control with the -- with the
11 medications that are listed here, the Lantus
12 and the sliding scale; and we've started the
13 process of getting -- getting him physical
14 therapy. So at this point he really didn't
15 meet the definition of being critically ill
16 anymore and was stable enough to be taken
17 care of on the ward service.
18 Q. So after about eight days, he was
19 able to leave the ICU and go into the -- the
20 ward.
21 A. Yes, sir.
22 Q. All right. And at the bottom,
23 again, you're listed as the attending
24 physician.
25 A. Yes, sir.

1 Q. And -- and does all of the
2 information you've just gone through appear
3 to be a correct overview of the treatment,
4 again, that -- that you provided to Mr. Burke
5 while he was your patient in the ICU?
6 A. Yes, sir.
7 Q. All right. Now, if you would, pull
8 out what we've marked as Exhibit No. 2 --
9 A. (Complies with request.) Okay.
10 Q. -- which is described as a Discharge
11 Summary. Tell the jury what that document is
12 intended to do.
13 A. So a Discharge Summary is similar to
14 a Transfer Summary except it's at the end of
15 the hospital course. So, essentially, it
16 summarizes the hospital stay of the patient.
17 Q. And this is dated on the 13th,
18 February 13; is that correct?
19 A. Yes, sir, it is.
20 Q. All right. And it's my
21 understanding -- and correct me if I am
22 wrong -- a Transfer Summary is a transfer
23 within MUSC from the ICU to the ward, and the
24 Discharge Summary summarizes all of the
25 treatment while at MUSC as MUSC is

1 discharging Bob Burke.
2 A. Yes, sir, that's correct.
3 Q. All right. And before we go any
4 further, where was Mr. Burke discharged to?
5 Did he go home?
6 A. He was -- no, he was discharged to
7 Roper rehab.
8 Q. And we'll get into that in just a
9 second, but he was -- in your mind, was he
10 able to go home after he left MUSC on the
11 13th?
12 A. Well, I mean, no. Otherwise, we
13 would have sent him home. So that's why he
14 went to the rehab center 'cause he -- he
15 hadn't met, you know, appropriate criteria
16 to -- to go home.
17 Q. In the same series of questions,
18 where does the information come from that is
19 contained in the Discharge Summary?
20 A. It -- it comes from the person
21 that's dictating it. So it's usually, you
22 know, one of our residents or one of the
23 advanced practitioners or one of the
24 attendings.
25 Q. And in this case --

1 A. And it's based on the hospital
2 course.
3 Q. And this is Stephanie Montgomery.
4 Was she one of those folks that you described
5 that was treating Bob together with your
6 assistance?
7 A. She is -- Dr. Montgomery is one of
8 my partners.
9 Q. And so --
10 A. And it was -- I'll tell you who it
11 was dictated by. It was dictated by
12 Brandi -- it's listed on the last page here.
13 I guess page 4 or something. Brandi Aquino.
14 And she was one of our advanced practitioners
15 who dictated this.
16 Q. And, again, is this normal MUSC
17 practice, although multiple physicians may
18 treat a patient, one person takes the lead of
19 that group to dictate the summary and then
20 sign off on it?
21 A. Yes.
22 Q. Despite the fact that you didn't
23 sign off on this particular document, were
24 you a participant in Mr. Burke's care and
25 treatment that is described in the Discharge

1 Summary?
2 A. Yes.
3 Q. And do you have firsthand account of
4 the information contained herein?
5 A. Yes.
6 Q. And is this a normal MUSC document
7 used for patient's well-being and for the
8 physicians to communicate patient's
9 information?
10 A. Yes. All patients treated at MUSC
11 have a Discharge Summary.
12 Q. And you regularly rely on this
13 document, these types of documents, here at
14 MUSC?
15 A. Yes.
16 MR. MCCULLOUGH: All right. At this
17 time I would admit Exhibit No. 2 into
18 evidence.
19 Q. All right. Doctor, let's look at
20 this. Again, Bob was admitted on January 25
21 and discharged on February 13; is that
22 accurate?
23 A. Yes, sir.
24 Q. And, again, you've got a history and
25 physical exam; and, again, it states down

1 here, and I'll read it. You confirm whether
2 or not this was your understanding of what
3 happened.
4 A. Okay.
5 Q. That "Bob tripped over a curb onto
6 concrete, landed on his right thigh, and was
7 brought to MUSC with bleeding and right thigh
8 pain."
9 A. Yes, sir.
10 Q. All right. I want to go through --
11 I've marked all of the X rays or CT Scans
12 that were taken that are listed here.
13 First of all, how do you determine or
14 how does MUSC determine what to X ray and
15 what scans a patient should receive?
16 A. So it's based really on the
17 attending that's evaluating the patient; but
18 there's, you know, certain clinical criteria
19 of trauma patients that's, you know,
20 identified through the American College of
21 Surgeons that would suggest, you know, that
22 you should do X number of tests in order to
23 diagnose patients after trauma, especially
24 those who have an elevated INR. Meaning that
25 their blood is very thin because there's

1 potential for, you know, for not being able
2 to clinically see an internal injury.
3 Q. And so if you x-rayed something
4 here, would it be a result of either seeing
5 some injury to that area or some patient
6 complaint to that area?
7 A. It would be, you know, mechanism,
8 patient complaint, overall clinical picture.
9 Q. And I just want to run through and
10 make sure I get them all. You x-rayed Bob's
11 right femur; is that correct?
12 A. Yes, sir.
13 Q. Right elbow?
14 A. Uh-huh. (Nods head.)
15 Q. His chest?
16 A. Yes.
17 Q. Given a brain CT?
18 A. Yeah.
19 Q. What is a "CT"?
20 A. It's a CT Scan so computer
21 tomography image that allows for detailed
22 imaging of the internal wounds.
23 Q. All right. He was given a CT of the
24 chest, abdomen, and pelvis.
25 A. Yes.

1 Q. And it goes on. It says, "Showed a
2 small right knee effusion." What does that
3 mean?
4 A. It means that there's some fluid
5 within the knee joint.
6 Q. All right. And you x-rayed or MUSC
7 x-rayed both his right knee and his left
8 knee; is that correct?
9 A. Yes.
10 Q. Okay. And so during Bob's
11 treatment, based on those litany you provided
12 the jury a minute ago, MUSC deemed it
13 necessary to provide -- to either perform a
14 CT Scan or an X ray on all those areas of Bob
15 Burke while he was being treated here?
16 A. Yes, sir.
17 Q. And as part of that, because based
18 on what we just went through while he was in
19 the ICU, he was continuing to have blood
20 loss, continuing to have his levels not come
21 where they -- where you would hope they would
22 be?
23 MS. REYNOLDS: Objection.
24 VIDEOGRAPHER: Off.
25 MS. REYNOLDS: Leading.

1 MR. MCCULLOUGH: I'll ask it again.
2 VIDEOGRAPHER: Okay. Back on.
3 BY MR. MCCULLOUGH:
4 Q. Why would you give -- or why was a
5 decision made to take this many various
6 X rays and scans, CT Scans, of Bob Burke
7 while he was in your care?
8 A. Initially?
9 Q. Yes, sir.
10 A. Because it was felt that it was
11 clinically necessary based on the injury
12 complex that we were seeing.
13 Q. And does the fact that there were
14 the issues, as we just went through in
15 Exhibit No. 1, while he was in ICU, did that
16 dictate some further testing?
17 A. Yes. 'Cause his hemoglobin didn't
18 respond appropriately, and so that required
19 that we repeat his CT Scan of his abdomen and
20 pelvis as well as his thigh to ensure that
21 there was no further active bleeding.
22 Q. On the next page it describes Bob --
23 and I'll read it. "The patient had severe
24 deconditioning, malnutrition, and was
25 determined to require rehab placement once he

1 was stable."
2 Describe for the jury what that means,
3 please.
4 A. So patients that are critically ill
5 and -- and severely injured, they end up
6 becoming deconditioned, meaning they lose a
7 lot of muscle mass. They can become
8 malnourished because, you know, they're sick.
9 They're lying in bed. Initially they're not
10 eating, and they have a lot of different
11 factors going on. So all of that really can
12 take a toll on the human body.
13 And so that's what happened to him; and
14 so he was, you know, pretty weak, you know,
15 after his ICU portion required, you know, a
16 lot of rehabilitation, which is why we got
17 physical therapy and occupational therapy to
18 work with him in addition to the nutritional
19 factors.
20 Q. And just to be clear, he didn't come
21 into the hospital deconditioned,
22 malnourished. This was something that
23 happened as a result of being in the hospital
24 for this long?
25 A. Right. This wasn't his base line.

