

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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FEB 25 2016

APPEAL FROM SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

SC Court of Appeals

Appellate Case No.: 2014-001788

Clarence Winfrey, Employee, Claimant Respondent,

v.

Archway Services Inc, Employer, and
American Fire & Casualty Insurance Company c/o
Liberty Mutual Group, Carrier, ... Appellants,

RECORD ON APPEAL – VOLUME I

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Company, and Liberty Mutual Group

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AUG 20 2014

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

SC Court of Appeals

WCC File No. 1306305

Clarence Winfrey Respondent,

v.

Archway Services Inc, ... Employer,

and

American Fire & Casualty Insurance Company c/o
Liberty Mutual Group, ... Appellants,

NOTICE OF APPEAL

The Employer/Carrier, Archway Services Inc and American Fire & Casualty Insurance Company c/o Liberty Mutual Group, appeal the Order of South Carolina Workers' Compensation Commission filed July 25, 2014. Appellants received written notice of entry of this Order on July 28, 2014.

August 20 2014

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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AUG 20 2014

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

SC Court of Appeals

Case No. 1306305

Clarence Winfrey Respondent,

v.

Archway Services Inc, ...Employer,

and

American Fire & Casualty Insurance Company c/o
Liberty Mutual Group, ... Appellants,

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on the attorney of record for Clarence Winfrey,
by depositing a copy of it in the United States Mail, postage prepaid, on the 20 day of August,
2014 addressed to his attorney of record,

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August 20, 2014


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**APPELLATE PANEL DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO: 1306305**

Clarence Winfrey

**EMPLOYEE,
CLAIMANT/RESPONDENT**

VS.

Archway Services Inc

EMPLOYER,

AND

**American Fire & Casualty Insurance Company
c/o Liberty Mutual Group**

**CARRIER,
DEFENDANTS/APPELLANTS,**

**Appellate Panel Review held in Columbia, South
Carolina, on May 19, 2014 per notices timely
And properly served upon all parties of interest.**

Appellate Panel Decision and Order Filed:

July 25, 2014

APPEARANCES: **Claimant/Appellant represented by Preston F. McDaniel, Esquire**
Defendants/Respondents represented by Brett H. Bayne

STATEMENT OF THE CASE

This claim arises out of an alleged work-related accident on May 22, 2013. On that date, Claimant contends he was momentarily shocked by a rotisserie oven he was working on. Following the accident, Claimant continued to work for the remainder of the day and the following day. On May 28, 2013—six days after the accident—Claimant presented to Doctor's Care and Lexington Medical Center with severe three vessel coronary disease as well as an acute myocardial infarction which caused an acute ventricular septal defect. At Doctor's Care, Claimant reported he was having no chest pressure and had started sweating that morning (May 28th). At Lexington Medical Center, Claimant indicated he was not having chest pain but had been sweating. Following the diagnosis, Claimant underwent surgery to repair the ventricular septal defect caused by the acute myocardial infarction. The medical records in the case revealed that Claimant has a distinct family history of coronary disease with his father passing away at a similar age from coronary disease and a myocardial infarction. Further, the medical records indicated that Claimant was a 35 year pack-a-day smoker and drank a case of beer per week. Based on all of the medical records available to Carrier, this claim was ultimately denied by verbal communication to Claimant on September 13, 2013.

Immediately following the denial of benefits, Claimant filed a Form 15, Section III requesting a hearing as well as a Summons and Complaint in Richland County Circuit Court alleging a bad faith denial of benefits, alleging that S.C. Code Ann. § 42-9-260 is unconstitutional, seeking a temporary restraining order to stop Defendants from denying the claim, and seeking an Order from Judge Lee finding the claim compensable and awarding benefits. Judge Lee issued and then rescinded the temporary restraining order sought by Claimant. A hearing on the merits of Claimant's Complaint has not been set by the Court. After

the temporary restraining order was rescinded, the Commission set Claimant's Form 15, Section III for a hearing before Commissioner Beck. In addition, Defendants filed several motions with the Commission including a Motion to Quash the deposition of the adjuster, a Motion to Quash discovery of the adjuster's claim file, and a Motion to Postpone the Hearing.

A hearing on all of the motions and on Claimant's Form 15, Section III was set on September 30, 2013 for November 11, 2013. Prior to the hearing, Commissioner Beck conducted a standard pre-hearing conference as well as a Motions Hearing wherein Commissioner Beck ruled on all outstanding issues raised by the motions including Defendants' Motion to Postpone. Each of these motions affected the ability to conduct the Form 15 hearing and were necessary to have prior to the hearing. Commissioner Beck gave Claimant the opportunity to postpone the Form 15 hearing in order to spend time preparing for each of the motions that were timely served. Claimant turned down that opportunity. At the hearing, all parties agreed that the only issue for Commissioner Beck was to determine whether or not Defendants had conducted a good faith investigation. In order to make that determination, Commissioner Beck limited the review of evidence to only those documents produced prior to the date of denial – September 13, 2013. Following the hearing, Commissioner Beck issued a Decision and Order on December 5, 2013 finding that Defendants had conducted a good faith investigation. Thereafter, Claimant timely filed a Form 30. The Full Commission has issued a preliminary Decision and Order in that portion of the case and a final Order is forthcoming.

On October 22, 2013, after the Form 15 hearing was set by the Commission, Claimant filed a Form 50 requesting a hearing on compensability for alleged injuries to his head, brain, left hand, left arm, chest, heart, and all other organs, members, and bodily parts. A hearing notice for the Form 50 hearing was sent by the Commission on December 6, 2013 with explicit instructions

that the hearing would be to determine compensability of Claimant's alleged injuries to his head, brain, left hand, left arm, chest, heart, and all other organs, members, and bodily parts. The Form 50 hearing was held before the Single Commissioner on January 13, 2014. Following the hearing, the Single Commissioner issued a Decision and Order on February 27, 2014. Defendants timely filed a Form 30 based on legal errors contained in the Single Commissioner's Decision and Order. The Full Commission conducted a review hearing on Defendants' Form 30 on May 19, 2014 and now issues this Decision and Order. Based on a review of the evidence submitted to the Commission and oral arguments before the Full Commission, the Single Commissioner's Decision and Order on compensability is hereby **AFFIRMED IN PART** and **REVERSED IN PART** as set forth below.

SINGLE COMMISSIONER FINDINGS OF FACT

1. Claimant injured his neck and left shoulder in an admitted accident on May 22, 2013. Claimant alleges that he also injured his heart on the date of accident, which injury (a) aggravated a pre-existing condition, and (b) ultimately resulted in a myocardial infarction and subsequent ventricle septal defect.
2. Claimant is 51 years of age (testimony of Claimant).
3. Claimant finished the 12th grade, but did not receive a diploma (Claimant's Deposition, pages 6-7).
4. Claimant's prior employment includes work (a) at USC installing Wi-Fi, (b) as electrical maintenance man at F.B. Johnson, (c) as an electrician for a company that "roughs in" wiring for new houses; and (d) as a roofer (Claimant's Deposition, pages 9-11 and 13; testimony of Claimant).

5. On the date of the accident, Claimant's job with Employer was equipment maintenance worker for dell and bakery departments at Publix and Wal-Mart stores (testimony of Claimant; Defendants' APA #9, page 94; Claimant's Deposition, page 11).
6. In the mechanics of the accident, Claimant was shocked with 240-480 volts of electricity; Claimant believed the actual voltage was 480 volts. Defendants' witness admitted at the hearing that he was unsure of the voltage amount involved, and Defendants did not present any evidence to rebut Claimant's estimation even though Employer had access to the rotisserie in question. The fact that Defendants did not present any specific evidence leads me to rely on Claimant's estimation. (Defendants' APA #7, page 90; testimony of Warren; Claimant's APA #5, page 78).
7. Temporal medical evidence from May 28, 2013, supports Claimant's testimony that Claimant experienced pain (the worst of which was in his neck, but was also in the front of his shoulder and his left arm as well) from the moment of the accident which got progressively worse. Dr. Greenfield testified that Claimant (a) rubbed his arm during the examination, and (b) reported that his arm hurt. Claimant began sweating the same night of the Thursday accident and also the next morning. (Defendants' APA #7, page 90; Defendants' APA #8, page 91; Claimant's APA #2, page 56; Claimant's APA #3, page 66; Deposition of Dr. Feldman, page 35, Claimant's Deposition, pages 13-16, 18, 20-21, and 32; Deposition of Dr. Greenfield, including but not limited to pages 5, 8, 16, and 21).
8. Dr. Travis stated that neck pain is a common presentation for a heart attack (Deposition of Dr. Travis, page 21).
9. Three physicians have all opined to a reasonable degree of medical certainty that the electric shock ultimately resulted in Claimant's heart attack, regardless of the date on

which the infarction occurred. The deposition testimony of Dr. Travis (the treating cardiovascular surgeon) is very compelling, as he—unlike any of the other physicians involved in this case—actually examined Claimant's heart in the operating room. Dr. Lide (the treating cardiologist) also links the electrical shock to Claimant's post-accident heart condition; in fact, Dr. Lide testified twice that he does not "see any way" that Claimant's infarction and VSD are not related to the injury. The third physician is a general physician board certified in family medicine (Claimant's APA #1, page 1; Claimant APA #2, pages 23-24; Claimant's APA #3, page 65; Deposition of Dr. Greenfield, pages 30-31; Deposition of Dr. Travis, including but not limited to pages 8, 13-17, and 23-32; Deposition of Dr. Lide in its entirety, including but not limited to pages 14, 23-24, 28, and 39).

10. Even if I discount or disregard the opinion of the general physician (board certified in family medicine), I give great weight to the opinions of Drs. Travis and Lide, who both opine that the heart condition is causally related. I fully considered the opinion of Dr. Feldman (the only physician who stated that there is no nexus between the electrical shock and the heart condition), but his opinion is outweighed by the opinions of the three other doctors, all three of whom treated Claimant rather than simply reviewing his medical records. I note that Dr. Feldman (a) did not examine Claimant or even speak with Claimant; (b) did not see Claimant's heart, as opposed to Dr. Travis who held it in his hand; (c) initially states in his written opinion that it is "possible" that there was no connection between the plaque rupture and the electrical shock, and then in the very next sentence states that it is of the "highest certainty;"; (d) Dr. Feldman is a cardiologist and not a cardiovascular surgeon; nor has he undergone a surgical residency; and (e) Dr.

Feldman was specifically asked to opine in writing as to whether there was a connection between an electrical shock and a VSD, although he does address other pertinent issues for Defendants in his deposition (Defendants' APA #10, page 97; Deposition of Dr. Feldman in its entirety, including but not limited to pages: 5-6, 10-11, and 17—lines 15 through 25; page 18—lines 1-4; pages 22-23, 31, 42-43, and 45-47; Deposition of Dr. Greenfield, page 4).

11. The statement by Ruppe is dispositive only of the fact that Claimant has a good work ethic. (Defendants' APA, Exhibit 1).
12. Claimant has not reached maximum medical improvement.
13. Drs. Travis and Lide are hereby named the treating physicians. Although Defendants have denied compensability of Claimant's heart condition, Defendants do not object to Drs. Travis and Lide serving as treating physicians.
14. The Claimant is specifically requesting a finding of compensability for the heart and no medical evidence was presented that Claimant sustained or even may have sustained a head or brain injury. I therefore find that at this point he has not met his burden of proof with regard to any injury to head/brain, and any benefits for the head/brain are denied at this juncture.
15. While the head and brain are listed a bodily parts involved under #3 in the Pre-Hearing Brief, the Claimant also notes in his Pre-Hearing Brief that this is a systemic electrical shock and requests treatment for, "all organs, members and bodily parts determined to be related." I note from the testimony and records of Dr. Greenfield that the Claimant had tenderness in the left arm and shoulder and was diagnosed with muscle shock. In her deposition she stated that this tenderness found on examination is more indicative of

actual injury to those areas than just the pain that is caused by a heart attack. Dr. Lide in his treatment notes and specifically on September 17, 2013, recorded that, "we tried this patient on Neurontin last month when he appears to have peripheral neuropathy secondary to electrocution at work. Dr. Lide also recorded on the August 13th visit that he was having numbness in his great toe and suggested this neurological symptom was due to the electrical shock he experienced rather than the myocardial infarction. Thus, if any problems are opined to have stemmed from the electrical shock injury which is outside of the area and expertise of Dr. Lide and Dr. Travis, those doctors may request referral for him to other physicians for evaluation and treatment but the Defendants retain the right to contest whether those are related to the accident and to select the physicians for treatment for any causally related problems.

16. For purposes of the hearing before the undersigned, Claimant is very credible. I base this finding on my observations of Claimant's demeanor and on the delivery of his testimony.
17. In reaching my conclusions, I fully considered the facts that Claimant (a) is a smoker, (b) has hypertension, (c) has a family history of "premature coronary artery disease, and (d) had pre-existing severe 3-vessel disease on the date of the accident. However, those four facts were also specifically considered by the 3 physicians who provided opinions to a reasonable degree of medical certainty. Further, Claimant does not allege that his pre-existing disease was caused by the accident; he only alleges an aggravation resulting in an injury to his heart (Defendants' APA #8, pages 91-92; Defendants' APA #9, page 94; Claimant's APA #2, pages 26 and 28, Deposition of Dr. Feldman, page 37; Claimant's Deposition, pages 26 and 29).

18. Although certainly not dispositive on the issue of compensability, I do not that Claimant had no coronary symptoms prior to the date of the electrical shock (Claimant's Deposition, page 27; Deposition of Dr. Lide, page 7, lines 21-22).
19. Claimant to receive temporary total disability benefits from September 15, 2013, through the present and continuing until further Order of the Commission or by agreement of the parties.
20. Claimant to receive ongoing treatment until he reaches maximum medical improvement.
21. Permanency is premature.
22. The issue of average weekly wage/compensation rate is held in abeyance.

SINGLE COMMISSIONER CONCLUSIONS OF LAW

In accordance with SC Code §42-17-40, the following conclusions of law apply in this case:

1. Under SC Code §42-1-160, the decision is made as an injury by accident arising out of and in the course of the employment. The medical problems which the Claimant has and which have resulted in his disability stem from the physical injury, the electrical shock that he sustained on May 22, 2013. Any medical condition and/or disability that either results directly from the physical injury or which is a pre-existing condition that is aggravated, accelerated or caused to become symptomatic by the physical injury is compensable as injury by accident under SC Law. See for example, Buff v. Columbia Baking Co., 215 S.C. 41, 53 S.E.2d 879 (1949); Walker v. City of Columbia, 247 S.C. 241, 146 S.E.2d 856 (1966); (as to the pre-existing conditions being compensable), Mullinax v. Winn Dixie Stores, Inc., 318 S.C. 431, 458 S.E.2d 76 (SC App. 1995).

2. Under SC Code §42-9-10 and SC Code §41-2-120, the determination is made as to the entitlement to disability compensation.
3. Under SC Code §42-15-60 the determination is made as to the provision of medical care.
4. Under the stipulation of the parties, venue is proper and the applicable average weekly wage and compensation rate that applies for the purpose of this hearing is determined. As to jurisdiction, SC Code §42-3-180 provides that this Commission has jurisdiction to decide all questions arising under the Title and states in pertinent part, "all questions arising under this Title...shall be determined by the Commission except as otherwise provided in this Title." The Defendants main argument in taking the position that this Commission does not have jurisdiction is based upon the doctrine of Law of the Case and is based upon certain Findings made by Commissioner Beck in his Order. However, after review of the position of the parties, arguments of the parties, and after review of Commissioner Beck's Order and the general jurisdiction of this Commission to decide issues arising under the Title and the Form 50 and 51 filed in this matter, this Commissioner is found, as a matter of law, to have jurisdiction over these proceedings. The Form 51 filed in this matter specifically admits that both employee and the employer were subject to the Workers' Compensation Act at the time in question. Further, Commissioner Beck's Order which serves as the basis for the Defendants' argument states and holds:

"IT IS FURTHERMORE ORDERED that all other issues in contention, specifically including the question of whether the Claimant sustained an injury by accident arising out of and in the course of his employment with Defendants resulting on compensable disability is preserved for adjudication at the hearing set pursuant to Claimant's October 21, 2013 Form 50 Employee's Request for Hearing."

5. Under the issues before the Commission for decision, all other issues are held in abeyance for further decision by the Commission.

LEGAL ISSUES RAISED BY DEFENDANT-APPELLANTS

- I. Did the Single Commissioner err in holding the hearing over Defendants' objections because, by conducting the hearing and ruling on material compensability issues, the Single Commissioner operated in an appellate capacity without proper jurisdiction?
- II. Did the Single Commissioner err in holding the hearing over Defendants' objections when specific rulings from a prior Single Commissioner Decision and Order may become the law of the case and, if upheld in that proceeding, would render any decision by the Single Commission to be in error?
- III. Did the Single Commissioner err in failing to find a date on which Claimant suffered a plaque rupture in Claimant's heart?
- IV. Did the Single Commissioner err in failing to find what caused the plaque rupture in Claimant's heart?
- V. Did the Single Commissioner err in failing to find a date on which Claimant suffered a myocardial infarction?
- VI. Did the Single Commissioner err in relying on Dr. Travis' written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts his written medical opinion?
- VII. Did the Single Commissioner err in relying on Dr. Lide's written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts his written medical opinion?

- VIII. Did the Single Commissioner err in relying on Dr. Greenfield's written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts her written medical opinion?
- IX. Did the Single Commissioner err in failing to deny compensability for a brain injury because Claimant presented no evidence of any brain injury even though Claimant specifically included a brain injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
- X. Did the Single Commissioner err in failing to deny compensability for a head injury because Claimant presented no evidence of any head injury even though Claimant specifically included a head injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
- XI. Did the Single Commissioner err in failing to deny compensability for a left hand injury because Claimant presented no evidence of any left hand injury even though Claimant specifically included a left hand injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
- XII. Did the Single Commissioner err in failing to deny compensability for a left arm injury because Claimant presented no evidence of any left arm injury even though Claimant specifically included a left arm injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
- XIII. Did the Single Commissioner err in failing to deny compensability for all other organs, members, and bodily parts because Claimant presented no evidence of any injury to any organs, members, or bodily parts even though Claimant specifically included other

organs, members, and bodily parts on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?

- XIV. Did the Single Commissioner err in Finding of Fact #1 in that the Finding is limited only to Claimant alleging an injury to his heart when the record is clear that Claimant alleged injuries to his head, brain, left hand, left arm, and all other organs, members, and bodily parts?
- XV. Did the Single Commissioner err in Finding of Fact #6 by finding that Claimant believed the actual voltage to be 480 volts when Claimant's own testimony refutes that finding?
- XVI. Did the Single Commissioner err in Finding of Fact #6 that Defendants had access to the rotisserie oven when the record is clear that the oven belonged to a third party and Defendants did not own or control the oven?
- XVII. Did the Single Commissioner err in Finding of Fact #7 by finding that Claimant began sweating the night of the electrical shock when Claimant's own testimony refutes that finding?
- XVIII. Did the Single Commissioner err in Finding of Fact #9 that three physicians have opined the electrical shock resulted in Claimant's heart attack regardless of the date on which the heart attack occurred?
- XIX. Did the Single Commissioner err in Finding of Fact #14 that Claimant specifically requested a finding of compensability for the heart when there is no evidence in the record the hearing was limited in scope to the heart, when Claimant's own Form 50 and Form 58 demanded a hearing on compensability of the left hand, arm, shoulder, neck, head, brain, chest, and all organs, members, and bodily parts determined to be related and when the Notice of Hearing from the Commission included a determination of

compensability for the left hand, arm, shoulder, neck, head, brain, chest and all organs, members, and bodily parts determined to be related?

XX. Did the Single Commissioner err by not making any findings of fact or conclusions of law related to an aggravation of a pre-existing heart condition as alleged by Claimant?

EVIDENCE OF THE CASE

Claimant filed a Form 50 on October 21, 2013 alleging injuries to his "heart, left hand/arm/shoulder, neck, head (brain), chest." Thereafter, Defendants filed a Form 51 on or about November 19, 2013 denying every alleged injury and stated that "Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the Act." This matter was set for a hearing on January 13, 2013 by a Notice of Hearing issued on December 6, 2013. That Notice of Hearing specifically stated that the purpose of the hearing was to "determine issues as set forth on Forms 50 and 51." Claimant's Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are "heart, left hand/arm/shoulder, neck, head (brain), chest."

At the hearing, the issues were stated for the record and included an allegation of a head and possible brain injury. The Defendants position was that there was not any credible medical evidence establishing a relationship between the neck and any heart or brain injury.

Claimant notified Employer he was shocked while working on a rotisserie oven on May 22, 2013. (Def. APA p. 8). Employment records of Claimant indicate that he continued working the remainder of the day and the entire following day. (Def. APA p. 10-11). An email from Claimant to Employer indicates that he was experiencing neck pain on May 27, 2013 (5 days post-accident). (Def. APA p. 9). Claimant first presented to Doctor's Care on May 28, 2013 (6 days post-accident) complaining that he woke up sweating that morning (Def. APA p. 1).

Claimant was treated by Dr. Greenfield at Doctors' Care. Dr. Greenfield noted that Claimant had some tenderness in his shoulder and neck area. *Id.*

Claimant was then referred to and saw Dr. Dasgupta at the South Carolina Heart Center on May 28. Dr. Dasgupta also noted sweating and noted that Claimant denied chest pain but did have minimal left shoulder pain. (Def. APA p. 2). Dr. Dasgupta diagnosed Claimant with an acute myocardial infarction. *Id.* Dr. Dasgupta also noted that Claimant appeared to have a ventricular septal defect as a possible completion of his acute myocardial infarction. (Def. APA p. 2). Dr. Dasgupta referred Claimant to Lexington Medical Center where Dr. Travis performed surgery to repair an acute ventricular septal defect that formed following the myocardial infarction. (Def. APA p. 5-7). "

All of the submissions to the Single Commissioner were reviewed, including the testimony presented at the hearing; medical opinions and records; and depositions of the Claimant, Dr. Larneau Lide, Dr. Karen Greenfield, Dr. Barry Feldman and Dr. Jeffrey Travis.

FULL COMMISSION FINDINGS OF FACT

1. Claimant injured his neck and left shoulder in an admitted accident on May 22, 2013. Claimant alleges that he also injured his heart on the date of accident, which injury (a) aggravated a pre-existing condition, and (b) ultimately resulted in a myocardial infarction and subsequent ventricle septal defect.
2. Claimant is 51 years of age (testimony of Claimant).
3. Claimant finished the 12th grade, but did not receive a diploma (Claimant's Deposition, pages 6-7).
4. Claimant's prior employment includes work (a) at USC installing Wi-Fi, (b) as electrical maintenance man at F.B. Johnson, (c) as an electrician for a company that "roughs in"

wiring for new houses; and (d) as a roofer (Claimant's Deposition, pages 9-11 and 13; testimony of Claimant).

5. On the date of the accident, Claimant's job with Employer was equipment maintenance worker for deli and bakery departments at Publix and Wal-Mart stores (testimony of Claimant; Defendants' APA #9, page 94; Claimant's Deposition, page 11).
6. In the mechanics of the accident, Claimant was shocked with 240-480 volts of electricity; Claimant believed the actual voltage was 480 volts. Defendants' witness admitted at the hearing that he was unsure of the voltage amount involved, and Defendants did not present any evidence to rebut Claimant's estimation even though Employer had access to the rotisserie in question. The fact that Defendants did not present any specific evidence leads us to rely on Claimant's estimation. (Defendants' APA #7, page 90; testimony of Warren; Claimant's APA #5, page 78).
7. Temporal medical evidence from May 28, 2013 supports Claimant's testimony that Claimant experienced pain (the worst of which was in his neck, but was also in the front of his shoulder and his left arm as well) from the moment of the accident which got progressively worse. Dr. Greenfield testified that Claimant (a) rubbed his arm during the examination, and (b) reported that his arm hurt. Claimant began sweating the same night of the Thursday accident and also the next morning. (Defendants' APA #7, page 90; Defendants' APA #8, page 91; Claimant's APA #2, page 56; Claimant's APA #3, page 66; Deposition of Dr. Feldman, page 35, Claimant's Deposition, pages 13-16, 18, 20-21, and 32; Deposition of Dr. Greenfield, including but not limited to pages 5, 8, 16, and 21).
8. Dr. Travis stated that neck pain is a common presentation for a heart attack (Deposition of Dr. Travis, page 21).

9. Three physicians have all opined to a reasonable degree of medical certainty that the electrical shock resulted in Claimant's heart attack, regardless of the date on which the infarction occurred. The deposition testimony of Dr. Travis is very compelling, as he actually examined Claimant's heart in the operating room. Dr. Lide also links the electrical shock to Claimant's post-accident heart condition. Dr. Lide testified that he does not "see any way" that Claimant's infarction and VSD are not related to the injury. (Claimant's APA #1, page 1; Claimant APA #2, pages 23-24; Claimant's APA #3, page 65; Deposition of Dr. Greenfield, pages 30-31; Deposition of Dr. Travis, including but not limited to pages 8, 13-17, and 23-32; Deposition of Dr. Lide in its entirety, including but not limited to pages 14, 23-24, 28, and 39).

10. We give great weight to the opinions of Drs. Travis and Lide, who both opine that the heart condition is causally related. We fully considered the opinion of Dr. Feldman (the only physician who stated that there is no nexus between the electrical shock and the heart condition), but his opinion is outweighed by the opinions of the three other doctors, all three of whom treated Claimant rather than simply reviewing his medical records. We note that Dr. Feldman (a) did not examine Claimant or speak with Claimant; (b) did not see Claimant's heart; (c) states in his written opinion that it is "possible" that there was no connection between the plaque rupture and the electrical shock and later states that it is of the "highest certainty"; (d) is a cardiologist and not a cardiovascular surgeon; and (e) was specifically asked to opine in writing as to whether there was a connection between an electrical shock and a VSD, although he does address other pertinent issues in his deposition (Defendants' APA #10, page 97; Deposition of Dr. Feldman in its entirety,

including but not limited to pages: 5-6, 10-11, and 17—lines 15 through 25; page 18—lines 1-4; pages 22-23, 31, 42-43, and 45-47; Deposition of Dr. Greenfield, page 4).

11. The statement by Ruppe is dispositive only of the fact that Claimant has a good work ethic. (Defendants' APA, Exhibit 1).
12. Claimant has not reached maximum medical improvement.
13. Drs. Travis and Lide are hereby named the treating physicians. Although Defendants have denied compensability of Claimant's heart condition, Defendants do not object to Drs. Travis and Lide serving as treating physicians.
14. Claimant filed a Form 50 on October 21, 2013 alleging injuries to his "heart, left hand/arm/shoulder, neck, head (brain), chest."
15. Defendants filed a Form 51 on or about November 19, 2013 denying every alleged injury and stated that "Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the Act."
16. This matter was set for a hearing before the Single Commissioner on January 13, 2013 by a Notice of Hearing issued on December 6, 2013.
17. That Notice of Hearing specifically stated that the purpose of the hearing was to "determine issues as set forth on Forms 50 and 51."
18. Claimant's Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are "heart, left hand/arm/shoulder, neck, head (brain), chest."
19. There is no question that Claimant alleged a head and/or brain injury on his Form 50.
20. There is no question that the Notice of Hearing indicated that all issues on the Form 50 would be determined at the hearing.

21. There is no question that Claimant had sufficient notice of the hearing and what was contained on his own Form 50.
22. There is no question that Claimant filed a Pre-Hearing brief indicating that he was seeking compensation for a head and/or brain injury.
23. There is no question that Defendants filed a Pre-Hearing Brief denying compensability of this claim.
24. There is no question that Claimant did not withdraw his allegations related to a head and/or brain injury prior to or at the hearing.
25. Claimant did not present any evidence at the hearing to substantiate his alleged head and/or brain injury.
26. Claimant had the absolute burden of proving the right to compensation for each and every injury alleged on the Form 50. If Claimant failed to present evidence, as he did in this claim related to the head and/or brain injury, then his right to compensation for the alleged head and/or brain injury should be denied.
27. We decline to leave the claim open for possibly unlimited future hearings to determine compensability of presently alleged body parts as it would be grossly prejudicial to Defendants.
28. Because Claimant failed to present any evidence of a head and/or brain injury, his claim for a head and/or brain injury is denied.
29. We note from the testimony and records of Dr. Greenfield that the Claimant had tenderness in the left arm and shoulder and was diagnosed with muscle shock. In her deposition she stated that this tenderness found on examination is more indicative of actual injury to those areas than just the pain that is caused by a heart attack. Dr. Lide in

his treatment notes and specifically on September 17, 2013, recorded that, "we tried this patient on Neurontin last month when he appears to have peripheral neuropathy secondary to electrocution at work. Dr. Lide also recorded on the August 13th visit that he was having numbness in his great toe and suggested this neurological symptom was due to the electrical shock he experienced rather than the myocardial infarction. Thus, if any neuropathic problems are opined to have stemmed from the electrical shock injury which is outside of the area and expertise of Dr. Lide and Dr. Travis, those doctors may request referral for him to other physicians for evaluation and treatment but the Defendants retain the right to contest whether those are related to the accident and to select the physicians for treatment for any causally related problems.

30. In reaching our conclusions, we fully considered the facts that Claimant (a) is a smoker, (b) has hypertension, (c) has a family history of "premature coronary artery disease, and (d) had pre-existing severe 3-vessel disease n the date of the accident. However, those four facts were also specifically considered by the 3 physicians who provided opinions to a reasonable degree of medical certainty. Further, Claimant does not allege that his pre-existing disease was caused by the accident; he only alleges an aggravation resulting in an injury to his heart (Defendants' APA #8, pages 91-92; Defendants' APA #9, page 94; Claimant's APA #2, pages 26 and 28, Deposition of Dr. Feldman, page 37; Claimant's Deposition, pages 26 and 29).

31. Although certainly not dispositive on the issue of compensability, we do note that Claimant had no coronary symptoms prior to the date of the electrical shock (Claimant's Deposition, page 27; Deposition of Dr. Lide, page 7, lines 21-22).

32. Due to the compensable injury to his heart, Claimant shall receive temporary total disability benefits from September 15, 2013, through the present and continuing until further Order of the Commission or by agreement of the parties.
33. Claimant shall receive ongoing treatment until he reaches maximum medical improvement.
34. A finding of permanency for Claimant's injuries is premature at this juncture.
35. The issue of average weekly wage/compensation rate is held in abeyance.

FULL COMMISSION CONCLUSIONS OF LAW

In accordance with S.C. Code Ann. § 42-17-50, the following conclusions of law apply in this case:

1. Reg. 67-701 provides the mechanism for the Full Commission review hearing.
2. Pursuant to S.C. Code Ann. § 42-1-160, Claimant sustained a compensable injury to his heart as a result of his May 22, 2013 work accident.
3. Pursuant to S.C. Code Ann. § 42-15-60, Claimant is entitled to medical treatment for his heart condition.
4. Pursuant to S.C. Code Ann. § 42-15-60, Claimant may be entitled to additional medical treatment for other causally related conditions subject to the findings of fact as stated herein.
5. Pursuant to S.C. Code Ann. § 42-15-60, Claimant is not entitled to any medical treatment or evaluation for any alleged head and/or brain injury.
6. Pursuant to S.C. Code Ann. § 42-15-60, Defendants have the right to choose authorized treating physicians for any additional medical care recommended for Claimant.

7. Pursuant to S.C. Code Ann. § 42-15-60, Drs. Travis and Lide will remain the authorized treating physicians for Claimant's heart condition.
8. Pursuant to Reg. 67-607, the Hearing Notice issued by the Commission shall contain the purpose of the hearing. In the present case, the Hearing Notice indicated the purpose of this underlying hearing was to resolve all issues on Claimant's Form 50 and Defendants' Form 51.
9. Pursuant to Reg. 67-610, the Claimant had the right to amend his Form 50 prior to the hearing. Claimant did not amend his Form 50 related to the alleged head and/or brain injury.
10. Pursuant to Reg. 67-611, Claimant was required to file a Form 58 Pre-Hearing Brief and was required to supplement or amend the Form 58 if there was any change. Claimant did not amend his Form 58 related to the alleged head and/or brain injury.
11. Pursuant to Reg. 67-613, the Commission may continue a Hearing if additional discovery is necessary or if it is premature to hear the case. Claimant did not seek a continuance for the purposes of additional discovery or timeliness of the hearing related to the alleged head and/or brain injury.
12. Pursuant to S.C. Code Ann. § 42-9-10 and 42-1-120, Claimant is entitled to temporary total disability benefits at this time.
13. Pursuant to S.C. Code Ann. § 42-3-180, we find the Single Commissioner had jurisdiction over this matter such that a hearing on compensability could be conducted despite the ongoing appeal from a prior order of the Commission.

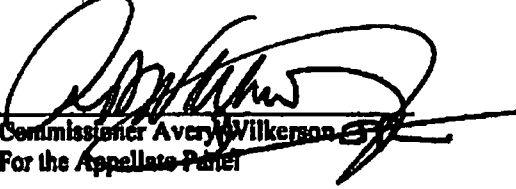
ORDER

IT IS HEREBY ORDERED that the Single Commissioner's findings of facts and conclusions of law related to the alleged head and/or brain injury are **REVERSED**.

IT IS FURTHER ORDERED that Claimant's alleged head and/or brain injury is hereby **DENIED** due to insufficient medical evidence presented to the Commission after raising the alleged head and/or brain injury as an issue before the Commission.

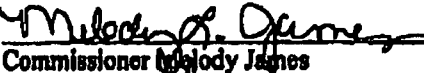
IT IS FURTHER ORDERED that all remaining issues decided by the Single Commissioner and appealed by Defendants on their Form 30 are **AFFIRMED**.

SO ORDERED.


Commissioner Avery Wilkerson
For the Appellate Panel

WE CONCUR:

1st/


Commissioner Melody James


Commissioner Alisha Taylor

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Kim Falls on July 25, 2014



REPLY TO
BRETT H. BAYNE
Direct Dial: (803) 227-2281
brett.bayne@mgclaw.com

RECEIVED

AUG 20 2014

August 20, 2014

SC Court of Appeals

VIA/HAND DELIVERY

Amy Bracy
S.C. Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

RE: Clarence Winfrey v. Archway Services and American Fire & Casualty
Insurance Company c/o Liberty Mutual Group
Date of Accident: May 22, 2013
WCC File No.: 1306305
Our File No.: 2095.13137
Claim No.: 22209963

Dear Ms. Bracy:

Enclosed for filing in the above referenced matter are a Notice of Appeal and Proof of Service. By copy of this letter, I am filing copies of the same documents with the South Carolina Court of Appeals.

Also, by copy of this letter, I am serving a copy of the same on Preston F. McDaniel, Esquire, attorney for the Claimant/Respondent with the Notice of Appeal, Proof of Service, Order being appealed, and this correspondence.

If you have any additional questions regarding the enclosed information, please do not hesitate to contact me.

With kindest regards,

Very truly yours,


Brett H. Bayne

BHB/jjp
Enclosures

McANGUS GODELOCK & COURIE LLC

1320 MAIN STREET, 10TH FLOOR
POST OFFICE BOX 12519
COLUMBIA, SC 29211

803.779.2300 PHONE
803.748.0526 FAX
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000027

ORDER AND AWARD

OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 1306305

Clarence B. Winfrey, Jr.,

Employee/Claimant,

v.

Archway Services,

Employer,

and

American Fire & Casualty,

Carrier,

Defendant(s).

HEARING:

Date: January 13, 2014

Location: Columbia, South Carolina

APPEARANCES:

Claimant represented by
Preston F. McDaniel, Esquire

Defendant(s) represented by
Brett Bayne, Esquire

PURPOSE OF HEARING:

This matter came before the
Commissioner on a Form 50 and 51

COMMISSIONER:

Susan S. Barden

FILED:

February 27, 2014

APA SUBMISSIONS

At the time for Hearing, pursuant to the Administrative Procedures Act and the Rules of this Commission the parties have made records and reports from the following a part of the Record in this matter: Dr. Jeffrey A. Travis, Lexington Cardiovascular Surgery; Dr. Lanneau D. Lide, Dr. Himadri Dasgupta, SC Heart Center; Dr. Karen Greenfield, Doctor's Care; Lexington Medical Center; Dr. Barry J. Feldman, Lexington Heart; and employer records including a statement of Mr. Bobby Ruppe, emails between Mr. Bobby Ruppe and Clarence Winfrey and driver's daily logs. The Decision and Order of Commissioner T. Scott Beck was also offered as an exhibit but that is part of the Commission file which is admitted without objection. In addition to the APA Submissions and Exhibits, the depositions of Dr. Lanneau D. Lide dated January 23, 2014; Dr. Karen Greenfield dated January 9, 2014; Dr. Barry J. Feldman dated January 6, 2014; Dr. Jeffrey A. Travis dated December 16, 2013; and the Claimant's discovery deposition were admitted into evidence without objection. The Record was left open at the hearing on January 13th for the deposition of Dr. Lide. Counsel for the Claimant noted for the Record that Dr. Barry J. Feldman had neither seen nor evaluated the Claimant and had no personal knowledge of the Claimant and had only performed a records review and therefore his opinions

were not based on personal knowledge nor is there any evidence they are based on a properly phrased hypothetical; however Counsel did not enter any objection to this evidence being received but only asked the Commission to consider this in reference to the weight to be given to this evidence.

STIPULATIONS

The parties stipulated to venue. As to jurisdiction, the Defendants object to jurisdiction based on their argument (based on "law of the case" doctrine) that certain Findings in Commissioner Beck's Order from the Form 15(III) hearing concerning the Defendants stopping temporary benefits without a hearing under SC Code §42-9-260, which is on appeal, deprives this Commissioner of jurisdiction to hear the case on the merits/compensability issue. For the purpose of this hearing, the parties stipulated to an average weekly wage of \$663.57 with a resulting compensation rate of \$442.40 which is the compensation rate at which benefits were initially paid, have been paid and at which the Claimant requests that benefits be reinstated in this matter at this time. This stipulation of the average weekly wage and compensation rate is specifically for the purpose of this hearing only and it is agreed that the Claimant reserves the right to challenge the compensation rate at a later date. No inquiry has been made nor information

requested as to the applicable compensation rate at this point.

The Commission File with the exception of self-serving declarations and unstipulated medicals is made a part of the Record.

STATEMENT OF THE CASE

It is admitted that the Claimant sustained an electrical shock injury on May 22, 2013. The injury was immediately reported by the Claimant to his supervisors and subsequent to that, temporary total disability benefits were started and authorization was given for medical care. Subsequently on September 13th and by written notice on September 16th within the 150 day period allowed by statute, the Defendants through a Form 15 advised the Claimant that they were as of that date denying benefits with the reason given being that a good faith investigation had determined grounds to deny the claim. The Claimant then filed for a Form 15 hearing and filed a Form 50 with the Commission requesting a hearing and a determination that the Claimant had suffered a compensable injury involving injury and conditions resulting from that injury to his heart. Through their Form 51, the Defendants denied that the Claimant sustained injury by accident under the Act. At the hearing, the Defendants' position was that they admitted that the Claimant had sustained an electrical shock injury and based on the

medical reports and depositions, admitted injuries to the left shoulder and neck but specifically denied that the accident had resulted in any injury and/or related conditions to his heart. The Defendants admitted that they had previously authorized treatment with Dr. Lide and Dr. Travis and if Claimant's heart condition is determined to be compensable, Defendants have no opposition to the Claimant continuing to treat with Drs. Lide and Travis for his heart condition, which is injury to the heart. Also, as set out in the Statement of the Case the Defendants take the position that this Commissioner lacks jurisdiction to hear this case. The Claimant's position is that as a result of the electrical shock, he sustained compensable injury including injury to the heart and that temporary total benefits should be reinstated back to the date that they were stopped on September 15th and that he should be provided medical care through Dr. Lide and Dr. Travis until such time as he reaches maximum medical improvement or further order of the Commission. Both parties agree that the issue before the Commission is whether or not the Claimant has sustained compensable injury under the Act as a result of the electrical shock and specifically including injury to his heart which is the major injury and problem for which the Claimant is currently being treated; and that the doctors have not been requested to

opine as to whether or not there are any other medical conditions, problems or injuries stemming from the electrical shock injury.