1 Q. Now, describe his condition upon
2 release on the 13th to Roper Rehabilitation.
3 Why was he released to Roper rehab?
4 A. Well, so after the ICU course and
5 the course in the ward, Mr. Burke had
6 improved significantly; but he still was very
7 weak, requiring a lot of assistance with
8 physical therapy. And we were just getting
9 his nutrition up to par. So he was not found
10 to be appropriate to send home at this point
11 'cause he still required significant help
12 from a multi-disciplinary team.
13 Q. What types of things did he require
14 significant help to do on his own at the time
15 he was discharged from your hospital?
16 A. You know, just, you know, basic
17 things like, you know, getting up out of bed,
18 transitioning, walking, you know. He was
19 starting to be able to do some of those
20 things, but it was still very difficult
21 because of his injury.
22 Even though his hemoglobin had
23 stabilized, he still had a very large
24 hematoma on his thigh; and it takes quite a
25 while for blood to be able to be reabsorbed

1 and for that swelling to decrease. So it
2 still required significant amount of -- of
3 support.
4 Q. Your Honor -- Doctor, if you would,
5 pull out Exhibit No. 3, please.
6 A. (Complies with request.) Okay.
7 Q. What is this document?
8 A. This is a Diagnosis and Procedure
9 Summary that is part of the MUSC Medical
10 Center.
11 Q. All right. And what is it -- why
12 does this document exist? What does it --
13 what does it do?
14 A. So it essentially lists different
15 diagnoses that the patient had throughout the
16 hospital stay.
17 Q. And would these diagnoses have been
18 made either by yourself or your team in your
19 treatment of Mr. Burke while he was here at
20 this hospital?
21 A. Yes.
22 Q. And, again, as to the other
23 documents, is this something that is created
24 to help all of the staff here at MUSC treat
25 the patients?

1 A. You know, I can't answer that. We
2 don't typically, you know, look at this from
3 a treatment perspective. We use the
4 Discharge Summary, the Transfer Summary for a
5 recollection; but it essentially summarizes
6 the different diagnoses that the patient had
7 during the hospital stay.
8 Q. And the information as to the
9 diagnoses would either come from yourself or
10 your fellow physicians --
11 A. Yes.
12 Q. -- on your team where you would have
13 been a participant in those diagnoses?
14 A. Yes.
15 Q. All right. And -- and this is a --
16 a regular MUSC medical record created and
17 used here at the hospital?
18 A. Yes, sir.
19 MR. MCCULLOUGH: All right. Again,
20 I'd like to admit this into evidence at this
21 time.
22 Q. Doctor, if you would, walk the jury
23 through these -- well, first, are these 23
24 separate diagnosis and procedure -- or
25 summaries for Bob Burke?

1 A. Yes, sir. It says "Robert Burke."
2 Q. Okay. And walk the jury through, of
3 these 23, those that, in your opinion, were
4 caused by his trip and fall on January 25,
5 2013.
6 A. Okay. Do you want me to read them
7 out?
8 Q. Please.
9 A. Contusion of thigh; severe
10 malnutrition; acute renal failure; pleural
11 effusion; posthemorrhage anemia; fall, slip,
12 trip; accident in place; contusion of chest
13 wall; retention urine; contusion of forearm.
14 I believe that's it.
15 Q. What about joint effusion of --
16 A. Oh, yeah. Sorry. Joint effusion as
17 well. That was right knee.
18 Q. All right. So in your opinion to a
19 reasonable degree of medical certainty most
20 probably, all of those diagnoses or issues
21 were caused by Mr. Burke's trip and fall on
22 January 25, 2013?
23 A. Yes.
24 Q. And tell the jury what is "acute
25 renal failure"?

1 A. It's when your kidneys take a hit
2 and the -- they don't function as they did
3 base line.
4 Q. And did Mr. Burke have a continuing
5 kidney issue while he was at MUSC?
6 A. Well, Mr. Burke, as I said earlier,
7 did have some chronic renal insufficiency;
8 but on top of that, he had acute -- what we
9 call acute on chronic renal insufficiency.
10 And so the objective value that we use to --
11 to measure kidney function is called
12 "creatinine," and that went up and then came
13 back down towards the end of the hospital
14 stay.
15 Q. So any -- did his kidney issues,
16 were they worsened or exacerbated as a result
17 of his injuries suffered in this trip and
18 fall?
19 A. They were worsened.
20 Q. Doctor, referring back to all of
21 your testimony here today where you have
22 provided an opinion, has that opinion been
23 provided to a reasonable degree of medical
24 certainty most probably?
25 A. Yes.

1 MR. MCCULLOUGH: Thank you. I've
2 got no further questions.
3 MR. DARLING: Go by the order of the
4 pleadings, I guess. Andrew, I think
5 you're --
6 MR. DINKELACKER: I've got no
7 questions right now.
8 MR. DARLING: Guess I'm next.
9 VIDEOGRAPHER: Do you want me to go
10 off? Okay. Off the record at 3:52 p.m.
11 (Recess taken 3:52 p.m. to
12 3:53 p.m.)
13 VIDEOGRAPHER: Going back on the
14 record. Time now is 3:53 p.m.
15
16 CROSS-EXAMINATION
17 BY MR. DARLING:
18 Q. Doctor, good afternoon. I'm Steve
19 Darling. We've met before --
20 A. Good afternoon, yeah.
21 Q. -- when your -- your discovery
22 deposition was taken. I represent one of the
23 defendants in this lawsuit.
24 A. Okay.
25 Q. I have a few questions just to --

1 A. Sure. No problem.
2 Q. Just to clear up a few things.
3 A couple of the things that you
4 mentioned in direct examination were that one
5 of the things Mr. Burke had when he came to
6 you are what you call "contusions."
7 A. Yes, sir.
8 Q. And in layman's terms, a "contusion"
9 is a bruise; is that correct?
10 A. Yes, sir.
11 Q. Okay. And you also said that -- I
12 believe your words were Bob had some
13 comorbidities. In layman's terms, a
14 "comorbidity" is something that's
15 preexisting. In other words, something
16 Mr. Burke had before this accident; is
17 that --
18 A. Yes, yes, sir.
19 Q. Okay. And actually you -- you went
20 through some of those comorbidities. One is
21 diabetes.
22 A. Yes, sir.
23 Q. He had that before the accident.
24 A. Yes, sir.
25 Q. Another is coronary artery disease.

1 That's disease of the heart. He had that
2 before the accident.
3 A. Yes, sir.
4 Q. He had atrial fibrillation. Again,
5 that's something to do with the heart, which
6 he had before the accident.
7 A. Yes, sir.
8 Q. And basal-cell carcinoma of the
9 lower extremities. That's skin cancer of the
10 legs; correct?
11 A. Yes.
12 Q. He had that before the accident.
13 A. Yes, sir.
14 Q. As a matter of fact, he was
15 receiving some treatment for that before the
16 accident; correct?
17 A. I believe so, yes.
18 Q. All right. He had some open wounds
19 on his legs as a result of that.
20 A. Yes, sir.
21 Q. And some bleeding from that before
22 the accident.
23 A. I'm not -- I can't answer that. I
24 don't know if he had bleeding or not.
25 Q. You're not sure one way or the

1 other.
2 A. Yes, sir.
3 Q. Okay. He also had chronic renal
4 insufficiency. That's lessened function of
5 the kidneys before the accident.
6 A. Yes, sir.
7 Q. Okay. So we have all of those
8 things before this fall; correct?
9 A. Yes, sir.
10 Q. All right. Now, the atrial
11 fibrillation and the coronary artery disease,
12 as we talked about, involve the heart;
13 correct?
14 A. Yes, sir.
15 Q. And were you aware that he had had a
16 significant or serious heart -- I don't want
17 to say "heart attack" because that may not be
18 a correct medical term, but a heart issue
19 several years before this accident.
20 A. What type of heart issue are you
21 referring to?
22 Q. I believe he passed out and almost
23 died before the accident, a couple years
24 before.
25 A. I'm not -- I'm not aware of that.

1 Q. Okay. He didn't tell you that?
2 A. I can't recall, to be honest, no.
3 Q. His wife didn't tell you that?
4 A. I can't recall.
5 Q. I believe he was giving a talk to a
6 group of coaches or basketball people and --
7 and passed out, and they had to take him to
8 the hospital in a severe condition.
9 A. Perhaps, again, I -- we -- I don't
10 remember discussing that specifically.
11 Q. Okay. But in any event, he had at
12 least two heart conditions when he came to
13 you.
14 A. Yes, sir.
15 Q. All right. And I believe you
16 testified that he took a medication called
17 Coumadin as a result of especially the atrial
18 fibrillation.
19 A. Yes, sir.
20 Q. All right. The generic name for
21 Coumadin is warfarin; correct?
22 A. Yes, sir.
23 Q. That's something that was developed
24 many years ago as a rat poison; correct?
25 A. Rat poison, yes.