Finally as to the Defendants' position challenging the jurisdiction of this Commissioner to hear this case; Commissioner Beck had been assigned to that portion of the claim, and after a hearing issued an Order; in reference to the specific issue concerning the termination of temporary benefits without a hearing by the Defendants under SC Code §42-9-260. This Commissioner was assigned to hear this case as to the merits/compensability issue. The Decision of Commissioner Beck is under appeal and after the arguments made at the hearing on this issue were considered by me, this Commissioner would not have held this hearing on the merits if this Commissioner did not believe that in doing so that I was not operating within my authority to hold the hearing on the merits/compensability. Further, in reference to my decision as set forth hereinafter, this Order is not inconsistent with Commissioner Beck's Findings and no attempt was made to change or disagree with Commissioner Beck's Finding of a heart attack occurring on a particular date. In fact, it is my specific and intentional finding based on the evidence presented before me that the Claimant injured his heart on the date of the accident. Under the testimony and evidence

presented, having made that decision, whether or not the heart attack occurred on a particular date is not made and there is no Finding contained within this Order that the Claimant sustained a heart attack on the date of the shock/electrocution. This Order is written to make Findings in reference to the merits of the claim as to whether or not the injury to the Claimant's heart stemmed from the accident. Whether or not I agree or disagree with Commissioner Beck's Finding as to a particular date for the heart attack, no decision is made on that issue so as to prevent any conflict with the previous Decision by Commissioner Beck and as being an unnecessary Finding to the issues before me, i.e., merits/compensability.

STATEMENT OF FACTS

In addition to the deposition testimony and APA Submissions, the following is a summary of the testimonial evidence given in this matter in relationship to the other evidence presented.

Testimony was taken from the Claimant, Mr. Clarence Winfrey and Mr. Mark Warren. A review of the Form 58 filed by the Defendants did not list Mr. Warren as a potential witness but his testimony was allowed without objection.

Based on the testimony and evidence submitted, the Claimant was working on a commercial rotisserie in the Deli Department of

Publix Supermarket wherein he was tracing a wire on May 22, 2013 when his left hand came in contact with a loose electrical wire resulting in a severe shock knocking and causing him to jerk backwards. Mr. Winfrey during his testimony showed the entrance location and scar from the wound where the electricity entered his left hand. His testimony and description is confirmed by the records of Dr. Karen Greenfield where she recorded at her initial visit on May 28, 2013 an entry wound on the dorsum of the left third finger.

According to both the testimony of Mr. Winfrey and Mr. Mark Warren, this commercial unit would be rated between 208 and 480 volts as to the power feeding into and supplying the rotisserie unit. Both witnesses agreed also that the exact power rating could not be determined without testing the machine. After receiving the electrical shock, the Claimant immediately went outside because he was stunned and wherein he was having pain from his left hand extending through his left arm into his left shoulder and into and over his left shoulder and into his neck. When describing the pain and location, the Claimant described the pain in his shoulder area as being from the top of his shoulder into the front part of the shoulder which he demonstrated by extending his hand from just on top of the shoulder into the front part of the shoulder and chest area.

According to Mr. Winfrey's testimony which is confirmed by the employer records and particularly the statement of Mr. Bobby Ruppe, and as confirmed on the driver's daily log, he immediately reported the shock to his employer when he was advised that if he needed to, to go to the doctor. The records also confirm Mr. Winfrey's testimony that he received a hard shock.

Mr. Winfrey testified that when he received the shock that he both jerked and was knocked away from the machine and because of the location of the pain and the severe pain he was having in his shoulder and neck, he thought he had hurt his neck. He tried to avoid going to the doctor hoping that he would get better but his pain continued in his left hand, arm, shoulder and up into the left side of his neck as described previously from the time of the shock until he finally went to the doctor. He first went to a Minute Clinic on the day before he went to see Dr. Greenfield but due to the severity of his pain, he was told he would have to seek medical attention outside of the Minute Clinic, at which point he went to Dr. Greenfield at Doctor's Care. He testified that while his pain was continuous from the time of the shock, it continued to worsen until he finally had to seek medical attention. A review of the histories of all doctors that initially treated the Claimant establish a

consistent history that the problems he had begun with and continued from the point of the shock and continuing until he sought medical care with Dr. Greenfield. For example, Dr. Dasgupta, to whom Mr. Winfrey was sent by Dr. Greenfield immediately upon the abnormal EKG and diagnosing him with tachycardia, electrical shock, and muscle shock, recorded in his medical summary, "received an electric shock in five days ago and since then has complained of a pain in his left shoulder radiating to the left scapula region, the left side of his neck, left intraclavicular region and left arm." This description again is consistent with the history given by Mr. Winfrey to all doctors involved initially in his treatment.

The Claimant's condition was such on May 28th that Dr. Dasgupta whose office is directly across the street from Lexington Medical Center required an ambulance to take the Claimant to Lexington Medical Center where he was admitted and where he immediately had the catheterization performed by Dr. Lide, and then immediate surgery by Dr. Travis.

This injury was properly reported and once reported, benefits were started and medical care was authorized through Dr. Greenfield, Dr. Lide and Dr. Travis and he remains under the care of Dr. Travis and Dr. Lide at the time of this hearing. Compensation benefits were paid at the rate of \$442.40 up to and

including September 15th when compensation benefits and medical care were stopped based on an alleged good faith investigation which established grounds for denial.

Based on the above summary of the evidence and after due and proper consideration of the testimony and evidence presented, I find that Mr. Winfrey has sustained his burden of proof by proving by a preponderance of the evidence that he sustained compensable injury to include specifically injury to his heart as a result of the electrical shock that occurred on May 22, 2013, and specifically including that the electrical shock resulted in the Claimant's heart attack, myocardial infarction, and ventricular septal defect (VSD), and including the specific entrance and exit wounds and damage to the heart as described by Dr. Travis all being physical injuries to the heart stemming from this accident. Therefore, the Claimant is entitled to the benefits sought to include the provision of medical care and the resumption of temporary total benefits from September 15, 2013 when those benefits were stopped until further order of the Commission. Wherefore, I have made the following findings of salient fact:

FINDINGS OF FACT

1. Claimant injured his neck and left shoulder in an admitted accident on May 22, 2013. Claimant alleges that he

also injured his heart on the date of the accident, which injury (a) aggravated a pre-existing condition, and (b) ultimately resulted in a myocardial infarction and subsequent ventricle septal defect.

2. Claimant is 51 years of age (testimony of Claimant).

3. Claimant finished the 12th grade, but did not receive a diploma (Claimant's Deposition, pages 6-7).

4. Claimant's prior employment includes work (a) at USC installing Wi-Fi, (b) as electrical maintenance man at F. B. Johnson, (c) as an electrician for a company that "roughs in" wiring for new houses; and (d) as a roofer (Claimant's Deposition, pages 9-11 and 13; testimony of Claimant).

5. On the date of the accident, Claimant's job with Employer was equipment maintenance worker for deli and bakery departments at Publix and Wal-Mart stores (testimony of Claimant; Defendants' APA #9, page 94; Claimant's Deposition, page 11).

6. In the mechanics of the accident, Claimant was shocked with 240-480 volts of electricity; Claimant believes the actual voltage was 480 volts. Defendants' witness admitted at the hearing that he was unsure of the voltage amount involved, and Defendants did not present any evidence to rebut Claimant's estimation even though Employer had access to the rotisserie in question. The fact that Defendants did not present any specific

evidence leads me to rely on Claimant's estimation (Defendants' APA #7, page 90; testimony of Warren; Claimant's APA #5, page 78).

7. Temporal medical evidence from May 28, 2013, supports Claimant's testimony that Claimant experienced pain (the worst of which was in his neck, but was also in the front of his shoulder and his left arm as well) from the moment of the accident which got progressively worse. Dr. Greenfield testified that Claimant (a) rubbed his arm during the examination, and (b) reported that his arm hurt. Claimant began sweating the same night of the Thursday accident and also the next morning (Defendants' APA #7, page 90; Defendants' APA #8, page 91; Claimant's APA #2, page 56; Claimant's APA #3, page 66; Deposition of Dr. Feldman, page 35; Claimant's Deposition, pages 13-16, 18, 20-21, and 32; Deposition of Dr. Greenfield, including but not limited to pages 5, 8, 16, and 21).

8. Dr. Travis stated that neck pain is a common presentation for a heart attack (Deposition of Dr. Travis, page 21).

9. Three physicians have all opined to a reasonable degree of medical certainty that the electric shock ultimately resulted in Claimant's heart attack, regardless of the date on which the infarction occurred. The deposition testimony of Dr.

Travis (the treating cardiovascular surgeon) is very compelling, as he--unlike any of the other physicians involved in this case--actually examined Claimant's heart in the operating room. Dr. Lide (the treating cardiologist) also links the electrical shock to Claimant's post-accident heart condition; in fact, Dr. Lide testified twice that he does not "see any way" that Claimant's infarction and VSD are not related to the injury. The third physician is a general physician board certified in family medicine (Claimant's APA #1, page 1; Claimant APA #2, pages 23-24; Claimant's APA #3, page 65; Deposition of Dr. Greenfield, pages 30-31; Deposition of Dr. Travis, including but not limited to pages 8, 13-17, and 23-32; Deposition of Dr. Lide in its entirety, including but not limited to pages 14, 23-24, 28, and 39).

10. Even if I discount or disregard the opinion of the general physician (board certified in family medicine), I give great weight to the opinions of the Drs. Travis and Lide, who both opine that the heart condition is causally related. I fully considered the opinion of Dr. Feldman (the only physician who states that there is no nexus between the electrical shock and the heart condition), but his opinion is outweighed by the opinions of the three other doctors, all three of whom treated Claimant rather than simply reviewing his medical records. I

note that Dr. Feldman (a) did not examine Claimant or even speak with Claimant; (b) did not see Claimant's heart, as opposed to Dr. Travis, who held it in his hand; (c) initially states in his written opinion that it is "possible" that there was no connection between the plaque rupture and the electrical shock, and then in the very next sentence states that it is of the "highest certainty;" (d) Dr. Feldman is a cardiologist and not a cardiovascular surgeon; nor has he undergone a surgical residency; and (e) Dr. Feldman was specifically asked to opine in writing as to whether there was a connection between an electrical shock and a VSD, although he does address other pertinent issues for Defendants in his deposition (Defendants' APA #10, page 97; Deposition of Dr. Feldman in its entirety, including but not limited to pages: 5-6, 10-11, and 17-lines 15 through 25; page 18-lines 1-14; pages 22-23, 31, 42-43, and 45-47; Deposition of Dr. Greenfield, page 4).

11. The statement by Ruppe is dispositive only of the fact that Claimant has a good work ethic (Defendants' APA, Exhibit 1).

12. Claimant has not reached maximum medical improvement.

13. Drs. Travis and Lide are hereby named the treating physicians. Although Defendants have denied the compensability of Claimant's heart condition, Defendants do not object to Drs.

Travis and Lide serving as treating physicians.

14. The Claimant is specifically requesting a finding of compensability for the heart and no medical evidence was presented that Claimant sustained or even may have sustained a head or brain injury. I therefore find that at this point he has not met his burden of proof with regard to any injury to the head/brain, and any benefits for the head/brain are denied at this juncture.

15. While the head and brain are listed as bodily parts involved under #3 in the Pre-Hearing Brief, the Claimant also notes in his Pre-Hearing Brief that this is a systemic electrical shock and requests treatment for, "all organs, members and bodily parts determined to be related." I note from the testimony and records of Dr. Greenfield that the Claimant had tenderness in the left arm and shoulder and was diagnosed with muscle shock. In her deposition she stated that this tenderness found on examination is more indicative of actual injury to those areas than just the pain that is caused by a heart attack. Dr. Lide in his treatment notes and specifically on September 17, 2013 recorded that, "we tried this patient on Neurontin last month when he appeared to have peripheral neuropathy secondary to electrocution at work. Dr. Lide also recorded on the August 13th visit that he was having numbness in

his great toe and suggested this neurological symptom was due to the electrical shock he experienced rather than the myocardial infarction. Thus, if any problems are opined to have stemmed from the electrical shock injury which is outside of the area and expertise of Dr. Lide and Dr. Travis, those doctors may request referral for him to other physicians for evaluation and treatment but the Defendants retain the right to contest whether those are related to the accident and to select the physicians for treatment of any causally related problems.

16. For purposes of the hearing before the undersigned, Claimant is very credible. I base this finding on my observations of Claimant's demeanor and on the delivery of his testimony.

17. In reaching my conclusions, I fully considered the facts that Claimant (a) is a smoker, (b) has hypertension, (c) has a family history of "premature coronary artery disease, and (d) had pre-existing severe 3-vessel disease on the date of the accident. However, those four facts were also specifically considered by the 3 physicians who provided opinions to a reasonable degree of medical certainty. Further, Claimant does not allege that his pre-existing disease was caused by the accident; he only alleges an aggravation resulting in an injury to his heart (Defendants' APA #8, pages 91-92; Defendants' APA

#9, page 94; Claimant's APA #2, pages 26 and 28; Deposition of Dr. Feldman, page 37; Claimant's Deposition, pages 26 and 29).

18. Although certainly not dispositive on the issue of compensability, I do note that Claimant had no coronary symptoms prior to the date of the electrical shock (Claimant's Deposition, page 27; Deposition of Dr. Lide, page 7, lines 21-22).

19. Claimant to receive temporary total disability benefits from September 15, 2013, through the present and continuing until further Order of the Commission or by agreement of the parties.

20. Claimant to receive ongoing treatment until he reaches maximum medical improvement.

21. Permanency is premature.

22. The issue of average weekly wage/compensation rate is held in abeyance.

CONCLUSIONS OF LAW

In accordance with SC Code §42-17-40, the following conclusions of law apply in this case:

1. Under SC Code §42-1-160, the decision is made as an injury by accident arising out of and in the course of the employment. The medical problems which the Claimant has and which have resulted in his disability stem from the physical

injury, the electrical shock that he sustained on May 22, 2013. Any medical condition and/or disability that either results directly from the physical injury or which is a pre-existing condition that is aggravated, accelerated or caused to become symptomatic by the physical injury is compensable as injury by accident under SC Law. See for example, Buff v. Columbia Baking Co., 215 S.C. 41, 53 S.E.2d 879 (1949); Walker v. City of Columbia, 247 S.C. 241, 146 S.E.2d 856 (1966); (as to pre-existing conditions being compensable), Mullinax v. Winn Dixie Stores, Inc., 318 S.C. 431, 458 S.E.2d 76 (SC App. 1995).

2. Under SC Code §42-9-10 and SC Code §42-1-120, the determination is made as to the entitlement to disability compensation.

3. Under SC Code §42-15-60 the determination is made as to the provision of medical care.

4. Under the stipulation of the parties, venue is proper and the applicable average weekly wage and compensation rate that applies for the purpose of this hearing is determined. As to jurisdiction, SC Code §42-3-180 provides that this Commission has jurisdiction to decide all questions arising under the Title and states in pertinent part, "all questions arising under this Title . . . shall be determined by the Commission except as otherwise provided in this Title." The Defendants main argument

in taking the position that this Commission does not have jurisdiction is based upon the doctrine of Law of the Case and is based upon certain Findings made by Commissioner Beck in his Order. However, after review of the position of the parties, arguments of the parties, and after review of Commissioner Beck's Order and the general jurisdiction of this Commission to decide issues arising under the Title and the Form 50 and 51 filed in this matter, this Commissioner is found, as a matter of law, to have jurisdiction over these proceedings. The Form 51 filed in this matter specifically admits that both the employee and the employer were subject to the Workers' Compensation Act at the time in question. Further, Commissioner Beck's Order which serves as the basis for the Defendants' argument states and holds:

"IT IS FURTHERMORE ORDERED that all other issues in contention, specifically including the question of whether the Claimant sustained an injury by accident arising out of and in the course of his employment with Defendants resulting on compensable disability is preserved for adjudication at the hearing set pursuant to Claimant's October 21, 2013 Form 50 Employee's Request for Hearing."

5. Under the issues before the Commission for decision, all other issues are held in abeyance for further decision by the Commission.

ORDER AND AWARD

THEREFORE IT IS ORDERED that the Claimant having been found to have sustained compensable injury, temporary total benefits

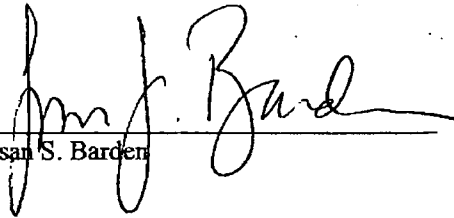
are ordered at this time to be reinstated from September 15, 2013 at the compensation rate of \$442.40 with weekly compensation payments to continue until further order of the Commission. All benefits which have accrued prior to the date of this Order and which shall accrue before the resumption of weekly compensation payments shall be paid to the Claimant in a lump sum.

IT IS FURTHER ORDERED that the Claimant having been found to have sustained compensable injury specifically to include injury to his heart, the Claimant is to receive medical care for all injuries and conditions stemming from the accident that occurred in this matter and specifically to include all conditions related to the heart as found to be causally related by the authorized treating physicians which are hereby declared to be Dr. Jeffrey A. Travis and Dr. Lanneau D. Lide. The Defendants reserve the right to contest the compensability of any injury or condition opined to be related to the injury involving any bodily part, member, organ or system and the right to direct the treatment for all causally related medical problems outside of the area of expertise of the two (2) authorized treating physicians including the right to choose

authorized treating physicians to provide that medical care.

All other issues are held in abeyance.

AND IT IS SO ORDERED.


Susan S. Barden

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid, in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

February 27, 2014

By: Kristi Love, Administrative
Assistant to Commissioner Barden

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1306305

CLARENCE WINFREY,

Employee,

Claimant,

vs.

ARCHWAY SERVICES INC,

Employer,

AND

AMERICAN FIRE & CASUALTY
INSURANCE COMPANY c/o LIBERTY
MUTUAL GROUP,

Carrier,

Defendants.

**FULL COMMISSION DECISION
AND ORDER ON CLAIMANT'S
APPEAL FROM COMMISSIONER
BECK'S DECISION AND ORDER**

DATE OF HEARING:

Hearing held in Columbia, South Carolina on May 19, 2014.

APPEARANCES:

Claimant appeared and represented by Preston F. McDaniel, Esquire, of The McDaniel Law Firm of Columbia, South Carolina.

Defendants represented by Brett H. Bayne, Esquire of McAngus Goudelock & Courie, L.L.C. of Columbia, South Carolina.

PURPOSE OF THE HEARING: To determine all issues as set forth in Claimant's Form 30.

COMMISSIONER:

FILED:

July 25, 2014

000050

STATEMENT OF THE CASE

This claim arises out of a work-related accident on May 22, 2013. On that date, Claimant was momentarily shocked by a rotisserie oven he was working on. Following the accident, Claimant continued to work for the remainder of the day and the following day. On May 28, 2013—six days after the accident—Claimant presented to Doctor's Care and Lexington Medical Center with severe three vessel coronary disease as well as an acute myocardial infarction which caused an acute ventricular septal defect. At Doctor's Care, Claimant reported he was having no chest pressure and had started sweating that morning (May 28th). At Lexington Medical Center, Claimant indicated he was not having chest pain but had been sweating. Following the diagnosis, Claimant underwent surgery to repair the ventricular septal defect caused by the myocardial infarction. The medical records in the case revealed that Claimant has a distinct family history of coronary disease with his father passing away at a similar age from coronary disease and a myocardial infarction. Further, the medical records indicated that Claimant was a 35 year pack-a-day smoker and drank a case of beer per week. Based on all of the medical records available to Carrier, this claim was ultimately denied by verbal communication to Claimant on September 13, 2013.

Following the denial of benefits, Claimant filed a Form 15, Section III requesting a hearing as well as a Summons and Complaint in Richland County Circuit Court alleging a bad faith denial of benefits, alleging that S.C. Code Ann. § 42-9-260 is unconstitutional, seeking a temporary restraining order to stop Defendants from denying the claim, and seeking an Order from Judge Lee finding the claim compensable and awarding benefits. Judge Lee issued and then rescinded the temporary restraining order sought by Claimant. A hearing on the merits of Claimant's Complaint has not been set by the Court. After the temporary restraining order was

rescinded, the Commission set Claimant's Form 15, Section III for a hearing before the Hearing Commissioner. In addition, Defendants filed several motions with the Commission including a Motion to Quash the deposition of the adjuster, a Motion to Quash discovery of the adjuster's claim file, and a Motion to Postpone the Hearing.

A hearing on all of the motions and on Claimant's Form 15, Section III was set on September 30, 2013 for November 11, 2013. Prior to the hearing, the Hearing Commissioner conducted a standard pre-hearing conference as well as a Motions Hearing wherein the Hearing Commissioner ruled on all outstanding issues raised by the motions including Defendants' Motion to Postpone. The Hearing Commissioner gave Claimant the opportunity to postpone the Form 15 hearing in order to spend time preparing for each of the motions that were timely served. Claimant turned down that opportunity. At the hearing, all parties agreed that the only issue for the Hearing Commissioner to determine was whether or not Defendants had conducted a good faith investigation. In order to make that determination, the Hearing Commissioner limited the review of evidence to only those documents produced prior to the date of denial - September 13, 2013. Following the hearing, the Hearing Commissioner issued a Decision and Order on December 5, 2013 finding that Defendants had conducted a good faith investigation. Thereafter, Claimant timely filed a Form 30 and this appeal followed. A hearing on this appeal was held on May 19, 2014 before the Full Commission. After hearing oral argument from both parties and considering the evidence submitted in the record, the Single Commissioner's Decision and Order is **AFFIRMED AS MODIFIED**.

SINGLE COMMISSIONER'S FINDINGS OF FACT

Based on my consideration of the relevant evidence submitted into the record, excluding all evidence dated after September 13th, 2013, as well as the testimony of the Claimant offered at the Hearing, I make the following findings of fact:

1. Claimant suffered an incident while working on electrical equipment at work that he believed to be an electrical shock on May 22nd, 2013. This is based on the testimony of the Claimant as well as the medical records submitted by the Claimant from Lexington Medical Center.
2. Claimant suffered a myocardial infarction on May 28th, 2013. This is based on the medical records submitted by the Claimant from Lexington Medical Center.
3. Claimant alleged that he suffered an injury by accident arising out of and in the course and scope of his employment to his heart, left hand/arm/shoulder, neck, head (brain), and chest, and filed a claim for workers' compensation benefits. This is based on the Form 50 Employee's Notice of Claim filed by Claimant on June 6th, 2013.
4. Defendants began providing Claimant with temporary total disability benefits beginning on June 1st, 2013 and continuing through September 14th, 2013. This is based on the Form 19 Status Report and Compensation Receipt filed by Defendants on September 12th, 2013.
5. Defendants also provided Claimant with medical treatment between the alleged date of injury and September 12th, 2013. This is based on the Form 19 Status Report and Compensation Receipt filed by Defendants on September 12th, 2013.
6. Defendants terminated Claimant's workers' compensation benefits 114 days after employer could have had notice of his alleged injury, on September 12th, 2013. The

termination was based on a denial of the claim following an investigation. This is based on the Form 15, Section II dated September 12th, 2013.

7. The Form 15, Section II was received by the Commission no later than September 18th, 2013. This is based on the records in the Commission's file and the Form 15, Section III filed by the Claimant.
8. The Form 15, Section II documented that the reason for termination was that the employee fails to meet the burden of a compensable injury under the S.C. Workers' Compensation Act. This is based on the Form 15, Section II dated September 12th, 2013.
9. Claimant received the Form 15, Section II in a timely manner and was able to exercise his rights under § 42-9-260(C) and R.67-504(C). This is based on the Form 15, Section III filed by the Claimant. Claimant alleged that the Form 15, Section II was not served on him properly pursuant to R.67-504(A) because he was only served with one copy of the Form 15, Section II and the documented reason for termination was printed on the Form 15 under Section II, rather than on an attached document. However, Claimant was in no way prejudiced from exercising his rights under the Act by the manner of service of This is evident by the fact that Claimant filed a Form 15, Section III asserting his rights shortly after receiving the Form 15, Section II. Claimant had the benefit of counsel at the time he was served with the Form 15, Section II, rendering the requirement to provide him with two copies unnecessary. Therefore, Defendants alleged failure to provide Claimant with a second copy of the Form 15, Section II, and including the reasons for denial on the form itself rather than on a separate attachment are not grounds to find the termination of benefits was improper.

10. Claimant did not provide any evidence at the Hearing to indicate that Defendants acted in anything other than good faith during the investigation and eventual denial of the claim. This is based on the evidence (or lack thereof) submitted by the Claimant at the Hearing.
11. I find the Claimant's argument that the apparent failure of Defendants to interview Claimant prior to the denial of the claim as evidence of bad faith is unpersuasive. Claimant is alleging a medically complex condition resulting from an injury by accident. Defendants have not denied that Claimant suffered an incident he believed to be an electrical shock on May 22nd, 2013. The causal relation between Claimant's alleged electrical shock and his current medical condition is one that can best be determined by review of the expert medical reports, to which Defendants had access by operation of §42-15-95. Claimant's statement would have been of little value to Defendants in attempting to determine whether his heart condition was causally related to the alleged electrical shock.

SINGLE COMMISSIONER'S CONCLUSIONS OF LAW

Based on the foregoing, I make the following rulings of law:

1. The Workers' Compensation Act provides "[o]nce temporary disability payments are commenced, the payments may be terminated or suspended immediately at any time within the one hundred fifty days if... a good faith investigation by the employer reveals grounds for denial of the claim." § 42-9-260(B)(3).
2. Defendants properly terminated Claimant's workers' compensation benefits on September 12th, 2013 by meeting all the required elements for termination under § 42-9-260(B)(3).
 - a. Benefits were commenced on or about June 1st, 2013. See Finding of Fact No. 4.

- b. Benefits were terminated on or about September 12th, 2013, well within 150 days after the employer could have received notice of the injury. See Finding of Fact No. 6.
- c. Defendants represented to the Commission they conducted a good faith investigation of the claim. See Form 15, Section II dated September 12th, 2013.
- d. Claimant did not provide any evidence that Defendants conducted their investigation in anything other than good faith. See Finding of Fact Nos. 10-11
- e. Defendants represented the grounds for denial revealed during their investigation was a good faith belief that "Claimant fails to meet the burden of a compensable injury under the SC Workers' Compensation Act". See Form 15, Section II, dated September 12th, 2013. Under the Act, Claimant bears the burden of proving by a preponderance of the evidence that it is more likely than not that Claimant suffered an injury by accident arising out of and in the course of his or her employment resulting in disability. See § 42-1-160; Hall v. Desert Aire, Inc., 376 S.C. 338, 656 S.E.2d 753 (S.C. App. 2009) ("A claimant has the burden of proving facts sufficient to allow recovery under the Workers' Compensation Act"); Fowler v. Abbott Motor Co., 236 S.C. 226, 113 S.E.2d 737 (1960) ("The burden rests upon claimants to show by competent testimony, not only the fact of injury, but that it occurred in connection with the employment of the deceased; and to furnish evidence from which the inference can logically be drawn that the injury arose out of and in the course of the employment." (Internal citations omitted)); S.C. Second Injury Fund v. Liberty Mut. Ins. Co., 353 S.C. 117, 576

S.E.2d 119 (S.C. App. 2003) ("The burden lies with the workers' compensation claimant to demonstrate causation by a preponderance of the evidence."),

f. Therefore, a belief of Defendants formed following a good faith investigation that Claimant had not met his burden of proving compensability is adequate grounds for denial of the claim by the Defendants.

3. § 42-9-260(C) and R.67-504(C) provide a mechanism for a Claimant whose temporary disability benefits have been terminated by action of § 42-9-260(B)(3) to have an Order issued reinstating benefits following a Hearing held pursuant to a request made by Claimant on a Form 15, Section III. Counsel for Claimant stipulated on the record that the sole purpose of the Hearing he had requested was to determine whether Defendants properly stopped benefits under § 42-9-260.
4. Based on the foregoing, I find that Defendants properly stopped benefits under § 42-9-260 on September 12th, 2013. Defendants terminated benefits on the justification that a good faith investigation reveals grounds for the denial of the claim. See Finding of Fact # 8. This is a permissible ground for termination under the statute. See § 42-9-260(B)(3). At the time Defendants terminated Claimant's benefits on September 12th, 2013, Defendants had access to Claimant's medical records by operation of § 42-15-95 and had knowledge of the course of Claimant's treatment through its Nurse Case Manager. See Claimant's APA Submission # 5, p. 17. It is possible for Defendants to have drawn a conclusion in good faith based on Claimant's medical records that he suffered from preexisting medical conditions unrelated to his employment that could be contributing to his current symptoms that would justify denying the claim. See e.g. Claimant's APA Submission #3, p.4 ("Discharge Diagnosis(es) ... 3. Coronary artery disease[,] ... 5. Hypertension[,] 6.

Congestive heart failure."). The fact that there also exists evidence that was available to Defendants that could lead to the conclusion that Claimant's current condition is causally related to a compensable injury by accident does not lead me to conclude that Defendant's termination of benefits was improper. Claimant bears the ultimate burden of proving his claim is compensable and he has requested the Commission provide him an opportunity to do so.

5. Specifically, Claimant has requested a Hearing on the merits of whether Claimant sustained a compensable injury by accident and is entitled to benefits by operation of the Form 50 Employee's Request for Hearing filed on October 21st, 2013. Therefore, the question of whether Claimant sustained a compensable injury by accident and is entitled to benefits under the Act will be decided by the Commission at the Hearing set pursuant to Claimant's Form 50 Request for Hearing.
6. Claimant has availed himself of all relief available under § 42-9-260 and R.67-504 and, therefore, these provisions of the Workers' Compensation Act are no longer in contention in Claimant's claim for benefits against Defendants.

LEGAL ISSUES RAISED BY CLAIMANT-APPELLANT

- I. Did the Hearing Commissioner err as a matter of law by holding that the Defendants do not have the burden of proof to prove that they conducted a good faith investigation allowing them to stop benefits without a hearing any by shifting the burden of proof requiring the Claimant to prove that the Defendants did, "not" conduct a good faith investigation?

- II. The Hearing Commissioner erred as a matter of law by not ordering reinstatement of benefits where the Defendants failed to comply with the mandatory requirements of SC Code §42-9-260.
- III. The Hearing Commissioner abused his discretion by considering the late filed pre-hearing brief and the late filed APA submissions of the defendants.
- IV. The Hearing Commissioner erred by excluding evidence from the Claimant after September 13, 2013.
- V. The Hearing Commissioner erred as a matter of law by making the Finding of Fact #2 that the Claimant suffered a myocardial infarction, "on May 28, 2013".
- VI. The Commissioner erred as a matter of law by making a finding of fact that is not supported by the evidence that an investigation was conducted as found in finding of fact #6 and by making other findings of fact #4 through #9, which are not supported by the testimony, stipulations or documentary evidence submitted in the record.
- VII. The Hearing Commissioner erred as a matter of law in making Finding of Fact No. 9.
- VIII. The Hearing Commissioner erred as a matter of law in making Finding of Fact No. 10.
- IX. The Hearing Commissioner erred as a matter of law in making Finding of Fact No. 11.
- X. The Hearing Commissioner erred as a matter of law by delaying a decision from November 13, 2013 until December 5, 2013.
- XI. The Hearing Commissioner erred as a matter of law by holding a pre-hearing conference for over an hour and making substantive decisions on motions that were not properly noticed and which included the parties' positions on the issues before the Hearing Commissioner.

- XII. The Hearing Commissioner erred as a matter of law in his ancillary and interlocutory order concerning motions that has been filed.

EVIDENCE OF THE CASE

Claimant notified Employer he was shocked while working on a rotisserie oven on May 22, 2013. (Def. APA p. 8). Employment records of Claimant indicate that he continued working the remainder of the day and the following day. (Def. APA p. 10-11). An email from Claimant to Employer indicates that he was experiencing only neck pain on May 27, 2013 (5 days post-accident). (Def. APA p. 9). Claimant first presented to Doctor's Care on May 28, 2013 complaining that he woke up sweating (6 days post-accident). (Def. APA p. 1). Doctor's Care noted that he had some tenderness in his shoulder and neck area. *Id.* Further, Doctor's Care noted that Claimant did not complain of any chest pressure. *Id.* Claimant was referred to and saw Dr. Dasgupta at the South Carolina Heart Center. Dr. Dasgupta also noted sweating and noted that Claimant denied chest pain but did have minimal left shoulder pain. (Def. APA p. 2). Dr. Dasgupta diagnosed Claimant with an acute myocardial infarction. *Id.* Dr. Dasgupta indicated that Claimant had a prior history of hypertension, tobacco abuse, as well as a significant family history for heart disease (Claimant's father passed away from coronary disease and myocardial infarction). (Def. APA p. 2-3). Dr. Dasgupta also noted that Claimant appeared to have a ventricular septal defect as a possible completion of his myocardial infarction. (Def. APA p. 2). Dr. Dasgupta referred Claimant to Lexington Medical Center where he underwent surgery to repair an acute ventricular septal defect that formed following the myocardial infarction. (Def. APA p. 5-7).

FULL COMMISSION FINDINGS OF FACT

Based on our consideration of the relevant evidence submitted into the record, excluding all evidence dated after September 13th, 2013, as well as the testimony of the Claimant offered at the Hearing, We AFFIRM AS MODIFIED and make the following findings of fact:

1. Claimant suffered an incident while working on electrical equipment at work that he believed to be an electrical shock on May 22nd, 2013. This is based on the testimony of the Claimant as well as the medical records submitted by the Claimant from Lexington Medical Center.
2. The claimant was admitted to Lexington Medical Center on May 28, 2013 and underwent surgery for a myocardial infarction. This is based on the medical records submitted by the Claimant from Lexington Medical Center.
3. Claimant alleged that he suffered an injury by accident arising out of and in the course and scope of his employment to his heart, left hand/arm/shoulder, neck, head (brain), and chest, and filed a claim for workers' compensation benefits. This is based on the Form 50 Employee's Notice of Claim filed by Claimant on June 6th, 2013.
4. Defendants began providing Claimant with temporary total disability benefits beginning on June 1st, 2013 and continuing through September 14th, 2013. This is based on the Form 19 Status Report and Compensation Receipt filed by Defendants on September 12th, 2013.
5. Defendants also provided Claimant with medical treatment between the alleged date of injury and September 12th, 2013. This is based on the Form 19 Status Report and Compensation Receipt filed by Defendants on September 12th, 2013.

6. Defendants terminated Claimant's workers' compensation benefits 114 days after employer could have had notice of his alleged injury, on September 12th, 2013. The termination was based on a denial of the claim following an investigation. This is based on the Form 15, Section II dated September 12th, 2013.
7. We find that the communications by and through the Claimant's attorney and the Defendants' representatives are sufficient to prove that the medical records were provided to the Defendants prior to September 13, 2013, and provide a basis for the Defendants knowledge and good faith denial.
8. We find that a heart attack and its relationship to a work related injury is a medically complex case.
9. The Form 15, Section II was received by the Commission no later than September 18th, 2013. This is based on the records in the Commission's file and the Form 15, Section III filed by the Claimant.
10. The Form 15, Section II documented that the reason for termination was that the employee fails to meet the burden of a compensable injury under the S.C. Workers' Compensation Act. This is based on the Form 15, Section II dated September 12th, 2013.
11. Claimant received the Form 15, Section II in a timely manner and was able to exercise his rights under § 42-9-260(C) and R.67-504(C). This is based on the Form 15, Section III filed by the Claimant. Claimant alleged that the Form 15, Section II was not served on him properly pursuant to R.67-504(A) because he was only served with one copy of the Form 15, Section II and the documented reason for termination was printed on the Form 15 under Section II, rather than on an attached document. However, Claimant was in no way prejudiced from exercising his rights under the Act by the manner of service of this

is evident by the fact that Claimant filed a Form 15, Section III asserting his rights shortly after receiving the Form 15, Section II. Claimant had the benefit of counsel at the time he was served with the Form 15, Section II, rendering the requirement to provide him with two copies unnecessary. Therefore, Defendants alleged failure to provide Claimant with a second copy of the Form 15, Section II, and including the reasons for denial on the form itself rather than on a separate attachment are not grounds to find the termination of benefits was improper.

12. Claimant did not provide any evidence at the Hearing to indicate that Defendants acted in anything other than good faith during the investigation and eventual denial of the claim. This is based on the evidence (or lack thereof) submitted by the Claimant at the Hearing.
13. We find Claimant's argument that the apparent failure of Defendants to interview Claimant prior to the denial of the claim as evidence of bad faith is unpersuasive. Claimant is alleging a medically complex condition resulting from an injury by accident. Defendants have not denied that Claimant suffered an incident he believed to be an electrical shock on May 22nd, 2013. The causal relation between Claimant's alleged electrical shock and his current medical condition is one that can best be determined by review of the expert medical reports, to which Defendants had access by operation of §42-15-95. Claimant's statement would have been of little value to Defendants in attempting to determine whether his heart condition was causally related to the alleged electrical shock.

FULL COMMISSION CONCLUSIONS OF LAW

Based on the foregoing, we make the following rulings of law:

1. The Workers' Compensation Act provides "[o]nce temporary disability payments are commenced, the payments may be terminated or suspended immediately at any time within the one hundred fifty days if... a good faith investigation by the employer reveals grounds for denial of the claim." § 42-9-260(B)(3).
2. Defendants properly terminated Claimant's workers' compensation benefits on September 12th, 2013 by meeting all the required elements for termination under § 42-9-260(B)(3).
 - a. Benefits were commenced on or about June 1st, 2013. See Finding of Fact No. 4.
 - b. Benefits were terminated on or about September 12th, 2013, well within 150 days after the employer could have received notice of the injury. See Finding of Fact No. 6.
 - c. Defendants represented to the Commission they conducted a good faith investigation of the claim. See Form 15, Section II dated September 12th, 2013.
 - d. Claimant did not provide any evidence that Defendants conducted their investigation in anything other than good faith. See Finding of Fact Nos. 10-11
 - e. Defendants represented the grounds for denial revealed during their investigation was a good faith belief that "Claimant fails to meet the burden of a compensable injury under the SC Workers' Compensation Act". See Form 15, Section II, dated September 12th, 2013. Under the Act, Claimant bears the burden of proving by a preponderance of the evidence that it is more likely than not that Claimant suffered an injury by accident arising out of and in the course of his or her employment resulting in disability. See § 42-1-160; Hall v. Desert Aire, Inc., 376 S.C. 338, 656 S.E.2d 753 (S.C. App. 2009) ("A claimant has the burden of proving facts sufficient to allow recovery under the Workers' Compensation

Act"); *Fowler v. Abbott Motor Co.*, 236 S.C. 226, 113 S.E.2d 737 (1960) ("The burden rests upon claimants to show by competent testimony, not only the fact of injury, but that it occurred in connection with the employment of the deceased; and to furnish evidence from which the inference can logically be drawn that the injury arose out of and in the course of the employment." (Internal citations omitted)); *S.C. Second Injury Fund v. Luberty Mut. Ins. Co.*, 353 S.C. 117, 576 S.E.2d 119 (S.C. App. 2003) ("The burden lies with the workers' compensation claimant to demonstrate causation by a preponderance of the evidence."),

f. Therefore, a belief of Defendants formed following a good faith investigation that Claimant had not met his burden of proving compensability is adequate grounds for denial of the claim by the Defendants.

3. § 42-9-260(C) and R.67-504(C) provide a mechanism for a Claimant whose temporary disability benefits have been terminated by action of § 42-9-260(B)(3) to have an Order issued reinstating benefits following a Hearing held pursuant to a request made by Claimant on a Form 15, Section III. Counsel for Claimant stipulated on the record that the sole purpose of the Hearing he had requested was to determine whether Defendants properly stopped benefits under § 42-9-260.
4. Based on the foregoing, we find that Defendants properly stopped benefits under § 42-9260 on September 12th, 2013. Defendants terminated benefits on the justification that a good faith investigation reveals grounds for the denial of the claim. See Finding of Fact # 8. This is a permissible ground for termination under the statute. See § 42-9-260(B)(3). At the time Defendants terminated Claimant's benefits on September 12th, 2013, Defendants had access to Claimant's medical records by operation of § 42-15-95 and had

knowledge of the course of Claimant's treatment through its Nurse Case Manager. See Claimant's APA Submission # 5, p. 17. It is possible for Defendants to have drawn a conclusion in good faith based on Claimant's medical records that he suffered from preexisting medical conditions unrelated to his employment that could be contributing to his current symptoms that would justify denying the claim. See e.g. Claimant's APA Submission #3, p.4 ("Discharge Diagnosis(es) ... 3. Coronary artery disease[,] ... 5. Hypertension[,] 6. Congestive heart failure."). The fact that there also exists evidence that was available to Defendants that could lead to the conclusion that Claimant's current condition is causally related to a compensable injury by accident does not lead me to conclude that Defendant's termination of benefits was improper. Claimant bears the ultimate burden of proving his claim is compensable and he has requested the Commission provide him an opportunity to do so.

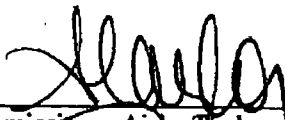
5. Specifically, Claimant has requested a Hearing on the merits of whether Claimant sustained a compensable injury by accident and is entitled to benefits by operation of the Form 50 Employee's Request for Hearing filed on October 21st, 2013. Therefore, the question of whether Claimant sustained a compensable injury by accident and is entitled to benefits under the Act will be decided by the Commission at the Hearing set pursuant to Claimant's Form 50 Request for Hearing.
6. Claimant has availed himself of all relief available under § 42-9-260 and R.67-504 and, therefore, these provisions of the Workers' Compensation Act are no longer in contention in Claimant's claim for benefits against Defendants.

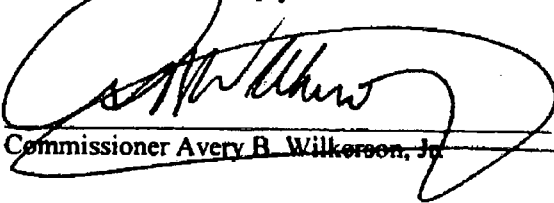
ORDER

IT IS HEREBY ORDERED that the Single Commissioner's Decision and Order is
AFFIRMED AS MODIFIED.

AND IT IS SO ORDERED.


Commissioner Melody James


Commissioner Aisha Taylor


Commissioner Avery B. Wilkerson, Jr.

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Kim Falls on July 25, 2014

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723



WCC File #: 1306305
Carrier File #: 22209963
Carrier Code #: 00475
Employer FEIN #: 510663955

Claimant's Name: Clarence Winfrey SSN: [REDACTED] Employer's Name: Archway-Services
Address: [REDACTED] Address: [REDACTED]
City: [REDACTED] State: [REDACTED] Zip: [REDACTED] City: [REDACTED] State: [REDACTED] Zip: [REDACTED]
Home Phone: [REDACTED] Work Phone: [REDACTED] Insurance Carrier: Liberty Mutual Insurance
Preparer's Name: Terri Hughes Law Firm: [REDACTED] Preparer's Phone #: 800 334 0078

Date of injury: 5/22/2013 (m/d/yyyy) Date of Notice to Employer of Injury: 5/22/2013 (m/d/yyyy)

I. Payment of Temporary Compensation Check one: ☒ Initial period ☐ Additional period ☐ Corrected compensation rate
(choose A, B, or C)

- ☒ A. Temporary Total at the compensation rate of \$426.69 per week. For this period of disability, disability began on 6/1/2013 (m/d/yyyy) and the date of first payment was 7/11/2013 (m/d/yyyy).
- ☐ B. Temporary Partial at the compensation rate of _____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on _____ (m/d/yyyy), and the date of first payment was _____ (m/d/yyyy).

Calculation of Temporary Partial Rate:

Average weekly wage before injury

-	Current weekly wage	
=	Difference in wages before injury and now	\$0.00
x	.6667	\$0.00
	Temporary Partial Compensation Rate	\$0.00

- ☐ C. Salary in lieu of Temporary ☐ Total ☐ Partial (choose one) compensation in the amount of _____ per week. For this period of disability, disability began on _____ (m/d/yyyy) and the date of first payment of salary in lieu of temporary compensation was _____ (m/d/yyyy).

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY. ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation Temporary compensation payments were stopped on 9/12/2013 (m/d/yyyy) for the following reason:

- ☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
- ☐ Claimant agrees he/she is able to return to work and has signed a Form 17.
- ☒ Based on a good faith investigation, the claim is denied. Reason for denial: Employee fails to meet the burden of a compensable injury under the SC Workers' Compensation Act.
- ☐ Claimant has been released to return to work without restrictions and employment has been offered.
- ☐ Claimant has been released to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
- ☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Terri Hughes
Signature of Claims Administrator

9/12/2013

Date (m/d/yyyy)

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15(D) ☐ Has ☐ Has not been received.

Signature of Claimant or Legal Representative

Date (m/d/yyyy)

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve Form 20 within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.

WCC Form # 15
Rev. 10/04

15

TEMPORARY COMPENSATION REPORT

000068

North Carolina Workers' Compensation Commission
1715
Street, Suite 500
Raleigh, NC 27601-1715
919-737-5723



WCC File #: 1306305
Carrier File #: 22209963
Carrier Code #: 00475
Employer FEIN #: 510663955

Claimant's Name: Clarence Winfrey SSN: [REDACTED] Employer's Name: Archway Services
Address: [REDACTED] Address: [REDACTED]
City: [REDACTED] State: [REDACTED] Zip: [REDACTED] City: [REDACTED] State: [REDACTED] Zip: [REDACTED]
Home Phone: [REDACTED] Work Phone: [REDACTED] Insurance Carrier: Liberty Mutual Insurance
Preparer's Name: Terri Hughes Law Firm: [REDACTED] Preparer's Phone #: 800 334 0078

Compensation Paid:	Number of Weeks	From (m/d/yyyy)	To (m/d/yyyy)	Amount
1. Number of Weeks T.T.	15	6/1/2013	9/14/2013	\$ 6,400.35
2. Number of Weeks T.P.				\$
3. Number of Weeks P.P.				\$
4. Disfigurement				\$
5. Agreement and Final Release				\$
Total Compensation Paid				\$ 6,400.35
6. Total Medical Benefits* Paid				\$ 2,543.47
7. Funeral Benefits				\$

☒ Case Denied

Date of Injury: 5/22/2013
(m/d/yyyy)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____
Claimant

By: Terri Hughes
Employer's Representative

9/12/2013
Date
(m/d/yyyy)

Terri Hughes

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of Additional Fees and Recoupment

A. Carrier Reimbursement by Third Party	\$
B. Attorney's Fee Paid by Employer	\$
C. Attorney's Fee Paid by Claimant (Non-contingent fees only)	\$

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. * Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within 16 days of final payment of compensation. Form 19 must be filed when a claim is denied.

WCC Form # 19
Rev. Date 3/96

19

STATUS REPORT AND COMPENSATION RECEIPT

000069

000069

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723



WCC File #: 1306305
Carrier File #: 22209963
Carrier Code #: 00475
Employer FEIN #: 510663955

Claimant's Name: Clarence Winfrey SSN: [REDACTED] Employer's Name: Archway Services
Address: [REDACTED] Address: [REDACTED]
City: [REDACTED] State: [REDACTED] Zip: [REDACTED] City: [REDACTED] State: [REDACTED] Zip: [REDACTED]
Home Phone: [REDACTED] Work Phone: [REDACTED] Insurance Carrier: Liberty Mutual Insurance
Preparer's Name: Terri Hughes Law Firm: [REDACTED] Preparer's Phone #: 800 334 0078

Date of injury: 5/22/2013 (m/d/yyyy) Date of Notice to Employer of Injury: 5/22/2013 (m/d/yyyy)

I. Payment of Temporary Compensation Check one: ☒ Initial period ☐ Additional period ☐ Corrected compensation rate
(choose A, B, or C)

- ☒ A. Temporary Total at the compensation rate of \$426.69 per week. For this period of disability, disability began on 6/1/2013 (m/d/yyyy) and the date of first payment was 7/11/2013 (m/d/yyyy).
- ☐ B. Temporary Partial at the compensation rate of _____ per week. Note: When the Temporary Partial compensation rate will vary, report the first payment here. Supplement this report throughout the period of Temporary Partial compensation by filing a Form 15S with the Form 18, which shall be filed six months after the date of injury and each six months thereafter until the file is closed. For this period of disability, disability began on _____ (m/d/yyyy), and the date of first payment was _____ (m/d/yyyy).

Calculation of Temporary Partial Rate:

Average weekly wage before injury

-	Current weekly wage	
=	Difference in wages before injury and now	\$0.00
x	.6667	\$0.00
	Temporary Partial Compensation Rate	\$0.00

- ☐ C. Salary in lieu of Temporary ☐ Total ☐ Partial (choose one) compensation in the amount of _____ per week. For this period of disability, disability began on _____ (m/d/yyyy) and the date of first payment of salary in lieu of temporary compensation was _____ (m/d/yyyy).

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF INJURY. ATTACH DOCUMENTATION AS TO THE REASON OF THE TERMINATION.

II. Termination of Temporary Compensation Temporary compensation payments were stopped on 9/12/2013 (m/d/yyyy) for the following reason:

- ☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
- ☐ Claimant agrees he/she is able to return to work and has signed a Form 17.
- ☒ Based on a good faith investigation, the claim is denied. Reason for denial: Employee fails to meet the burden of a compensable injury under the SC Workers' Compensation Act.
- ☐ Claimant has been released to return to work without restrictions and employment has been offered.
- ☐ Claimant has been released to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has been released.
- ☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator

9/12/2013

Date (m/d/yyyy)

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that the temporary compensation should not have been stopped, you may request a hearing by signing below and returning this form to SCWCC Judicial Department at the address at the top of this form. A hearing will be held within 60 days of receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15 (II) ☐ Has ☒ Has not been received.

Signature of Claimant or Legal Representative

9/17/13

Date (m/d/yyyy)

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the Form 15 on the claimant when compensation begins per R.67-211. Employer's representative must prepare and serve Form 20 within thirty days of beginning compensation per R.67-1603. Employer's representative must serve per R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termination of compensation by completing section III of the Form 15 and filing it with Judicial Department.

WCC Form # 15
Rev. 10/04

15

TEMPORARY COMPENSATION REPORT

000070

Claimant's Name: Clarence B. Winfrey, Jr. SSN: [REDACTED] Employer's Name: Archway Service, Inc.
 Address: [REDACTED] Address: [REDACTED]
 City: [REDACTED] State: [REDACTED] Zip: [REDACTED] City: [REDACTED] State: [REDACTED] Zip: [REDACTED]
 Home Phone: [REDACTED] Work Phone: [REDACTED] Insurance Carrier: American Fire & Casualty Co.
 Preparer's Name: Preston F. McDaniel Law Firm: McDaniel Law Firm Preparer's Phone #: 803-771-7211

Date of Injury or Illness: 5/22/2013

- Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I verify the contents of this form are accurate and true to the best of my knowledge.

Questions about the use of this form should be directed to the Claims Department at 803.737.5723. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615 as well as Reg. 67-1801.

50

000071

Clarence B. Winfrey, Jr. v. Archway Service, Inc.
WCC File No.: 1306305

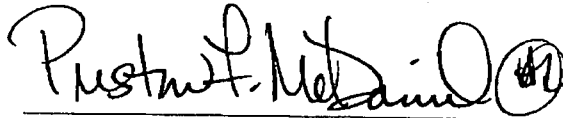
ATTACHMENT TO FORM 50 - REQUEST FOR HEARING

1. Heart, left hand/arm/shoulder, neck, head (brain), chest. System is electrical shock (all organs, members and bodily parts determined to be related).
2. While working on a rotisserie, Claimant touched a broken wire (480 volts) resulting in a severe electrical shock which entered his left hand and running through his arm, shoulder, neck, heart and chest and exiting through his heart and chest.
7. See #1 and #11.
- 10a. To be Determined
11. After the claim was immediately reported to his employer the case was accepted by the insurance carrier and compensation benefits were started and paid and medical care was authorized and provided. Approximately 120 days after the accident, on September 16, 2013, the claimant received a Form 15 notifying him that the case was being denied based on an alleged, "good faith investigation" which further stated that the claimant had failed to prove a compensable injury. Although Commission Rule 67-504 requires and provides that "shall serve two copies of the Form 15 immediately on the claimant according to Rule 67-211 with documentation attached as to the reason for termination or suspension." The claimant only received one copy of the Form 15 and no documentation was attached to that Form 15 documenting the, "good faith investigation" that was conducted. The claimant immediately has filed, and which is pending, a request to reinstate benefits for improper stop payment. However, due to the bases of the denial as being based on a good faith investigation, the claimant is filing this Form 50 requesting an Award be made by the Commission. In accordance with Rule 67-504 and Statute, SC Code §42-17-10, the defendants had accepted this case and agreed to pay compensation, this is enforceable as it becomes an Order of the Commission. However, due to the defendants' position and bases for denying this claim,

the claimant is filing this Form 50 for such determination. If the Commission finds after Hearing that the defendants have engaged in a frivolous defense, claimant would request that penalties and fines and hearing costs be assessed and that this matter be referred for further proceeding under the Frivolous Proceedings Act, depending on the issues that are raised as the defense in the response to Form 51, under SCRPC Rule 11 and the Frivolous Proceedings Act SC Code §15-36-10 particularly with the information available to the defendants at the time of this filing of this Form 50.

11a. Lexington Medical Center, Lexington, SC; Doctor's Care, Irmo, SC; Dr. Jeffrey A. Travis, Lexington Cardiovascular Surgery, West Columbia, SC; Dr. Lanneau Lide, Dr. Himadri Dasgupta, SC Heart Center, Columbia, SC.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "Preston F. McDaniel", followed by a circled number "11".

Preston F. McDaniel
Attorney for the Claimant

October 21, 2013

CERTIFICATE OF SERVICE BY MAIL

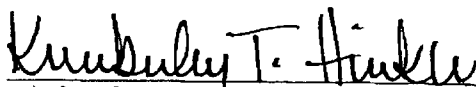
WCC FILE NO. 1306305

I hereby certify that I have on this day served the following in the matter of Clarence B. Winfrey, Jr. v. Archway Service, Inc. with a copy of the **FORM 50 - REQUEST FOR HEARING** by depositing the same in the United States Mail, with adequate postage thereon, addressed as follows:

Virginia L. Crocker, Judicial Director
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

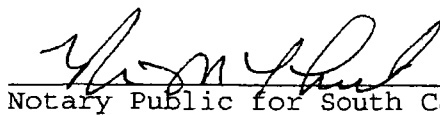
Landon L. Hughey, Esquire
Brett H. Bayne, Esquire
McAngus, Goudelock & Courie
Post Office Box 12519
Capitol Station
Columbia, SC 29211-2519

I also hereby certify that a regular communication by mail exists.



Kimberley T. Hinkle
Paralegal to Preston F. McDaniel

SWORN TO BEFORE ME this
21 day of OCTOBER 2013.

 (L.S.)
Notary Public for South Carolina

My Commission Expires: 1/21/14

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803)737-5723 www.wcc.sc.gov



WCC File #: 1306305
Carrier File #: 22209963
Carrier Code #: 00475
Employer FEIN #: 510663955

Claimant's Name: Clarence Winfrey SSN [REDACTED] Employer's Name: Archway Services Inc
Address: [REDACTED] Address: [REDACTED]
Home Phone: [REDACTED] Work Phone #: [REDACTED]
Date of Injury: 5/22/13 Insurance Carrier: American Fire & Casualty Insurance Company c/o Liberty Mutual Group
Preparer's Name: Landon Hughey Law Firm: McAngus Goudelock & Courie Preparer's Phone #: (803) 227-2261

Date of Injury or Illness: 5/22/13 Estimated time for hearing: 1 hour

Complete each information blank. Clearly specify when contentions are admitted in part and denied in part. The Employer-Carrier in answer to the claim, respectfully shows:

1. It is ☐ Admitted ☒ Denied the employee sustained an injury or illness on or about the date set forth in the application. The reasons for denial are: Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the Act.
2. It is ☒ Admitted ☐ Denied both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are:
3. It is ☒ Admitted ☐ Denied the relationship of employer and employee existed at the time in question. The reasons for denial are:
4. It is ☒ Admitted ☐ Denied at the time in question the employee was performing service arising out of and in the course of employment. The reasons for denial are:
5. It is ☐ Admitted ☒ Denied notice of injury was given the employer. The reasons for denial are: Claimant notified his employer of the alleged accident giving rise to the alleged injury. However, Claimant failed to report prior to surgery any chest pain or related chest injury.
6. It is ☐ Admitted ☒ Denied the employee ☐ needs ☐ is entitled to additional medical care as a result of injury or illness. The reasons for denial are: Claimant has failed to meet his burden of proving a compensable injury by accident within the course and scope of his employment. Defendants do not deny that if this claim is found to be compensable, Claimant is in need of additional medical care.
7. It is ☐ Admitted ☒ Denied the employee is entitled to temporary total disability for the period(s) of:
8. It is ☐ Admitted ☒ Denied the employee is permanently disabled. The reasons for denial are:
9. It is ☐ Admitted ☒ Denied the employee has serious disfigurement.
10. It is contended that an average weekly wage of \$ 663.57 applies, according to attached Form 20 as provided by law.
11. Further contentions, grounds of defense, or unusual aspects are: S.C. Code Ann. §§42-9-10, 42-9-20, 42-9-30, 42-9-303. All additional defenses available under the Act.

☐ Mediation

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67.1801. **NOV 19 2013**
- ☐ b. Mediation is required pursuant to Reg. 67.1802. **FRONT DESK**
- ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67.1803.
- ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I verify the contents of this form are accurate and true to the best of my knowledge.

B. W. B. Attorney for Employer/Carrier rhughey@mcgaw.com
Preparer's Signature Title Email

November 19, 2013
Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Refer to R. 67-1801 for mediation. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

WCC Form # 51
Revised 7/13

51

Employer's Answer to Request for Hearing

000075

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1306305

CLARENCE WINFREY,

Employee,

Claimant,

vs.

ARCHWAY SERVICES INC,

Employer,

AND

AMERICAN FIRE & CASUALTY
INSURANCE COMPANY C/O LIBERTY
MUTUAL GROUP,

Carrier,

Defendants.

CERTIFICATE
OF
SERVICE

The undersigned certifies that she is an employee at MCANGUS GOUDELOCK & COURIE, and that she has served, on the date set forth below, a copy of the document described below, in the above entitled action to the following persons, pursuant to Section 15-9-930 and Section 15-9-940 of the Code of Laws of South Carolina, 1976, by depositing a copy of same in the United States Mail, postage prepaid, addressed to:

TO: Preston F. McDaniel, Esquire
The McDaniel Law Firm
1315 Elmwood Avenue
Columbia, South Carolina 29201

South Carolina Worker's Compensation Commission
1333 Main Street, Suite 500 · Post Office Box 1715
Columbia, South Carolina 29202-1715
VIA HAND DELIVERY

DOCUMENT: Form 51

DATE OF MAILING: November 19, 2013


Susan Gosman

Legal Assistant to Landon Hughey

000076

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723



WCC File #: 1306305
Carrier File #: NRCF20130612
December 6, 2013

NOTICE OF HEARING

Clarence Winfrey v. Archway Service, Inc.

Subject: To determine issues as set forth on Forms 50 and 51.
Date: January 13, 2014 at 08:30 AM
Location: SC Workers' Compensation Commission, 1333 Main Street, Suite 500, Hearing Room A
Columbia, SC 29202

South Carolina Regulations 67-601 through 67-615 govern hearings before the South Carolina Workers' Compensation Commission. The claimant must attend when not represented by an attorney or when disfigurement is involved. Corporations must be represented by an attorney, and uninsured employers must attend.

Attorneys must file a Form 58 with proof of service pursuant to Regulation 67-611. Postponements are only granted pursuant to Regulation 67-613. Please visit www.wcc.sc.gov/Commissioners to view Commissioners' Preferences. If you have questions regarding this matter, please contact the office of the undersigned Jurisdictional Commissioner.

Commissioner Susan S. Barden
803-737-5660, klove@wcc.sc.gov

CERTIFICATE OF SERVICE - This is to certify the undersigned has served this notice in the above entitled action upon all parties to this cause by sending a copy hereof by electronic mail or United States mail.

By: Kristi L. Love, SC Workers' Compensation, December 6, 2013

Party

Employee: Clarence Winfrey

Employer: Archway Service, Inc.
Carrier: American Fire & Casualty Co

Employer: Archway Service, Inc.
Carrier: American Fire & Casualty Co

Attorney

Preston F. McDaniel
mcdaniellaw@hotmail.com
803-771-7211

Landon L. Hughey (5)
lhughey@mgclaw.com
803-779-2300

Brett Harris Bayne (5)
brett.bayne@mgclaw.com
803-227-2281

RECEIVED
DEC 05 2013

BY:

PHB due:
1/13/14

000077

McDANIEL LAW FIRM
ATTORNEYS AND COUNSELORS AT LAW
1315 ELMWOOD AVENUE
COLUMBIA, SOUTH CAROLINA 29201

Proudly representing injured workers
for over 25 years.

Preston F. McDaniel
Justin S. Byars
Matthew Robertson
OF COUNSEL:
Michael Johnson, P.C.

Telephone (803) 771-7211

Facsimile (803) 252-0709

December 23, 2013

Commissioner Susan S. Barden
SC Workers Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

RE: Clarence B. Winfrey, Jr. v. Archway Service, Inc.
WCC File No.: 1306305

Dear Commissioner Barden:

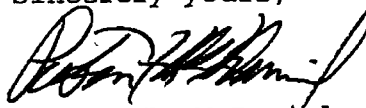
Please find enclosed a copy of the Claimant's Pre-Hearing Brief in the above referenced matter.

By copy of this letter, with enclosures, we are forwarding a copy of our Pre-Hearing Brief and APA submissions to opposing counsel on this date.

I hope this is sufficient for filing this matter with the Commission. However, if additional information is needed, please feel free to contact me at your convenience.

I look forward to seeing you at the hearing and to a resolution in the best interest of all parties concerned.

Sincerely yours,



Preston F. McDaniel

PFM/kth
Enclosures

cc: Landon L. Hughey, Esquire
Brett H. Bayne, Esquire

000078



Claimant's Name: Clarence B. Winfrey, Jr. Employer's Name: Archway Service, Inc.
Address: [REDACTED] Address: [REDACTED]
City: [REDACTED] State: [REDACTED] Zip: [REDACTED] City: [REDACTED] State: [REDACTED] Zip: [REDACTED]
Home Phone: () - Work Phone: () - Carrier: American Fire & Casualty Co.
Preparer's Name: Preston F. McDaniel Preparer's Phone #: (803) 771-7211

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$442.40 (See Attached) 2. AWW: \$663.57 Date of Injury: 05/22/2013
3. Type of injury and body part(s): Heart, left hand/arm/shoulder, neck, head (brain), chest. System is electrical shock (all organs, members and bodily parts determined to be related).
4. Facts in controversy: See Attachment.
5. Legal issues involved: See Attachment.
6. Unusual aspects: See Attachment.
7. Witnesses (designate if expert):* See Notice of Witnesses.
8. Exhibits: Claimant requests that WCC File No. 1306305 be made a part of the Record. See Notice of Witnesses and APA Submissions. Adjuster's file while ordered to be produced has not been received- employer/ carrier records may be submitted.
9. Medical evidence (Indicate report pursuant to R.67-612; deposition or appearance):
See Notice of Written Reports/Physicians.
10. Name, address, and specialty, if any, of the treating physician: See Attachment.
11. Impairment rating(s); body part(s); physician and date of opinion:
12. I am amending my Form 50/51 in the following manner:

☐ **Mediation**

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐ b. Mediation is required pursuant to Reg. 67-1802.
☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I verify the contents of this form are accurate and true to the best of my knowledge.

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to SEE ATTACHED CERTIFICATE OF SERVICE on the day of 20 by: ☒ first class postage ☐ certified mail ☐ personal service.

Signature: [Signature] Email: mdaniellaw@hotmail.com
Date of hearing: January 13, 2013 Time needed for hearing: 1.0 hour

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67-1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. * Commissioners reserve the right to admit expert witnesses at hearings.

ATTACHMENT TO FORM 58

Clarence B. Winfrey, Jr. v. Archway Service, Inc.
WCC FILE NO: 1306305

1. The Claimant has not requested a documentation nor has he investigated the compensation rate and reserves the right to have that corrected/addressed at a later date. However, the compensation rate of \$442.40 is the compensation rate at which the carrier initiated compensation and at which Mr. Winfrey was paid benefits until September 13th when the Claimant's attorney's office was verbally advised, followed by a written notice in the form of a Form 15(III) on the 16th which terminated his benefits. He therefore agrees to this compensation rate for the purposes of this hearing reserving the right to have it reviewed/adjusted at a later date.

In support of this position the Claimant was hired at \$15.00/hr. to work 40+ hours per week was raised to \$16.00/hr and was paid overtime for all work over 40 hours. He was paid from the time that he would leave his home until the time that he would return. In addition, he was required to work (be on call) every other weekend. A review of the Form 20 submitted to the Commission will establish that there was a steady increase of his income in ever quarter he was with the company (only 3) wherein his last quarter of employment prior to the injury in the amount of \$9,655.52 reflects a \$3,600.00 increase in his salary from the starting quarter that he started employment. Based on his last quarter of employment, his average weekly wage would be \$742.73, resulting in a compensation rate of \$495.18

4a. Facts in controversy:

Whether the Claimant sustained injury by accident - the facts will establish that on May 22nd, 2013, while working on a rotisserie, Claimant touched a broken wire (480 volts) resulting in a severe electrical shock which entered his left hand running through his left arm, shoulder, neck, heart and chest and entering and exiting through his heart and chest.

This claim was originally accepted, (although a Form 15 was not properly and timely filed for which the Defendants have been fined), and benefits were paid from the date of the injury through Friday, September 13th when Claimant's Counsel was verbally advised that the defendants

were stopping payments, "allegedly" based on a good faith investigation. That verbal notice was followed by a Form 15 stopping benefits on the same basis which was received on September 16th. While to the knowledge of the Claimant the Defendants did not contact any of the authorized treating physicians to determine their opinion, subsequent to the stopping of benefits all treating physicians have stated their opinions to a reasonable degree of medical certainty that the Claimant's problems in relation to his heart and all other bodily parts named in the Form 50 are related to his electrical shock. Further, in reference to his heart his authorized treating surgeon has stated that the Claimant sustained a direct entry and exit wound to his heart which killed part of tissue throughout the Claimant's heart and which resulted in all of the other problems with his heart.

- b. The Claimant would submit that the evidence establishes that he has sustained a compensable injury and is entitled to reinstatement of temporary compensation benefits from the date that those benefits were stopped and continuing until the Claimant reaches maximum medical improvement or as otherwise ordered by this Commission.
 - c. Medical care from the date that medical care was stopped being authorized and continuing until the Claimant reaches maximum medical improvement and/or further order of this Commission.
5. Legal issues involved:

IN CORRELATION WITH RESPONSES UNDER NUMBER 4:

- a. S.C. Code §42-1-160 injury by accident. The facts establish that the Claimant sustained injury by accident arising out of an in the course of his employment. Layton v. Hammond Brown-Jennings, 190 S.C. 425, 3 S.E.2d 492 (1939), Colvin v. E.I. DuPont De Nemours Co. 227 S.C. 465, 88 S.E.2d 581 (1955); Stokes v. First National Bank, 306 S.C. 46, 410 S.E.2d 248 (1991). While the Defendant's allege that the Claimant did not sustain compensable injury as defined in the Act, the Defendant's appear to not question the fact that he suffered an electrocution injury or that it affected certain parts of his body but only that the Claimant's heart problems have not been proved to be compensable under the Act. While most reported cases in reference to the heart deal with work conditions there are a few that deal with specific work

events/accidents, and if a heart attack or other heart related condition results directly from the physical injury then it is compensable under the Act. See for example: Buff v. Columbia Baking Company, 215 S.C. 41, 53 S.E.2d 879 (1949), Walker v. City of Columbia, 247 S.C. 241, 146 S.E.2d 856 (1966). That has never been questioned and in addition any heart condition or cardiovascular problem constitutes compensable injury by accident if it is induced by unexpected strain or overexertion in the performance or the duties of the Claimant's employment (physical injury) or as a result of unusual and/or extraordinary conditions in the employment. Kearse v. S.C. Wildlife Resources Dept., 236 S.C. 540, 115 S.E.2d 183 (1960). The right to compensation is not effected by the fact that the unusual or excessive strain or work event which participates the heart condition occurs while the employee is performing work of the same general type as that in which he was regularly involved. McWhirter v. S.C. Dept. of Insurance, 252 S.C. 90, 165 S.E.2d 365 (1969); Second Injury Fund v. Liberty Mutual Ins. Co. 353 S.C. 117, 576 S.E.2d 199 (S.C. App 2003).

- b. The Claimant's entitlement to temporary total disability benefits as provided in §42-9-10 and §42-1-120 which defines disability from the date that such benefits were stopped until further order of the Commission:
 - c. The Claimant's entitlement to medical care as provided for in §42-15-60.
6. The Defendant's stopped payment in this case without a Hearing on 9/13/13 with a Form 15 being served on the Claimant on 9/16/13. The Defendant's started benefits following the injury on 5/23/13 and authorized medical care from that date forward, but no Form 15 was filed with the Commission. S.C. Code §42-9-260 is very specific and it is a mandatory requirement that the Defendant's must file a Form 15 immediately upon starting benefits. This was not done in this case nor was this issue addressed by the Hearing Commissioner in the Form 15 III Hearing Order.

Subsection "G" of that same Code section makes specific, strict and complete compliance with that Code section mandatory and imposes penalties and the reinstatement of benefits and medical care if it is not complied with in any regard. In the case of Martin v. Rapard City Plumbing Company, the Court of Appeals specifically held that the provisions of the Act are

mandatory and that strict compliance with that statute is required for the defendants to be entitled to the benefits of that Code section. The Claimant would submit that since the Defendants failed to comply with the provisions of the section and that they should be barred from now denying the claim or attempting to deny the claim.

Further, the Defendants have had a Records review performed by a Doctor and the Claimant objects to any opinion or report being submitted into evidence from that doctor. All of the specific bases for the objection will be made clear at time of the Deposition taken of this Doctor, which will be taken for the purpose of cross examination of the Physician, pursuant to the Claimants right to do so under §1-23-330, (3) and subsequently at the Hearing.

8. Medical records of: Dr. Jeffery Travis, Lexington Cardiovascular Surgery; Dr. Lanneau Lide, Dr. Himadri Dasgupta, South Carolina Heart Center; Dr. Karen Greenfield, Doctors Care; Lexington Medical Center. In addition to the medical records the Depositions of Doctors Jeffery Travis, Lanneau Lide, Karen Greenfield will be made a part of the Record. The cross-examination deposition of Dr. Barry J. Feldman will be submitted if records from him are allowed into the Record.
10. Dr. Jeffery Travis, Lexington Cardiovascular Surgery; Dr. Lanneau Lide, Dr. Himadri Dasgupta, South Carolina Heart Center; Dr. Karen Greenfield, Doctors Care; Lexington Medical Center.

Respectfully Submitted,



Preston F. McDaniel
Attorney for Claimant

December 23, 2013

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC File No: 1306305

Clarence B. Winfrey, Jr.)

Employee-Claimant,)

v.)

Archway Service, Inc.)

as Employer, and)

American Fire & Casualty Co.)

as Carrier,)

Defendants.)

NOTICE OF WITNESSES AND
WRITTEN REPORT(S)/PHYSICIAN
OR OTHER EVIDENCE TO BE
INTRODUCED ON BEHALF OF
CLAIMANT

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
ATTORNEY FOR THE EMPLOYER/CARRIER

YOU ARE HEREBY NOTIFIED THAT THE Claimant, Clarence B. Winfrey, Jr., pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), herewith submits the following reports/physician or other evidence on behalf of the Claimant, to wit:

NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE	DATE OF REPORT(S)	PAGE #
1) Dr. Jeffrey A. Travis Lexington Cardiovascular Surgery	05/29/13-09/30/13	1-22
2) Dr. Lanneau Lide Dr. Himadri Dasgupta SC Heart Center	05/28/13-10/04/13	23-64
3) Dr. Karen Greenfield Doctor's Care	05/28/13-09/17/13	65-74
4) Lexington Medical Center	05/28/13-06/07/13	75-77
5) Employer Records	05/23/13-09/23/13	78-81

6) Kristy Thompson
RN, BA, BS, BSN
Case Manager Records

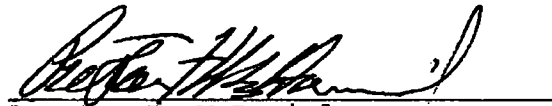
06/26/13-07/18/13

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Claimant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Claimant: the Claimant; Ms. Kristy Thompson, RN, BA, BS, BSN. any witness listed, named or called by the Defendants; and other lay witnesses to be named.

Respectfully submitted,



Preston F. McDaniel
McDaniel Law Firm
1315 Elmwood Avenue
Columbia, SC 29201
803-771-7211

12/23, 2013

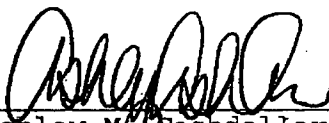
CERTIFICATE OF SERVICE BY MAIL

WCC File No. 1306305

I hereby certify that I have on this day served the following in the matter of Clarence B. Winfrey, Jr. v. Archway Service, Inc. with a copy of the CLAIMANT'S PRE-HEARING BRIEF, NOTICE OF WITNESSES AND WRITTEN REPORTS(S)/PHYSICIAN OR OTHER EVIDENCE, AND APA SUBMISSIONS WITH ENCLOSURES by depositing the same in the United States Mail, with adequate postage thereon, addressed as follows:

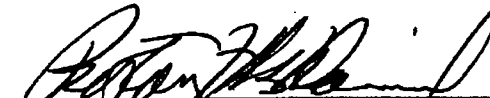
Commissioner Susan S. Barden
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

Landon L. Hughey, Esquire
Brett H. Bayne, Esquire
McAngus, Goudelock & Courie
Post Office Box 12519
Capitol Station
Columbia, SC 29211-2519



Ashley M. Cashdollar
Legal Assistant

SWORN TO BEFORE ME this
23~~rd~~ day of December, 2013.



(L.S.)
Notary Public for South Carolina
My Commission Expires: 10/28/18

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC FILE NO: 1306305

Clarence B. Winfrey, Jr.)
Employee-Claimant,)

v.)

Date of Hearing: 1-13-2014

Archway Service, Inc.)
As Employer, and)
American Fire & Casualty Co.,)
as Carrier,)
Defendants.)

APA SUBMISSIONS

Pursuant to South Carolina Code §1-23-330 and Commission Rule 67-612 Preston F. McDaniel, the Attorney for the Claimant, submits the following report(s) in support of and on behalf of the Claimant in this matter:

<u>NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE</u>	<u>DATE OF REPORT(S)</u>	<u>PAGE #</u>
1) Dr. Jeffrey A. Travis Lexington Cardiovascular Surgery	05/29/13-09/30/13	1-22
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5) Employer Records	05/23/13-09/23/13	78-81
6) Kristy Thompson RN, BA, BS, BSN Case Manager Records	06/26/13-07/18/13	82-89





Jeffrey A. Travis, MD

Victor A. Gomez, PA-C

2728 Sunset Boulevard, Suite 101
West Columbia, SC 29169
www.lexingtoncardiovascular.com

Ph (803) 936-7095
Fx (803) 936-7908

 Lexington Medical Center

September 30, 2013

Re: Clarence Winfrey

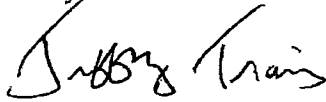
To Whom It May Concern:

Mr. Winfrey is a patient who presented with a very unusual cardiac lesion after suffering a large electrical shock. The lesion, a ventricular septal defect, is normally only seen very rarely in a setting of an acute myocardial infarction. I believe that Mr. Winfrey's electrical shock caused his heart attack and his ventricular septal defect.

Operative photos confirm a large white patch on both sides of his heart that were almost certainly entrance and exit wounds of the electricity. I have never seen anything like these patches in my 15 years of surgery. I have a photo of the anterior surface of the heart that demonstrates either the entrance or exit site.

I find it quite unbelievable that his surgery and postoperative course have been considered separate from his electrical injury at work. I see almost no other plausible explanation other than a direct cause and effect.

Sincerely,



Jeffrey A. Travis, MD

Kim Hinkle

From: Thompson, Kristy <Kristy.Thompson@genexservices.com>
Sent: Tuesday, October 01, 2013 5:36 PM
To: kim@pfmcdlaw.com
Subject: Fwd: Clarence Winfrey
Attachments: Clarence Winfrey 10.1.13.pdf, ATT00001.htm

Hi Kim,

Not sure if you got this.

Sent from my iPhone, please excuse any typos.

Begin forwarded message:

From: "Thompson, Kristy" <Kristy.Thompson@genexservices.com>
Date: October 1, 2013 at 3:11:43 PM EDT
To: "Terri.Hughes@LibertyMutual.com" <Terri.Hughes@LibertyMutual.com>
Subject: Clarence Winfrey

Hi Terri,

I am including a letter that was faxed to me from Dr. Travis regarding Mr. Winfrey, not sure if they sent it to you as well.