1 Q. And that makes people, or rats,
2 bleed more; correct?
3 A. It causes your blood to be thin,
4 yes.
5 Q. Yes. And if something happens to
6 you with that thin blood, you often bleed
7 more.
8 A. It can be exacerbated, yes.
9 Q. Bleed more than you normally would.
10 A. Sure, yeah.
11 Q. Okay. A person who's not on
12 Coumadin, if you took their INR, the measure
13 of their blood thinness, would normally be a
14 range of one to two. Is that about right?
15 A. Yeah, it's about right.
16 Q. Okay. Somebody that does take
17 Coumadin, like Mr. Burke did, you would
18 expect a normal INR range to be about two to
19 three.
20 A. Yes.
21 Q. Okay. When he came to the hospital,
22 his INR was either 3.25 or 3.35; correct?
23 A. Yes, sir.
24 Q. And you call that supratherapeutic,
25 which means that it's -- it's high.

1 A. Right. It's above three, yes.
2 Q. Which would cause someone to bleed
3 more than if their range of INR was two to
4 three.
5 A. Yes.
6 Q. Okay. And it would take some time.
7 In other words, he had this level of INR,
8 3.25 to 3.35, before his fall; correct?
9 A. Well, that's the level that we got
10 when he entered our facility so, yes.
11 Q. Now, someone who's taking Coumadin
12 knows that they've got to get their INR
13 levels checked on a pretty regular basis,
14 don't they?
15 A. Yes.
16 Q. And if they don't do that, the
17 Coumadin level, INR level, can be either too
18 high or too low.
19 A. Correct.
20 Q. And when it's too high, like 3.25 or
21 3.35, that means that somebody's on Coumadin,
22 if they have an accident, probably are going
23 to bleed more than they should.
24 A. Potentially.
25 Q. Okay. And a patient who's on

1 Coumadin should know that, shouldn't they?
2 A. That they have to -- I'm sorry.
3 What's the question?
4 Q. They should know that if their blood
5 level, INR level, gets too high, they have a
6 chance of bleeding more than they should.
7 A. Well, they should know that they
8 need to get their INR level checked on a
9 regular basis to make sure it's within the
10 right range.
11 Q. Okay. And here Mr. Burke's level
12 was not within the normal or right range.
13 A. That's correct.
14 Q. Okay. Do you know what medications
15 Mr. Burke was taking for his other
16 preexisting conditions?
17 A. Yes. He had a number of different
18 medications: Lisinopril, Lasix, Talson
19 (phonetic). I don't remember every one of
20 them off the top of my head. I could look
21 back at the documentation and let you know.
22 Q. Okay. But he was taking a number
23 of --
24 A. He was taking a number of
25 medications.

1 Q. Before the accident.
2 A. Uh-huh. (Nods head.)
3 Q. Getting back to Coumadin for a
4 second.
5 A. Yeah.
6 Q. One of the side effects of Coumadin
7 is that it sometimes causes vertigo,
8 imbalance, or lightheadedness, doesn't it?
9 A. That is one of the listed side
10 effects. Again, there's a whole slew of side
11 effects that are listed for --
12 Q. If you go to what's called a
13 "Physician's Desk Reference" --
14 A. Yeah.
15 Q. -- which doctors use, the PDR. That
16 -- those things are listed as potential side
17 effects of taking the Coumadin.
18 A. Yes, sir.
19 Q. Okay. Now, you talked about the --
20 the treatment that was given by you and --
21 and your family of doctors here at MUSC. Is
22 it fair to say that with that treatment,
23 Mr. Burke improved over time?
24 A. Yes, 'cause he was eventually, you
25 know, admitted through the hospital, stayed,

1 discharged. So he did improve.
2 Q. He got the right treatment here and
3 got better over time.
4 A. He did.
5 Q. Okay. Such to the point that you
6 discharged him to go over to Roper rehab next
7 door to do some rehabilitation before going
8 home.
9 A. We discharged him to a rehab center,
10 yes. It happened to be Roper.
11 Q. Okay. And I believe you've
12 testified on a prior occasion that people
13 with types of injuries that he had, you would
14 expect to get back to what's called "base
15 line"; is that correct?
16 A. Yeah. I mean, you would hope that
17 with those injuries, that they can return
18 back to their normal function prior to the --
19 to the fall.
20 Q. And that's what "base line" means.
21 A. Yes, sir.
22 Q. You would expect him to recover to
23 the way he was before the fall after the
24 appropriate treatment.
25 A. I would, yes.

1 Q. Okay. The type of treatment that
2 you and Roper rehab were giving him.
3 A. Yes.
4 Q. Okay. Doctor, since you discharged
5 Mr. -- Mr. Burke from -- from MUSC on
6 February 13, 2013, if I'm correct.
7 A. Yes, sir. That's what's stated
8 right here, yeah.
9 Q. Okay. You have not seen the need to
10 see him as a patient; is that correct?
11 A. No. I think if I saw him, it would
12 have been once; but I, you know, a lot of
13 times when they go to the rehab center, they
14 can be there for, you know, extended period
15 of time. So I don't recall seeing him in a
16 very long time.
17 Q. Okay. And as with most patients,
18 you tell them if they need to come back to
19 you, please schedule an employment.
20 A. Absolutely, yes.
21 Q. Right. He has -- he did not do that
22 and has not come back to you for treatment.
23 A. No.
24 Q. I'm correct?
25 A. Yes.

1 Q. Okay. Doctor, that's all I have.
2 MR. DARLING: Thank you very much.
3 THE WITNESS: Okay. Thanks.
4 VIDEOGRAPHER: Going off the record.
5 Time now is 4:03 p.m. This is the end of
6 Tape No. 1.
7 (Recess taken 4:03 p.m. to
8 4:07 p.m.)
9 VIDEOGRAPHER: We're going back on
10 the record. Beginning of Tape No. 2. Time
11 now is 4:07 p.m.
12
13 CROSS-EXAMINATION
14 BY MS. REYNOLDS:
15 Q. Dr. Sakran, hi, I'm Lisa Reynolds.
16 A. Hello.
17 Q. We have not met before. I'm here on
18 behalf of the City of Charleston.
19 A. Okay.
20 Q. I have a couple of follow-up
21 questions.
22 A. Sure.
23 Q. And I will try my best not to jump
24 around, but I may.
25 A. No, no problem.

1 Q. 'Cause I really don't -- try not to
2 rehash any ground we've already plowed.
3 You testified that your knowledge of
4 Mr. Burke's past medical history came from
5 speaking with him and his wife during the
6 course of treatment; is that correct?
7 A. Sure, yeah.
8 Q. What knowledge, if any, did you have
9 of his past medical history or other
10 issues -- health issues prior to arriving at
11 MUSC's Emergency Department?
12 A. I didn't know him prior to him
13 coming to the Emergency Department so I had
14 no knowledge of his past medical history.
15 Q. As we sit here today, have you
16 reviewed any medical records from any other
17 treating physicians of Mr. Burke?
18 A. I've reviewed stuff in the chart,
19 not -- you mean like within his hospital
20 course?
21 Q. Any.
22 A. Oh, no, just the stuff that, you
23 know. I reviewed typical stuff that we did
24 throughout the hospital course to refresh my
25 memory.

1 Q. Okay. You've not reviewed any
2 records from his primary care physician in
3 North Carolina; is that correct?
4 A. No.
5 Q. Any treatment he's ever received
6 from Duke; is that correct?
7 A. No.
8 Q. You said you believed that he was
9 brought in by EMS. Can you tell me what
10 information the EMT's provided to you prior
11 to his arrival?
12 A. Again, I -- I can't recollect so
13 either there's two modes of -- of
14 transportation. Either they're brought in by
15 EMS or they're, you know, brought in and seen
16 by the ED staff; and then we're consulted.
17 I can look back and find out but the --
18 what -- what I was told when they called me
19 was, you know, we have a gentleman that fell
20 and has significant pain and contusions and
21 what appears to be a pretty big hematoma over
22 his thigh; and so that's when we evaluated
23 him.
24 Q. You are aware that Mr. Burke has
25 diabetes; is that correct?