Kristy L. Thompson, RN, BA, BSN
Medical Case Manager
GENEX Services Inc.
(C) 803-210-5279
(F) 803-834-6102 Please note new fax number

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PAGES

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SEP-30-2013 14:25

From: 803-936-7908

Page: 1/2



Lexington Cardiovascular SURGERY

A Lexington Medical Center Physician Practice

Jeffrey A. Travis, MD

Victor A. Gomez, PA-C

FAX Cover Sheet

Lexington Medical Park 1

2728 Sunset Blvd., Suite 1011 West Columbia, SC 29169

phone: (803) 936-7095 | fax: (803) 936-7908

www.lexingtoncardiovascular.com

Date:

9-30-13

Attention:

Kristy Thompson

Company:

Genex

Fax #:

1-866-268-3974

Telephone #:

Your

Reference #:

From:

Dr. Travis

Company:

LCVS

Fax #:

803-936-7908

Telephone #:

803-936-7095

Sender's

Reference #:

☐ Urgent

☒ For Review

☐ Please Recycle

☐ Please Comment

☐ Please Reply

Number of Pages

(including this page)

2

Comments:

Re: Clarence Winfrey
Claim #: 22209963

Genex #: ONG-N45

Employer: Archway Service

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Jeffrey A. Travis, MD

Victor A. Gomez, PA-C

2728 Sunset Boulevard, Suite 101
West Columbia, SC 29169
www.lexingtoncardiovascular.com

Ph (803) 936-7095
Fx (803) 936-7908
Lexington Medical Center

September 30, 2013

Re: Clarence Winfrey

To Whom It May Concern:

Mr. Winfrey is a patient who presented with a very unusual cardiac lesion after suffering a large electrical shock. The lesion, a ventricular septal defect, is normally only seen very rarely in a setting of an acute myocardial infarction. I believe that Mr. Winfrey's electrical shock caused his heart attack and his ventricular septal defect.

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I find it quite unbelievable that his surgery and postoperative course have been considered separate from his electrical injury at work. I see almost no other plausible explanation other than a direct cause and effect.

Sincerely,

Jeffrey A. Travis, MD



Lexington Cardiovascular SURGERY

A Lexington Medical Center Physician Practice

Lexington Cardiovascular Surgery
2728 Sunset Boulevard
West Columbia, SC 29169
(803) 936-7095

Patient: CLARENCE WINFREY

DOS: 07/16/2013

DOB: [REDACTED]

Gender: M

MR#: 1238100

Provider: Jeffrey A. Travis M.D.

Vitals

Vital Signs [Data Includes: Current Encounter]

Recorded by: at 16Jul2013 12:55PM

Height: 5 ft 11 in
Weight: 225 lb
BMI Calculated: 31.5
BSA Calculated: 2.21
Blood Pressure: 77/60, LUE, Sitting
Respiration: 26
Heart Rate: 84
Temperature: 98.3 F, Oral

Chief Complaint

3 wk f/u
s/p CABG

Current Meds:

1. Amiodarone HCl - 400 MG Oral Tablet; TAKE 1 TABLET TWICE DAILY FOR 3 MONTHS;
Therapy: 13Jun2013 to Recorded
2. Aspirin 81 MG Oral Tablet; TAKE 1 TABLET DAILY;
Therapy: 13Jun2013 to Recorded
3. Hydrocodone-Acetaminophen 5-500 MG Oral Tablet (Lortab 5-500 MG Oral Tablet); TAKE 1 TABLET EVERY 4 TO 6 HOURS AS NEEDED;
Therapy: 13Jun2013 to (Evaluate: 12Jul2013); Last Rx: 05Jul2013 Ordered
4. Lasix 80-MG Oral Tablet; TAKE 1 TABLET TWICE DAILY;
Therapy: 16Jul2013 to Recorded
5. Metoprolol Tartrate 25 MG Oral Tablet; Take 2 tablets twice daily;
Therapy: 13Jun2013 to Recorded
6. Pepcid 20 MG Oral Tablet; TAKE 1 TABLET TWICE DAILY;
Therapy: 13Jun2013 to Recorded
7. Plavix 75 MG Oral Tablet; TAKE 1 TABLET DAILY;
Therapy: 13Jun2013 to Recorded
8. Ramipril 2.5 MG Oral Capsule (Altace 2.5 MG Oral Capsule); TAKE 1 CAPSULE DAILY;
Therapy: 13Jun2013 to (Evaluate: 01Jan2014); Last Rx: 05Jul2013 Ordered
9. Vitamin C 500 MG Oral Capsule; Take 1 capsule twice daily;
Therapy: 16Jul2013 to Recorded

Allergies

Medication

1. Allergy History Not Known

History of Present Illness

The patient returns today in followup of his VSD repair and one-vessel CABG. He had some complaints of lower

Date of Service: 07/16/2013
Patient Name: CLARENCE B. WINFREY
Patient DOB: [REDACTED]
MR#: 1238100
Gender: M
Provider: Jeffrey A. Travis M.D.

extremity swelling. He saw his cardiologist on Monday. They gave him some Lasix and he states he has lost 18 pounds for 24 hours and has not stopped urinating. He is mildly hypertensive here today and says he does not feel great because he has not slept.

Results/Data

All Results (Data Includes: Last 1 Week)

No recent results

His echo from Monday is essentially unchanged from when he was in the hospital. VSD appears closed. He has about a 30% ejection fraction.

Physical Exam

VITALS: are reviewed and as noted.
GENERAL APPEARANCE: benign and appropriate.
HEENT: benign.
NECK: no JVD.
CARDIAC: regular rate and rhythm.
CHEST: is clear.
ABDOMEN: is benign.
EXTREMITIES: no edema.
INTEGUMENT: all of the surgical wounds were examined. The sternum is tight; there are no pops, clicks or rubs. The incision is clean and dry and shows no signs of infection. There is no drainage or cellulitis noted. The saphenectomy site is healing perfectly and the leg is soft with no palpable hematomas or seromas within the endoscopic tunnel.

Assessment

Assessed

1. History of CABG (CABG)
2. Ventricular septal defect (745.4)

Plan

Overall patient is doing reasonably well. He asked him to hold his Lasix tonight as well as his Lopressor tonight. He will do both of those x1. He like the pain the labs drawn from his cardiologist. He also like to review the echo. He is doing well from a surgical standpoint. Cardiologist is contemplating an AICD pacemaker. There are going to see him again on Thursday to recheck him. I will see him again in one month.

Signatures

Electronically signed by : Jeffrey Travis, M.D.; Jul 16 2013 1:22PM EST



**Lexington
Cardiovascular
SURGERY**

A Lexington Medical Center Physician Practice

Lexington Cardiovascular Surgery
2728 Sunset Boulevard
West Columbia, SC 29169
(803) 936-7095

Patient: CLARENCE WINFREY
153 ARTIC CT
COLUMBIA, SC 29212

DOS: 07/16/2013

DOB: [REDACTED]

Gender: M

MR#: 1238100

Provider: Jeffrey A. Travis M.D.

CLARENCE WINFREY
[REDACTED]

Jul 16, 2013

Re: Mr. CLARENCE WINFREY

To Whom It May Concern:

The above named patient was in my office on Jul 16, 2013. For medical reasons, it is advised that this patient be out of work until further notice due to his open heart surgery that was done on May 29, 2013.

If you should have any questions, please feel free to contact my office at the number listed above.

Sincerely,

Dr. Jeffrey Travis

Electronically signed by : Ashlynn Wells, ; Jul 16 2013 1:17PM EST

From: LexCard Lide, MC

Received 07/16/2013 09:45AM in 03:19 on Line [8] for LEXCARDIOVASCULAR * Pg 2/4
To: Travis, Jeffrey A, MD 716/2013 9:46:53 AM

Page 2 of 3

Providence Hospital
2001 Laurel St
Columbia SC 29204PROVIDENCE HOSPITALS
A Ministry of the Society of Christy Health Systems

Phone: 803-254-3278 Fax: 803-376-8010

ECHOCARDIOGRAPHY REPORT

Name: CLARENCE WINFREY ID # 9112
 Age/Sex: 50.91/M Date of Service: 7/16/2013 7:45:25 AM
 DOB: 8/19/1962 B/P 128/80 mmHg
 Ht: 71.00 in Ref MD: LDL
 Wt: 230.00 lb BSA: 2.24

Technologist: KLE

Technical quality: Technical quality of the study is suboptimal due to poor acoustic window which may affect data interpretation.

Procedure: 2D/Mode Echo - 93307, Cardiac Doppler - 93320 and Color Flow Imaging - 93325.

Diagnosis: MI; CABG; VSD REPAIR

4-Mode		Normal			Normal
IVSd		0.6-1.2 cm	RVID		<3.0 cm
LVPWd		0.6-1.2 cm	Ao root	3.36 cm	3.0-3.7 cm
LVIDd		3.5-5.6 cm	LA	4.21 cm	1.5-4.0 cm
LVIDs			FS%		
2D		Normal			Normal
IVSd	1.33 cm	0.6-1.2 cm	RVID		<3.0 cm
LVPWd	1.06 cm	0.6-1.2 cm	Ao root		3.0-3.7 cm
LVIDd	4.97 cm	3.5-5.6 cm	LA		1.5-4.0 cm
LVIDs	3.65 cm		FS%	26.6 %	
AV					
LVOT diameter		Peak Grad		AR PL/2 time	
V1		Mean Grad			
V2		AVA			
Pulmonary Pressure			Diastolic Function		
TR Vmax			MV DT		
TR Pk (cm/s)			E velocity		
RA Pressure	10 mmHg		E velocity	0.77 m/s	
RVSP					

Echocardiographic Findings:

Left Ventricle: Normal left ventricular size and severely decreased systolic function. Estimated EF 30%. The apical segment of the left ventricle was hypokinetic. The mid to apical inferior segment of the left ventricle was akinetic and aneurysmal. The apical inferoseptal segment of the left ventricle was dyskinetic. Normal diastolic function. VSD patch stable.

Right Ventricle: Normal right ventricular size with normal systolic function.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is normal in size.

Mitral Valve: The mitral valve is structurally normal. Mild mitral annular calcification. No mitral stenosis. Mild to moderate regurgitation. The jet is posteriorly-directed.

Aortic Valve: The aortic valve is structurally normal. No aortic stenosis. No regurgitation.

Page 1 of 2

Final

From: Lexington Cardiovascular Surgery - (803) 7095

RECEIVED 07/23/2013 16:49
Page 6 of 10

Sent On: 04:37 PM, Tuesday, July 23, 2013

Received 07/16/2013 09:45AM in 03:19 on Line [8] for LEXCARDIOVASCULAR * Pg 3/4

From: Lannan Lide, MD

Received 07/16/2013 09:45AM in 03:19 on line [8] for LEXCARDIOVASCULAR * Pg 4/4
To: Travis Jeffery A, MD 7/16/2013 9:48 25 AM

Page 3 of 3

CLARENCE WINFREY

9112

Pulmonic Valve: The pulmonic valve is structurally normal. Trace regurgitation.
Tricuspid Valve: The tricuspid valve is structurally normal. Trace tricuspid regurgitation.
Pericardium/Extracardiac: No pericardial effusion.

Conclusions:

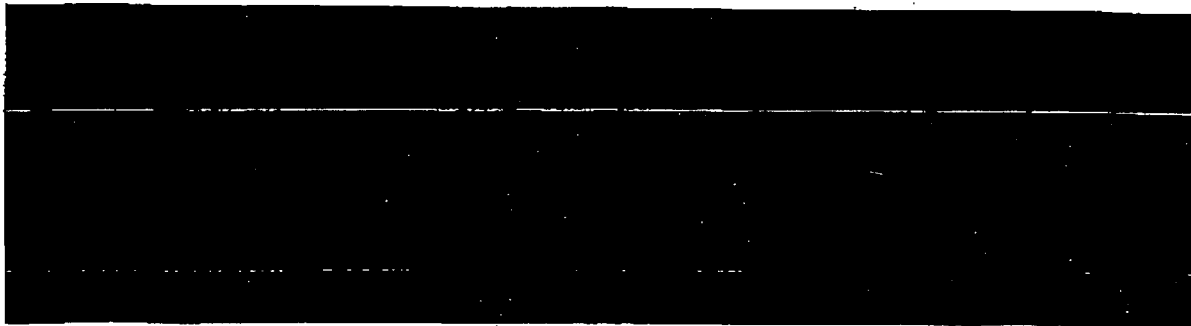
1. Technical quality of the study is suboptimal due to poor acoustic window which may affect data interpretation.
2. Normal left ventricular size and severely decreased systolic function.
3. Estimated EF 30%.
4. The apical segment of the left ventricle was hypokinetic.
5. The mid to apical inferior segment of the left ventricle was akinetic and aneurysmal.
6. The apical inferoseptal segment of the left ventricle was dyskinetic.
7. Mild to moderate mitral regurgitation.
8. No VSD apparent.

Electronically signed by: Lannan Lide MD Date: 7/16/2013 at 9:45:01 AM

cc: Jeffery A Travis MD/IV Department/HIMS TouchChart

Page 2 of 2

Final



SCHC

Received 07/19/2013 09:12AM in 01:27 on line [3] for LEXCARDIOVASCULAR * Pg 2/2
7/19/2013 9:12:05 AM PAGE 2/002 Fax Server

7/17/13 07:04AM PITTSPAD South Carolina Heart Center R082184580 PR 1/2



South Carolina Heart Center
2001 Laurel St
Columbia 29204
Phone: (803) 254-3278

Name: CLARENCE WINFREY Exam Date: 7/15/2013
Patient ID: SCHC112 Exam: Chest (PA only)
DOB: [REDACTED] Reason:
Phone: Refactor: Lumboldt Ltd. Jr. M.D.
Acct: 190663 Referrer 2: South Carolina Heart Center

Results

AP CHEST

INDICATION: Shortness of breath.

FINDINGS: The cardiac silhouette is enlarged. There is diffuse, fairly dense airspace opacity throughout the right lung, most notably in the lower lobe. On the left side, there is blurring and opacification of the left base suggesting a small effusion and adjacent collapse or consolidation of the lower lobe. There is no pneumothorax. There is evidence of prior pleurotomy. There is no acute osseous finding.

IMPRESSION: Extensive opacity throughout the right lung suggesting diffuse pneumonia on that side. There is also a left effusion and adjacent lower lobe collapse.

Douglas M. McConnell, M.D.
Radiologist
PITTS RADIOLOGY

Report Electronically Signed by: Douglas McConnell M.D.
Expert Signed on: 7/17/2013

PL Name:	CLARENCE WINFREY	Exam:	Chest (PA only)
Patient ID:	SCHC112	Acct:	190663
Completed Date:	7/17/2013 4:14:00 PM	Interpreting Ref:	Douglas McConnell M.D.
Transcribed By:	Sue Leon	Created Date:	
Revised Date:	7/17/2013 8:49:05 AM	Finalized Date:	7/17/2013



OFFICE VISIT
July 16, 2013

CLARENCE WINFREY 50 year old M (DOB: 10/10/1962) Account #: 000009112

Requesting the consult: Jeffery A Travis MD

Primary care physician: Jeffery A Travis MD

Cardiologist: Lanneau D. Lide MD, F.A.C.C

Chief complaint: Cardiomyopathy

, Post MI

, Post Valve Surgery

History of present illness:

This patient was seen yesterday in the office at which time he had shortness of breath at rest, right-sided pulmonary edema on chest x-ray, and marked peripheral edema. On Lasix 80 mg twice daily since then, including 2 doses yesterday, he has had a significant diuresis. His weight has declined from 239-222 pounds. He has not had chest pain. Laboratory studies yesterday included hematocrit 33% which I believe is stable. Creatinine was low normal at 0.7. Potassium was 3.8. Echocardiogram today shows a reduced left ventricular ejection fraction of about 30% with extensive wall motion abnormalities but with no evidence for a persistent ventricular septal defect.

CARDIAC HISTORY

CAD:

- 1 Interoseptal MI [1V CABG, VG-RI, VSD repair] - 5/29/2013

Risk Factors:

- 1 Family History of CAD [Less than 60 years of age]
- 2 Hypertension
- 3 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

CV Surgery:

CV Surgery (1V CABG, VSD repair with pericardial patch) - 5/29/2013

Echo/MUGA:

Echo (EF 0.50, NWMA) - 6/7/2013

Echo (EF 0.55, Mild LVH, Large infarct with VSD) - 5/28/2013

Electrophysiology:

EKG (Sinus Rhythm, RBBB, LAE, inferior infarct) - 7/15/2013

EKG (Sinus Rhythm, RBBB) - 6/2/2013

EKG (Sinus Tachy, RBBB, inferior infarct age undetermined.) - 5/28/2013

Other:

CXR (Infiltrate: Right, cardiomegaly, postop sternotomy) - 7/15/2013

Past medical history: Gout

South Carolina Heart Center Office Visit Note

Page 1/2

Allergies / Intolerances: None

Family history: There is a family history of premature coronary artery disease.

Review of symptoms:

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 221.7lbs. The BMI is 31.0 kg/m2. Blood pressure in the left arm is 120/80 mmHg in the sitting position. The pulse is 76/min. The respirations are 18/min. Nourishment - Obese. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. CHEST - Sternum - Stable. RESP - Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. Respirations - Labored. CARDIAC - Rhythm - Regular. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - II/VI holosystolic murmur heard at the left sternal border. ABD - Carotid - Bilateral Normal Pulse, No Bruits Noted. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Mild, Bilateral. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate. PROCSITE - Sternal Wound, d - Healed.

IMPRESSION AND PLAN

01. Recent MI, Inferior
02. S/P CABG
03. Hypercholesterolemia
04. Hypertension, Benign
05. Systolic Heart Failure, Acute On Chronic

This patient has had a dramatic diuretic response to increased Lasix dose. He still has some peripheral edema and I suspect he needs another 10 pounds of diuresis. He certainly may be at some risk of hypokalemia if his diuresis continues at a rapid rate. He has been on only low doses of Altace 2.5 mg daily and metoprolol 25 mg twice daily since hospitalization. His blood pressure and heart rate are high enough that I would ask him to go ahead and increase his metoprolol to 50 mg twice daily. He left the office before we had a report on his BMP. We will contact the patient by telephone and ask him to increase his Altace to 2.5 mg, 4 tablets daily. He should have a BMP drawn again in 2 days, on Thursday, July 18, and should see me in the office again on Friday morning July 19. If his edema resolves, he should cut back on his Lasix dose.

FINAL MEDICATION LIST

Altace 2.5 mg capsule	take 1 capsule by ORAL route every day
amiodarone 400 mg tablet	take 1 tablet by oral route twice a day
Lasix 80 mg tablet	take 1 tablet by oral route 2 times every day
metoprolol tartrate 25 mg tablet	take 1 by Oral route 2 times every day
Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day
Plavix 75 mg tablet	take 1 by Oral route every day
Vitamin C 500 mg tablet	take 1 twice a day

Electronically signed by: Lanneau D. Lide MD, F.A.C.C 07/16/2013 @ 12:23 PM



Lexington Cardiovascular SURGERY

A Lexington Medical Center Physician Practice

Lexington Cardiovascular Surgery
2728 Sunset Boulevard
West Columbia, SC 29169
(803) 936-7095

Patient: CLARENCE WINFREY

DOS:06/25/2013

DOB: [REDACTED]

Gender: M

MR#: 1238100

Provider:Jeffrey A. Travis M.D.

Vitals

Vital Signs [Data Includes: Last 1 Day]

Height: 5 ft 11 in
Weight: 226 lb
BMI Calculated: 31.64
BSA Calculated: 2.22
Blood Pressure: 112 / 77, LUE, Sitting
Respiration: 18
Heart Rate: 86
Temperature: 98.1 F, Oral

Chief Complaint

2-wk f/u
s/p CABG

Current Meds

1. Altace 2.5 MG Oral Capsule; TAKE 1 CAPSULE DAILY;
Therapy: 13Jun2013 to Recorded
2. Amiodarone HCl - 400 MG Oral Tablet; TAKE 1 TABLET TWICE DAILY FOR 3 MONTHS;
Therapy: 13Jun2013 to Recorded
3. Aspirin 81 MG Oral Tablet; TAKE 1 TABLET DAILY;
Therapy: 13Jun2013 to Recorded
4. Lasix 40 MG Oral Tablet; TAKE 1 TABLET DAILY FOR 30 DAYS;
Therapy: 13Jun2013 to Recorded
5. Lortab 5-500 MG Oral Tablet; TAKE 1 TO 2 TABLETS EVERY 4 TO 6 HOURS AS NEEDED FOR PAIN;
Therapy: 13Jun2013 to (Evaluate:17Jun2013) Recorded
6. Metoprolol Tartrate 25 MG Oral Tablet; TAKE 1 TABLET TWICE DAILY;
Therapy: 13Jun2013 to Recorded
7. Multivitamins Oral Capsule; TAKE 1 CAPSULE DAILY;
Therapy: 13Jun2013 to Recorded
8. Pepcid 20 MG Oral Tablet; TAKE 1 TABLET TWICE DAILY;
Therapy: 13Jun2013 to Recorded
9. Plavix 75 MG Oral Tablet; TAKE 1 TABLET DAILY;
Therapy: 13Jun2013 to Recorded
10. Potassium Chloride Crys ER 20 MEQ Oral Tablet Extended Release; TAKE 1 TABLET DAILY WITH LASIX FOR 30 DAYS;
Therapy: 13Jun2013 to Recorded
11. Vitamin D OTC; 500 mg twice daily;
Therapy: 13Jun2013 to Recorded

Allergies

1. Allergy History Not Known

Date of Service: 06/25/2013
Patient Name: CLARENCE B. WINFREY
Patient DOB: [REDACTED]
MR#: 1238100
Gender: M
Provider: Jeffrey A. Travis M.D.

History of Present Illness

The patient returns in followup of his one-vessel CABG and repair of the postinfarction ventricular septal defect. He is without significant complaints.

Active Problems

1. Acute myocardial infarction (410.80)
2. History of CABG (CABG)
3. Congestive heart failure (428.0)
4. Coronary artery disease (414.00)
5. Hypertension (401.9)
6. Pulmonary hypertension (416.8)
7. Ventricular septal defect (745.4)
8. Ventricular tachycardia (427.1)

Results/Data

ATI Results [Data Includes: Last 1 Week]

No recent results

EKG is in sinus rhythm

Physical Exam

VITALS: are reviewed and as noted.

GENERAL APPEARANCE: benign and appropriate.

HEENT: benign.

NECK: no JVD.

CARDIAC: regular rate and rhythm.

CHEST: is clear.

ABDOMEN: is benign.

EXTREMITIES: no edema.

INTEGUMENT: all of the surgical wounds were examined. The sternum is tight; there are no pops, clicks or rubs. The incision is clean and dry and shows no signs of infection. There is no drainage or cellulitis noted. The saphenectomy site is healing perfectly and the leg is soft with no palpable hematomas or seromas within the endoscopic tunnel.

Assessment

1. History of CABG (CABG)
2. Ventricular septal defect (745.4)

Plan

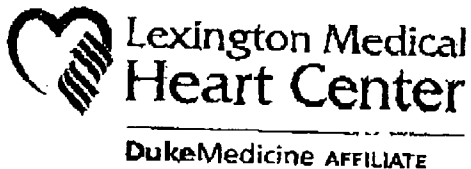
Overall he is doing reasonably well. He continues to wear his life vest. Will see him in 3 weeks. We will refer him to cardiac rehabilitation.

Signatures

Electronically signed by: Jeffrey Travis, M.D.; Jun 25 2013 1:14PM EST

Received 02/18/2013 01:57PM in 00:42 on line [4] for LEXCARDIOVASCULAR * Pg 2/2
FEB-18-2013 13:51 From: LMC CPU REHAB 8037912568 To: 99367908

Page: 2/2



Cardiovascular Rehabilitation
2720 Sunset Boulevard
West Columbia, SC 29169
Phone: 803-791-2621
Fax: 803-791-2568

I would like to refer the following patient to the Cardiovascular Rehabilitation Program at Lexington Medical Center.

Patient's Name: Clarence Ninfey

Social Security #: [REDACTED]

Date of Birth: [REDACTED]

Address: [REDACTED]

Home Phone: [REDACTED]

Work Phone: [REDACTED]

Diagnoses: CABG x1 5/29/13; V Tach on LifeVest

Please check one:

Criteria

- ☒ **Cardiac Rehab-Phase II**
Duration: Up to 36 visits
Frequency: 3 days per week (12 weeks)

Within 12 months of cardiac event: MI, CABG, Stable Angina, PCI, Post-heart transplant.

- ☐ **Cardiac Rehab-Phase III**
Duration: Up to 36 visits
Frequency: 3 days per week (12 weeks)

Does not meet Phase II criteria, but with disease and / or 2 or more cardiovascular risk factors.

- ☐ **Vascular Rehab- Phase III**
Duration: Up to 36 visits
Frequency: 3 days per week (12 weeks)

With diagnosis of vascular disease, vascular surgery, PAD with claudication.

****May continue into Phase III rehab per departmental policy.****

J. H. Lewis

6/25/13

Referring Physicians Signature/Printed Name

Date

Patient: Winfrey, Clarence B (MR#M002010261) Printed by HARLEY, SHARON D [51... Page 1 of 2

Winfrey, Clarence B (MR # M002010261)

Patient Information

Patient Name	Sex	DOB
Winfrey, Clarence B	Male	[REDACTED]

Op Note signed by Jeffrey Allen Travis, MD at 05/30/13 0650

Author:	Jeffrey Allen Travis, MD	Service:	(none)	Author	Physician
Filed:	05/30/13 0650	Note	05/29/13 2002	Type:	
Trans	Available	Time:		Trans ID:	3M927377
Status:					
Dictation	05/29/13 2002	Trans	05/30/13 0342	Trans	Operative Note
Time:		Time:		Doc	
				Type:	

DATE OF PROCEDURE: 05/29/2013

PREOPERATIVE DIAGNOSIS

- 1.Acute myocardial infarction.
- 2.Electrocution.
- 3.Acute post myocardial infarction ventricular septal defect.
- 4.Severe pulmonary hypertension.
- 5.Cardiogenic shock.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED

- 1.Repair of post infarct VSD.
- 2.Coronary artery bypass grafting x1 with saphenous vein graft to the ramus intermedius.
- 3.Percutaneous placement of intraaortic balloon pump.

SURGEON: Jeffrey A. Travis, MD

ASSISTANTS: Steven W. Marra, MD, and Victor Gomez, PA-C

ANESTHESIA: General endotracheal.

DESCRIPTION OF PROCEDURE: The patient was brought to the Operating Room and placed supine on the Operating Room table. After appropriate monitors were placed, general anesthesia was induced. The patient's chest, abdomen, and lower extremities were prepped and draped and isolated into a sterile field. We made a midline incision over the chest and carried down to subcutaneous tissues using electrocautery. A median sternotomy was performed. Thymus gland was taken down to the level of the innominate vein. The greater saphenous vein was harvested from the left lower extremity using endoscopic techniques. It was dilated and found to be adequate for grafting. We opened up the pericardium and tacked up as a pericardial well. The patient was systemically heparinized. The ascending aorta was normal to palpation. The ascending aorta was cannulated using a 20-French

Winfrey, Clarence B (MR # M002010261) Printed by Sharon D Harley [5173] at 6/26/13, 10:00 AM

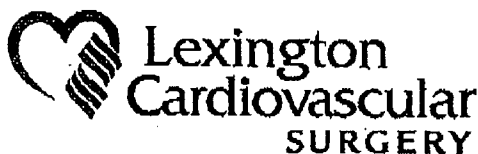
Patient: Winfrey, Clarence B (MR#M002010261) Printed by HARLEY, SHARON D [5173] Page 2 of 2

Winfrey, Clarence B (MR # M002010261)

arterial flow cannula. We put dual stage venous cannulas in, although we had a difficult time directing the SVC cannula in the correct location. We could not pass a coronary sinus catheter despite multiple attempts. We placed an ascending aortic root vent. We did have to crash on bypass due to severe hemodynamically compromise. The patient also had very significant pericarditis with large calcific plaques located anteriorly and posteriorly. These were unlike soldier plaques. They were heavily calcified and there was a real weirdness to the adhesions throughout. At this time, after going on bypass, we cross clamped the ascending aorta and arrested the heart with warm antegrade blood cardioplegia. With the heart completely arrested, we gave cold antegrade blood cardioplegia and gave this at 20-minute intervals throughout the case. We begun the procedure by dissecting out the ramus intermedius. It was intramyocardial. It was heavily diseased. It was grafted saphenous vein end to side using 7-0 Prolene. It was tested under pressure and found to be hemostatic. We then positioned the heart and exposed the base of the heart, the large infarct in the posterior descending coronary artery. The LV was opened along the long longitudinal incision, and this was obviously white infarcted tissue. This was () into the infarct for this tissue. We were able to identify the VSD, which was kind of basilar and apical in location. We placed multiple pledgeted sutures, affixing a patch to cover the left ventricular side of this, and then brought that patch out of the ventriculotomy. It was sutured into place circumferentially with pledgeted sutures and then a running suture was also added to make it watertight. At this time, we closed the ventriculotomy using 2 long strips of felt along either side, sewing 1st with a 4-0 Prolene and then with a 2-0 Ticron on an MH needle. We placed several buttressing sutures and also placed BioGlue over this. At this time, we turned our attention to the ascending aorta and created a 4.8-mm punch in the ascending aorta. The vein graft was anastomosed to the ascending aorta using 6-0 Prolene. The heart was de-aired. Cross clamp was removed. At this time, we placed a percutaneous Intraaortic balloon pump through the right femoral artery using ultrasound guidance. We began ventilating the patient. We placed atrial and ventricular pacing wires. We weaned the patient from bypass. Initially he separated from bypass but had some hemodynamic compromise, and we went back on bypass. Echo initially looked very good, and the ventricular function waned over the first few minutes off bypass. It appeared that perhaps the patient got some air. We gave 10 minutes of wait time and then re-separated from bypass without difficulties. Ventricular function was good. There was no evidence of VSD. At this time, both venous cannulas were removed. The defect was repaired with the previously placed pursestring suture. Protamine sulfate was administered to reverse the heparin, and the ascending aortic root vent was removed. The defect was repaired with the previously placed horizontal mattress pledgeted suture. At this time, with hemostasis adequate, the ascending aortic cannula was removed. The defect was repaired with the previously placed horizontal mattress pledgeted suture. Hemodynamics and hemostasis were adequate. Chest was closed using #6 sternal wire and a Pioneer Cable system. The wound was closed in layers. A sterile dressing was applied. The patient was transported to the Intensive Care Unit in satisfactory condition.

T: 05/30/2013 03:42 A/cir

Winfrey, Clarence B (MR # M002010261) Printed by Sharon D Harley [5173] at 6/26/13
10:00 AM



A Lexington Medical Center Physician Practice

Lexington Cardiovascular Surgery
2728 Sunset Boulevard
West Columbia, SC 29169
(803) 936-7095

Patient: CLARENCE WINFREY

DOS:06/07/2013

DOB: [REDACTED]

Gender: M

MR#: 1238100

Provider: Jeffrey A. Travis M.D.

Discharge Summary Notes

Discharge Summaries signed by Jeffrey Allen Travis, MD at 06/11/13 0638

Author:	Jeffrey Allen Travis, MD	Service:	(none)	Author	Physician
Filed:	06/11/13 0638	Note Time:	06/07/13 1405	Type:	

REASON FOR ADMISSION: Acute MI and acute post infarct ventricular septal defect.

DISCHARGE MEDICATIONS: The patient is given prescriptions for aspirin 81 mg p.o. daily, vitamin D 500 mg b.i.d., Lopressor 25 mg b.i.d., multivitamin a day, Lasix 40 mg a day for 30 days, potassium chloride 20-mEq a day with the Lasix for 30 days, Altace 2.5 mg a day, Amiodarone 400 mg p.o. b.i.d. for 3 months, Plavix 75 mg a day, Pepcid 20 mg p.o. b.i.d. He was also given a prescription for Lortab 5/500, 1-2 tabs p.o. every 4 - 6 hours p.r.n. pain (#60, no refill).

PROCEDURES DURING ADMISSION

1. Transthoracic echocardiogram on May 28.
2. Cardiac catheterization on May 28.
3. Urgent coronary artery bypass grafting x1 with saphenous vein graft to the ramus intermedius, repair of postinfarct ventricular septal defect with pericardial patch, and placement of intraaortic balloon pump done on May 29, 2013.
4. Repeat echocardiogram on June 27, 2013.

DISCHARGE DIAGNOSIS(ES)

1. ST-elevation myocardial infarction, inferior wall.
2. Postinfarct ventricular septal defect.
3. Coronary artery disease.
4. Ventricular tachycardia.
5. Hypertension.
6. Congestive heart failure.
7. Pulmonary hypertension.

HISTORY OF PRESENTING ILLNESS: For full H & P, please see dictated Admission H & P, CT Surgery. In brief, the patient is a 50-year-old gentleman who on Wednesday prior to this admission was working on some electrical equipment and got a large shock. He went home from work and experienced significant chest pain as well as back and shoulder pain. This persisted through the weekend and he really did not do much over the weekend other than sit around and watch TV. He experienced persistent pain and presented to the Urgent Care Center where his EKG was abnormal and he was sent to the hospital.

HOSPITAL COURSE: The patient was admitted with the above stated history. Again, he presented

Discharge Summary Notes

with an injury-type current ST elevation and was taken emergently to the Cardiac Catheterization Lab where he was found to have an occlusion of his posterior descending coronary artery as well as 3-vessel coronary disease and a VSD. We were asked to see the patient in consultation. Interestingly, the patient was fairly stable despite the magnitude of things. We assessed him and took him to the Operating Room the following morning where he underwent a single vessel bypass as outlined above and repair of a postinfarct ventricular septal defect. Also electively placed an intraaortic balloon pump to unload the patient prior to coming off cardiopulmonary bypass. He tolerated the procedure without complications and was taken to the Intensive Care Unit postoperatively. His drips were weaned early postop as well as his intraaortic balloon pump and that was removed without incident. He remained in the Intensive Care Unit and had gotten him up to the chair, began to do some ambulation. He was back in his chair and had a loss of consciousness and telemetry showed that he was in ventricular tachycardia. He was quickly cardioverted with 120 joules and converted back to his injury current type pattern. He was reboled on Amiodarone and continued on his Amiodarone drip. We asked Cardiology to see the patient who agreed with management and continued to follow him. He did well with maintaining him on the Amiodarone drip and we eventually transferred him to the Telemetry floor 2 days ago where he has continued to make steady progress. Again, he had an ST-elevation MI and a low ejection fraction, and of course in the setting of ventricular tachycardia we asked the reps with LifeVest to fit him for a device which he will wear for the next 90 days and then we will reassess him with a repeat echocardiogram 90 days after his surgery. This will be to assess his need for AICD. He was fitted for his LifeVest today. He had a repeat echocardiogram that showed improvement in his ejection fraction. The final report is pending on that. The patient continues to make steady progress. He is ambulating, voiding, having bowel movements without complaints. His wounds are clean, dry and intact. His sternum is tight.

DISCHARGE DIAGNOSTIC STUDIES: Most recent labs on the patient's chart prior to discharge show a sodium of 131, potassium 4.1, chloride 100, CO2 25, BUN 17, creatinine 0.8, glucose 100, white count 12, HGB 10.8, HCT 33, platelets 371. His troponins on admission were 4.140. Total bilirubin 0.6, direct 0.2, AST 38, ALT 81, GGTP 52, alkaline phosphatase 68. Heparin-dependent platelet antibody was negative. MRSA screening was negative. Cholesterol 125, LDL 80, HDL 23, triglycerides 109, non HDL was 102. He had been started on a statin early postop, but his LFTs were elevated and we stopped it. Urinalysis was negative. HGB A1C was 5.4.

DISPOSITION: To home.

DISCHARGE FOLLOW UP

1. Jeff Travis, MD, in 2 weeks.
2. Lanneau Lide, MD, in 4 weeks.
3. The patient will need a repeat echocardiogram in 90 days from the date of his surgery.

T: 06/07/2013 03:09 P/brb

Discharge Summaries signed by Victor A. Gomez, PA-C at 06/07/13 1420

Author:	Victor A. Gomez,	Service:	(none)	Author	Physician Assistant
	PA-C			Type:	
Filed:	06/07/13 1420	Note Time:	06/07/13 1420	Cosigner:	Jeffrey Allen Travis, MD at 06/08/13 0827

Discharge dictated #1193644

6/7/2013, 2:20 PM

JUN-26-2013 09:16 From:803 5-7900

RECEIVED 06/26/2013 10:23

Page:8/10

Discharge Summary Notes

Page 3 of 3

Name: Clarence Winfrey Acct: 100004421483	DOB: [REDACTED] Admit: 5/28/2013

Electronically signed by Gomez, Victor A.

Received for: Jeffrey A Travis M.D. Jun 11 2013 6:39AM Eastern Standard Time

ID: #130625130719
Winfrey, Clarence

06/25/2013 13:08:05

D.O.B.: 2 50 Years
Male Caucasian
Meds:
Class:
Dr:
Tech:

Vent. Rate: 82 bpm
RR Interval: 730 ms
PR Interval: 162 ms
QRS Duration: 160 ms
QT Interval: 416 ms
QTc (interval): 454 ms
QT Dispersion: 58 ms
P Axis: 41 deg
QRS Axis: 95 deg
T Axis: -74 deg

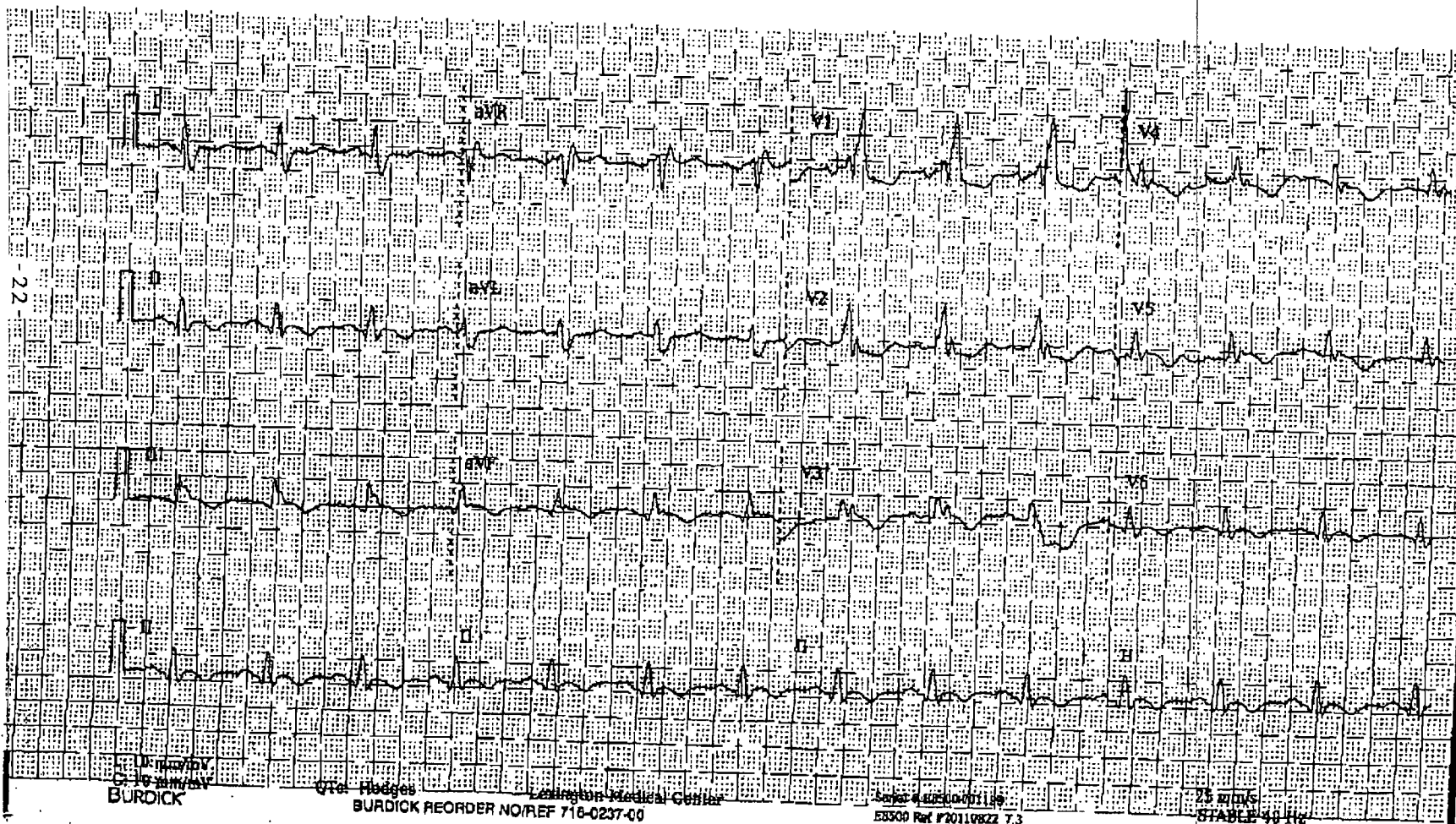
Sinus rhythm
Rightward axis
Right bundle branch block
Inferior infarct - age undetermined
Lateral ST-T changes may be due to myocardial ischemia

Abnormal ECG

* Unconfirmed Analysis *

Comment:

JAT



Printed by
C. J. HODGES
BURDICK

C. J. HODGES
BURDICK REORDER NO/REF 718-0237-00
Lexington Medical Center

Lexington Medical Center
ES300 Ref P20110822 7.3

25 mm/s
STABLE 40 Hz

JUN-26-2013 09:16

From: B03

5-7908

RECEIVED 06/26/2013 10:23

Page: 9/10

000110



October 4, 2013

Preston F. McDaniel
McDaniel Law Firm
1315 Elmwood Ave.
Columbia S. C. 29201

Dear Mr. McDaniel:

Re: CLARENCE WINFREY [REDACTED]

Mr. Winfrey had a severe myocardial infarction after electrocution in the workplace in May. He required emergency surgery. He has severe congestive heart failure and requires continuous treatment. Lack of continuous medical therapy would likely be fatal for him. Without insurance, he cannot afford essential medication.

Sincerely,

Lanneau D. Lide, M. D.

Dr. Lide, Jr.
September 16, 2013
Page 2

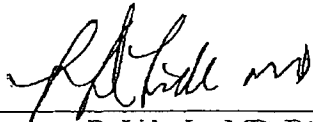
9112

WORKERS COMPENSATION QUESTIONNAIRE

Please indicate your medical opinion by choosing one of the options below.

☒ IT IS MY OPINION that to a reasonable degree of medical certainty (more likely than not) the symptoms and injuries that I have treated Mr. Winfrey for are a result of his work related accident on May 22, 2013, which occurred while he was working on a rotisserie when he accidentally came into contact with an exposed wire carrying 480 volts sending a severe electric shock through his left hand and arm injuring his heart.

☐ IT IS NOT MY OPINION that to a reasonable degree of medical certainty (more likely than not) the symptoms and injuries that I have treated Mr. Winfrey are a result of his work related accident on May 22, 2013, which occurred while he was working on a rotisserie when he accidentally came into contact with an exposed wire carrying 480 volts sending a severe electric shock through his left hand and arm injuring his heart.



Lanneau D. Lide, Jr., MD, FACC



OFFICE VISIT
September 25, 2013

CLARENCE WINFREY 51 year old M [REDACTED] Account #: 000009112

Requesting the consult: Jeffery A Travis MD

Primary care physician: Jeffery A Travis MD

Cardiologist: Lanneau D. Lide MD, F.A.C.C

Chief complaint: Post MI

, Post Open Heart

History of present illness:

This middle-aged man returns to the office having had a lipid profile. He has stopped taking Plavix, Neurontin, and amiodarone. He is still taking aspirin, Altace, Toprol, and spironolactone. He has not had palpitation. He has not had chest pain. He continues to be short of breath with exertion. He still participates in cardiac rehabilitation. He still has the life vest.

Lipid profile on September 19 included total cholesterol 152, HDL 34 and LDL 106.

Patient is still having trouble getting his medications. My understanding is that the worker's comp insurance carrier is declining to pay. We have made his basic medications as inexpensive as possible. He has not previously been on a statin for treatment of hyperlipidemia but we will begin pravastatin 40 mg daily, which should also be inexpensive.

CARDIAC HISTORY

CAD:

- 1 Inferior MI [1V CABG, VG-RI, VSD patch] - 5/29/2013

Arrhythmia:

- 1 Ventricular Tachycardia, postop [DCCV] - 1/2/2013

Risk Factors:

- 1 Hypertension
- 2 Family History of CAD [Less than 60 years of age]
- 3 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

CV Surgery:

CV Surgery (1V CABG: VG-RI and repair of post-infarct VDS; IABP) - 5/29/2013

Echo/MUGA:

Echo (EF 0.35, Basal-Inferolateral Akin, / Mid-Inferoseptal / Apical Hypo, Mild-Moderate MR) - 9/19/2013

Echo (EF 0.30, Mid-Inferior / Apical Akin, / Apical Hypo, Moderate MR, MAC) - 7/16/2013

Echo (EF 0.50, NWMA) - 6/7/2013

Echo (EF 0.55, Mild LVH, Large infarct with VSD) - 5/28/2013

South Carolina Heart Center Office Visit Note

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Electrophysiology:

EKG (Sinus Rhythm, RBBB, IMIQ) - 9/17/2013

EKG (Sinus Rhythm, RBBB, Inferior myocardial infarction with Q waves and persistent ST elevation, no change) - 8/13/2013

EKG (Sinus Rhythm, RBBB, IMI with Q waves and persistent STE) - 7/26/2013

EKG (Sinus Rhythm, RBBB, IMIQ) - 7/19/2013

EKG (Sinus Rhythm, RBBB, LAE, inferior infarct) - 7/15/2013

EKG (Sinus Rhythm, RBBB) - 6/2/2013

EKG (Sinus Tachy, RBBB, inferior infarct age undetermined.) - 5/28/2013

Vascular:

ABI (R ABI (1.1), L ABI (1.1)) - 8/13/2013

Other:

CXR (Effusion: Left, Infiltrate: Right, cardiomegaly, postop sternotomy. Extensive opacity throughout the right lung suggesting diffuse pneumonia on that side.) - 7/15/2013

Past medical history: Gout

LIPID SUMMARY

Date	Total Chol	Triglycerides	HDL	LDL	CPK	SGOT	SGPT
09/19/2013	152	58	34.00	106.00			

Allergies / Intolerances: None

SOCIAL HISTORY

Family: Divorced

Diet: Regular

Alcohol: Yes Occasional

Caffeine: Coffee

Primary Language: English

Family history: There is a family history of premature coronary artery disease. Father Hypertension, CVA, Myocardial Infarction at 54 (cause of death)

Review of symptoms: RESP - Negative for snoring, hemoptysis. Positive for dyspnea. CONST - Negative for weight gain, weight loss, fever. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, palpitation, syncope, pnd. VASC - Negative for claudication, edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for dizziness, memory loss, seizures. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 226.2lbs. The BMI is 31.6 kg/m2. Blood pressure in the left arm is 98/72 mmHg in the sitting position. The pulse is 69/min. The respirations are 18/min. Pulse oximetry at rest is 98%. Nourishment - Obese. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Neck Veins not Visible. CHEST - Sternum - Stable. life vest in place RESP - Respirations - Nonlabored. Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. CARDIAC - Rhythm - Regular. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - II/VI holosystolic murmur heard at the left sternal border. ABD - Carotid - Bilateral Normal Pulse, No Bruits Noted. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Absent. SKIN - Venous

Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person, and Place. Mood - Appropriate. PROCSITE - Sternal Wound - Healed.

IMPRESSION AND PLAN

01. Cardiomyopathy, Ischemic
02. Old MI, Inferior
03. Hypercholesterolemia
04. Peripheral neuropathy
05. S/P CABG

Patient should continue in cardiac rehab. Pravastatin 40 mg daily as the new medication added today. Patient's left ventricular ejection fraction of 35% is borderline for recommendation of an implantable defibrillator. I suggest the patient keep the life vest until the company asked to have it back, as he probably has been somewhat protected from ventricular tachycardia by amiodarone which was only recently discontinued.

Orders:

- 1 Have a Lipid Profile drawn in 3 Months.
- 2 Return office visit with Lanneau D. Lide MD, F.A.C.C in 3 Months.

FINAL MEDICATION LIST

Altace 5 mg capsule	take 1 capsule by oral route every day
aspirin 81 mg tablet, delayed release	take 1 by Oral route every day
pravastatin 40 mg tablet	take 1 tablet by ORAL route every bedtime
spironolactone 25 mg tablet	take 1 by Oral route every morning
Toprol XL 100 mg tablet, extended release	take 1 tablet by ORAL route every day
Vitamin C 500 mg tablet	take 1 twice a day

Electronically signed by: Lanneau D. Lide MD, F.A.C.C 09/26/2013 @ 4:07 PM



OFFICE VISIT
September 17, 2013

CLARENCE WINFREY 51 year old M [REDACTED] Account #: 000009112

Requesting the consult: Jeffery A Travis MD

Primary care physician: Jeffery A Travis MD

Cardiologist: Lanneau D. Lide MD, F.A.C.C

Chief complaint: Post MI
, Post Open Heart

History of present illness:

This 51-year-old man is seen in followup today after acute inferior myocardial infarction in late May complicated by ventricular septal defect, treated by coronary bypass surgery and a patch. He is not having chest pain. He feels very fatigued. He has been participating in cardiac rehabilitation. He still has the life vest in place and has not had a shock from that.

We tried this patient on Neurontin last month when he appeared to have a peripheral neuropathy secondary to electrocution at work. Neurontin has not been noticeably effective.

Patient is having trouble getting his medications now. He says he has been covered up to now by workers compensation but workers comp is declining to pay for additional medication. He has an attorney to help with his claim.

Patient has not had palpitation. He has continued on amiodarone since having ventricular tachycardia 2 or 3 days postop requiring cardioversion. His life vest has not fired.

CARDIAC HISTORY

CAD:

- 1 Inferior MI [1V CABG, VG-RI, VSD patch] - 5/29/2013

Arrhythmia:

- 1 Ventricular Tachycardia, postop [DCCV] - 1/2/2013

Risk Factors:

- 1 Hypertension
- 2 Family History of CAD [less than 60 years of age]
- 3 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

CV Surgery:

CV Surgery (1V CABG: VG-RI and repair of post-infarct VDS; IABP) - 5/29/2013

Echo/MUGA:

Echo (EF 0.30, Mid-Inferior / Apical Akin, / Apical Hypo, Moderate MR, MAC) - 7/16/2013

Echo (EF 0.50, NWMA) - 6/7/2013

Echo (EF 0.55, Mild LVH, Large infarct with VSD) - 5/28/2013

Electrophysiology:

EKG (Sinus Rhythm, RBBB, IMIQ) - 9/17/2013

EKG (Sinus Rhythm, RBBB, Inferior myocardial infarction with Q waves and persistent ST elevation, no change) - 8/13/2013

EKG (Sinus Rhythm, RBBB, IMI with Q waves and persistent STE) - 7/26/2013

EKG (Sinus Rhythm, RBBB, IMIQ) - 7/19/2013

EKG (Sinus Rhythm, RBBB, LAE, inferior infarct) - 7/15/2013

EKG (Sinus Rhythm, RBBB) - 6/2/2013

EKG (Sinus Tachy, RBBB, inferior infarct age undetermined) - 5/28/2013

Vascular:

ABI (R ABI (1.1), L ABI (1.1)) - 8/13/2013

Other:

CXR (Effusion: Left, Infiltrate: Right, cardiomegaly, postop sternotomy. Extensive opacity throughout the right lung suggesting diffuse pneumonia on that side.) - 7/15/2013

Past medical history: Gout

Allergies / Intolerances: None

SOCIAL HISTORY

Family: Divorced

Diet Regular

Alcohol: Yes Occasional

Caffeine: Coffee

Primary Language: English

Family history: There is a family history of premature coronary artery disease. Father Hypertension, CVA, Myocardial Infarction at 54 (cause of death)

Review of symptoms: RESP - Negative for snoring, hemoptysis, dyspnea. CONST - Negative for weight gain, weight loss, fever. Positive for fatigue. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, palpitation, syncope, pnd. VASC - Negative for claudication, edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for dizziness, memory loss, seizures. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 219lbs. The BMI is 30.6 kg/m2. Blood pressure in the left arm is 130/99 mmHg in the sitting position. The pulse is 90/min. The respirations are 18/min. Nourishment - Obese. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Neck Veins not Visible. CHEST - Sternum - Stable. Life vest in place. RESP - Respirations - Nonlabored. Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. CARDIAC - Rhythm - Regular. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - II/VI holosystolic murmur heard at the left sternal border. ABD - Carotid - Bilateral Normal Pulse, No Bruits Noted. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Absent. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate. PROCSITE - Sternal Wound - Healed.

IMPRESSION AND PLAN

South Carolina Heart Center Office Visit Note - 29 - Page 2/3

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- 01. Cardiomyopathy, Ischemic
- 02. Old MI, Inferior
- 03. S/P CABG
- 04. Hypercholesterolemia
- 05. Hypertension, Benign
- 06. Peripheral neuropathy

Patient is having trouble getting his medications. Workers comp was paying for his care but has recently refused. I do not see how anyone could argue that the electrocution on the job was not the proximate cause of his myocardial infarction and ventricular septal defect.

We reviewed the medications. I think he should continue daily low-dose aspirin. He may stop taking Plavix when he runs out. He may stop taking Neurontin, which did not seem to be helpful. He should continue Altace, spironolactone and Toprol. If Altace is more than \$4 a month, we will switch him to lisinopril. He may discontinue amiodarone. He needs to have an echocardiogram to evaluate his left ventricular systolic function after myocardial infarction and surgery, to see whether or not an AICD is indicated.

I do not have a record of this patient's lipids, and he does not appear to have been on lipid-lowering therapy. We'll get a lipid profile in the near future.

Continue cardiac rehabilitation as tolerated.

Orders:

1	Return office visit with Lanneau D. Lide MD, F.A.C.C in 2 Weeks.

FINAL MEDICATION LIST

Altace 5 mg capsule	take 1 capsule by oral route every day
aspirin 81 mg tablet, delayed release	take 1 by Oral route every day
spironolactone 25 mg tablet	take 1 by Oral route every morning
Toprol XL 100 mg tablet, extended release	take 1 tablet by ORAL route every day
Vitamin C 500 mg tablet	take 1 twice a day

Electronically signed by: Lanneau D. Lide MD, F.A.C.C 09/17/2013 @ 11:39 AM



OFFICE VISIT
August 13, 2013

CLARENCE WINFREY 50 year old M [REDACTED] Account #: 000009112

Requesting the consult: Jeffery A Travis MD

Primary care physician: Jeffery A Travis MD

Cardiologist: Lanneau D. Lide MD, F.A.C.C

Chief complaint: Post Open Heart

Post MI

History of present illness:

Mr. Winfrey presents today with numbness in his left great toe. Dr. Travis suggested this symptom was due to the electric shock he experienced prior to myocardial infarction. Patient has not been known to have peripheral vascular disease.

Patient also notes that the visiting nurse has detected a difference between blood pressure in the right arm and left arm, with the left arm a little more. In a similar difference has been seen at cardiac rehabilitation, where he has learned to ask the nurses to check the blood pressure in the right arm. He does not experience pain in his arms. He has had an 8-10 cardiac rehab sessions thus far.

CARDIAC HISTORY

CAD:

- 1 Myocardial Infarction [1V CABG, IABP, CV Surgery (1V CABG: VG-RI and repair of post-infarct VDS; IABP) - 5/29/2013] - 5/29/2013

Risk Factors:

- 1 Hypertension
- 2 Family History of CAD [Less than 50 years of age]
- 3 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

CV Surgery:

CV Surgery (1V CABG: VG-RI and repair of post-infarct VDS; IABP) - 5/29/2013

Echo/MUGA:

Echo (EF 0.30, Mid-Inferior / Apical Akin, / Apical Hypo, Moderate MR, MAC) - 7/16/2013

Echo (EF 0.50, NWMA) - 6/7/2013

Echo (EF 0.55, Mild LVH, Large infarct with VSD) - 5/28/2013

Electrophysiology:

EKG (Sinus Rhythm, RBBB, Inferior myocardial infarction with Q waves and persistent ST elevation, no change) - 8/13/2013

EKG (Sinus Rhythm, RBBB, IMI with Q waves and persistent STE) - 7/26/2013

South Carolina Heart Center Office Visit Note

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EKG (Sinus Rhythm, RBBB, IMIQ) - 7/19/2013
EKG (Sinus Rhythm, RBBB, LAE, inferior infarct) - 7/15/2013
EKG (Sinus Rhythm, RBBB) - 6/2/2013
EKG (Sinus Tachy, RBBB, inferior infarct age undetermined.) - 5/28/2013

Other:

CXR (Effusion: Left, Infiltrate: Right, cardiomegaly, postop sternotomy. Extensive opacity throughout the right lung suggesting diffuse pneumonia on that side.) - 7/15/2013

Past medical history: Gout

Allergies / Intolerances: None

SOCIAL HISTORY

Family: Divorced
Diet: Regular
Alcohol: Yes Occasional
Caffeine: Coffee
Primary Language: English

Family history: There is a family history of premature coronary artery disease.

Review of symptoms: RESP - Negative for snoring, hemoptysis. Positive for dyspnea. CONST - Negative for weight gain, weight loss, fever. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, palpitation, syncope, pnd. VASC - Negative for claudication, edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for dizziness, memory loss, seizures. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 220lbs. The BMI is 30.8 kg/m2. Blood pressure in the left arm is 110/80 mmHg in the sitting position. Blood pressure in the right arm is 120/80 mmHg in the sitting position. The pulse is 60/min. The respirations are 18/min. Nourishment - Obese. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. CHEST - Sternum - Stable. RESP - Respirations - Nonlabored. Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. CARDIAC - Rhythm - Regular. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - II/VI holosystolic murmur heard at the left sternal border. ABD - Carotid - Bilateral Normal Pulse, No Bruits Noted. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Absent. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, , Person and Place. Mood - Appropriate. PROCSITE - Sternal Wound - Healed.

IMPRESSION AND PLAN

01. Cardiomyopathy, Ischemic
02. Recent MI, Inferior
03. S/P CABG
04. Hypercholesterolemia
05. Hypertension, Benign
06. Peripheral neuropathy

This patient's new problem is numbness in the toe, probably a peripheral neuropathy secondary to be electric shock he experienced at work prior to myocardial infarction. We have done an ABI today which showed no evidence of peripheral vascular disease. It would be reasonable to try Neurontin 300 mg twice daily and patient was given a prescription.

South Carolina Heart Center Office Visit Note

We did not find a severe difference in blood pressure between the left upper extremity and right upper extremity on today's exam. There was no difference in right and left upper extremity blood pressure during ABI. There is probably only mild stenosis of the subclavian or axillary artery causing this symptom. I do not believe further evaluation of this problem is indicated now. Patient was encouraged to continue in cardiac rehab.

Orders:

1 Return office visit with Lanneau D. Lide MD, F.A.C.C in 1 Month.

FINAL MEDICATION LIST

Altace 5 mg capsule	take 1 capsule by oral route every day
amlodarone 200 mg tablet	take 1 tablet by oral route 2 times every day
aspirin 81 mg tablet, delayed release	take 1 by Oral route every day
Neurontin 300 mg capsule	take 1 capsule by oral route 2 times every day
Plavix 75 mg tablet	take 1 by Oral route every day
spironolactone 25 mg tablet	take 1 by Oral route every morning
Toprol XL 100 mg tablet, extended release	take 1 tablet by ORAL route every day
Vitamin C 500 mg tablet	take 1 twice a day

Electronically signed by: Lanneau D. Lide MD, F.A.C.C 08/13/2013 @ 11:09 AM



OFFICE VISIT
July 26, 2013

CLARENCE WINFREY 50 year old M [REDACTED] Account #: 000009112

Requesting the consult: Jeffery A Travis MD

Primary care physician: Jeffery A Travis MD

Cardiologist: Lanneau D. Lide MD, F.A.C.C

Chief complaint: Cardiomyopathy

, Post MI
, Post Open Heart

History of present illness:

Mr. Winfrey is seen for the first time in one week. He has returned to cardiac rehab. Once his blood pressure was low enough that he was advised to drink water while there. He has only felt lightheaded when standing up suddenly. He has not had chest pain. He is breathing fairly well. He has not had peripheral edema. He continues to wear the life vest.

CARDIAC HISTORY

CAD:

- 1 Myocardial Infarction [1V CABG, IABP, CV Surgery (1V CABG: VG-RI and repair of post-infarct VDS; IABP) - 5/29/2013] - 5/29/2013

Risk Factors:

- 1 Hypertension
- 2 Family History of CAD [Less than 60 years of age]
- 3 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

CV Surgery:

CV Surgery (1V CABG: VG-RI and repair of post-infarct VDS; IABP) - 5/29/2013

Echo/MUGA:

Echo (EF 0.30, Mid-Inferior / Apical Akin, / Apical Hypo, Moderate MR, MAC) - 7/16/2013
Echo (EF 0.50, NWMA) - 6/7/2013
Echo (EF 0.55, Mild LVH, Large infarct with VSD) - 5/28/2013

Electrophysiology:

EKG (Sinus Rhythm, RBBB, IMI with Q waves and persistent STE) - 7/26/2013
EKG (Sinus Rhythm, RBBB, IMIQ) - 7/19/2013
EKG (Sinus Rhythm, RBBB, LAE, inferior infarct) - 7/15/2013
EKG (Sinus Rhythm, RBBB) - 6/2/2013
EKG (Sinus Tachy, RBBB, inferior infarct age undetermined.) - 5/28/2013

Other:

CXR (Effusion: Left, Infiltrate: Right, cardiomegaly, postop sternotomy. Extensive opacity throughout the right lung suggesting diffuse pneumonia on that side.) - 7/15/2013

Past medical history: Gout

Allergies / Intolerances: None

SOCIAL HISTORY

Family: Divorced

Diet: Regular

Tobacco Cessation: The patient was counseled on tobacco cessation.

Alcohol: Yes Occasional

Caffeine: Coffee

Primary Language: English

Family history: There is a family history of premature coronary artery disease. Father Hypertension, CVA, Myocardial Infarction at 54 (cause of death)

Review of symptoms: RESP - Negative for snoring, hemoptysis, dyspnea. CONST - Negative for weight gain, weight loss, fever. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, palpitation, syncope, pnd. VASC - Negative for claudication, edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for memory loss, seizures, dizziness. Positive for lightheadedness. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 226.3lbs. The BMI is 31.6 kg/m2. Blood pressure in the left arm is 97/69 mmHg in the sitting position. The pulse is 69/min. The respirations are 18/min. Nourishment - Obese. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. CHEST - Sternum - Stable. RESP - Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. Respirations - Labored. CARDIAC - Rhythm - Regular. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - II/VI holosystolic murmur heard at the left sternal border. ABD - Carotid - Bilateral Normal Pulse, No Bruits Noted. W/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Absent. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate. PROCSITE - Sternal Wound - Healed.

IMPRESSION AND PLAN

01. Cardiomyopathy, Ischemic
02. Hypertension, Benign
03. S/P CABG
04. Recent MI, Inferior
05. Hypercholesterolemia

At weight of 226.3, this patient's chronic systolic congestive heart failure appears well compensated. He has no edema and has not been short of breath. I suspect he could probably back off a low more on his Lasix 80 mg daily without developing decompensated heart failure, and his blood pressure might be a little higher. He may skip Lasix if he has major plans for the day which make Lasix inconvenient. He may try taking only 40 mg of Lasix in the morning rather than 80. He understands that he will need to take extra Lasix if he has edema or shortness of breath. His insurance company was going to provide bathroom scales but that he has not received them yet. He understands that weight gain of more than 2 or 3 pounds would be a clear indicator of fluid retention.

We will need to reevaluate this patient in 5 or 6 weeks with an echocardiogram to see whether he needs heart failure

criteria for ICD implantation then. In the meantime, he should reduce his amiodarone dose to 400 mg daily.

Orders:

Patient counseled on tobacco cessation.

FINAL MEDICATION LIST

Altace 5 mg capsule	take 1 capsule by oral route every day
amiodarone 400 mg tablet	take 1 tablet by oral route twice a day
aspirin 81 mg tablet, delayed release	take 1 by Oral route every day
metoprolol tartrate 25 mg tablet	take 1 by Oral route 2 times every day
Plavix 75 mg tablet	take 1 by Oral route every day
spironolactone 25 mg tablet	take 1 by Oral route every morning
Vitamin C 500 mg tablet	take 1 twice a day

Electronically signed by: Lanneau D. Lide MD, F.A.C.C 07/26/2013 @ 9:50 AM



PROVIDENCE HOSPITALS
A Division of the Sisters of Charity Health System

Providence Hospital
2001 Laurel St.
Columbia SC 29204

Phone: 803-254-3278 Fax: 803-376-8010



ECHOCARDIOGRAPHY REPORT

Name: CLARENCE WINFREY ID # 9112
Age/Sex: 51.08/M Date of Service: 9/19/2013 8:34:50 AM
DOB: [REDACTED] B/P 130/99 mmHg
Ht: 71 in Ref MD: LDL
Wt: 219 lb BSA: 2.19

Technologist: MBS

Technical quality: Technical quality of the study is fair. Acoustic window is fair due to body habitus.

Procedure: 2D/Mode Echo - 93307, Cardiac Doppler - 93320 and Color Flow Imaging - 93325.

Diagnosis: CAD, CABG, VSD REPAIR

M-Mode		Normal			Normal
IVSd		0.6-1.2 cm	RVID		<3.0 cm
LVPWd		0.6-1.2 cm	Ao root	2.85 cm	3.0-3.7 cm
LVIDd		3.5-5.6 cm	LAs		1.5-4.0 cm
LVIDs			FS%		
2D		Normal			Normal
IVSd	1.25 cm	0.6-1.2 cm	RVID		<3.0 cm
LVPWd	1.20 cm	0.6-1.2 cm	Ao root		3.0-3.7 cm
LVIDd	6.64 cm	3.5-5.6 cm	LAs		1.5-4.0 cm
LVIDs	5.59 cm		FS%	15.8 %	
AV					
LVOT diameter		Peak Grad		AR PL/2 time	
V1		Mean Grad			
V2		AVA			
Pulmonary Pressure		Distalole Function			
TR Vmax		MV DT			
TR Pk Grad		E velocity			
RA Pressure	10 mmHg	E velocity	cm/sec		
RVSP					

Echocardiographic Findings:

Left Ventricle: Mildly dilated left ventricular size and moderate to severely reduced systolic function. Estimated EF 35%. Calculated ejection fraction is 46.3 %. The apical segment of the left ventricle was hypokinetic. The basilar to apical inferolateral segment of the left ventricle was akinetic. The mid to apical inferoseptal segment of the left ventricle was severely hypokinetic. Unable to assess diastolic function.

Right Ventricle: Normal right ventricular size with normal systolic function.

Left Atrium: The left atrium is mildly dilated.

Right Atrium: The right atrium is normal in size.

Mitral Valve: The mitral valve is structurally normal. Mild mitral annular calcification. No mitral stenosis. Mild to moderate regurgitation. The jet is posteriorly-directed.

Aortic Valve: The aortic valve is structurally normal. No aortic stenosis. No regurgitation.

Pulmonic Valve: The pulmonic valve is structurally normal. Trace regurgitation.

CLARENCE WINFREY

9112

Tricuspid Valve: The tricuspid valve is structurally normal. Trace tricuspid regurgitation.
Masses, Thrombi, Vegetations: No obvious intracardiac masses, thrombi or vegetations.
Pericardium/Extracardiac: No pericardial effusion.

Conclusions:

1. Mildly dilated left ventricular size and moderate to severely reduced systolic function.
2. Estimated EF 35%.
3. The apical segment of the left ventricle was hypokinetic.
4. The basilar to apical inferolateral segment of the left ventricle was akinetic.
5. The mid to apical inferoseptal segment of the left ventricle was severely hypokinetic.
6. Mild to moderate mitral regurgitation.

Electronically signed by: Lanncau Lide MD

Date: 9/22/2013 at 2:53:10 PM

cc: Jeffery A Travis MDEV DepartmentHIMS TouchChart

Page 2 of 2

Fi-38-

000127

LAB ACCESSION #	LAB ORDER #	REPORT STATUS
002478-3469-0	ED-PROJ221	Pos
PATIENT NAME	PATIENT ID	
WINFREY, CLARECE B	00009112	
PATIENT PHONE	SEX	P.O.B.
	Male	
		AGE (YR/MON)
		57 / 1

Laboratory Corporation of America

DATE AND TIME DRAWN	DATE RECEIVED	PHYSICIAN NAME
8/19/2013 8:14	9/19/2013	Dr. L.
DATE AND TIME REPORTED	DATE AND TIME PRINTED	ACQUITTAL
9/23/2013 5:36	9/23/2013 8:09	South Carolina Heart Center
		Interface, Account
		2007 Laurel Street
		COLUMBIA, SC 29204-0000

TEST	RESULT	LIMITS	LAB
Lipid Panel With HDL-C, Ratio			
Cholesterol, Total	152	180 - 240 mg/dL	01
Triglycerides	58	0 - 145 mg/dL	01
HDL Cholesterol		34 L >39 mg/dL	01
Comment			01
According to ATP-III Guidelines, HDL-C >39 mg/dL is considered a negative risk factor for CHD.			
VLDL Cholesterol Calc	12	0 - 40 mg/dL	
LDL Cholesterol Calc		0 - 99 mg/dL	
LDL/HDL Ratio	3.1	0.0 - 3.0 ratio units	

LAB: 01 00 LabCorp Burlington DIRECTOR: William F Hancock MD
1447 York Court, Burlington, NC 27217-3361

END OF REPORT

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LCM Version: 03/26/11

000128

**Lower Extremity Arterial Imaging Report
Ankle/Brachial Index**

Pt Name:	CLARENCE WINFREY	Exam Date:	8/13/2013
Pt ID:	9112	Exam Time:	9:23:07 AM
DOB:	51 years	Ref Physician:	LDL
Sex:	M	Sonographer:	KLE

Indications: Hypertension, Heart Disease and Cigarette/Tobacco Use

Symptoms: Numbness, Tingling

BP at Rest:	RIGHT		LEFT	
Brachial:	140 mmHg		140 mmHg	
Ankle PT:	160 mmHg	Triphasic	158 mmHg	Triphasic
Ankle DP:	160 mmHg	Triphasic	158 mmHg	Biphasic
ABI:	1.1 mmHg		1.1 mmHg	

Post-Exercise Pressure:	RIGHT		LEFT	
Arto:	mmHg			
Ankle:	mmHg		mmHg	
ABI:	mmHg		mmHg	

ABI Values: 0.90 or Above - Generally Normal
 0.75 - 0.90 - Mild Disease
 0.50 - 0.75 - Moderate Disease
 Less than 0.50 - Severe Disease

Impression/Comments: ABI's indicated normal arterial flow bilaterally.

Information entered by KLE of SC Heart Center.

Electronically signed by: Norma Khoury MD on 8/14/2013 at 6:53:13 AM

cc: Jeffery A Travis MD EV Department HMS TouchChart



OFFICE VISIT
July 19, 2013

CLARENCE WINFREY 50 year old M [REDACTED] Account #: 000009112

Requesting the consult: Jeffery A Travis MD

Primary care physician: Jeffery A Travis MD

Cardiologist: Lanneau D. Lide MD, F.A.C.C

Chief complaint: Cardiomyopathy
, Post Open Heart

History of present illness:

Mr. Winfrey returns today in close followup after presenting with acute on chronic systolic CHF Monday July 15, including right sided pulmonary edema on CXR. By the time he got over to see Dr. Travis Tuesday PM, his BP was less than 80 although he did not feel especially lightheaded. We had to back off on his medications. He feels well today, with no chest pain except postop pain. Lab yesterday included BUN 25, creatinine 1.35 and K+ 3.4.

CARDIAC HISTORY

CAD:

- 1 Myocardial Infarction (1V CABG, IABP, CV Surgery (1V CABG: VG-RI and repair of post-infarct VDS; IABP) - 5/29/2013) - 5/29/2013

Risk Factors:

- 1 Hypertension
- 2 Family History of CAD (Less than 60 years of age)
- 3 Tobacco Abuse: cigarettes (Tobacco per day: 0.50)

CARDIOVASCULAR PROCEDURES

CV Surgery:

CV Surgery (1V CABG: VG-RI and repair of post-infarct VDS; IABP) - 5/29/2013

Echo/MUGA:

Echo (EF 0.30, Mid-Inferior / Apical Akin, / Apical Hypo, Moderate MR, MAC) - 7/16/2013

Echo (EF 0.50, NWMA) - 6/7/2013

Echo (EF 0.55, Mild LVH, Large Infarct with VSD) - 5/28/2013

Electrophysiology:

EKG (Sinus Rhythm, RBBB, IMIQ) - 7/19/2013

EKG (Sinus Rhythm, RBBB, LAE, inferior infarct) - 7/15/2013

EKG (Sinus Rhythm, RBBB) - 6/2/2013

EKG (Sinus Tachy, RBBB, inferior infarct age undetermined.) - 5/28/2013

Other:

CXR (Effusion: Left, Infiltrate: Right, cardiomegaly, postop sternotomy. Extensive opacity throughout the right lung

suggesting diffuse pneumonia on that side.) - 7/15/2013

Past medical history: Gout

Allergies / Intolerances: None

SOCIAL HISTORY

Family: Divorced

Diet: Regular

Alcohol: Yes Occasional

Caffeine: Coffee

Primary Language: English

Family history: There is a family history of premature coronary artery disease. Father Hypertension, CVA, Myocardial Infarction at 54 (cause of death)

Review of symptoms: RESP - Negative for snoring, hemoptysis, dyspnea. CONST - Negative for weight gain, weight loss, fever. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, palpitation, syncope, pnd. VASC - Negative for claudication, edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for dizziness, memory loss, seizures. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 225.00lbs. The BMI is 31.5 kg/m2. Blood pressure in the left arm is 118/82 mmHg in the sitting position. The pulse is 79/min. The respirations are 18/min. Nourishment - Obese. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. CHEST - Sternum - Stable. RESP - Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. Respirations - Labored. CARDIAC - Rhythm - Regular. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - IIAI holosystolic murmur heard at the left sternal border. ABD - Carotid - Bilateral Normal Pulse, No Bruits Noted. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Mild, Bilateral. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate. PROCSITE - Exam ess. a, s on July 16, with minimal edema.

IMPRESSION AND PLAN

01. Recent MI, Inferior
02. S/P CABG
03. Hypercholesterolemia
04. Hypertension, Benign
05. Systolic Heart Failure, Acute On Chronic

Lasix 40 daily, Altace 2.5 daily and metoprolol 25 BID was not enough medication for this patient's CHF. Lasix 80 BID, Altace 10 daily and metoprolol 50 BID was too much. Patient will try taking Altace 5 mg daily, metoprolol 25 mg BID, and Lasix 80 mg daily. We will add spironolactone 25 mg daily. He can double his Lasix back to 80 BID if he has worsening edema or dyspnea. If he has no edema, he does not have to take Lasix.

Rx written for scales and home BP device.

Return visit one week with BMP the day before. Resume cardiac rehab as tolerated.

FINAL MEDICATION LIST

Altace 5 mg capsule	take 1 capsule by oral route every day
amiodarone 400 mg tablet	take 1 tablet by oral route twice a day
aspirin 81 mg tablet, delayed release	take 1 by Oral route every day
metoprolol tartrate 25 mg tablet	take 1 by Oral route 2 times every day
Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day
Plavix 75 mg tablet	take 1 by Oral route every day
spironolactone 25 mg tablet	take 1 by Oral route every morning
Vitamin C 500 mg tablet	take 1 twice a day

Electronically signed by: Lanneau D. Lide MD, F.A.C.C 07/19/2013 @ 5:25 PM



OFFICE VISIT
July 16, 2013

CLARENCE WINFREY 50 year old M [REDACTED] Account #: 000009112

Requesting the consult: Jeffery A Travis MD

Primary care physician: Jeffery A Travis MD

Cardiologist: Lanneau D. Lide MD, F.A.C.C

Chief complaint: Cardiomyopathy

, Post MI

, Post Valve Surgery

History of present illness:

This patient was seen yesterday in the office at which time he had shortness of breath at rest, right-sided pulmonary edema on chest x-ray, and marked peripheral edema. On Lasix 80 mg twice daily since then, including 2 doses yesterday, he has had a significant diuresis. His weight has declined from 239-222 pounds. He has not had chest pain. Laboratory studies yesterday included hematocrit 33% which I believe is stable. Creatinine was low normal at 0.7. Potassium was 3.8. Echocardiogram today shows a reduced left ventricular ejection fraction of about 30% with extensive wall motion abnormalities but with no evidence for a persistent ventricular septal defect.

CARDIAC HISTORY

CAD:

- 1 Inferoseptal MI [1V CABG, VG-RI, VSD repair] - 5/29/2013

Risk Factors:

- 1 Family History of CAD [Less than 60 years of age]
- 2 Hypertension
- 3 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

CV Surgery:

CV Surgery (1V CABG: VSD repair with pericardial patch) - 5/29/2013

Echo/MUGA:

Echo (EF 0.50, NWMA) - 6/7/2013

Echo (EF 0.55, Mild LVH, Large infarct with VSD) - 5/28/2013

Electrophysiology:

EKG (Sinus Rhythm, RBBB, LAE, inferior infarct) - 7/15/2013

EKG (Sinus Rhythm, RBBB) - 6/2/2013

EKG (Sinus Tachy, RBBB, inferior infarct age undetermined.) - 5/28/2013

Other:

OCR (Infiltrate: Right, cardiomegaly, postop sternotomy) - 7/15/2013

Past medical history: Gout

Allergies / Intolerances: None

Family history: There is a family history of premature coronary artery disease.

Review of symptoms:

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 221.7lbs. The BMI is 31.0 kg/m2. Blood pressure in the left arm is 120/80 mmHg in the sitting position. The pulse is 76/min. The respirations are 18/min. Nourishment - Obese. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. CHEST - Sternum - Stable. RESP - Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. Respirations - Labored. CARDIAC - Rhythm - Regular. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - II/VI holosystolic murmur heard at the left sternal border. ABD - Carotid - Bilateral Normal Pulse, No Bruits Noted. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Mild, Bilateral. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate. PROCSITE - Sternal Wound, d - Healed.