1 A. Yes, ma'am.
2 Q. Do you know how long he's had
3 diabetes?
4 A. I can't recall.
5 Q. Do you know or would you disagree
6 if -- if his records indicated he was
7 diagnosed in 1985 with diabetes?
8 A. I haven't looked at his records, so
9 I would not -- I won't disagree.
10 Q. In your knowledge and experience,
11 what is -- are some of the complications of
12 being diabetic for 28 years?
13 A. You can get, you know, neuropathies.
14 You can get kidney disease. There's all
15 sorts of, you know, a whole slew of problems
16 that can happen --
17 Q. Okay.
18 A. -- from diabetes.
19 Q. What else other than neuropathy and
20 kidney disease?
21 A. Sometimes a lot of people can get
22 different infections. They can get, you
23 know, ulcerations. They can have
24 hyperglycemic episodes where, you know, they
25 go into comas and need to be hospitalized;

1 and it's a very, very wide list.
2 Q. Mr. Burke had several of these
3 complications from diabetes prior to arriving
4 at MUSC's Emergency Department; is that
5 correct?
6 A. Again, I haven't reviewed his
7 medical records prior to him coming here,
8 which you've asked me about. So I can't
9 agree or disagree to that.
10 Q. He self-reported in the MUSC records
11 that he had peripheral neuropathy; is that
12 correct?
13 A. That is correct. He did have some
14 peripheral neuropathy.
15 Q. And can you tell me what "peripheral
16 neuropathy" is?
17 A. It's when you get a decrease in the
18 sensation of your, you know, your toes or
19 fingertips.
20 Q. And he self-reported that he had a
21 decrease in sensation in the bottom of his
22 feet; is that correct?
23 A. He had peripheral neuropathy, yes.
24 That would -- that would include that.
25 Q. Do you know where he was --

1 A. What's that?
2 Q. Do you know where he was suffering
3 the neuropathy or to what extent?
4 A. It was -- it was vague when he
5 described it. He said, you know, it was kind
6 of around his foot.
7 Q. Did -- he also self-reported that he
8 had retinopathy; is that correct?
9 A. I do not remember that self-report.
10 Q. Do you know or were you aware that
11 he had had prior eye surgery?
12 A. I don't recall off the top of my
13 head.
14 Q. He self-reported that he had prior
15 kidney disease; is that correct?
16 A. That is correct.
17 Q. You talked about the renal -- the
18 chronic renal versus the acute renal --
19 A. Uh-huh.
20 Q. -- issues. You talked about his --
21 that that was -- that's measured by the
22 creatinine levels; is that correct?
23 A. That's an objective measure, yes.
24 Q. Do you know what his base line
25 creatinine level is prior to --

1 A. It was somewhere around 1.2.
2 Q. And where did you get that course --
3 that base line?
4 A. From the family.
5 Q. And what was his base -- what was
6 his creatinine level when he arrived at
7 the --
8 A. I believe it had gone as high as
9 1.8. Again, it's hard to remember every
10 little number. So I'm sure it's listed
11 somewhere in the document.
12 Q. You believe it was around 1.8 when
13 he arrived at the Emergency Department?
14 A. I believe that was the highest level
15 that we saw. I can't remember his exact
16 number when he arrived.
17 Q. Would -- it would be in the records?
18 A. Sure, yeah.
19 Q. Do you know what was -- when was his
20 creatinine level checked? After arrival?
21 A. Well, it's checked -- it's checked
22 upon arrival. So we get a set of labs on
23 someone that's, you know, critically ill. So
24 you would see a creatinine level was checked
25 at that time; and then you would see it

1 throughout the hospital stay, especially with
2 someone that sick, 'cause you would expect
3 that that would, you know.
4 If he's bleeding and not perfusing his
5 kidneys, it would get worse throughout the
6 hospital stay before it got better
7 potentially, which is what his did 'cause it
8 went up to 1.8 plus or minus before it came
9 back down to relatively base line levels.
10 Q. You don't know what his creatinine
11 level was immediately prior to arrival at the
12 Emergency Department; is that correct?
13 A. That is correct.
14 Q. And as we sit here right now, you're
15 not aware of what his creatinine level was
16 upon arrival; is that correct?
17 A. Again, there's -- there's a lot of
18 numbers so I haven't memorized the numbers.
19 I'm happy to look in the records.
20 MS. REYNOLDS: Okay. Can we get
21 them?
22 MR. MCCULLOUGH: I'm not sure why
23 you're looking at me. I think you've got the
24 records right in front of you.
25 MS. REYNOLDS: I have --

1 MR. MCCULLOUGH: If you want to show
2 the doctor something, you can.
3 MS. REYNOLDS: I have some, but I
4 don't think I have them all.
5 A. I mean, no one -- honestly, no one
6 asked me to prepare and bring very detailed
7 numbers. So next time I'm happy to do that,
8 if that's what you'd like.
9 Q. Okay. Do you know when his
10 creatinine level was checked after the --
11 when it was checked immediately upon arrival?
12 When would be the next one?
13 A. So it just depends on when his
14 chemistries are drawn. There's different
15 indications to draw chemistries, and so
16 there's typically periodic evaluation based
17 on how they're doing clinically. So there's
18 not like a set time -- it's not like, oh,
19 they're drawn every day at 5 o'clock.
20 Q. How often did you order his
21 creatinine levels to be drawn?
22 A. Again, it -- it depends. He had
23 multiple draws throughout his hospital
24 course; and so, you know, it depends on how
25 he was doing clinically. If we felt it was

1 necessary clinically, then we would order
2 them; and if we felt it wasn't, we wouldn't.
3 Q. Do you know what were his -- any of
4 his creatinine levels other than the 1.8 some
5 time --
6 A. I have not memorized the list of his
7 creatinine levels.
8 Q. Okay. How quickly would you expect
9 to see a reaction in his creatinine levels if
10 it was a result of injury to the kidneys from
11 bleeding or excessive blood loss?
12 A. That depends on a number of factors.
13 Depends on, you know, how extensive they're
14 bleeding, how quick it was, over what time
15 period; but typically, you know, you can see
16 it in the first 24 to 48 hours.
17 Q. Is it unusual to see it in over ten
18 days?
19 A. Not if they're continuing to have
20 problems.
21 Q. You said Mr. Burke was bleeding
22 extensively, both internal and external; is
23 that correct?
24 A. Uh-huh.
25 Q. How much did Mr. Burke bleed?

1 A. Well, it's hard to really quantify
2 an amount; but we know that he was bleeding
3 because the objective numbers signified by
4 his hemoglobin levels continued to drop.
5 Q. And what else would affect the
6 hemoglobin levels?
7 A. If, you know, you had a significant
8 amount of fluid, theoretically, you know, if
9 you had sickle cell, you know, some sort of
10 other hemolytic-type of disease.
11 Q. Do you know how much fluid was --
12 Mr. Burke was given upon his arrival at the
13 Emergency Department?
14 A. I don't recall the exact amount.
15 Q. Do you know how much he was given
16 during his course of treatment at MUSC both
17 whether in the ICU or in the ward?
18 A. Well, he was given, you know,
19 maintenance fluids and probably some boluses;
20 but, again, that exact amount I don't have.
21 Q. Now, you said his hematoma on his
22 thigh was expanding. Can you tell me what
23 was the -- what was its original size when he
24 first presented to the Emergency Department?
25 A. So we physically didn't measure the

1 actual size; but clinically you could tell
2 that upon his arrival to very soon after his
3 evaluations, it had gotten bigger, more tense
4 on examination, more extensive bruising, and
5 ecchymosis; and that was a clinical
6 evaluation.
7 Q. So from eyeballing it, it was
8 getting bigger.
9 A. And examining it, it was more
10 tender. It was firmer. It was tighter.
11 Q. Is that -- would that be contained
12 in the notes as to the -- how it changed?
13 What was the difference in the tenseness?
14 What was the difference in size?
15 A. Yeah. I mean, we typically, you
16 know, say that it's, you know, whether or not
17 it expanded, whether or not it stayed the
18 same and was stable. And I believe in some
19 of the documentation, it says, "Oh, yeah, at
20 this point it was stable. It wasn't
21 expanding anymore" or it wasn't --
22 Q. The hemoglobin level would indicate
23 both -- or the -- let me say it -- let me
24 back up.
25 The results on a hemoglobin test would

1 be -- would be affected by whether or not he
2 was continuing to bleed as well as if he had
3 a significant amount of fluid in him; is that
4 correct?
5 A. Yes.
6 Q. 'Cause it's simply a -- it could be
7 blood loss or dilution; correct?
8 A. If you have -- if you have a small
9 amount of decrease in your hemoglobin level,
10 that can be dilution; but what he had was not
11 dilution.
12 He continued to progressively bleed a
13 significant amount despite getting blood
14 products, and so he didn't respond
15 appropriately to those levels; and that's
16 listed in the Transfer Summary, and I think
17 which is Exhibit 1, that says we ended up
18 keeping him in the ICU because his hemoglobin
19 and response of three units of packed red
20 blood cells was not appropriate.
21 So typically you would expect it to go
22 up by one point for every unit of packed red
23 blood cells, and so that's not secondary to
24 fluid.
25 I was just giving you a response to your

1 question as to what other potential causes
2 could be; and you would have to get a
3 significant amount of fluid to even get a
4 small amount of drop, let alone someone like
5 him who progressively continued to decree.
6 Q. And what if he had already
7 significant swelling and fluid retention
8 before he came?
9 A. Well, upon his arrival, he had,
10 again, some contusions and what appeared to
11 be a hematoma. That got significantly worse,
12 and even throughout his hospital stay got
13 worse. It got tighter. His hemoglobin
14 levels continued to fall, if that makes any
15 sense.
16 Q. Yes, sir. I'm talking about his
17 fluid levels. Do you know -- did he have --
18 or do you know did -- did Mr. Burke have
19 significant swelling or fluid retention prior
20 to his arrival at the Emergency Department at
21 MUSC?
22 A. Not that we saw on clinical exam.
23 We have his, you know, base line labs and his
24 clinical exam, which, you know, didn't appear
25 to have any significant overall edema.