IMPRESSION AND PLAN

01. Recent MI, Inferior
02. S/P CABG
03. Hypercholesterolemia
04. Hypertension, Benign
05. Systolic Heart Failure, Acute On Chronic

This patient has had a dramatic diuretic response to increased Lasix dose. He still has some peripheral edema and I suspect he needs another 10 pounds of diuresis. He certainly may be at some risk of hypokalemia if his diuresis continues at a rapid rate. He has been on only low doses of Altace 2.5 mg daily and metoprolol 25 mg twice daily since hospitalization. His blood pressure and heart rate are high enough that I would ask him to go ahead and increase his metoprolol to 50 mg twice daily. He left the office before we had a report on his BMP. We will contact the patient by telephone and ask him to increase his Altace to 2.5 mg, 4 tablets daily. He should have a BMP drawn again in 2 days, on Thursday, July 18, and should see me in the office again on Friday morning July 19. If his edema resolves, he should cut back on his Lasix dose.

FINAL MEDICATION LIST

Altace 2.5 mg capsule	take 1 capsule by ORAL route every day
amiodarone 400 mg tablet	take 1 tablet by oral route twice a day
Lasix 80 mg tablet	take 1 tablet by oral route 2 times every day
metoprolol tartrate 25 mg tablet	take 1 by Oral route 2 times every day
Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day
Plavix 75 mg tablet	take 1 by Oral route every day
Vitamin C 500 mg tablet	take 1 twice a day



OFFICE VISIT
July 15, 2013

CLARENCE WINFREY 50 year old M [REDACTED] Account #: 000009112

Requesting the consult: Jeffery A Travis MD

Primary care physician: Jeffery A Travis MD

Cardiologist: Lanneau D. Lide MD, F.A.C.C

Chief complaint: Post MI
, Post Open Heart

History of present illness:

Mr. Winfrey he is seen in the office for the first time. He presented in late May with acute infero-septal myocardial infarction complicated by a ventricular septal defect. He underwent surgery which included a vein graft to the ramus intermedius and repair of his VSD using a pericardial patch. He required a prolonged hospitalization. He had ventricular tachycardia after transfer out of intensive care and was started on amiodarone. He was discharged with a life vest. The plan was to evaluate his left ventricular function 3 months postop to decide whether an ICD should be implanted.

Patient has been feeling short of breath the last few days. He has nocturia x2 or 3. He has had PND almost every night this past week. He has had peripheral edema every day, although it mostly resolves at night. He has not had chest pain and has not taken nitroglycerin.

Patient has been in cardiac rehabilitation at Lexington but has not been able to do much exercise.

CARDIAC HISTORY

CAD:

- 1 Inferoseptal MI [1V CABG, VG-RI, VSD repair] - 5/29/2013

Risk Factors:

- 1 Family History of CAD [Less than 60 years of age]
- 2 Hypertension
- 3 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

CV Surgery:

CV Surgery (1V CABG: VSD repair with pericardial patch) - 5/29/2013

Echo/MUGA:

Echo (EF 0.50, NWMA) - 6/7/2013

Echo (EF 0.55, Mild LVH, Large infarct with VSD) - 5/28/2013

Electrophysiology:

EKG (Sinus Rhythm, RBBB, LAE, inferior infarct) - 7/15/2013

EKG (Sinus Rhythm, RBBB) - 6/2/2013

EKG (Sinus Tachy, RBBB, inferior infarct age undetermined) - 5/28/2013

Other:

CXR (Infiltrate: Right, cardiomegaly, postop sternotomy) - 7/15/2013

Past medical history: Gout

Allergies / Intolerances: None

SOCIAL HISTORY

Family: Divorced

Diet: Regular

Alcohol: Yes Occasional

Caffeine: Coffee

Primary Language: English

Family history: There is a family history of premature coronary artery disease. Father Hypertension, CVA, Myocardial Infarction at 54 (cause of death)

Review of symptoms: RESP - Negative for snoring, hemoptysis. Positive for dyspnea. CONST - Negative for weight gain, weight loss, fever. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, palpitation, syncope, pnd. VASC - Negative for claudication. Positive for edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for dizziness, memory loss, seizures. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 239lbs. The BMI is 33.4 kg/m2. Blood pressure in the left arm is 128/80 mmHg in the sitting position. The pulse is 80/min. The respirations are 18/min. Nourishment - Obese. Appearance - Well Developed. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. CHEST - Sternum - Stable. RESP - Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. Respirations - Labored. CARDIAC - Rhythm - Regular. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - II/VI holosystolic murmur heard at the left sternal border. ABD - Carotid - Bilateral Normal Pulse, No Bruits Noted. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Moderate, Bilateral. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate. PROCSITE - Sternal Wound - Healed.

IMPRESSION AND PLAN

01. Recent MI, Inferior
02. Ventricular Septal Defect
03. S/P CABG
04. Hypercholesterolemia
05. Hypertension, Benign
06. Systolic Heart Failure, Acute On Chronic

This patient's main problem is acute on chronic congestive heart failure. He appears short of breath at rest. He has had PND most nights recently. He has peripheral edema. He has what appears to be right-sided pulmonary edema on his chest x-ray, which also shows cardiomegaly but shows a clear left lung. He is on only very small doses of metoprolol, Altace and Lasix, although I suspect these doses were appropriate when he was hospitalized and his blood pressure was not very high. I recommended hospitalization, but he declined. We will have blood drawn today for CBC and BMP. An echocardiogram will be done. I will see this patient back in the office tomorrow to review his results with him. In the

meantime, he was given a new prescription for Lasix 80 mg twice daily and was instructed to begin this medication by taking 80 mg twice today. He understands he may have to go to the emergency room if he does not experience prompt relief of dyspnea. He will keep the life vest on.

FINAL MEDICATION LIST

Altace 2.5 mg capsule	take 1 capsule by ORAL route every day
amiodarone 400 mg tablet	take 1 tablet by oral route twice a day
Lasix 80 mg tablet	take 1 tablet by oral route 2 times every day
Lortab 5 mg-500 mg tablet	take 1 tablet by oral route every 4-6 hours as needed for pain
metoprolol tartrate 25 mg tablet	take 1 by Oral route 2 times every day
Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day
Plavix 75 mg tablet	take 1 by Oral route every day
Vitamin D3 5,000 unit tablet	take 1 by Oral route every day

Electronically signed by: Lanneau D. Lide MD, F.A.C.C 07/15/2013 @ 6:54 PM



PROVIDENCE HOSPITALS
A Division of the Sisters of the Holy Family

Providence Hospital
2001 Laurel St.
Columbia SC 29204

Phone: 803-254-3278 Fax: 803-376-8010



ECHOCARDIOGRAPHY REPORT

Name: CLARENCE WINFREY ID #: 9112
Age/Sex: 50.91/M Date of Service: 7/16/2013 7:45:25 AM
DOB: [REDACTED] B/P: 128/80 mmHg
Ht: 71.00 in Ref MD: LDL
Wt: 230.00 lb BSA: 2.24

Technologist: KLE

Technical quality: Technical quality of the study is suboptimal due to poor acoustic window which may affect data interpretation.

Procedure: 2D/MMode Echo - 93307, Cardiac Doppler - 93320 and Color Flow Imaging - 93325.

Diagnosis: MI; CABG; VSD REPAIR

M-Mode		Normal			Normal
IVSd		0.6-1.2 cm	RVID		<3.0 cm
LVPWd		0.6-1.2 cm	AO root	3.36 cm	3.0-3.7 cm
LVIDd		3.5-5.6 cm	LAd	4.21 cm	3.5-4.0 cm
LVIDs			FS%		
2D		Normal			Normal
IVSd	1.33 cm	0.6-1.2 cm	RVID		<3.0 cm
LVPWd	1.06 cm	0.6-1.2 cm	AO root		3.0-3.7 cm
LVIDd	4.97 cm	3.5-5.6 cm	LAd		3.5-4.0 cm
LVIDs	3.65 cm		FS%	26.6 %	
AV					
LVOT diameter		Peak Grad	AR PUL dms		
V1		Mean Grad			
V2		AVA			
Pulmonary Pressure		Diastolic Function			
TR Vmax		MV DT			
TR Pk Grad		E velocity			
RA Pressure	10 mmHg	E velocity	cm/sec		
RVSP					

Echocardiographic Findings:

Left Ventricle: Normal left ventricular size and severely decreased systolic function. Estimated EF 30%. The apical segment of the left ventricle was hypokinetic. The mid to apical inferior segment of the left ventricle was akinetic and aneurysmal. The apical inferoseptal segment of the left ventricle was dyskinetic. Normal diastolic function. VSD patch stable.

Right Ventricle: Normal right ventricular size with normal systolic function.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is normal in size.

Mitral Valve: The mitral valve is structurally normal. Mild mitral annular calcification. No mitral stenosis. Mild to moderate regurgitation. The jet is posteriorly-directed.

Aortic Valve: The aortic valve is structurally normal. No aortic stenosis. No regurgitation.

CLARENCE WINFREY

9112

Pulmonic Valve: The pulmonic valve is structurally normal. Trace regurgitation.
Tricuspid Valve: The tricuspid valve is structurally normal. Trace tricuspid regurgitation.
Pericardium/Extracardiac: No pericardial effusion.

Conclusions:

1. Technical quality of the study is suboptimal due to poor acoustic window which may affect data interpretation.
2. Normal left ventricular size and severely decreased systolic function.
3. Estimated EF 30%.
4. The apical segment of the left ventricle was hypokinetic.
5. The mid to apical inferior segment of the left ventricle was akinetic and aneurysmal.
6. The apical inferoseptal segment of the left ventricle was dyskinetic.
7. Mild to moderate mitral regurgitation.
8. No VSD apparent.

Electronically signed by: Lannau Lide MD

Date: 7/16/2013 at 9:45:01 AM

cc: Jeffery A Travis MDEV DepartmentHIMS TouchChart

LAB ACCESSION#		LAB ORDER NUM.		REPORT STATUS	
199-878-0132-D		CD-PRO10304		Final	
PATIENT NAME				PATIENT ID	
WINFREY, CLARENCE B				000009112	
PATIENT PHONE		SEX	D.O.B	AGE/YR/MOS	
[REDACTED]		Male	[REDACTED]	50 / 10	
Fasting				Physician Name	
				Lide, L	
DATE AND TIME DRAWN				ACCOUNT	
7/18/2013		7:51		3919-000	
DATE RECEIVED				South Carolina Heart Center	
7/18/2013				Interface Account	
DATE AND TIME REPORTED				2001 Laurel Street	
7/18/2013		16:37		COLUMBIA, SC 29204-0000	
DATE AND TIME PRINTED					
7/18/2013		17:37			
TEST	RESULT	LIMITS	LAB		

Basic Metabolic Panel (8)

Glucose, Serum	91	65 - 99	mg/dL	01
BDN	25 H	6 - 24	mg/dL	01
Creatinine, Serum	1.35 H	0.76 - 1.27	mg/dL	01
eGFR If NonAfrican Am	61	>59	mL/min/1.73	
eGFR If African Am	70	>59	mL/min/1.73	
BUN/Creatinine Ratio	19	9 - 20		
Sodium, Serum	140	134 - 144	mmol/L	01
Potassium, Serum	3.4 L	3.5 - 5.2	mmol/L	01
Chloride, Serum	98	97 - 108	mmol/L	01
Carbon Dioxide, Total	27	19 - 28	mmol/L	01
Calcium, Serum	9.1	8.7 - 10.2	mg/dL	01

LAB: 01 CS LabCorp Columbia DIRECTOR: Joseph Modzelewski MD
 2 Southern Court, West Columbia, SC 29169-3060

K

7/26/13
COL

END OF REPORT

LAB ACCESSION#		LAB ORDER NUMBER		REPORT STATUS	
196-078-1343-0		CD-PRQ10244		Final	
PATIENT NAME				PATIENT ID	
WINFREY CLARENCE D				000009112	
PATIENT PHONE		SEX	DOB	AGE/YR (MM/DD)	
[REDACTED]		Male	[REDACTED]	50 / 10	
Fasting				Physician Name	
[REDACTED]				[REDACTED]	
DATE AND TIME DRAWN				DATE RECEIVED	
7/15/2013 12:52				7/15/2013	
DATE AND TIME REPORTED				DATE AND TIME PRINTED	
7/16/2013 13:37				7/16/2013 17:07	
ACCOUNT# 78435900 South Carolina Heart Center Interface Account 2001 Laurel Street COLUMBIA, SC 29204-0000					
TEST	RESULT	LIMITS		LAB	

CBC with Differential/Platelet

WBC	9.8	4.0 - 10.5	x10E3/uL	01
RBC	3.66 L	4.14 - 5.86	x10E6/uL	01
Hemoglobin	10.7 L	12.6 - 17.7	g/dL	01
Hematocrit	32.7 L	37.5 - 51.0	%	01
MCV	89	79 - 97	fL	01
MCH	29.2	26.6 - 33.0	pg	01
MCHC	32.7	31.5 - 35.7	g/dL	01
RDW	16.0 H	12.3 - 15.4	%	01
Platelets	277	140 - 415	x10E3/uL	01
Neutrophils	75 H	40 - 74	%	01
Lymphs	14	14 - 46	%	01
Monocytes	7	4 - 13	%	01
Eos	3	0 - 7	%	01
Basos	1	0 - 3	%	01
Neutrophils (Absolute)	7.4	1.8 - 7.8	x10E3/uL	01
Lymphs (Absolute)	1.4	0.7 - 4.5	x10E3/uL	01
Monocytes (Absolute)	0.7	0.1 - 1.0	x10E3/uL	01
Eos (Absolute)	0.3	0.0 - 0.4	x10E3/uL	01
Baso (Absolute)	0.1	0.0 - 0.2	x10E3/uL	01
Immature Granulocytes	0	0 - 2	%	01
Immature Grans (Abs)	0.0	0.0 - 0.1	x10E3/uL	01
Basic Metabolic Panel (8)				
Glucose, Serum	77	65 - 99	mg/dL	01
BUN	9	6 - 24	mg/dL	01
Creatinine, Serum	0.70 L	0.76 - 1.27	mg/dL	01
eGFR If NonAfrican Am	110	>59	mL/min/1.73	01
eGFR If African Am	127	>59	mL/min/1.73	01
BUN/Creatinine Ratio	13	9 - 20		01
Sodium, Serum	140	134 - 146	mmol/L	01
Potassium, Serum	3.8	3.5 - 5.2	mmol/L	01
Chloride, Serum	101	97 - 108	mmol/L	01
Carbon Dioxide, Total	19	19 - 28	mmol/L	01
Calcium, Serum	9.4	8.7 - 10.2	mg/dL	01
B-Type Natriuretic Peptide				
B-Type Natriuretic Peptide	377.8 H	0.0 - 100.0	pg/mL	01

LAB: 01 BN LabCorp Burlington) DIRECTOR: William F Hancock MD
1447 York Court, Burlington, NC 27215-3361

END OF REPORT

- 52 -

LCM Version: 01.20.01

000141

WINFREY, CLARENCE

ID: 000009112

19-Jul-2013 8:35:28

South Carolina Heart

Vent. rate 79 bpm
PR interval 194 ms
QRS duration 140 ms
QT/QTc 430/493 ms
P-R-T axes 82-81-65

Normal sinus rhythm
Right bundle branch block
ST elevation consider anterolateral injury or acute infarct
ST elevation consider inferior injury or acute infarct
***** Acute MI *****
Abnormal ECG

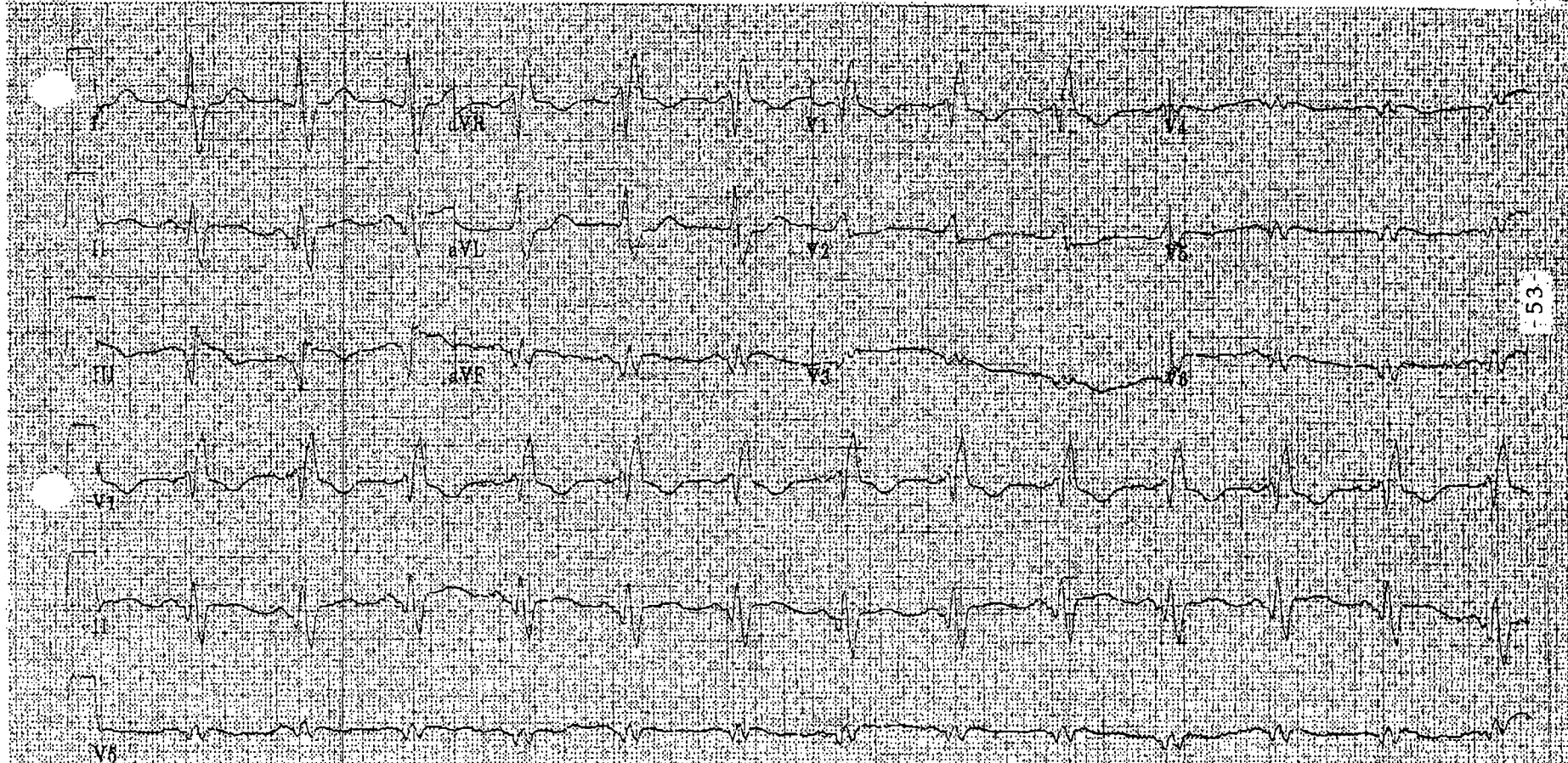
Technician:
Test ind:

Referred by:

Reviewed by:

NC

Handwritten signature



53

000142

40 Hz 25.0 mm/s 10.0 mm/mV

4 by 2.0s + 3 x 5s Chn 1ds

MAC 8 002B

12SL 100 x 250

PRINTED IN U.S.A.

WINFREY, CLARENCE

ID: 000009112

15-Jul-2013 10:15:28

South Carolina Heart

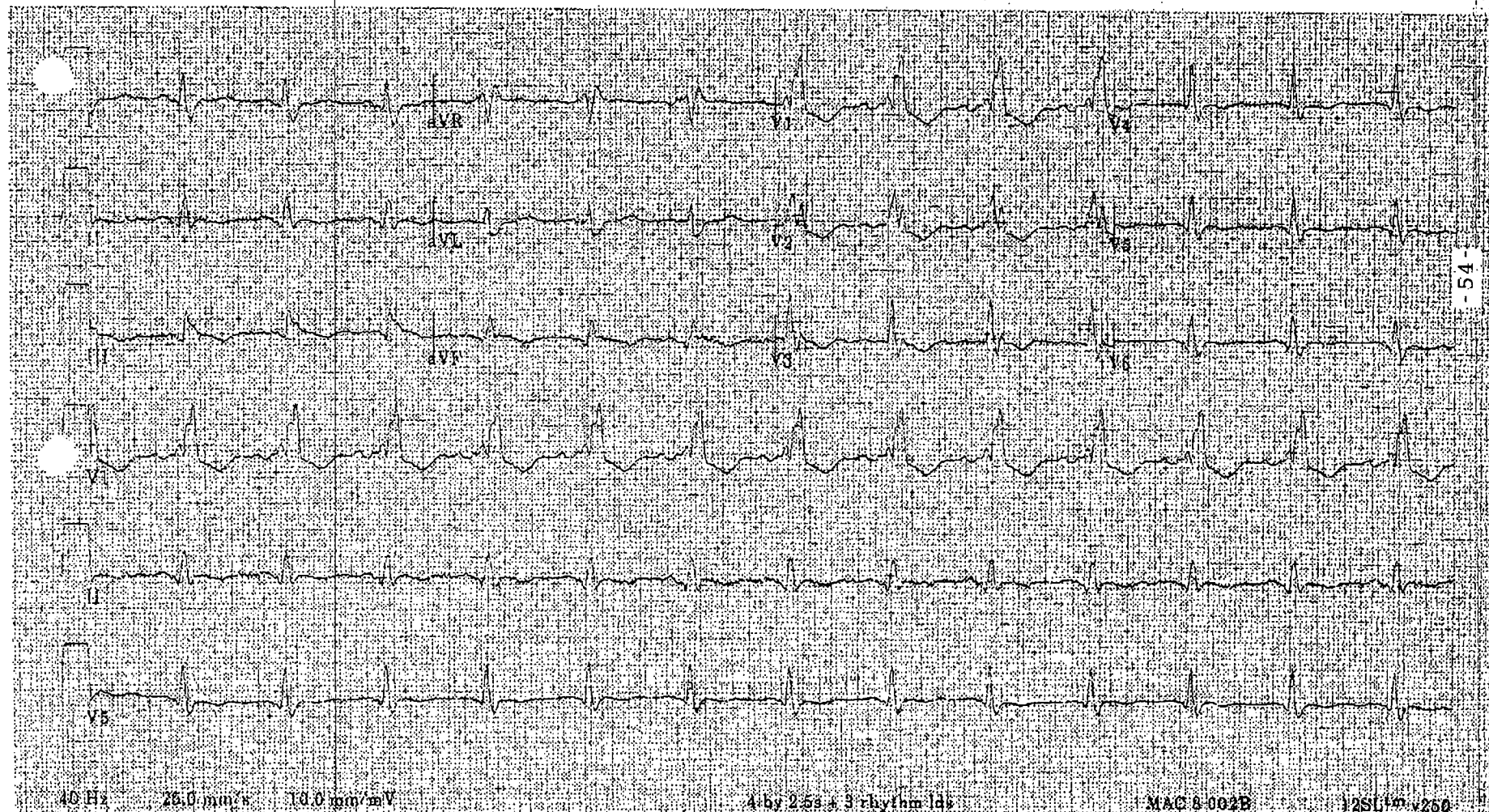
Vent. rate 80 bpm
PR interval 160 ms
QRS duration 138 ms
QT/QTc 362/418 ms
P-R-T axes 55.68 20

Normal sinus rhythm
Left atrial enlargement
Right bundle branch block
ST elevation consider inferolateral injury or acute infarct
***** Acute MI *****
Abnormal ECG

Technician:
Test ind:

Referred by:

Reviewed by:



- 54 -

000143



South Carolina Heart Center
2001 Laurel St
Columbia 29204
Phone: (803)254-3278

Name: CLARENCE WINFREY Exam Date: 7/15/2013
Patient ID: SCH9112 Exam: Chest (PA only)
DOB: [REDACTED] Reason:
Phone: [REDACTED] Referrer: Lawrence Lide, Jr, M.D.
Acct: 190663 Referrer 2: South Carolina Heart Center

Results

AP CHEST

INDICATION: Shortness of breath.

FINDINGS: The cardiac silhouette is enlarged. There is diffuse, fairly dense airspace opacity throughout the right lung, most locally in the lower lobe. On the left side, there is blunting and opacification of the left base suggesting a small effusion and adjacent collapse or consolidation of the lower lobe. There is no pneumothorax. There is evidence of prior sternotomy. There is no acute osseous finding.

IMPRESSION: Extensive opacity throughout the right lung suggesting diffuse pneumonia on that side. There is also a left effusion and adjacent lower lobe collapse.

Douglas M. McConnell M.D.
Radiologist
PITTS RADIOLOGY

Report Electronically Signed by: Douglas McConnell M.D.
Report Signed on: 7/17/2013

Pt. Name:	CLARENCE WINFREY	Exam:	Chest (PA only)
Patient ID:	SCH9112	Acct:	190663
Completed Date:	7/15/2013 4:14:00 PM	Interpreting Rad:	Douglas McConnell M.D.
Transcribed By:	Sue Leon	Dictated Date:	
Transcribed Date:	7/17/2013 8:43:06 AM	Finalized Date:	7/17/2013



OFFICE CONSULT
May 28, 2013

CLARENCE WINFREY 50 year old M [REDACTED] Account #: 000009112

Requesting the consult: PCP No

Consultation is requested for

Primary care physician: PCP No

Cardiologist: Himadri Dasgupta M.D.

Chief complaint: New Pt Exam, Palpitations / Arrhythmias, Dyspnea

History of present illness:

Mr. Clarence Winfrey is a 50-year-old male is being seen in consultation at the request of Dr. Greenfield at doctor's care for further workup of an abnormal EKG and new onset heart murmur. A review of his records today shows that he received an electric shock in 5 days ago and since then has complained of a pain in his left shoulder radiating to the left scapular region, the left side of his neck, left infraclavicular region and left arm. He has also been having excessive diaphoresis and has dyspnea with exertion. The patient states that none of his symptoms have really progress. His pain appears to have been responding to Tylenol and Motrin but comes back when the effect wears off. The patient denies any palpitation, syncope or presyncope. He denies any orthopnea or dependent edema. At the time of this interview the patient denied any chest pain but had minimal left shoulder pain.

The patient denied any prior cardiac history and stated that many years ago he had a normal cardiac catheterization. On auscultation today he was found to have a grade 4/6 early and mid systolic murmur in the left parasternal region. A stat echocardiogram cyst and a tiny cyst with possible expansion of the distal and apical inferior and inferoseptal segments with a possible VSD with left to right shunting.

His EKG was reviewed and showed significant ST elevation in leads L2 and L3 with ST depression in V1 through V3 and a right bundle branch block. A repeat EKG in our office was the same as that from doctor's care.

On arrival the patient was found to be tachycardic with a heart rate of around 120 beats per minute. On arrival discussed with the pressure was about 100 but at the time of this interview his blood pressure was 128/88.

Mr. WINFREY has not had palpitations, syncope or near syncope. He denies claudication. There is no discoloration or ulceration of the lower extremities. He has had no TIA or stroke-like symptoms.

CARDIAC HISTORY

Risk Factors:

- 1 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

Echo/MUGA:

Echo (EF 0.55, Mild LVH, Mid to apical inferior and inferoseptal segment of the left ventricle was akinetic, Moderate across distal inferior septum, possible complication of acute MI ventricular septal defect with left to right shunting) - 5/28/2013

Electrophysiology:

EKG (Sinus Tachy, RBBB, inferior infarct age undetermined.) - 5/28/2013

Past medical history: ABN EKG, Gout, Hypertension

Allergies / Intolerances: None

SOCIAL HISTORY

Family: Unknown

Diet: Regular

Tobacco Cessation: The patient was counseled on tobacco cessation.

Alcohol: Yes Occasional

Caffeine: Coffee

Primary Language: English

Family history: There is a family history of premature coronary artery disease. Father Hypertension, CVA, Myocardial Infarction at 54 (cause of death)

Review of symptoms:

RESP - Negative for snoring, hemoptysis. Positive for dyspnea. CONST - Negative for weight gain, weight loss, fever. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, syncope, pnd. Positive for palpitation. VASC - Negative for claudication, edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for dizziness, memory loss, seizures. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 240.8lbs. The BMI is 33.7 kg/m2. Blood pressure in the left arm is 138/104 mmHg in the sitting position. The pulse is 122/min. The respirations are 22/min. Nourishment - Obese. Appearance - Well Developed. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. RESP - Respirations - Nonlabored. Breath Sounds - Clear Throughout. Rales - Absent. Rhonchi - Absent. Wheezes - Absent. CARDIAC - Rhythm - Regular. Palpation - PMI Normal. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - IV/VI systolic ejection murmur heard at the left sternal border. VASC - Carotid - Bilateral Normal. Aorta - Normal Size. Femoral - Bilateral Normal. Pulse. Post Tibial - Bilateral Normal. ABD - Tenderness - None. Hepatomegaly - Absent. Splenomegaly - Absent. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Absent. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate.

IMPRESSION AND PLAN

01. Acute MI, Inferior
02. Shortness of Breath
03. Chest Pain, Unspecified
04. Limb Pain, Arm
05. Obesity
06. Tobacco Abuse
07. Ventricular Septal Defect

It appears that the patient has had a myocardial infarction in the last few days but has persistent estimation and some symptoms. It is also possible that he has had a VSD is a completion of this MI. I have informed him of our findings, the current diagnosis and his prognosis and a plan of action. STEMI protocol was activated at Lexington Medical Center. The patient is being transferred by ambulance to the cardiac catheterization laboratory. I have discussed with our interventionalists Dr. Lide who do emergent cardiac catheterization and decide further management. A CVTS consultation will be obtained if the VSD is confirmed. The patient will be given beta blockers and aspirin.

Orders:

1 Patient counseled on tobacco cessation.

FINAL MEDICATION LIST

ibuprofen 200 mg tablet take 2 tablet by ORAL route every 6 hours as needed with food

Tylenol Extra Strength 500 mg tablet take 2 tablet by ORAL route every day as needed

Electronically signed by: Himadri Dasgupta M.D. 05/28/2013 @ 1:18 PM

D: T:06/19/2013



PROVIDENCE HOSPITALS

A Ministry of the Sisters of Charity Health System

Providence Hospital

2001 Laurel St.

Columbia SC 29204

Phone: 803-254-3278 Fax: 803-376-8010



ECHOCARDIOGRAPHY REPORT

Name: CLARENCE WINFREY ID # 9112
Age/Sex: 50.78/M Date of Service: 5/28/2013 9:58:10 AM
DOB: [REDACTED] B/P 138/104 mmHg
Ht: 71.00 in Ref MD: HD
Wt: 240.00 lb BSA: 2.28

Technologist: MBS

Technical quality: Technical quality of the study is fair. Acoustic window is fair due to body habitus.

Procedure: 2D/M-Mode Echo - 93307, Cardiac Doppler - 93320 and Color Flow Imaging - 93325.

Diagnosis: CP, ABN ECG

M-Mode		Normal		Normal
IVSd		0.6-1.2 cm	RVID	<3.0 cm
LVPWd		0.6-1.2 cm	Ao root	3.0-3.7 cm
LVIDd		3.5-5.6 cm	LAd	1.5-4.0 cm
LVIDs			FS%	
2D		Normal		Normal
IVSd	1.35 cm	0.6-1.2 cm	RVID	2.90 cm
LVPWd	1.28 cm	0.6-1.2 cm	Ao root	<3.0 cm
LVIDd	6.24 cm	3.5-5.6 cm	LAd	3.0-3.7 cm
LVIDs	2.24 cm		FS%	1.5-4.0 cm
AV				
LVOT diameter		Peak Grad	AR P1/2 time	
V1		Mean Grad		
V2		AVA		
Pulmonary Pressure		Diastolic Function		
TR Vmax	2.25 m/s	MV DT	119 msec	
TR Pk Grad	20.2 mmHg	E velocity		
RA Pressure	10 mmHg	E velocity	cm/sec	
RVSP	30.2 mmHg			

Echocardiographic Findings:

Left Ventricle: Normal left ventricular size and normal systolic function. Estimated EF 55%. The mid to apical inferior and inferoseptal segment of the left ventricle was akinetic. Mild concentric left ventricular hypertrophy. Normal diastolic function. There is a moderate Across distal inferior septum, possible complication of acute MI ventricular septal defect with left to right shunting.

Right Ventricle: Mildly dilated right ventricular size with normal systolic function.

Left Atrium: The left atrium is normal in size.

Right Atrium: The right atrium is normal in size.

Mitral Valve: The mitral valve is structurally normal. No mitral stenosis. Trace regurgitation.

Aortic Valve: The aortic valve is structurally normal. No aortic stenosis. No regurgitation.

Pulmonic Valve: The pulmonic valve is structurally normal. Trace regurgitation.

Tricuspid Valve: The tricuspid valve is structurally normal. Mild tricuspid regurgitation.

CLARENCE WINFREY

9112

Pulmonary Hypertension: Normal pulmonary artery systolic pressure. Calculated systolic pressure is 30.2 mmHg.
Masses, Thrombi, Vegetations: No obvious intracardiac masses, thrombi or vegetations.

Pericardium/Extracardiac: No pericardial effusion.

Conclusions:

1. Normal left ventricular size and normal systolic function.
2. Estimated EF 55%.
3. The mid to apical inferior and inferoseptal segment of the left ventricle was akinetic.
4. Mild concentric left ventricular hypertrophy.
5. Mildly dilated right ventricular size with normal systolic function.
6. Moderate Across distal inferior septum, possible complication of acute MI ventricular septal defect with left to right shunting.

Electronically signed by: Himadri Dasgupta MD

Date: 5/28/2013 at 1:08:12 PM

cc: HIMS TouchChartLex EV

WINFREY, CLARENCE

56 years
Male

ID: 000009112

28-May-2013 11:14:26

SOUTH CAROLINA HEART

#10

Heart rate 127 bpm
PR interval 182 ms
QRS duration 150 ms
QT/QTc 352/482 ms
P-R-T axes 61 75 54

*** Age and gender specific ECG analysis ***
Signs tachycardia
Right bundle branch block
Inferior infarct, age undetermined
Abnormal ECG

Technician

Referred by:

Reviewed by:

6/3/13

-61-

40 Hz

25.0 mm/s

10.0 mm/mV

4 by 2.5s 3 rhythm lls

MAC5X-005A

1251 12/13

000150

Winfrey, Clarence
10 681533

D.O.B.: 08/19/1962 50
MCL2
Tech: JJ

05/28/2013 9:44:35

Heart Rate:	122 bpm
PR Interval:	490 ms
PR Interval:	194 ms
QRS Duration:	160 ms
QT Interval:	328 ms
QTc Interval:	436 ms
QT Dispersion:	68 ms
P-R-T Axis:	52° 70° 01°

*** CONSIDER ACUTE ST ELEVATION MI ***

Sinus tachycardia

Possible left atrial abnormality

Right bundle branch block

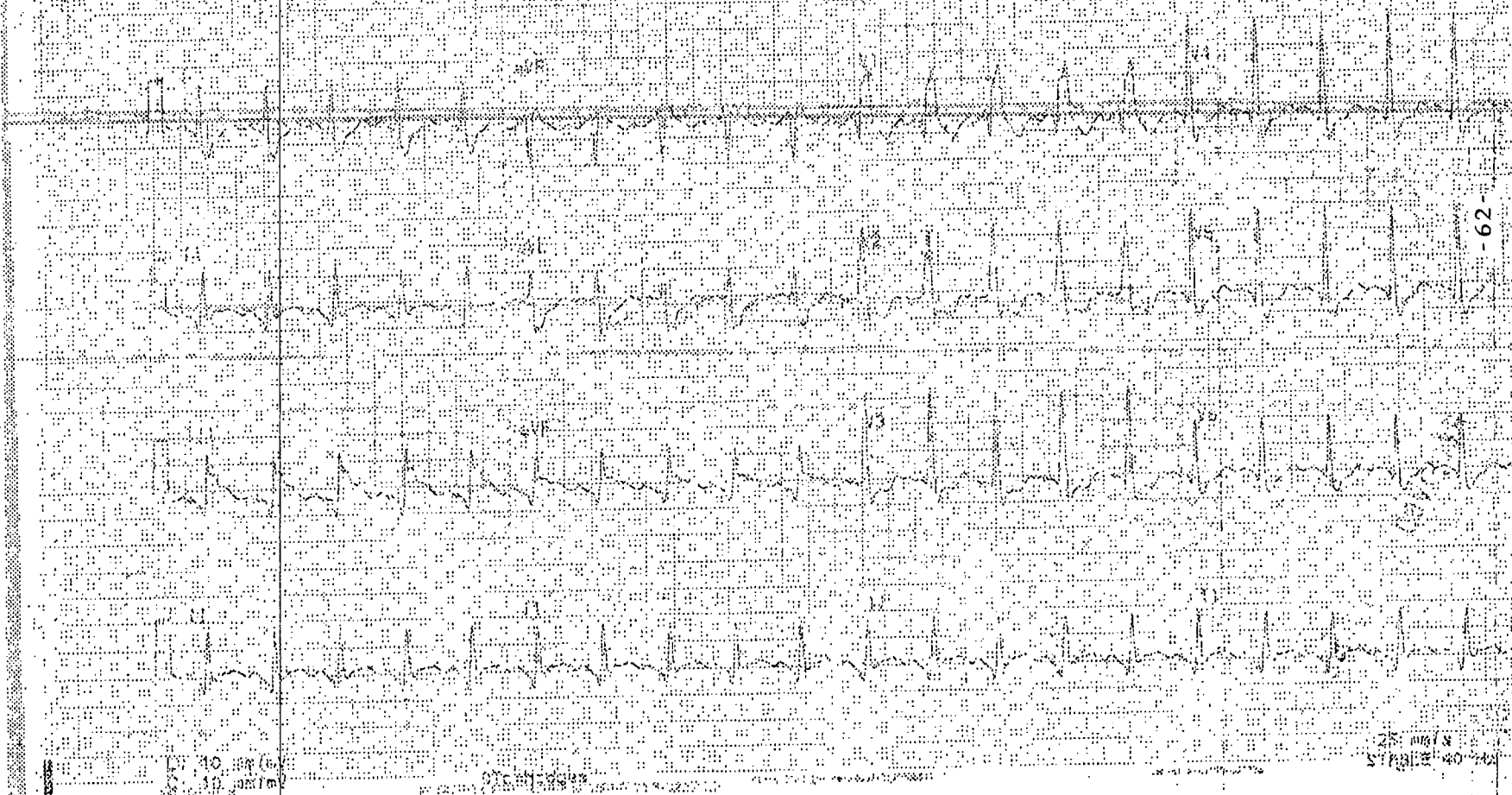
Intention ST elevation CONSIDER ACUTE INFARCT

Intention ST-T changes suggest myocardial injury/ischemia

Abnormal ECG

* Unconfirmed Analysis *

Shawfield MS



000151

-62-

Winifrey, C. Clarence
ID: 662509

DOB: 08/19/1962 50

MALE

Tach

Heart Rate: 123 bpm
PR Interval: 483 ms
PP Interval: 130 ms
QRS Duration: 162 ms
QT Interval: 332 ms
QTc Interval: 442 ms
QT Dispersion: 70 ms
P-R-T AXIS: S2° 69° 80°

*** CONSIDER ACUTE ST ELEVATION MI ***

Sinus tachycardia

Possible left atrial abnormality

Right bundle branch block

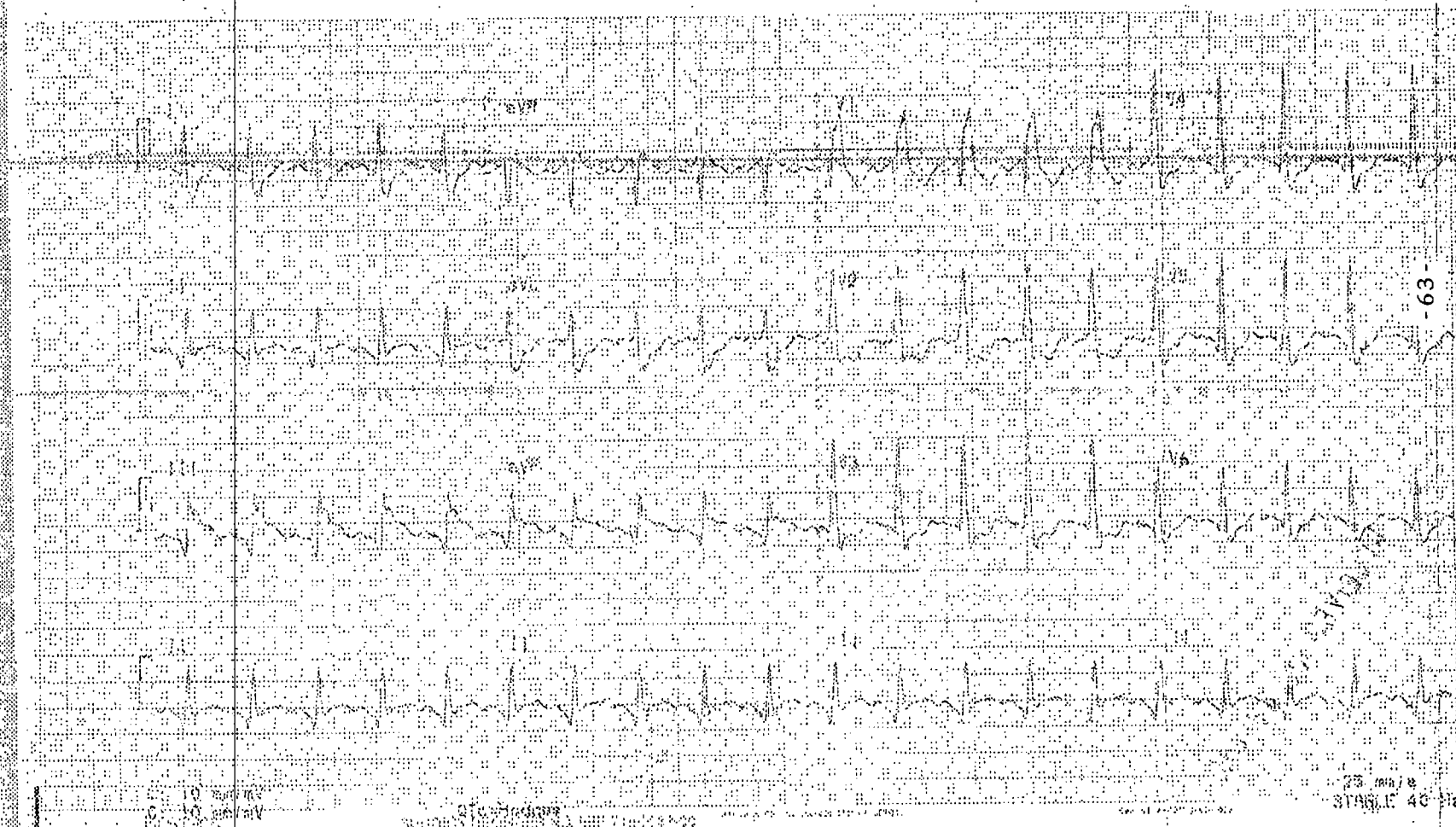
Inferior ST elevation, CONSIDER ACUTE INFARCT

Lateral ST-T changes suggest myocardial injury/ischemia

Abnormal ECG

* Unconfirmed Analysis *

Handwritten signature



25 min 8
STABLE 40 12

WINFREY, CLARENCE

50 years
Male

ID: 000099112

28-May-2013 11:15:25

SOUTH CAROLINA HEART

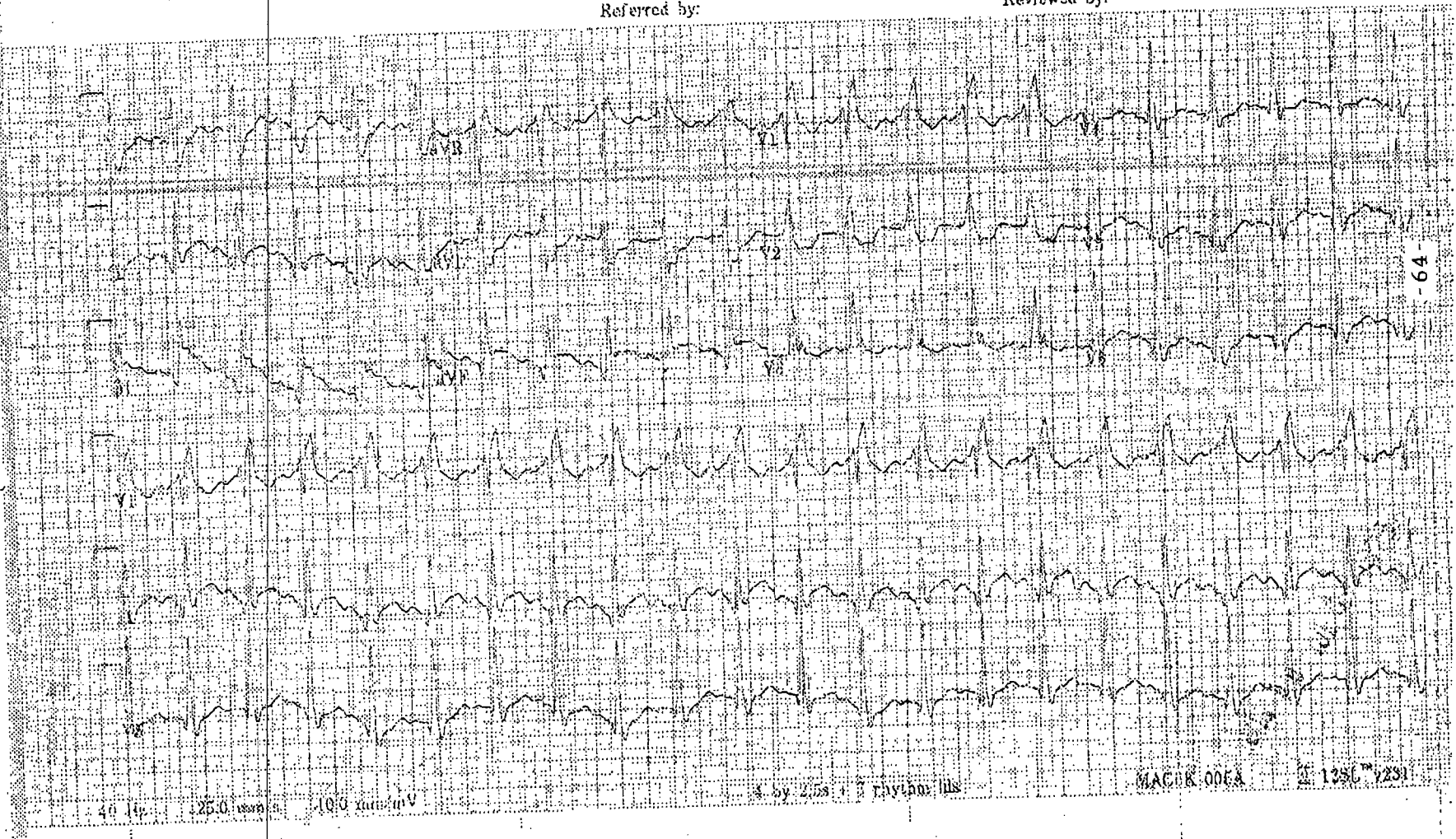
Veget. rate 127 bpm
PR interval 132 ms
QRS duration 150 ms
QT/QTc 332/482 ms
P-R-T axes 81 76 64

*** Age and gender specific ECG analysis ***
Sinus tachycardia
Right bundle branch block
Inferior infarct, age undetermined
Abnormal ECG

Technician:

Referred by:

Reviewed by:



000153

WORKERS COMPENSATION QUESTIONNAIRE

Please indicate your medical opinion by choosing one of the options below.

☒ IT IS MY OPINION that to a reasonable degree of medical certainty (more likely than not) the symptoms and injuries that I have treated Mr. Winfrey are a result of his work related accident on May 22, 2013, which occurred while he was working on a rotisserie when he accidentally came into contact with an exposed wire carrying 480 volts sending a severe electric shock through his left hand and arm injuring his heart.

☐ IT IS NOT MY OPINION that to a reasonable degree of medical certainty (more likely than not) the symptoms and injuries that I have treated Mr. Winfrey are a result of his work related accident on May 22, 2013, which occurred while he was working on a rotisserie when he accidentally came into contact with an exposed wire carrying 480 volts sending a severe electric shock through his left hand and arm injuring his heart.

K Greenfield MD 9-17-13
Karen J. Greenfield, M.D. Date
6

RECEIVED 07/19/2013 14:29

100
Rm 1



1028

ACCOUNT NUMBER	DATE	TIME	CHECKOUT TIME	TICKET NO.
662500	05/28/13	08:25am	DE SEVEN DAKS,	1103635

NAME & ADDRESS	DOB	RENDERER	INSURANCE BALANCE	ACCOUNT BALANCE	CURRENT CHARGES	AMOUNT PAID	NEW BALANCE
WINFREY, CLARENCE	(50 years)	M	\$0.00	\$0.00	\$0.00		

IBG	CELL	RELATION	REASON	NICKNAME	COPY
		SELF	NECK PAIN (shocked by 480 Volts, jerked down to shoulder)	(down to shoulder)	SP neck

Personal Hx	Family Hx	Social Hx	ROS (if or):	Allergies
DM	DM	Alcohol	Fatigue, Dizzy, Weak, WL Loss, Fever, Chills, Nasal Congestion, Sinus Pain, Ear Pain, Sore Throat, SOB, CP, Cough, Sputum, Wheeze, ABD Pain, N, V, D, Constip, Dysuria, Freq., Urgency, Back Pain, Pelvic Pain, Vag. D/C, Headache, Syncope, Rash	NKDA

HT	WT	BMI	PULSE	RESP	TEMP	LMP	Tetanus
29.4	128	128	128	20	97.5		

PHYSICAL: (see reverse) Omit if N/A
(✓ if rx'd, O if abnrm, & give details)

General
HEENT
Neck
Nodes
Lungs
CV
Abd
Back
Ext
GU
Neuro
Skin/Orals
Chaperone
LV
Injection
Nebulizer
Procedure
Pulse Ox

Chief Complaint: 480 V electrical shock on Thursday, June 27th, 2013. Woke up sweating this AM. C/o pain @ neck. No chest pressure.

Diagnosis: Tachycardia / electrical shock / muscle shock

DIAGNOSIS:	PSR Notes:
Tachycardia / electrical shock / muscle shock	99203-100 NEW 81024-25 93000-20

Signature	Date
K. Kreinfield	7-2-2013

UCI medical affiliates

Laboratory Report



- ☐ STAT
☐ WAITING
☐ NOT WAITING

Winfrey	Clarema	5-28-13	10:20	163
Last Name	First Name	Date	Time	Provider
062509		50	M	shock - electrical
Medical Record #	D-O-B	Age	Sex	Clinical Information

URINALYSIS

ROUTINE		MICROSCOPIC	
Color	amber	WBC (0-3/hpf)	
Appearance	clear	RBC (0-3/hpf)	
Glucose (neg)		Epith.	
Bilirub		Casts (neg)	
Keton		Crystals	
Sp. Gr	1.020	Bacteria	
Blood		Amorphous	
pH (sc)	6.0	Mucous	
Protei	1+		
Urobil	SC		
Nitrite	BLD		
Leuko	PRO		
	NIT		
	LEU		

CHEMISTRY

Glucose mg/dl	
70 - 115 mg/dl	
☐ Fasting	☐ Random
☐ Venous	☐ Finger stick

WET PREP - KOH

Trichomonas (neg)
Yeast (neg)
Clue Cells (neg)
WBC (0 to 3)
Epithelial (0 to 3)
Bacteria (trace)

MISCELLANEOUS

Mono Test (neg)
Urine HCG
Hemocult (neg)
☐ 1 slide ☐ 2 Slides ☐ Home kit
H. Pylori (neg)
Microalbumin (neg)
HGBAIC (3.9-6.5)
Rapid Strep A (neg)

Doctors Care Seven Oaks
 100 Jimmy Love Lane
 Columbia, SC 29212
 CLIA #42106694394

OTHER LABS

Collected By	Time	Performed By	Time
		K. Kneufeld MD	5-28-13
Phoned To	Time	Reviewed By	Date

[LAB-F001-17-07]

Wintrey, Clarence
IO: 662509

05/28/2013 9:44:36

D.O.B.: [REDACTED] 50
MALE
Tech: JJ

Vent. Rate: 122 bpm
PR Interval: 490 ms
PR Interval: 184 ms
QRS Duration: 160 ms
QT Interval: 328 ms
QTc Interval: 436 ms
QT Dispersion: 68 ms
P-R-T AXIS: 52° 70° 81°

*** CONSIDER ACUTE ST ELEVATION MI ***

Sinus tachycardia

Possible left atrial abnormality

Right bundle branch block

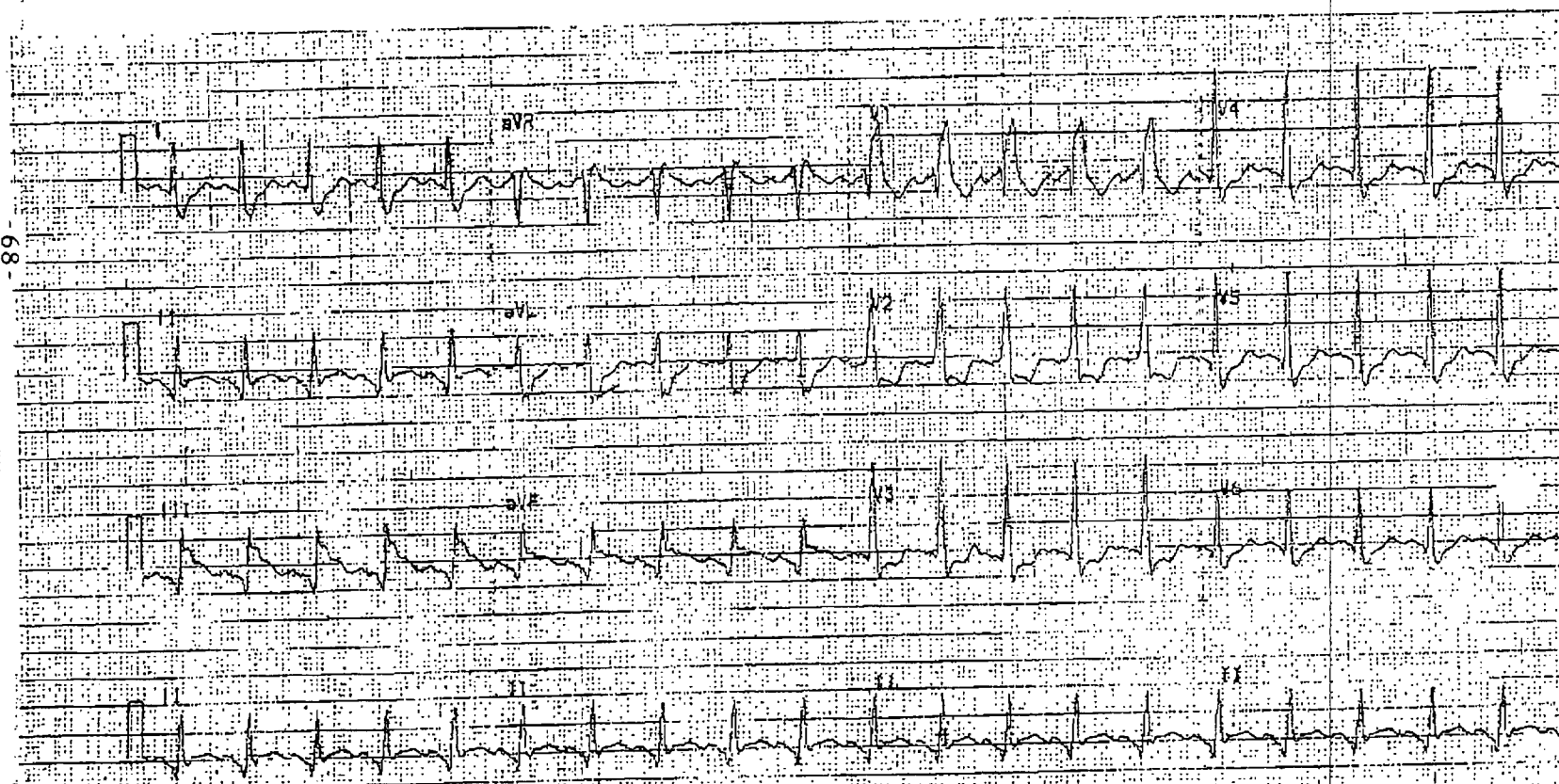
Inferior ST elevation, CONSIDER ACUTE INFARCT

Lateral ST-T changes suggest myocardial injury/ischemia

Abnormal ECG

* Unconfirmed Analysis *

Greenfield MD



Lead 10: me/mV
Lead 11: me/mV

QTc Hodges

25 mm/s
STABLE 40 Hz

JUL-19-2013 14:15 From: UCI-Med

11:19 PM Dept 803 376 4335

RECEIVED 07/19/2013 14:29
To 3709

Page: 5/10

000158

Winfrey, Clarence
ID: 662509

05/28/2013 9:44:54

D.O.B.: 50
MALE
Tech: JJ

Vent. Rate: 123 bpm
RR Interval: 485 ms
PR Interval: 180 ms
QRS Duration: 162 ms
QT Interval: 332 ms
QTc Interval: 442 ms
QT Dispersion: 70 ms
P-R-T AXIS: 52° 69° 80°

*** CONSIDER ACUTE ST ELEVATION MI ***

Sinus tachycardia

Possible left atrial abnormality

Right bundle branch block

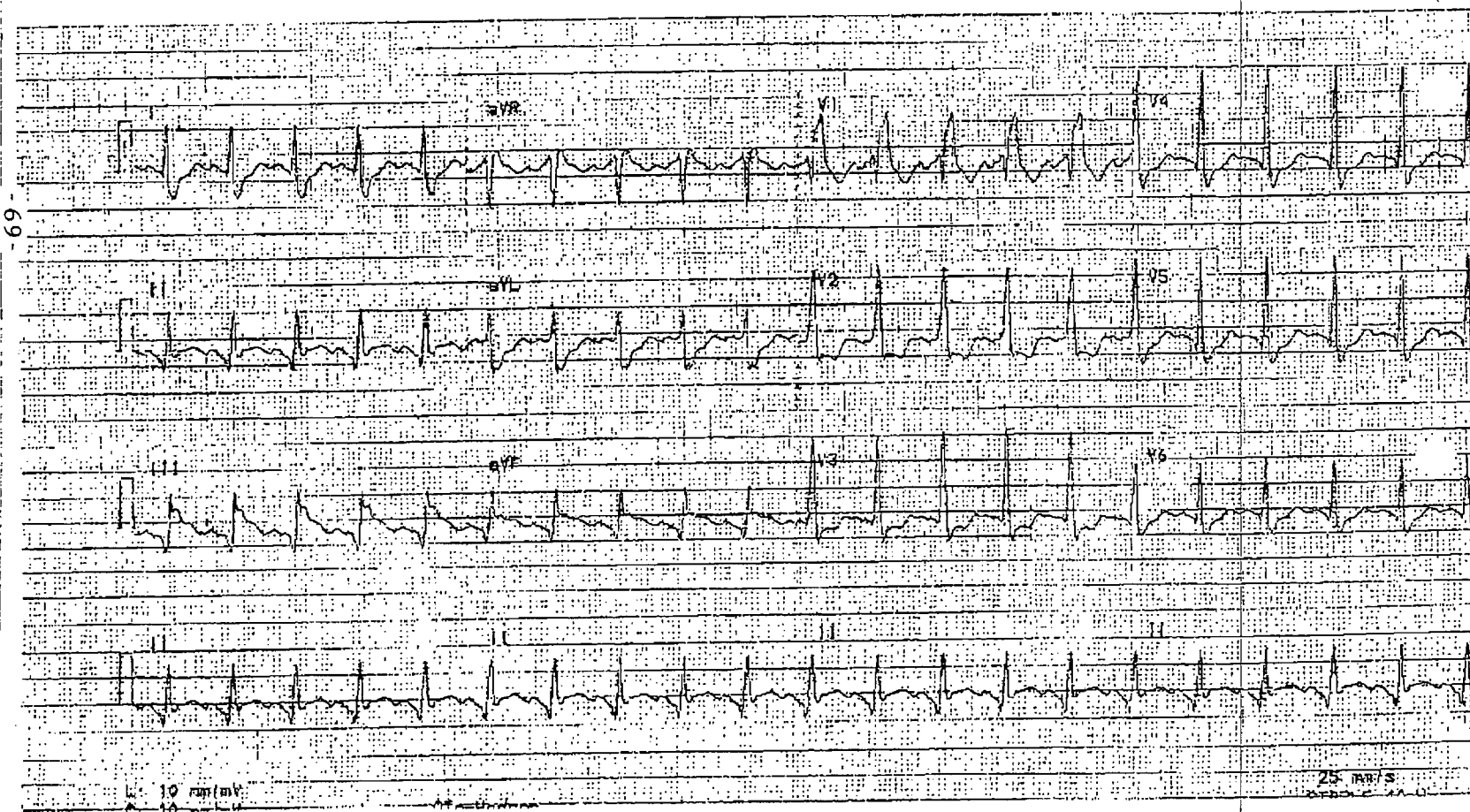
Inferior ST elevation, CONSIDER ACUTE INFARCT

Lateral ST-T changes suggest myocardial injury/ischemia

Abnormal ECG

* Unconfirmed Analysis *

Handwritten signature



JUL-19-2013 14:15 From:UCI-Med

Ilina Dept 903 376 4335

To: 1709

RECEIVED 07/19/2013 14:29

Page:6-10

000159



Return To Work Form

CENTER LOCATION:

☐ Aiken Mall - 850 Aiken Mall Drive, Aiken, SC 29803 - (803) 648-1464	☐ North Augusta - 1520 Knox Avenue, North Augusta, SC 29841 - (803) 277-1120
☐ Augusta Road - 2836 Augusta Road, West Columbia, SC 29170 - (803) 939-0545	☐ Northst - 10040 Two Notch Road, Columbia, SC 29223 - (803) 788-1153
☐ Bellline - 511 Bellline Boulevard, Columbia, SC 29215 - (803) 782-4051	☐ Orangeburg - 1748 St. Matthews Road, Orangeburg, SC 29118 - (803) 536-0613
☐ Cayce - 977 Knox Abbott Drive, Cayce, SC 29033 - (803) 794-0476	☐ Red Bank - 1847 South Lake Drive, Lexington, SC 29073 - (803) 350-8298
☐ City of Columbia - 2012 Market Street, Ste. 112, Columbia, SC 29204 - (803) 231-3122	☐ Ridgewood - 4214 Hardscrabble Road, Columbia, SC 29223 - (803) 736-8045
☐ Columbia East - 7653 Gamewell Ferry Road, Columbia, SC 29209 - (803) 783-2661	☒ Seven Oaks - 100 Jimmy Love Lane, Columbia, SC 29212 - (803) 772-5030
☐ Forest Acres - 4500 Forest Drive, Suite A, Columbia, SC 29204 - (803) 738-0522	☐ Sumter - 2475 Broad Street, Sumter, SC 29150 - (803) 778-6555
☐ Lexington - 247 Columbia Avenue, Lexington, SC 29072 - (803) 359-5533	☐ Wateree - 1060 Highway 1 South, Lugert, SC 29078 - (803) 438-9759
☐ Newberry - 1410 Wilson Road, Newberry, SC 29108 - (803) 276-2106	☐ West Columbia - 3240 Sunset Blvd, West Columbia, SC 29169 - (803) 796-4251
☐ North Aiken - 1029 York Street NE, Aiken, SC 29801 - (803) 648-4119	

PATIENT INFORMATION:

Name: Clarence Wintrey Arrival Time: 835 Discharge Time: _____
 Date: 5-28-13 Company Name: _____

WORK STATUS: (Check Appropriate Boxes)

- ☐ 1. May perform full duty activities as of _____ without accommodations.
- ☒ 2. Off duty due to work-related condition.
 Estimated return to work date with modified duty: _____
 Estimated return to work date for full duty: _____
 Return for re-evaluation at this location on _____ Time: _____
- ☐ 3. May work with the following accommodations as of: _____
- ☐ No lifting more than _____ lbs.
 - ☐ No operation of hazardous or fast-moving machinery, no diving.
 - ☐ Ground level work only, no ladders or heights.
 - ☐ No repetitive bending, stooping, squatting, pushing, jacking, twisting, or bouncing.
 - ☐ No continuous standing and/or sitting.
 - ☐ Minimal walking or climbing (including stairs).
 - ☐ Limited use of _____
 - ☐ No overhead lifting.
 - ☐ No high repetitive hand activities for extended periods of time.
 - ☐ No use of _____
- ☐ 4. Has reached Maximum Medical Improvement (MMI)
- ☐ 5. Return for re-evaluation at this office on _____ Time: _____

Additional Comments: _____

PATIENT DISCHARGE INSTRUCTIONS:

Diagnosis: Cardiac arrhythmia Medications: ☐ as directed ☐ as needed

Wound or Injury Care: ☐ keep dry and clean ☐ do not remove dressing ☐ elevate extremity ☐ warm soaks

☐ ice every _____ ☐ apply heat every _____ ☐ wear elastic support/immobilizer/keep taped

☐ home exercise instructions given ☐ follow instructions sheet given ☐ bed rest for _____

REFERRAL: (If a referral is made for physical therapy, or to another physician, please complete this section.)

To: Dr Dasgupta Date: _____ Time: _____

For: arrhythmia

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my employer.

Employee Signature: [Signature] Date: 5-28-13 Provider Signature: [Signature] Date: _____

JUL-19-2013 14:16 From:UCI-Med .ling Dept 803 376 4335 To: 1709 Page:8/10

05/28/2013 09:09 7044674 ARCHWAY SERVICE PAGE 01/02
APR-15-2013 05:01 From:DPS CARE SEVEN DAKS 803 551 5477 To:1704467999 Page:1/1

****COMPLETE AND FAX BACK TO 803-551-5477****



Employer Authorization Form

Complete this form and give it to your Doctor's Care Center

Patient Name: Clarence Winfrey Date: 5-28-2013
Company: Archway Service Contact/Phone: [REDACTED] Fax: [REDACTED]
Company Address: [REDACTED] B1 Account #: [REDACTED]
Temporary Staffing: [REDACTED] Contact/Phone: NA

REQUIRED SERVICES (check all that apply)

Work Related	Physical Examination
☒ Worker's Compensation Injury Treatment Date of Injury: <u>5-23-2013</u> Type of Injury: <u>Back neck</u>	☐ DOT Physical ☐ Pre-Employment PE ☐ Respirator Clearance PE ☐ Physical (Other): _____ Specify: _____
☐ Post-accident Drug Screen required	
Drug Screen/Breath Alcohol Testing	Special Examination
☐ Drug Screen: ☐ NIDA (check agency below) DOT Agency: ☐ FMCSA ☐ FTA ☐ FMMSA ☐ FAA ☐ FKA ☐ USCG ☐ Non-NIDA (fill in test code below) ☐ 5 Panel ☐ 9 Panel ☐ 10 Panel ☐ 7 Panel ☐ Other: _____ ☐ Urine	☐ Audiogram ☐ Blood Lead Level ☐ Chest X-ray ☐ Hepatitis B Immunization ☐ Hepatitis B Profile ☐ Spirometry with Letter ☐ PPD (TB test) ☐ Tetanus ☐ Flu Shot ☐ Other: _____ ☐ Other: _____ ☐ Other: _____
☐ Breath Alcohol ☐ NIDA ☐ Non-NIDA	☐ Other: _____

REQUIRED FOR ALL WORKER'S COMPENSATION CLAIMS:

Has Employer filled out First Report of Injury? ☐ Yes ☒ No (send copy if available)
Where are claims to be filed? ☒ Employer ☐ Carrier
WC Carrier: Montgomery Ins. Liberty Mutual
Address: _____
City: _____ State: _____ Zip: _____

This Certifies that the above information is correct.
I authorize the medical provider to provide medical treatment to the employee named above.

Signature of Company Authorized Number: Susan M. Kiser Date: 5-28-2013
Printed Name: Susan M. Kiser Position Title: Bookkeeper

For Internal Use Only	
Form Completed By	Initials
Center Name	Date

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(CCC-601-Rev 11)

05/26/2013 09:00 7044574701

ARCHWAY SERVICE

PAGE 02/02

ACORD WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS							
EMPLOYER (NAME & ADDRESS INCL. ZIP) Archway Service, Inc [REDACTED]		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE			
JURISDICTION		JURISDICTION CLAIM NUMBER					
INSURED REPORT NUMBER							
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #: PHONE #					
SIG CODE		EMPLOYER FOR 5110663955					
CARRIER/CLAIMS							
CARRIER (NAME, ADDRESS & PHONE NO) Montgomery Insurance Company Toll Free Express Reporting 1-800-561-0178 Fax Claims Reporting 1-888-854-2329 Glass Claims 1-800-835-2257		POLICY PERIOD 09/12/2012 TO 09/12/2013 CHECK IF APPROPRIATE ☐ SELF INSURANCE		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)			
CARRIER PEN		POLICY/SELF-INSURED NUMBER XWA55266239		ADMINISTRATOR PEN			
AGENT NAME & CODE NUMBER Peoples First							
EMPLOYEE/INJURY							
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED	
ADDRESS (INCL. ZIP)		SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN		MARITAL STATUS ☐ UNMARRIED ☐ SINGLE/SEPARATED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN		OCCUPATION/JOB TITLE	
PHONE		# OF DEPENDENTS		EMPLOYMENT STATUS		NCCI CLASS CODE	
RATE		PER: DAY MONTH OTHER		# DAYS WORKED/ WEEK		FULL PAY FOR DAY OF INJURY? YES NO	
						DID SALARY CONTINUE? YES NO	
OCCURRENCE/TREATMENT							
THAT EMPLOYER BEGAN WORK		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		LAST WORK DATE	
CONTACT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED			
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?		TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE			
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR OTHERS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL		CAUSE OF INJURY CODE					
DATE RETURNED TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		YES NO	
				WERE THEY USED?		YES NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HRS ☐ FUTURE MAJOR MEDICAL LOSS TIME ANTICIPATED			
WITNESSES (NAME & PHONE #)		PHONE NUMBER					
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARED BY NAME & TITLE			

ACORD 4 (7/97)

SEE BACK FOR IMPORTANT STATE

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000162

Patient: Winfrey, Clarence B (MR#M002010261) Printed by HARLEY, SHARON D [51... Page 1 of 2

Winfrey, Clarence B (MR # M002010261)

Patient Information

Patient Name	Sex	DOB
Winfrey, Clarence B	Male	8/19/1962

Op Note signed by Jeffrey Allen Travis, MD at 05/30/13 0650

Author:	Jeffrey Allen Travis, MD	Service:	(none)	Author	Physician
Filed:	05/30/13 0650	Note	05/29/13 2002	Type:	
Trans	Available	Time:		Trans ID:	3M927377
Status:					
Dictation	05/29/13 2002	Trans	05/30/13 0342	Trans	Operative Note
Time:		Time:		Doc	
				Type:	

DATE OF PROCEDURE: 05/29/2013

PREOPERATIVE DIAGNOSIS

1. Acute myocardial infarction.
2. Electrocutation.
3. Acute post myocardial infarction ventricular septal defect.
4. Severe pulmonary hypertension.
5. Cardiogenic shock.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED

1. Repair of post infarct VSD.
2. Coronary artery bypass grafting x1 with saphenous vein graft to the ramus intermedius.
3. Percutaneous placement of intraaortic balloon pump.

SURGEON: Jeffrey A. Travis, MD

ASSISTANTS: Steven W. Marra, MD, and Victor Gomez, PA-C

ANESTHESIA: General endotracheal.

DESCRIPTION OF PROCEDURE: The patient was brought to the Operating Room and placed supine on the Operating Room table. After appropriate monitors were placed, general anesthesia was induced. The patient's chest, abdomen, and lower extremities were prepped and draped and isolated into a sterile field. We made a midline incision over the chest and carried down to subcutaneous tissues using electrocautery. A median sternotomy was performed. Thymus gland was taken down to the level of the innominate vein. The greater saphenous vein was harvested from the left lower extremity using endoscopic techniques. It was dilated and found to be adequate for grafting. We opened up the pericardium and tacked up as a pericardial well. The patient was systemically heparinized. The ascending aorta was normal to palpation. The ascending aorta was cannulated using a 20-French

Winfrey, Clarence B (MR # M002010261) Printed by Sharon D Harley [5173] at 6/26/13, 10:00 AM

Patient: Winfrey, Clarence B (MR#M002010261) Printed by HARLEY, SHARON D [51... Page 2 of 2

Winfrey, Clarence B (MR # M002010261)

arterial flow cannula. We put dual stage venous cannulas in, although we had a difficult time directing the SVC cannula in the correct location. We could not pass a coronary sinus catheter despite multiple attempts. We placed an ascending aortic root vent. We did have to crash on bypass due to severe hemodynamically compromise. The patient also had very significant pericarditis with large calcific plaques located anteriorly and posteriorly. These were unlike soldier plaques. They were heavily calcified and there was a real weirdness to the adhesions throughout. At this time, after going on bypass, we cross clamped the ascending aorta and arrested the heart with warm antegrade blood cardioplegia. With the heart completely arrested, we gave cold antegrade blood cardioplegia and gave this at 20-minute intervals throughout the case. We begun the procedure by dissecting out the ramus intermedius. It was intramyocardial. It was heavily diseased. It was grafted saphenous vein end to side using 7-0 Prolene. It was tested under pressure and found to be hemostatic. We then positioned the heart and exposed the base of the heart, the large infarct in the posterior descending coronary artery. The LV was opened along the anterior longitudinal incision, and this was obviously white infarcted tissue. This was () into the infarct for this tissue. We were able to identify the VSD, which was kind of basilar and apical in location. We placed multiple pledgeted sutures, affixing a patch to cover the left ventricular side of this, and then brought that patch out of the ventriculotomy. It was sutured into place circumferentially with pledgeted sutures and then a running suture was also added to make it watertight. At this time, we closed the ventriculotomy using 2 long strips of felt along either side, sewing 1st with a 4-0 Prolene and then with a 2-0 Ticron on an MH needle. We placed several buttressing sutures and also placed BioGlue over this. At this time, we turned our attention to the ascending aorta and created a 4.8-mm punch in the ascending aorta. The vein graft was anastomosed to the ascending aorta using 6-0 Prolene. The heart was de-aired. Cross clamp was removed. At this time, we placed a percutaneous intraaortic balloon pump through the right femoral artery using ultrasound guidance. We began ventilating the patient. We placed atrial and ventricular pacing wires. We weaned the patient from bypass. Initially he separated from bypass but had some hemodynamic compromise, and we went back on bypass. Echo initially looked very good, and the ventricular function waned over the first few minutes off bypass. It appeared that perhaps the patient got some air. We gave 10 minutes of wait time and then re-separated from bypass without difficulties. Ventricular function was good. There was no evidence of VSD. At this time, both venous cannulas were removed. The defect was repaired with the previously placed pursestring suture. Protamine sulfate was administered to reverse the heparin, and the ascending aortic root vent was removed. The defect was repaired with the previously placed horizontal mattress pledgeted suture. At this time, with hemostasis adequate, the ascending aortic cannula was removed. The defect was repaired with the previously placed horizontal mattress pledgeted suture. Hemodynamics and hemostasis were adequate. Chest was closed using #6 sternal wire and a Pioneer Cable system. The wound was closed in layers. A sterile dressing was applied. The patient was transported to the Intensive Care Unit in satisfactory condition.

T: 05/30/2013 03:42 A/cir

Winfrey, Clarence B (MR # M002010261) Printed by Sharon D Harley [5173] at 6/26/13 10:00 AM



LEXINGTON MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, SC 29169

WINFREY, CLARENCE B
MRN: M002010261
DOB: [REDACTED] Sex: M
Adm: 5/28/2013, D/C: 6/7/2013

Patient Demographics

Address	Phone
[REDACTED]	[REDACTED]

Admission Information - Patient Record Only

Arrival Date/Time:	None	Admit Date/Time:	05/28/2013 3:23 PM	IP Adm. Date/Time:	05/28/2013 3:23 PM
Admission Type:	Urgent	Point of Origin:	Physician Or Clinic Referral	Admit Category:	None
Means of Arrival:	None	Primary Service:	Med/surg	Secondary Service:	N/A
Transfer Source:	None	Service Area:	Lchs Service Area	Unit:	Lmc 4th Flr Nt
Admit Provider:	Jeffrey Allen Travis, MD	Attending Provider:	Himadri Dasgupta, MD	Referring Provider:	None

Discharge Summaries

Discharge Summaries signed by Jeffrey Allen Travis, MD at 06/11/13 0636

Author:	Jeffrey Allen Travis, MD	Service:	(none)	Author Type:	Physician
Filed:	06/11/13 0636	Note Time:	06/07/13 1405		

REASON FOR ADMISSION: Acute MI and acute post infarct ventricular septal defect.

DISCHARGE MEDICATIONS: The patient is given prescriptions for aspirin 81 mg p.o. daily, vitamin D 500 mg b.i.d., Lopressor 25 mg b.i.d., multivitamin a day, Lasix 40 mg a day for 30 days, potassium chloride 20 mEq a day with the Lasix for 30 days, Altace 2.5 mg a day, Amiodarone 400 mg p.o. b.i.d. for 3 months, Plavix 75 mg a day, Pepcid 20 mg p.o. b.i.d. He was also given a prescription for Lorlab 5/500, 1-2 tabs p.o. every 4 - 6 hours p.r.n. pain (#60, no refill).

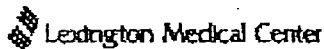
PROCEDURES DURING ADMISSION

1. Transthoracic echocardiogram on May 28.
2. Cardiac catheterization on May 28.
3. Urgent coronary artery bypass grafting x1 with saphenous vein graft to the ramus intermedius, repair of postinfarct ventricular septal defect with pericardial patch, and placement of intraaortic balloon pump done on May 29, 2013.
4. Repeat echocardiogram on June 27, 2013.

DISCHARGE DIAGNOSIS(ES)

1. ST-elevation myocardial infarction, inferior wall.
2. Postinfarct ventricular septal defect.
3. Coronary artery disease.
4. Ventricular tachycardia.
5. Hypertension.
6. Congestive heart failure.
7. Pulmonary hypertension.