1 Trauma patients, they do develop edema
2 throughout the hospital course. That's
3 common.
4 Q. In reviewing the MUSC records or
5 notes, I had -- I had noted that on
6 January 27, there was a note that he required
7 a two-person assist.
8 What -- is that normal to require a
9 two-person assist two days into the hospital?
10 A. Well, it -- it -- that means that
11 probably they were trying to help him and get
12 him up and -- 'cause, you know, he was having
13 so much pain and so deconditioned that it
14 required multiple people to physically help
15 him do that.
16 Q. So he was already severely
17 deconditioned by Day 2?
18 A. Yeah. It appears that way, yes. Or
19 it could also be pain.
20 Q. Do you know whether it was pain or
21 deconditioning?
22 A. It was a combination.
23 Q. Do you know where was -- where was
24 the pain from?
25 A. The pain was primarily in his right

1 thigh 'cause he had that significant
2 hematoma, and then he was having pain in his
3 knee as well and his -- where some of his
4 contusions were.
5 Q. And as we sit here today, we don't
6 know the exact size of the hematoma; is that
7 correct?
8 A. I did not measure the exact size,
9 no. It's hard to measure because a lot of
10 this is internal bleeding.
11 Q. Mr. Burke had pulmonary hypertension
12 prior to his presenting at MUSC's Emergency
13 Department; is that correct?
14 A. That's not listed in our past
15 medical history here.
16 Q. Would pulmonary hypertension cause
17 water retention in lower extremities?
18 A. Pulmonary hypertension could
19 potentially cause that.
20 Q. Do you know what is the -- what's
21 the test for pulmonary hypertension?
22 A. I don't typically treat pulmonary
23 hypertension so I'm not the appropriate
24 person to ask.
25 Q. Can you define the term "anasarca"

1 for me?
2 A. That just means diffuse swelling.
3 Q. Diffuse swelling?
4 A. Uh-huh.
5 Q. Do you know how much Mr. Burke bled?
6 A. I think you asked me that so he --
7 he bled a significant amount. You can't
8 really, you know, quantify it. He was -- we
9 were following it objectively by the
10 hemoglobins, and so we saw that his levels
11 were decreasing; and we would, you know,
12 respond appropriately by giving him blood
13 products.
14 Q. And as we sit here today, do we know
15 how much fluid he was given during his
16 course?
17 A. Again, I don't recall how much fluid
18 he was given during his course.
19 Q. Did you follow Mr. Burke's weight
20 during his stay at MUSC?
21 A. So the nurses will typically get bed
22 weights. It's not done consistently. So I
23 don't recall his specific weight throughout
24 the hospital stay, but the nurses do follow
25 that every now and then.

1 Q. Malnutrition wouldn't occur within a
2 first -- within a day or two of a hospital
3 stay; is that correct?
4 A. No.
5 Q. Can you tell me what is the normal
6 course -- PT course for the ICU?
7 A. Well, it just depends on the patient
8 and their injury complex. So it's -- it's --
9 there's a wide variety, you know. Some
10 people are intubated and on a ventilator, and
11 they can't get physical therapy; and there's
12 others that are -- we are more able to
13 provide them with a little bit more therapy
14 so there's -- there's a full range.
15 Q. When was Mr. Burke first given PT?
16 A. It was in his initial first few
17 days. I want to say his second or third day.
18 Can't recall the exact number he was given.
19 Q. He was up and moving during his time
20 in the ICU?
21 A. We are -- we try to get patients up,
22 if possible, so, yes.
23 Q. And if he was started with PT within
24 the first day -- within the second or third
25 day of his stay, he was up and moving. I

1 mean, he was getting PT.
2 A. Right. So "physical therapy"
3 doesn't necessarily mean that they're up and
4 moving. So sometimes they're used -- you had
5 mentioned the two assist. So sometimes
6 they're used to help them just get into a
7 chair. We would try to mobilize them as
8 early as possible.
9 Q. Mr. Burke was not on a ventilator;
10 correct?
11 A. He was not on a ventilator.
12 Q. He was fully functional; is that
13 correct?
14 A. What do you mean by "functional"?
15 Q. He was not in a coma?
16 A. He was not in a coma.
17 Q. He was not on a ventilator?
18 A. He was not on a ventilator.
19 Q. Nothing prevented him from being
20 able to sit up?
21 A. The only thing that prevented him
22 from being able to fully sit up was he had --
23 he had a lot of thigh pain and a lot of
24 swelling; and so he had tended to, you know,
25 be reclining back because every time he sat

1 up, he did get a little bit more pain. We
2 encouraged him to get up and, you know. We
3 got our physical therapist involved to help
4 with that process.
5 Q. So the pain and swelling is what
6 kept him down?
7 A. Yes.
8 Q. Okay. You talked about Mr. Burke
9 was bleeding externally from -- I believe you
10 said he had some contusions or some
11 lacerations on -- on the lower extremities;
12 is that correct?
13 A. So he had contusions over the thigh,
14 the arms, the chest; and he had some stuff
15 over the lower extremities. Some of it was
16 older from his basal-cell carcinoma, but the
17 primary stuff was on his right side as I
18 described.
19 Q. Okay. Do you know -- or can you
20 explain for me or describe to me what a "Unna
21 boot" is?
22 A. It's just essentially a -- a wrap, a
23 zinc oxide wrap that they use on the legs;
24 and they use zinc oxide 'cause it helps
25 maintain moisture.

1 Q. And Mr. Burke had Unna boots on when
2 he came in; is that correct?
3 A. When he physically came in, when I
4 saw him, he didn't have the boots on. Now,
5 perhaps, they brought him with the boots on.
6 A lot of times we'll cut the clothes off and
7 everything they have on so we can evaluate
8 the patient.
9 Q. Were the Unna boots eventually put
10 back on?
11 A. Yeah, at some point during the
12 hospital stay. I believe it was when he got
13 to the ward; but, again, I'd have to look
14 back into the chart to see --
15 Q. Okay.
16 A. -- specifically when he got them.
17 Q. Do you know how often those -- that
18 Unna boots or the Unna boots were changed?
19 A. I don't recall.
20 Q. Do you know why he was wearing the
21 Unna boots?
22 A. Well, he had some -- he had some
23 wounds and I -- I -- as best as I can recall,
24 he had some wounds from his basal-cell
25 carcinoma from the past.

1 Q. And Unna boots are for the wounds if
2 they're having trouble healing; is that
3 correct?
4 A. Yes.
5 Q. Do you know why he was having
6 trouble healing?
7 A. I don't.
8 Q. You've talked about Mr. Burke's
9 blood loss. Do you know where he was
10 losing -- where he was bleeding?
11 A. Yes. So he -- he was bleeding from
12 wounds that he had on his thigh. He was
13 bleeding primarily internally around his
14 thigh. He had a little bit in his chest and
15 from his contusions on the chest. The
16 primary source was his thigh.
17 Q. Do you know if Mr. Burke had
18 anasarca prior to his presenting to MUSC's
19 Emergency Department?
20 A. Anasarca?
21 Q. Yes, sir.
22 A. No.
23 Q. You don't know?
24 A. I don't.
25 Q. Do you know what Mr. Burke's level

1 of kidney function was prior to his
2 presentation to MUSC's Emergency Department?
3 A. I believe his base line creatinine
4 level was around 1.2.
5 Q. And that's from what his wife told
6 you?
7 A. From his family, yes.
8 Q. You said he had some blood in his
9 chest?
10 A. Yeah. He had a -- a small effusion
11 in his chest.
12 Q. How do you know that was blood and
13 not from his prior heart disease?
14 A. So after -- so it was on the right
15 side. It's where he had the contusions. So
16 typically in heart disease, you'll find it on
17 both sides; and so after trauma, that's
18 considered blood until proven otherwise.
19 Q. And how else would you prove
20 otherwise?
21 A. Unless you tapped it, you couldn't;
22 and sometimes we do depending upon how
23 extensive it is.
24 Q. How long did you treat Mr. Burke?
25 A. Well, throughout the hospital stay.

1 Again, I have eight other partners; and so it
2 just depends on who's on call and who's on
3 for the weekend. So we, you know, take turns
4 taking care of him; but I took care of him
5 for a significant portion of the time. I
6 don't recall the exact number of hours or
7 days.
8 Q. You retained treatment of him or
9 your -- after he was released from ICU and
10 into the ward?
11 A. So, yes. Typically what happens is
12 the attending that the patient gets admitted
13 to, you remain that patient's attending for
14 the hospital stay.
15 Q. When did you learn of the --
16 Mr. Burke's kidney problem?
17 A. Upon him coming to the hospital.
18 Q. On the day of admission?
19 A. Yes.
20 Q. And you said you were not aware of
21 him having pulmonary hypertension?
22 A. I'm not -- I don't specifically
23 recall that fact.
24 Q. Do you know whether an echo was done
25 during his course?

1 A. It was done during his course, yes.
2 Q. And do you know what the echo
3 showed?
4 A. He had, if I can recall, an EF of
5 somewhere around 60 percent. There's a lot
6 of very minute details within the echo, which
7 I have not memorized.
8 Q. Mr. Burke had venous insufficiency
9 prior to his presentation to the MUSC
10 Emergency Department; is that correct?
11 A. I cannot confirm that.
12 Q. Venous insufficiency could result in
13 fluid accumulating; is that correct? Or it
14 does result in fluid accumulating; is that
15 correct?
16 A. It can result in fluid accumulating,
17 yes.
18 Q. I believe Mr. Burke was on diuretics
19 prior to his presentation at MUSC's Emergency
20 Department; is that correct?
21 A. That is correct.
22 Q. Do you know why he was on a
23 diuretic?
24 A. I'm not specifically aware of why he
25 was on it.

1 Q. How common is it to have blood in
2 the chest cavity without any broken bones in
3 the cavity?
4 A. We see it quite often. Depends on
5 really how significant the fall or their --
6 their trauma is.
7 Q. Two CTs were done of Mr. Burke's --
8 I think it was his abdomen, his chest, and
9 his pelvis, both on the 25th and 29th of
10 January; is that correct?
11 A. Yeah. So he had a repeat CT Scan of
12 his abdomen and pelvis, absolutely, yeah.
13 Q. And it showed no evidence of
14 bleeding; is that correct?
15 A. That's right.
16 MS. REYNOLDS: Doctor, I believe
17 that's all I have. I appreciate your time.
18 Thank you.
19 THE WITNESS: No problem.
20
21 REDIRECT EXAMINATION
22 BY MR. MCCULLOUGH:
23 Q. Doctor, this is --
24 A. Yes, sir.
25 Q. -- Clay McCullough. Just a couple

1 of very brief follow-ups.
2 In your opinion, was Bob's swelling
3 caused by internal bleeding?
4 A. His -- his swelling of his thigh?
5 Q. Yes, sir.
6 A. Yes. That was -- that was not
7 swelling. That was -- that was hematoma.
8 His swelling, in general, like I said, trauma
9 patients develop swelling. It's very common.
10 We see it in many of our trauma patients.
11 Q. And -- and the way you described Bob
12 over the -- that course, is that normal for
13 his type of injuries, or you see it in
14 your -- in your line?
15 A. We see -- we see it in our line,
16 yes.
17 Q. All right. And was his internal
18 bleeding and the pain you described, in your
19 opinion, caused by his trip and fall?
20 A. Yes.
21 Q. And he reported to you -- what --
22 why did he describe to you why did he trip
23 and fall? What caused it?
24 A. He said that it was because there
25 was poor lighting, and he didn't see the

1 curb. He tripped over the curb and fell.
2 Q. All right. Thank you.
3 MR. MCCULLOUGH: No further
4 questions.
5 MR. DINKELACKER: I've got nothing.
6
7 RECROSS-EXAMINATION
8 BY MR. DARLING:
9 Q. Doctor, just a couple of follow-ups.
10 A. Yes, sir, yes.
11 Q. Not to belabor anything and subject
12 to my prior objections.
13 A. No problem.
14 Q. Look at Exhibit 3.
15 A. Yes, sir. (Complies with request.)
16 Q. A -- a number of the conditions
17 listed there you said were not resulting from
18 the -- the fall, that you believe were
19 preexisting. I just want to go over a few of
20 those.
21 A. Yes, sir.
22 Q. One is No. 7 is CHR pulmonary heart
23 disk; and you see in layman's terms, what
24 does that mean?
25 A. I think it means chronic pulmonary

1 heart disease.
2 Q. Okay. And that's something he had
3 before the accident.
4 A. Yes, sir.
5 Q. No. 11, cardiomegaly?
6 A. Yes, sir.
7 Q. What's that?
8 A. So that just means an enlarged
9 heart.
10 Q. So he had an enlarged heart before
11 the accident --
12 A. Uh-huh.
13 Q. -- correct?
14 No. 13 liver disorders NEC. What does
15 that mean?
16 A. So he had a liver cyst that was seen
17 on the CT Scan so I believe that's referring
18 to the liver cyst.
19 Q. Okay. That's something he had
20 before the accident.
21 A. Yes.
22 Q. 14, calculus of kidney. What does
23 that mean?
24 A. That means a stone of the kidney.
25 Q. Had that before the accident.

1 A. Yes, sir.
2 Q. No. 15, HCRD. And it's got some
3 other things. What does that mean?
4 A. I don't know what these acronyms
5 stand for. They use a lot of acronyms. We'd
6 have to look it up, and then I could tell you
7 specifically what it stands for.
8 Q. It has HCRD UNS, which, I guess, is
9 unspecified.
10 A. Again, I wish I could answer for
11 you, you know. There's thousands of
12 different acronyms that people use, and I
13 just -- if you can tell me what it stands
14 for, I can tell you what the disease process
15 is.
16 Q. That's kind of why I'm asking you.
17 It's your record, not mine, so I need you to
18 explain, if you could.
19 With CRD stage 1 through 4.
20 A. Right. Again, it -- it probably
21 means, you know, maybe chronic renal disease.
22 Again, I just don't have, you know, the
23 acronyms spelled out in front of me.
24 Q. Okay.
25 A. And so I don't want to guess for

1 you.
2 Q. Okay. And "chronic" means long
3 standing.
4 A. Yes, sir.
5 Q. Okay. No. 16, chronic kidney
6 disease; is that correct?
7 A. Yes, sir.
8 Q. And NOS, what does that mean?
9 A. Again, I don't know what this
10 acronym stands for.
11 Q. Okay. 19DM 2WOCMP.
12 A. Yeah. So it's just -- this is his
13 diabetes. Diabetes melitis.
14 Q. Got you. Diabetes he had --
15 A. Type 2 diabetic.
16 Q. All right. And 20 cor F.
17 A. Coronary atherosclerotic disease.
18 Q. This is heart disease.
19 A. Yes, sir.
20 Q. For which he took the Coumadin?
21 A. Yes, sir.
22 Q. Okay. And 22 is use of aspirin. I
23 guess that's for the heart disease.
24 A. Yes, sir.
25 Q. Okay. 23, LGTRM?

1 A. I believe that's long-term use of
2 anticoagulants.
3 Q. And that's for the heart disease?
4 A. No. That's for the atrial
5 fibrillation.
6 Q. That's the Coumadin.
7 A. Yes, sir.
8 Q. Okay. That's the blood thinner he's
9 taking.
10 A. Yes, sir.
11 Q. Okay. And all those things we've
12 just gone over he had before this accident.
13 A. Yes, sir, he did.
14 MR. DARLING: Thank you, sir.
15 That's all I have.
16 THE WITNESS: You're welcome.
17 MS. REYNOLDS: Just one quick
18 follow-up.
19
20 RECROSS-EXAMINATION
21 BY MS. REYNOLDS:
22 Q. You didn't see Mr. Burke fall; is
23 that correct?
24 A. Absolutely.
25 Q. So you don't know what made him

1 fall.
2 A. No.
3 Q. Other than what he had told you.
4 A. Exactly.
5 MS. REYNOLDS: Thank you.
6 VIDEOGRAPHER: Anybody else? That's
7 it. All right. This concludes the videotape
8 deposition of Dr. Joseph V. Sakran. Time now
9 is 4:38 p.m. We're off the record.
10 (Deposition concluded at 4:38 p.m.)
11 - - -
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1 STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON
2
I, Ronda K. Blanton, a Registered
3 Professional Reporter and Notary Public for
the State of South Carolina at Large, do
4 hereby certify that the witness in the
foregoing deposition was by me duly sworn to
5 testify to the truth, the whole truth, and
nothing but the truth in the within-entitled
6 cause; that said deposition was taken at the
time and location therein stated; that the
7 testimony of the witness and all objections
made at the time of the examination were
8 recorded stenographically by me and were
thereafter transcribed by computer-aided
9 transcription; that the foregoing is a full,
complete, and true record of the testimony of
10 the witness and of all objections made at the
time of the examination; and that the witness
11 was given an opportunity to read and correct
said deposition and to subscribe the same.
12
Should the signature of the witness not
13 be affixed to the deposition, the witness
shall not have availed himself of the
14 opportunity to sign or the signature has been
waived.
15
I further certify that I am neither
16 related to nor counsel for any party to the
cause pending or interested in the events
17 thereof.
18 Witness my hand, I have hereunto
affixed my official seal on June 18, 2014, at
19 Charleston, Charleston County, South
Carolina.
20
21
22
23
Ronda K. Blanton, RPR
24 Notary Public, South Carolina
My Commission expires:
25 May 14, 2018.

1 DEPONENT CORRECTION SHEET

2

3 I, the undersigned, JOSEPH V. SAKRAN, MD, do hereby certify that I have read the foregoing

4 deposition and wish to make the following clarifications and/or corrections, if any.

5

6 PAGE LINE CHANGE REASON

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20 JOSEPH V. SAKRAN, MD Date

21

22

23

24

25

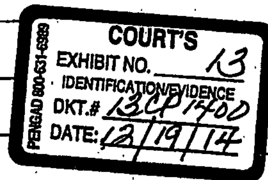
PREPARED BY

DATE

Judge,

We will want a written copy of the new charge that you will give us as you provided to us last time as being able to see that was so helpful. Thanks!

~~ability~~ Juror #28



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Charge

To determine the facts in this case, you will have to evaluate the credibility and believability of each witness. The fact that testimony is not contradicted directly does not necessarily render it undisputed. There remains the question of the inherent probability and credibility of the testimony of a witness which you of course are to decide. In deciding these issues, you may consider what was the manner and appearance of the witness who testified -- was he or she straightforward, or hesitant in answering? Was the testimony of a witness consistent -- or inconsistent? How did the witness come to know the facts that he or she testified to? What was his ability to know these facts? Is there some reason a witness would want to give testimony which would help -- or hurt -- one side or the other? In other words, was the witness biased or prejudiced? Was the testimony of a witness strengthened -- or weakened -- by other testimony or evidence?

Our law allows you certain very broad discretions in deciding truth. You have the right to believe one wit3ness ... These considerations you do not exercise arbitrarily, but if, in your good judgment there is a sound reason in the record of this case for so doing, you do have that prerogative. During this process you do not determine the truth merely by counting the number of witnesses presented by each side. Your objective, ladies and gentlemen, is to find the truth, regardless of the source of evidence.

The evidence you are to consider consists of the testimony of the witnesses and the exhibits that have offered and received during the trial. The remarks of the attorneys are not evidence. Their statements and their arguments are intended to help you understand the evidence and apply the law. You should disregard any remark, statement or argument which is not supported by the evidence or the law as given to you by the court. The law does not permit me to comment on the evidence. If it appears to you that I have so commented, during either the trial or the giving of

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these instructions, you must disregard such comment entirely. You are the judges of the facts and I cannot interfere with that responsibility.

The rules of evidence ordinarily do not permit witnesses to testify to opinions or conclusions. An exception to this rule exists for witnesses we call expert witnesses. A witness who, by education and experience, has become expert in some art, science, or profession, may give an opinion as to the subject the witness claims to be an expert in, and may also give the reasons for the opinion.

You should consider any expert opinion given by a witness and, like any other evidence, give it the weight you think it deserves. If you decide that an expert witness' opinion is not based on sufficient education and experience, or if you decide that the reasons given in support of the opinion are not sound, or that the opinion is outweighed by other evidence, you may disregard the opinion entirely. An expert witness' testimony is to be given no greater weight than that of other witnesses simply because the witness is an expert, and you do not have to accept an expert's opinion, even though it is not contradicted directly.

Burden of proof

To "establish by a preponderance of the evidence" does not mean to prove something to an absolute certainty. Rather, it means to prove that something is more likely so than not so. In other words, a preponderance of the evidence means the evidence, when considered and compared to the evidence opposed to it, which has more convincing force and produces in your mind's belief that what plaintiff seeks to prove is more likely true than not true.

Proximate cause

The plaintiff must establish by a preponderance of the evidence the negligence of defendant was a proximate cause of the injuries sustained. A given injury may result from multiple causes, and it is enough if the negligent act complained of is at least one of the causes without which the injury would not have

occurred. The law defines the proximate cause of an injury to be something that produces a natural chain of events which, in the end, brings about the injury. In other words, proximate cause is the direct cause, without which the injury would not have occurred. Proof of proximate cause requires proof that the injury or damage would not have occurred "but for" the defendant's negligence and that the consequence was foreseeable which is determined by looking to the natural and probable consequences of the act of which the plaintiff complains. I further charge you that foreseeability of some injury from a negligent act or omission is a prerequisite to its being a proximate cause of the injury for which recovery is sought. The law requires only reasonable foresight. When the injury complained of is not reasonably foreseeable, in the exercise of due care, there is no liability. One is not charged with foreseeing that which is unpredictable or which would not be expected to happen as a natural and probable consequence of the defendant's negligent act. Foreseeability is to be judged from the perspective of the defendant of the defendant at the time of the negligent act, not after the injury has occurred. However, in order to establish liability it is not necessary that the party charged with negligence should have contemplated the particular event that occurred. It is sufficient that the defendant should have foreseen that its negligence would probably result in injury of some kind to someone.

Damages

In this case you will be concerned with actual damages. Actual damages are also called compensatory damages, meaning to compensate, to make the injured party whole, to put him or her in the same position he or she was in prior to the damages received insofar as this is possible. In other words, actual damages would be the actual losses and expenses which the person has suffered because of another's carelessness.

In determining the amount of compensation for injuries suffered by the

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plaintiff, as a result of the defendant's negligence, it is proper to consider:

(1) Expenses incurred for all reasonable and necessary medical treatment.

(2) The character of the injury with regard to how has the injury impaired one's health or physical condition and the amount that would be necessary to make the injured person whole.

(3) Pain and suffering as well as mental anguish endured by the injured party, impairment of health or physical condition. Pain and suffering is recognized by the courts of this state as a material element of damages on which a recovery may be bottomed. Pain and suffering have no market price. They are not capable of being exactly and accurately determined, and there is no fixed rule or standard whereby damages for them can be measured. The amount of damage is left to you as to what amount of money is necessary to compensate him of the pain, suffering, mental anguish and emotional distress that evidence convinces you that he most probably has suffered and is likely to suffer.

(4) an award for actual damages may also include any proven loss of enjoyment of life. Loss of enjoyment of life is essentially an assessment of plaintiff's injury and how it impairs or interferes with such things in one's daily life as recreational activities, family activities, hobbies, and social activities. As with pain, suffering, emotional distress and mental anguish, this type of damage has no fixed rule or standard for measuring this type of damage. It too is left to your judgment as to what amount is necessary to compensate him for this damage that you are convinced from the evidence that he most probably has suffered or like will suffer.

(5) Actual damages would include reduced earning capacity. In determining the amount of compensation due to the plaintiff for loss or impairment of earning capacity, you shall consider the following:

(a) loss of future earning power, which requires a consideration of

RWP 4

all matters that relate to the issue of any impairment;

(b) the effect which the impairment will have on the plaintiff's capacity to work;

(c) the extent to which the impairment will impair the plaintiff's earning capacity;

(d) the evidence of what the plaintiff had previously earned, when employed, in the past is a factor upon which to base any loss or impairment of earning capacity.

In awarding damages for loss or impairment to earning capacity, the law provides that a person who is injured may recover for the loss or diminution of his earning capacity during his entire expectancy of life and is entitled to such amount as will compensate him for such loss.

Pre-existing condition

I further charge you that it is the law of this state that one who negligently inflicts a personal injury on another is responsible for all ill affects which, considering the condition of health in which the plaintiff has when he received the injury, naturally and necessarily follows such injury. In other words a negligent defendant, who causes an injury, takes the plaintiff as he finds that plaintiff whether the plaintiff is in perfect health or in poor health or somewhere in between. Hence, a defendant's liability is in no way lessened or affected by reason of the fact that the injury would not have resulted or would not have been as serious or severe had the plaintiff been in good health; or that injury or injuries were aggravated and rendered more difficult to cure by reason of the fact that he (she) was not in good health. In other words, if the presence of condiiton or pre-existing injury aggravates and prolongs the injury and correspondingly increases the damages, and that is established by a preponderance of the evidence, then the plaintiff would be compensated for such increased or added damages.

RNP 5

I further charge you that a person with a pre-existing injury or a condition is not however entitled to any compensation for the existence of such pre-existing injury or condition. Also if the problems are the result of the natural progression of the worsening of a pre-existing injury or condition, then the plaintiff likewise would not be entitled to be compensated for such condition.

You are further instructed that a pre-existing infirmity does not excuse a negligent defendant because it causes the plaintiff to be more susceptible to injury, nor does such a pre-existing condition resulting in a greater susceptibility to injury diminish the plaintiff's entitlement to just and fair compensation for personal injuries. The plaintiff is entitled to recover all damages which she established by a preponderance of the evidence proximately result from the negligent acts of the defendant, which would include the aggravation of his pre-existing condition, if any.

Ladies and gentlemen, your verdict for actual damages, should include all damages which have been sustained which are naturally the proximate consequence of the negligence and it should also include as it pertains to such future and prospective damages, if any, as the evidence renders it reasonably certain to most probably occur in the future. The standard is most probable not simply possible because that would be speculative. Future damages are those which the evidence convinces you that the plaintiff will most likely suffer. These future damages must be the result of the defendant's negligence and these damages must be most probably permanent. If you do find that the plaintiff is entitled to future or prospective damages, you may consider the increased cost of living or the diminished purchasing power of money. Reasonable compensation means compensation in value. The value of money lies not in what it is but what it will buy. You are expected to use common sense and good judgment in this regard. Also if your award incudes such damages, they must be reduced to their present

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day value.

To aid you in this determination you may consider as evidence a statute enacted by the state legislature commonly called the "mortuary table", section 19-1-150, 1976 code; according to the table, a (male) who is the age of the plaintiff today has a life expectancy of 13.99 years.

This fact, of which the court takes judicial notice, is now in evidence to be considered by you in arriving at the amount of damages to be awarded, in the event you find that the plaintiff is entitled to a verdict. Also, before considering the mortality table you must first have concluded that the plaintiff had proved by a preponderance of the evidence that he has sustained an injury or damage as a proximate result of the defendant's negligence and that such injury was most probably permanent. If plaintiff has failed to prove this by the preponderance of the evidence then you should disregard the mortality table.

Now the life expectancy, as shown by a mortality table, is merely an estimate of the probable average remaining length of life of all persons in our state of a given age, and that estimate is based on not a complete but only a limited record of experience. So the inference which may be drawn from the life expectancy shown by the table of mortality, all other facts and circumstances in evidence bearing on the life expectancy of the plaintiff, including his occupation, habits and state of health.

Plaintiff would of course not be entitled to conjectural or speculative damages in any event, but he is entitled to a verdict for actual damages, which includes all damages which have been sustained which are naturally the proximate consequence of the negligent act. As with all other facts in this case, the plaintiff must prove his actual damages by the greater weight of the evidence but this does not mean that he must prove them to a mathematical certainty, or produce evidence of the precise amount of damages he has suffered--rather the evidence put forth

RW/7

should be such as to enable you to determine what amount of damages is fair, just and reasonable.

Now, your verdict in this case should do one thing. It should speak the truth of this controversy as you twelve folks see that to be. You have got no friends to reward. You have got no enemies to punish. That is evidence. You should not be motivated by or consider in any passion, prejudice, caprice, or arbitrary whim should be involved in this process. Neither should you be motivated by sympathy, for either side in reaching your decision. You should conscientiously adhere to your oath, take the law as I've given it to you, examine these facts as you see them to be, the documents that you'll have with you and reach a decision which speaks the truth. No one will then have any right to criticize your verdict if you conscientiously apply your oath.

RMO/8

PREPARED BY

DATE

Judge,

We need a

Calculator

please.

AB

Juror #28

COURT'S
EXHIBIT NO. 15
CKT.# 13CP 4460
DATE: [illegible]

STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)
)
ROBERT J. BURKE AND JANE B.)
BURKE,)
)
Plaintiffs,)
)
v.)
)
INDIGO REALTY COMPANY,)
LLC, REPUBLIC PARKING)
SYSTEM, INC., and THE CITY OF)
CHARLESTON)
)
Defendants.)

IN THE COURT OF COMMON PLEAS
CASE NO.: 2013-CP-10-1400

POTENTIAL EXPERT WITNESSES OF THE CITY OF CHARLESTON

TO ALL PARTIES NAMED ABOVE, AND THEIR RESPECTIVE COUNSEL:

Defendant City of Charleston may call the following as expert witnesses:

J. David Horne, P.E.
Engineering Design & Testing Corp.
Charleston District Office
P.O. Box 50368
Summerville, SC 29485

Todd A. Shuman, MD
316 Calhoun St
Charleston, SC 29401

Gary Cooper
City of Charleston

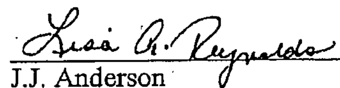
Mr. Cooper is the Director of Procurement for the City of Charleston and is hereby identified to the extent he is/can be qualified as an expert in his field.

Scott Maxie
City of Charleston

Mr. Maxie is a Contracts Coordinator for the City of Charleston and is hereby identified to the extent he is/can be qualified as an expert in his field.

Further, Defendant City of Charleston reserves the right to call any witness(es) identified by other parties as expert or lay witnesses.

ANDERSON REYNOLDS, &
STEPHENS, LLC



J.J. Anderson
Lisa A. Reynolds
Attorneys for Defendant
City of Charleston
37 ½ Broad Street
P.O. Box 87
Charleston, SC 29402
(843) 723-0185 telephone
(843) 723-0977 facsimile
lreynolds@arlawsc.com

Charleston, South Carolina
May 1, 2014

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON Robert J. Burke and Jane B. Burke, Plaintiffs, vs. Indigo Realty Company, Ltd., Clarence D. Melton, Jr., and Republic Parking System, Inc. Defendants.	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT CASE NO.: 2013-CP-10-1400 **PLAINTIFFS' FIRST SUPPLEMENTAL ANSWERS TO INTERROGATORIES**

Plaintiffs Robert J. Burke and Jane B. Burke hereby supplement answers to Interrogatories hereby as follows:

1. Please identify each person whom you expect to call as an expert witness at the trial, state the subject matter on which each such expert is expected to testify and state the substance of the facts and opinions to which each such expert is expected to testify and give a summary of the grounds for each such opinion.

Answer: **Sarah Lustig, RN**
Certified Life Care Planner
Lustig Consulting, LLC
410 Mill Street, Suite 101
Mt. Pleasant, SC 29464

Sarah Lustig, RN, is expected to testify to the grounds, process and generation of the Life Care Plan she developed. She will also testify about her opinion (and the basis for the opinions) contained in the Plan.

Dr. Marshall White
Neurology & Pain Management
1275 Ben Sawyer Blvd., Suite B

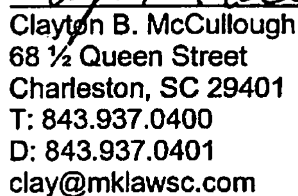
Mount Pleasant, SC 29464

Dr. White will testify about his consultation with Bob Burke, his review of Mr. Burke's medical records, his diagnosis of Mr. Burke's current medical condition, future health issues, expected future medical treatments/procedures, and related items.

2. Please set forth an accurate statement of all medical, hospital and drug or other related costs incurred by you on your behalf as a result of the incident alleged in the Complaint.

Answer: **Please see documents being produced herewith.**

McCULLOUGH KHAN, LLC



Clayton B. McCullough
68 ½ Queen Street
Charleston, SC 29401
T: 843.937.0400
D: 843.937.0401
clay@mklawsc.com

12·2, 2013
Charleston, SC

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED
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SC Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

R. Markley Dennis, Jr., Circuit Court Judge

C.A. No.: 2013-CP-10-1400

Robert J. Burke ....Respondent,

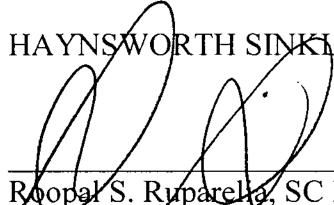
v.

Republic Parking System, Inc. ....Appellant.

CERTIFICATE OF APPELLANT

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material and that all material complies with the April 15, 2014 Order of the South Carolina Supreme Court Relating to personal data identifiers.

HAYNSWORTH SINKLER BOYD, PA



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Attorneys for Appellant Republic Parking System, Inc.

Dated: March 21, 2016