HISTORY OF PRESENTING ILLNESS: For full H & P, please see dictated Admission H & P, CT Surgery. In brief, the patient is a 50-year-old gentleman who on Wednesday prior to this admission was working on some electrical equipment and got a large shock. He went home from work and experienced significant chest pain as well as back and shoulder pain. This persisted through the weekend and he really did not do much over the weekend other than sit around and watch TV. He experienced persistent pain and presented to the Urgent Care Center where his EKG was abnormal and he was sent to the hospital.



LEXINGTON MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, SC 29169

WINFREY, CLARENCE B
MRN: M002010261
DOB: [REDACTED] Sex: M
Adm: 5/28/2013, D/C: 6/7/2013

Discharge Summaries (- continued-)

HOSPITAL COURSE: The patient was admitted with the above stated history. Again, he presented with an injury-type current ST elevation and was taken emergently to the Cardiac Catheterization Lab where he was found to have an occlusion of his posterior descending coronary artery as well as 3-vessel coronary disease and a VSD. We were asked to see the patient in consultation. Interestingly, the patient was fairly stable despite the magnitude of things. We assessed him and took him to the Operating Room the following morning where he underwent a single vessel bypass as outlined above and repair of a postinfarct ventricular septal defect. Also electively placed an intraaortic balloon pump to unload the patient prior to coming off cardiopulmonary bypass. He tolerated the procedure without complications and was taken to the Intensive Care Unit postoperatively. His drips were weaned early postop as well as his intraaortic balloon pump and that was removed without incident. He remained in the Intensive Care Unit and had gotten him up to the chair, began to do some ambulation. He was back in his chair and had a loss of consciousness and telemetry showed that he was in ventricular tachycardia. He was quickly cardioverted with 120 joules and converted back to his injury current type pattern. He was rebolused on Amiodarone and continued on his Amiodarone drip. We asked Cardiology to see the patient who agreed with management and continued to follow him. He did well with maintaining him on the Amiodarone drip and we eventually transferred him to the Telemetry floor 2 days ago where he has continued to make steady progress. Again, he had an ST-elevation MI and a low ejection fraction, and of course in the setting of ventricular tachycardia we asked the reps with LifeVest to fit him for a device which he will wear for the next 90 days and then we will reassess him with a repeat echocardiogram 90 days after his surgery. This will be to assess his need for AICD. He was fitted for his LifeVest today. He had a repeat echocardiogram that showed improvement in his ejection fraction. The final report is pending on that. The patient continues to make steady progress. He is ambulating, voiding, having bowel movements without complaints. His wounds are clean, dry and intact. His sternum is light.

DISCHARGE DIAGNOSTIC STUDIES: Most recent labs on the patient's chart prior to discharge show a sodium of 131, potassium 4.1, chloride 100, CO2 25, BUN 17, creatinine 0.8, glucose 100, white count 12, HGB 10.8, HCT 33, platelets 371. His troponins on admission were 4.140. Total bilirubin 0.6, direct 0.2, AST 38, ALT 81, GGTP 52, alkaline phosphatase 68. Heparin-dependent platelet antibody was negative. MRSA screening was negative. Cholesterol 125, LDL 80, HDL 23, triglycerides 109, non HDL was 102. He had been started on a statin early postop, but his LFTs were elevated and we stopped it. Urinalysis was negative. HGB A1C was 5.4.

DISPOSITION: To home.

DISCHARGE FOLLOW UP

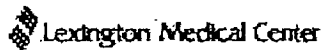
1. Jeff Travis, MD, in 2 weeks.
2. Lanneau Lide, MD, in 4 weeks.
3. The patient will need a repeat echocardiogram in 90 days from the date of his surgery.

T: 06/07/2013 03:09 P/brb

Electronically Signed by Jeffrey Allen Travis, MD on 06/11/13 0638

Discharge Summaries signed by Victor A. Gomez, PA-C at 06/07/13 1420

Author:	Victor A. Gomez, PA-C	Service:	(none)	Author	Physician Assistant
Filed:	06/07/13 1420	Note Time:	06/07/13 1420	Type:	
				Cosigner:	Jeffrey Allen Travis, MD at 06/08/13 0827



LEXINGTON MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, SC 29169

WINFREY, CLARENCE B
MRN: M002010261
DOB: 8/19/1962, Sex: M
Adm: 5/28/2013, D/C: 6/7/2013

Discharge Summaries (- continued-)

Discharge dictated #1193644

6/7/2013, 2:20 PM

Name: Clarence Winfrey	DOB: [REDACTED]
Acct: 100004421483	Admit: 5/28/2013

Electronically signed by Gomez, Victor A.

Electronically Signed by Jeffrey Allen Travis, MD on 06/08/13 0827

ED Notes

No notes of this type exist for this encounter.

Final Diagnoses

Principal [P]	Code	Name	POA	CC	HAC	Affects DRG
	410.41	Acute myocardial infarction of other inferior wall, initial episode of care	Yes	CC		Yes
	785.51	Cardiogenic shock	Yes	MCC		Yes
	427.1	Paroxysmal ventricular tachycardia	No	CC		No
	429.71	Acquired cardiac septal defect	Yes	CC		No
	416.8	Other chronic pulmonary heart diseases	Yes			
	287.5	Thrombocytopenia, unspecified	Yes			
	414.01	Coronary atherosclerosis of native coronary artery	Yes			
	401.9	Unspecified essential hypertension	Yes			
	994.8	Electrocution and nonfatal effects of electric current	Yes			
	E925.9	Accident caused by unspecified electric current	Yes			
	E849.3	Place of occurrence, industrial places and premises	Exempt from POA reporting			
	E000.0	Civilian activity done for income or pay	Exempt from POA reporting			
	305.1	Tobacco use disorder	Yes			
	305.00	Alcohol abuse, unspecified	Yes			

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit

Generated on 6/24/2013 9:10 AM

Page 3



Statement: Bobby Ruppe

RE: Clarence Winfrey

On May 22, 2012 Clarence called me and said a wire in the rotisserie was broken. Clarence had not seen the wire. While tracing out light wires he got shocked. He jerked his neck to get away and hurt his neck. I told him that if he needed to go to the doctor to go, that worker's compensation would pay. He did not want to go to the doctor because of money and said he would be okay in a few days. I told him if he got hurt at work, worker's compensation would pay. He was told this by me several times. He did go to the doctor on the Tuesday the 27th, and they said it was not his neck, it was his heart. He was sent to the hospital and they performed surgery on him that day.

Bobby Ruppe

Service Manager

09-23-2013

Bobby Ruppe

From: Clarence Winfrey
Sent: Monday, May 27, 2013 12:27 PM
To: Bobby Ruppe
Subject: Re: They can't do anything

Wire in rotisserie broken did not see traced out light wire and got hit by power jerked my neck to get away from rotisserie I do not want to lose my job from being hurt

Sent from my iPad

On May 27, 2013, at 12:21 PM, "Bobby Ruppe" <Bobby.Ruppe@asi-cfc.com> wrote:

> If you did it at work workers comp should pay we will have to talk to Susan tomorrow go ahead and do me a letter on what happened and email it to me

>

> Sent from my iPhone

>

> On May 27, 2013, at 11:52 AM, "Clarence Winfrey" <clarence.winfrey@asi-cfc.com> wrote:

>

>> They can't do anything for neck pain I've been trying to stay away med help do to money but if I have to go to hospital that's means I'm hurt I I'm trying to avoid

>>

>> Sent from my iPad

>>

>> On May 27, 2013, at 11:47 AM, "Bobby Ruppe" <Bobby.Ruppe@asi-cfc.com> wrote:

>>

>>> What did they say

>>>

>>> Sent from my iPhone

>>>

>>> On May 27, 2013, at 11:15 AM, "Clarence Winfrey" <clarence.winfrey@asi-cfc.com> wrote:

>>>

>>>>

>>>>

>>>> <photo.JPG>

>>>>

>>>>

>>>>

>>>> Sent from my iPad

5-23/13

DRIVERS DAILY LOG

START TIME: 5:30

END TIME: 1:30

DATE: 5/22/2013

DRIVER: HI57

*Clarence
Winfrey*

BEGINNING MILEAGE: 03011.9

ENDING MILEAGE: 03187.3

Store Name and Number: Publix 0067

Mileage Start: 03011.9

Mileage End: 03031.6

Activity: Driving

Activity: On Duty

Start Time: 5:30

End Time: 6:00

Start Time: 6:00

End Time: 7:45

Notes: Found big problem and I got shocked hard

Store Name and Number: Wall mart 514

Mileage Start: 03031.6

Mileage End: 03097.4

Activity: Driving

Activity: On Duty

Start Time: 7:45

End Time: 9:00

Start Time: 9:00

End Time: 10:15

Notes:

Store Name and Number: Wall mart 881

Mileage Start: 03097.4

Mileage End: 03147.5

Activity: Driving

Activity: On Duty

Start Time: 10:15

End Time: 11:30

Start Time: 11:30

End Time: 12:15

Notes:

Store Name and Number:

Mileage Start:

Mileage End:

Activity:

Activity:

Start Time:

End Time:

Start Time:

End Time:

Notes:

Store Name and Number:

Mileage Start:

Mileage End:

DRIVERS DAILY LOG

START TIME: 8:00

END TIME: 3:30

DATE: 5/23/2013

*Clarence
Winfrey*

DRIVER: H157

BEGINNING MILEAGE: 03189.6

ENDING MILEAGE: 03257.9

Store Name and Number: <u>Wall mart 881</u>	
Mileage Start: <u>03189.6</u>	Mileage End: <u>03196.4</u>
Activity: <u>Driving</u>	Activity: <u>On Duty</u>
Start Time: <u>8:00</u>	End Time: <u>8:30</u>
Start Time: <u>8:30</u>	End Time: <u>3:30</u>
Notes: <u>Went to whaley's two times then get call none of</u> <u>The fryers are working go back they lost power going to fryers</u>	

Store Name and Number: _____	
Mileage Start: _____	Mileage End: _____
Activity: _____	Activity: _____
Start Time: _____	End Time: _____
Start Time: _____	End Time: _____
Notes: _____	

Store Name and Number: _____	
Mileage Start: _____	Mileage End: _____
Activity: _____	Activity: _____
Start Time: _____	End Time: _____
Start Time: _____	End Time: _____
Notes: _____	

Store Name and Number: _____	
Mileage Start: _____	Mileage End: _____
Activity: _____	Activity: _____
Start Time: _____	End Time: _____
Start Time: _____	End Time: _____
Notes: _____	

Store Name and Number: _____	
Mileage Start: _____	Mileage End: _____
Activity: _____	Activity: _____
Start Time: _____	End Time: _____
Start Time: _____	End Time: _____
Notes: _____	

Store Name and Number: _____	
Mileage Start: _____	Mileage End: _____
Activity: _____	Activity: _____
Start Time: _____	End Time: _____
Start Time: _____	End Time: _____
Notes: <u>I'm going to a friend doctor tonite to look at my neck he says sounds like wipe lash</u>	

Lunch Hours: _____ Driving Hours: 1 Labor Hours: 7
Standby Hours: _____



Initial Report

Claim Number: 22209963 Date of Assignment: 26-Jun-2013
Claimant Name: Clarence Winfrey
RN Name: Kristy Thompson RN, BA, Report Date: July 22, 2013
BS, BSN
Diagnosis: ICD-9 Code(s):

Target RTW Date: Treating Provider: Lexington Cardiovascular

Treatment History: Claimant underwent heart surgery on May 29, 2013 as a result of an MI caused by electrical shock.

Medications: Metoprolol 25mg
Aspirin 81mg
Plavix 75mg
Amiodarone 200mg
Altace 5mg
Lasix 80mg
Vitamin C
Pepcid 20mg

Current Medical Status: Claimant is treating with Dr. Lide with South Carolina Heart Center and Dr. Travis, Cardiothoracic surgeon with Lexington Cardiology since suffering MI.

Provider Treatment Plan: On Monday 7.15.13, Mr. Winfrey met with Dr. Lide. Mr. Winfrey had a lot of fluid retention in his lungs as well as his legs. Dr. Lide placed him on a diuretic and obtained some lab work and scheduled him to come back in on Tuesday for an EKG. Tuesday morning, Mr. Lide's weight had dropped from 239 on Monday to 221. Dr. Lide informed him that he wanted him to take about 10lbs more of fluid off and increased his BP medications and instructed Mr. Lide to return Thursday for addition blood work and come in on Friday for a follow up visit. He also d/c'd Mr. Winfrey's physical therapy for now due to the visible shortness of breath. On Tuesday, Mr. Lide also had an appointment with Dr. Travis. On that visit Dr. Travis advised Mr. Winfrey not to take the Lasix and the BP meds because his BP was 77/60. I called Dr. Lide's office and advised them of this.

Dr. Travis also indicated that Mr. Winfrey is healing well. Mr. Winfrey had a lot of pain when Dr. Travis assessed the surgical site but otherwise everything looked good. I spoke with Dr. Lide's office again the morning 7.18.2013, and they made some more changes to his meds and placed BP parameters regarding taking the medication.

On Friday's visit, Dr. Lide reviewed Mr. Winfrey's medication and requested an EKG. Dr. Lide advised Mr. Winfrey to take Lasix 80mg once daily and to take 25mg of Metoprolol 2x a day and increased his Altace to 5mg daily and added Spironolactone to his medication. Because of the problems with his BP, Dr. Lide requested Mr. Winfrey come in next week for an appointment and additional blood work.

Current Work Status: () Full Duty? () Modified Duty? ☒ Out of Work?

Physical Requirements of Regular Job: Claimant works as an electrician.

Modified Duty Available? () Yes? () No?

Physical Requirements of Modified Duty Available: N/A

Information Obtained:

Activity Date: 28-Jun-2013 - 22-Jul-2013

6/28/2013 Introduction email to adjuster.

GENEX Services, Inc., 8310 University Executive Park Drive, Suite 520, Charlotte, NC 28262
Phone: (704)-503-4775 Fax: (866)-769-3974 www.genexservices.com



7/1/2013	Phone call to claimant's attorney, message left.
7/1/2013	Contact approval letter sent to attorney.
7/2/2013	Two copies of the GENEX introduction letter and grievance policy were sent to Attorney McDaniel, one for his file and a second copy to be provided to Mr. Winfrey at his discretion.
7/8/2013	Phone call to SCHC to confirm appointment. Advised that claimant had 10:45am with Dr. Lide, advised that I was case manager and would be attending appointment with claimant.
7/15/2013	Case Manager Geneva Bookman accompanied Mr. Winfrey to the 10:45 am cardiology evaluation where following a lengthy wait the Claimant was sent into an examination room before an addition wait before being examined privately by Dr. Lide.
7/15/2013	After another lengthy wait Case Manager Geneva Bookman was allowed to speak with Dr. Lide via his Clinical Assistant while Mr. Winfrey was being prepared for blood-work. Dr. Lide advised
7/15/2013	Phone call to SCHC to confirm which location appointment is at.
7/16/2013	Travel.
7/16/2013	Mileage.
7/16/2013	Wait.
7/16/2013	Mr. Lide's weight had dropped from 239 on Monday to 221. Dr. Lide informed him that he wanted him to take about 10lbs more of fluid off and increased his BP medications and instructed Mr. Lide to return Thursday for addition blood work and come in on Friday for a follow up visit. He also d/c'd Mr. Winfrey's physical therapy for now due to the visible shortness of breath.
7/16/2013	Phone call to Dr. Travis office to confirm appointment and confirm address and directions.
7/16/2013	Travel.
7/16/2013	Mileage.
7/16/2013	Wait.
7/16/2013	Dr. Travis advised Mr. Winfrey not to take the Lasix and the BP meds prescribed by Dr. Lide tonight because his BP was 77/60. I called Dr. Lide's office and advised them of this. Dr. Travis indicated that Mr. Winfrey is healing well. Mr. Winfrey had a lot of pain when Dr. Travis assessed the surgical site but otherwise everything looked good. Dr. Travis was advised that Mr. Winfrey was no longer in PT as recommended by Dr. Lide.
7/16/2013	Email update to adjuster.
7/16/2013	Email update to claimant's attorney.
7/16/2013	Message left for adjuster to call regarding claimant's appointments and approval for BP machine.
7/16/2013	Phone call to Liberty Mutual advising that my emails are not reaching adjuster and given alternative email address.
7/17/2013	Travel to claimant.
7/17/2013	Mileage.
7/17/2013	Well check visit with claimant to assess his medications and any side effects. Initial assessment completed. Confirmed claimant's upcoming appointments.
7/18/2013	File staffed via telephone w/assigned Field Case Manager (FCM) Kristy Thompson. Client is status post heart surgery on 5/29/13 and had several office visits this week (week of 7.15.13) w/treating cardiologist. In addition, FCM Thompson made a home visit this week for purposes of patient education and client's blood pressure concerns. All case management activities thus far are appropriate to case status. Debra B. Gray, Case Management Supervisor
7/18/2013	Message left by Tammy regarding claimant's BP medication and indicated she would call claimant at well.
7/18/2013	Phone call to Mr. Winfrey to make sure that Dr. Lide's office called him. Confirmed his appointment for Friday and assessed whether he was experiencing any side effects or increased SOB and he denied.
7/18/2013	Introductory letter sent to Dr. Lide explaining my involvement.
7/18/2013	Introductory letter to Dr. Travis explaining my role.
7/18/2013	Phone call to adjuster, unable to leave a message.

GENEX Services, Inc., 8310 University Executive Park Drive, Suite 520, Charlotte, NC 28262
 Phone: (704)-503-4775 Fax: (866)-268-3974 www.genexservices.com



7/18/2013	Phone call to Liberty Mutual advising that I am unable to contact adjuster, advised at that time that Rebecca is no longer with Liberty Mutual and new adjuster would be Ruth Schmitt, message left for new adjuster.
7/19/2013	Travel.
7/19/2013	Wait.
7/19/2013	Dr. Lide reviewed Mr. Winfrey's medication and requested an EKG. Dr. Lide advised Mr. Winfrey to take Lasix 80mg once daily and to take 25mg of Metoprolol 2x a day and increased his Altace to 5mg daily and added Spironolactone to his medication. Because of the problems with his BP, Dr. Lide requested Mr. Winfrey come in next week for an appointment and additional blood work. Dr. Lide wrote a prescription for BP monitor and a scale.
7/21/2013	Mileage.
7/22/2013	Initial Report.

Assessment:

Claimant is a 50 year old man that suffered an electrical shock on May 22, 2013. As a result of the shock, claimant suffered a myocardial infarction and underwent heart surgery on May 29, 2013. Prior to injury, claimant not taking medication and since injury, claimant taking multiple medications and medication management needed.

A home visit was made during this report period for purposes of client teaching/safety in regards to medications and physician orders.

Case Management Action Plan:

Goal	Complete Date	Target Date
STG: Claimant will verbalize understanding of Case Manager Role & Responsibilities Disclosure		10/31/2013

Issue	Date Identified	Date Resolved
Alteration in comfort related to fluid overload.	7/15/2013	
Identification of complex medical issues	7/16/2013	

Action Plan:

Attend follow up appointment with Dr. Lide on 7.27.13

Obtain Medical notes

Maintain weekly contact with claimant

Provide updates to all parties

Kristy Thompson

Submitted By: Kristy Thompson RN, BA, BS, BSN
Title: Case Manager - Medical
Phone #: (704) 503-4775, Ext. 3698
Email: kristy.thompson@genexservices.com

Debra Gray

Supervised By: Debra Gray, M.Ed., CRC, CCM
Title: Supervisor - CM

KT/dng

CC: Preston Daniel

GENEX Services, Inc., 8310 University Executive Park Drive, Suite 520, Charlotte, NC 28262
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GENEX Services, Inc.
5255 Triangle Parkway, Suite 100
Nortcross, GA 30092
770-582-9292 Fax: 1-888-838-0381
www.genexservices.com

Angelia

Preston McDaniel
1315 Elmwood Avenued
Columbia, South Carolina 29202



GENEX Services, Inc.
8310 Univeristy Executive Park Drive
Suite 520
Charlotte, NC 28262
704-503-4775 Fax: 866-268-3974
Toll Free: 800-477-2028
www.genexservices.com

July 18, 2013

Dr. Jeffrey Travis
Lexington Cardiovascular
2728 Sunset Blvd
West Columbia, SC 29169

RE: Claimant: Clarence Winfrey
 Date of Injury: 22-May-2013
 Date of Birth [REDACTED]
 Employer: Archway Service
 Carrier: Montgomery Insurance Co
 Claim #: 22209963
 GENEX #: CNGNY5

Dear Dr. Travis:

I am a medical case manager employed by GENEX Services, Inc. I have been requested by Montgomery Insurance Co to provide medical care coordination for Clarence Winfrey's industrial injury.

My role is to facilitate services and communications among the professionals involved in our client's treatment plan. I will be meeting with you, Clarence Winfrey and his employer as necessary to provide the client with support and guidance through his/her recovery process and successful return to employment.

I will be attending Clarence Winfrey's appointments with you. During each appointment, I will need to review and update the following areas related to Clarence Winfrey's work related injury:

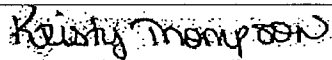
1. Diagnosis
2. Prognosis as it relates to this patient's medical condition
3. Any suggested treatment plans
4. Any physical limitations/restrictions
5. Return to work date
6. Could he/she return to his/her former job
7. If not, what are your recommendations for job modifications?
8. Is additional treatment indicated?
9. Anticipated permanent and stationary date?

As a medical case manager, my role is to assure that the client receives timely and appropriate medical treatment. We will coordinate with you in providing quality of care and

attainment of appropriate goals. I will need a copy of all reports sent to 8310 University Executive Park Drive, Suite 520, Charlotte, NC 28262.

Should you have any questions or wish to discuss this case in greater detail, please feel free to contact me at (803) 210-5279. Thank you for your anticipated cooperation in this matter.

Sincerely,



Kristy Thompson RN, BA, BS, BSN
Case Manager - Medical

KT/dng

cc: Preston McDaniel, Esq.



GENEX Services, Inc.
8310 Univeristy Executive Park Drive
Suite 520
Charlotte, NC 28262
704-503-4775 Fax: 866-268-3974
Toll Free: 800-477-2028
www.genexservices.com

July 18, 2013

South Carolina Heart Center
Dr. Lanneau Lide
2001 Laurel Street
Columbia, SC 29204

RE: Claimant: Clarence Winfrey
Date of Injury: 22-May-2013
Date of Birth: [REDACTED]
Employer: Archway Service
Carrier: Montgomery Insurance Co
Claim #: 22209963
GENEX #: CNGNY5

Dear Dr. Lide:

I am a medical case manager employed by GENEX Services, Inc. I have been requested by Montgomery Insurance Co to provide medical care coordination for Clarence Winfrey's industrial injury.

My role is to facilitate services and communications among the professionals involved in our client's treatment plan. I will be meeting with you, Clarence Winfrey and his/her employer as necessary to provide the client with support and guidance through his/her recovery process and successful return to employment.

I will be attending Clarence Winfrey's appointments with you. During each appointment, I will need to review and update the following areas related to Clarence Winfrey's work related injury:

1. Diagnosis
2. Prognosis as it relates to this patient's medical condition
3. Any suggested treatment plans
4. Any physical limitations/restrictions
5. Return to work date
6. Could he/she return to his/her former job
7. If not, what are your recommendations for job modifications?
8. Is additional treatment indicated?
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As a medical case manager, my role is to assure that the client receives timely and appropriate medical treatment. We will coordinate with you in providing quality of care and

attainment of appropriate goals. I will need a copy of all reports sent to 8310 University Executive Park Drive, Suite 520, Charlotte, NC 28262.

Should you have any questions or wish to discuss this case in greater detail, please feel free to contact me at (803) 210-5279. Thank you for your anticipated cooperation in this matter.

Sincerely,

Kristy Thompson

Kristy Thompson RN, BA, BS, BSN
Case Manager - Medical

KT/dng

cc: Preston McDaniel, Esq.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5739 www.wcc.sc.gov



PRE-HEARING BRIEF
WCC File No: 1306305

Claimant's Name: Clarence Winfrey SSN: [REDACTED]
Address: [REDACTED]
Home Phone: [REDACTED] Work Phone: [REDACTED]
Preparer's Name: Landon L. Hughey

Employer's Name: Archway Services Inc.
Address: [REDACTED]
American Fire & Casualty Insurance Company
Carrier: c/o Liberty Mutual Insurance
Preparer's Phone #: (803) 227-2261

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Comp. Rate: \$442.40 2. AWW: \$ 663.57 Date of Injury: 05/22/13
3. Type of injury and body part(s): Claimant alleges injury to his neck, left shoulder and heart. Defendants have denied this claim as failing to meet the standards for being a compensable claim.
4. Facts in controversy: Defendants have denied this claim pursuant to S.C. Code 442-9-260. The issue for this Hearing is whether or not Claimant can meet his burden of proving a compensable claim pursuant to the Act.
5. Legal issues involved: Section 42-9-10, Section 42-9-20, Section 42-9-30, and Section 42-9-260.

6. Unusual aspects: Claimant has filed a companion case in the South Carolina Circuit Court. In that case, Claimant has alleged a bad faith denial of benefits and asked for a declaratory judgment finding 442-9-260 unconstitutional. Through the Circuit Court, Claimant initially sought and received a temporary restraining order preventing Defendants from denying the claim and ordering that Defendants should pay all back benefits and medical benefits. Defendants moved to quash the Order and were successful. Judge Lee issued an Order revoking the temporary restraining order and keeping the declaratory judgment action in place. To that end, the Circuit Court still retains jurisdiction over the declaratory judgment action and the question raised by Claimant as to whether S.C. Code 442-9-260 is unconstitutional. The Circuit Court has yet to rule on whether or not the Workers' Compensation Act is unconstitutional.

The parties participated in a hearing on November 13, 2013 to determine whether or not Claimant had properly terminated benefits pursuant to 442-9-260 on September 12, 2013. Commissioner Beck in his Decision & Order dated December 5, 2013 found that the Defendants properly terminated benefits pursuant to 442-9-260 on September 12, 2013. Commissioner Beck also denied Claimant's request for sanctions against the Defendants pursuant to 442-9-260(g) for failure to comply with the provisions of the statute. Commissioner Beck also found that Claimant suffered a myocardial infarction on May 28, 2013. However, that specific finding is currently under appeal pursuant to Claimant's Form 30 filed on December 18, 2013.

This claim surrounds an alleged shock suffered by Claimant that Claimant alleges then resulted in a VSD to his heart resulting in a myocardial infarction. Defendants dispute that the shock either caused the myocardial infarction or that the shock caused the VSD. Claimant has scheduled the deposition of Dr. Barry J. Feldman for January 6, 2014 and Defendants have scheduled the deposition of Dr. Karen Greenfield on January 9, 2014. Deposition transcripts of Dr. Feldman and Dr. Greenfield may be submitted into the record prior to the hearing in following their depositions. In addition, the deposition of Dr. Jeffrey Allen Travis was taken on December 16, 2013. At this time, Defendants have not received a copy of Dr. Travis' deposition transcript and will submit that transcript as soon as one is received.

7. Witnesses (designate if expert):* Designated Employer representatives including, but not limited to, Bobby Ruppe and Clarence Winfrey.
8. Exhibits: Statement of Bobby Ruppe dated 09/23/13; Emails between Bobby Ruppe and Clarence Winfrey dated 05/27/13; Drivers Daily Logs dated 05/22/13-05/23/13; Order (dated 12/5/13)(consisting of 9 pages); Depositions of Dr. Feldman, Dr. Travis, and Dr. Greenville (TBS).
9. Medical evidence (Indicate report pursuant to R.67-612; deposition or appearance): Doctors Care, record dated 05/28/13, consisting of 1 page; South Carolina Heart Center, records dated 05/28/13, consisting of 3 pages; Jeffrey Allen Travis, M.D., records dated 05/28/13, consisting of 3 pages; Barry J. Feldman, MD, FACC, FACP, FSCAI, Lexington Heart, record dated 11/04/13, consisting of 1 page. Defendants reserve the right to amend this Pre-Hearing Brief with additional medical evidence if it becomes available prior to the Hearing.
10. Name, address, and specialty, if any, of the treating physician: Jeffrey A. Travis, M.D., Lexington Cardiovascular Surgery; Lanneau D. Lide, M.D.; Karen Greenfield, M.D.
11. Impairment rating(s); body part(s); physician and date of opinion: No impairment ratings have been given at this point.

12. I am amending my Form 50/51 in the following manner: None.

☐ **Mediation**

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐ b. Mediation is required pursuant to Reg. 67-1802.
☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-4803.
☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I verify the contents of this form are accurate and true to the best of my knowledge.

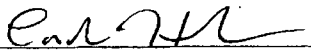
I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Preston F. McDaniel, Esquire, The McDaniel Law Firm

1315 Elmwood Avenue

address Columbia, South Carolina 29201

on the 2nd day of January 20 14.

by ☒ first class postage ☐ certified mail ☐ personal service.

Signature: 

Email: rhughey@mgclaw.com

Date of Hearing: January 13, 2014

Time needed for hearing: 1 hour

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 67-204 through 67-211, 67-211, and Regulations 67-601 through 67-615; as well as Reg. 67-1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. *Commissioners reserve the right to admit expert witnesses at hearings.

WCC FORM # 53
Revised 7/13

58

PRE-HEARING BRIEF

000184

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1306305

CLARENCE WINFREY,

Employee,

Claimant,

vs.

ARCHWAY SERVICES INC,

Employer,

AND

AMERICAN FIRE & CASUALTY
INSURANCE COMPANY C/O LIBERTY
MUTUAL INSURANCE,

Carrier,

Defendants.

**NOTICE OF WITNESSES AND
WRITTEN MEDICAL REPORTS
TO BE INTRODUCED AS
DIRECT EVIDENCE ON BEHALF
OF DEFENDANT**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
PRESTON F. MCDANIEL, ESQUIRE:

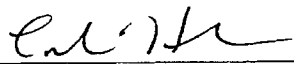
YOU ARE NOTIFIED that the Defendants, pursuant to the provisions of the South Carolina Workers' Compensation Act and Section 1-23-330 of the South Carolina Code of Laws (Cum. Supp. 1988) submit the following medical records and other documents as evidence:

APA#	DOCTOR	PRACTICE	DATES	PAGE #
7.		Doctors Care	05/28/13	90
8.		South Carolina Heart Center	05/28/13	91-93
9.	Jeffrey A. Travis, M.D.	Lexington Cardiovascular Surgery	05/28/13	94-96
10.	Barry J. Feldman, MD, FACC, FACP, FSCAI	Lexington Heart	11/04/13	97
Ex. 1	Statement of Bobby Ruppe		09/23/13	98
Ex. 2	Emails Between Bobby Ruppe and Clarence Winfrey		05/27/13	99
Ex. 3	Drivers Daily Log		05/22/13 – 05/23/13	100-101
Ex. 4	Decision & Order of Commissioner T. Scott Beck		12/5/13	102-110

YOU ARE FURTHER NOTIFIED that you have the right to cross-examine or otherwise oppose this evidence and, should you desire to exercise this right, you are to promptly schedule the deposition of any provider whose records are submitted, for the purposes of cross-examination, or otherwise promptly submit opposing medical records into evidence.

YOU ARE FURTHER NOTIFIED that these records, or photocopies of the same, will be provided to the South Carolina Workers' Compensation Commission for insertion in their file and for consideration as evidence on behalf of the Defendants.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Defendants: Designated Employer representative.



LANDON L. HUGHEY
MCANGUS GOUDELOCK & COURIE, L.L.C.
Post Office Box 12519, Capitol Station
Meridian, 1320 Main Street, 10th Floor
Columbia, South Carolina 29211-2519
(803) 779-2300
Attorneys for the Employer/Carrier

Columbia, South Carolina
January 2, 2014

(F) 603-334-8122 Claim # 22209963
10⁴⁰

BAD COPY

FROM FROM TIME	CHECKOUT TIME
NAME & ADDRESS	66500
05/20/13	09:35am
DC SEVEN OAKS,	1102635

WINFREY, CLARENCE

DOB: [REDACTED] (50 years)
GENDER: MIBG:
CELL:INSURED: WINFREY, CLARENCE
INS: WKC
RELATION: SELFREASON: NECK PAIN (shocked by 480 volt, jerked)
NICKNAME: (down to [REDACTED] shoulder) COPY: SP neck)

INSURANCE BALANCE	\$0.00
ACCOUNT BALANCE	\$0.00
CURRENT CHARGES	
AMOUNT PAID	
NEW BALANCE	

Personal Hx	Family Hx	Social Hx	ROS (I or O): Fatigue, Dizzy, Weak, Wt. Loss, Fever, Chills, Nasal Congestion, Sinus Pain, Ear Pain, Sore Throat, SOB, CP, Cough, Sputum, Whoeze, ABD Pain, N, V, D, Constip., Dysuria, Freq., Urgency, Back Pain, Pelvic Pain, Vag. D/C, Headache, Syncope, Rash	Allergies: NKDA
M / DM / TN	DM / HTN	Alcohol / Tobacco		Medications: Tylenol / Naproxen, Nitro
accident? ☐ yes ☐ no If yes, which state:	ale of Accident:	rev. chart rev. no sig chg.	Above Hx rev.: 10	
HT	BMI	BRT	PULSE	RESP
69.4		128	128	20
TEMP	97.5	LMP	Tetanus	

HYSCAL: (see reverse) Omit if N/A

Chief Complaint:

General	HEENT	Neck	Nodes	Lungs	CV	Abd	Back	Ext	GU	Neuro	Skin/Breasts	Chaperone	I.V.	Injection	Nebulizer	Procedure	Pulse Ox

480 V
rotational shock on
Thursday
sweated profusely PM
woke up sweating this AM
c/o pain @ neck
no chest pressure

WINDOWN WIA WIA NAD: HPI
appears SOB but denies
entry wound
dorsum 3rd
finger
tenderness @
trapezius
COR - GR III/VI SEAM
tachycardia

AGNOSIS: Tachycardia / electrical shock / murder shock

AGNOSIS: Tachycardia / electrical shock / murder shock

Patient Care Instructions Discussed	Dr. Dasgupta	PSR Notes
Lifestyle Modification	FLU NEW	NEW
Preventative Recommendation(s)	FLU NEW	
Prescriptions / OTC Meds	FLU NEW	
Side Effects Discussed	FLU NEW	
Follow-Up:	FLU NEW	
Worsening symptoms:	FLU NEW	
If not better:	FLU NEW	
-to ER if:	FLU NEW	

Off Work / School: [REDACTED]

Signature: [REDACTED]

Date: 7-2-2013

Physician Compensation: I hereby authorize Doctors Care to report to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care or rehabilitation, regarding my medical records and the treatment I have received or will receive.

Signature: [REDACTED]

1. [Illegible text]

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100. [Illegible text]



OFFICE CONSULT
May 28, 2013

CLARENCE WINFREY 50 year old M [REDACTED] Account #: 000009112

Requesting the consult: PCP No

Consultation is requested for

Primary care physician: PCP No

Cardiologist: Himadri Dasgupta M.D.

Chief complaint: New Pt Exam, Palpitations / Arrhythmias, Dyspnea

History of present illness:

Mr. Clarence Winfrey is a 50-year-old male is being seen in consultation at the request of Dr. Greenfield at doctor's care for further workup of an abnormal EKG and new onset heart murmur. A review of his records today shows that he received an electric shock in 5 days ago and since then has complained of a pain in his left shoulder radiating to the left scapular region, the left side of his neck, left infraclavicular region and left arm. He has also been having excessive diaphoresis and has dyspnea with exertion. The patient states that none of his symptoms have really progress. His pain appears to have been responding to Tylenol and Motrin but comes back when the effect wears off. The patient denies any palpitation, syncope or presyncope. He denies any orthopnea or dependent edema. At the time of this interview the patient denied any chest pain but had minimal left shoulder pain.

The patient denied any prior cardiac history and stated that many years ago he had a normal cardiac catheterization. On auscultation today he was found to have a grade 4/6 early and mid systolic murmur in the left parasternal region. A stat echocardiogram cyst and a tiny cyst with possible expansion of the distal and apical inferior and inferoseptal segments with a possible VSD with left to right shunting.

His EKG was reviewed and showed significant ST elevation in leads L2 and L3 with ST depression in V1 through V3 and a right bundle branch block. A repeat EKG in our office was the same as that from doctor's care.

On arrival the patient was found to be tachycardic with a heart rate of around 120 beats per minute. On arrival discussed with the pressure was about 100 but at the time of this interview his blood pressure was 128/88.

Mr. WINFREY has not had palpitations, syncope or near syncope. He denies claudication. There is no discoloration or ulceration of the lower extremities. He has had no TIA or stroke-like symptoms.

CARDIAC HISTORY

Risk Factors:

- 1 Tobacco Abuse: cigarettes [Tobacco per day: 0.50]

CARDIOVASCULAR PROCEDURES

Past medical history: ABN EKG, Gout, Hypertension

SOCIAL HISTORY

Family: Unknown

Diet: Regular

Tobacco Cessation: The patient was counseled on tobacco cessation.

Alcohol: Yes Occasional

Caffeine: Coffee

SEE ATTACHED

Family history: There is a family history of premature coronary artery disease. Father Hypertension, CVA, Myocardial Infarction at 54 (cause of death)

Review of symptoms:

RESP - Negative for snoring, hemoptysis. Positive for dyspnea. CONST - Negative for weight gain, weight loss, fever. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, syncope, pnd. Positive for palpitation. VASC - Negative for claudication, edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for dizziness, memory loss, seizures. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

Physical exam: CONST - The patient is 5ft 11in tall, and weighs 240.8lbs. The BMI is 33.7 kg/m2. Blood pressure in the left arm is 138/104 mmHg in the sitting position. The pulse is 122/min. The respirations are 22/min. Nourishment - Obese. Appearance - Well Developed. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. RESP - Respirations - Nonlabored. Breath Sounds - Clear Throughout. Rales - Absent. Rhonchi - Absent. Wheezes - Absent. CARDIAC - Rhythm - Regular. Palpation - PMI Normal. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Murmurs - IV/VI systolic ejection murmur heard at the left sternal border. VASC - Carotid - Bilateral Normal. Aorta - Normal Size. Femoral - Bilateral Normal Pulse. Post Tibial - Bilateral Normal. ABD - Tenderness - None. Hepatomegaly - Absent. Splenomegaly - Absent. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Absent. SKIN - Venous Stasis Ulcers - Absent. PSYCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate.

IMPRESSION AND PLAN

01. Acute MI, Inferior
02. Shortness of Breath
03. Chest Pain, Unspecified
04. Limb Pain, Arm
05. Obesity
06. Tobacco Abuse
07. Ventricular Septal Defect

It appears that the patient has had a myocardial infarction in the last few days but has persistent estimation and some symptoms. It is also possible that he has had a VSD a completion of this MI. I have informed him of our findings, the current diagnosis and his prognosis and a plan of action. STEMI protocol was activated at Lexington Medical Center. The patient is being transferred by ambulance to the cardiac catheterization laboratory. I have discussed with our interventionalists Dr. Lide who do emergent cardiac catheterization and decide further management. A CVTS consultation will be obtained if the VSD is confirmed. The patient will be given beta blockers and aspirin.

Orders:

- 1 Patient counseled on tobacco cessation.

FINAL MEDICATION LIST

ibuprofen 200 mg tablet
Tylenol Extra Strength 500 mg tablet

take 2 tablet by ORAL route every 6 hours as needed with food
take 2 tablet by ORAL route every day as needed

SEE ATTACHED

Electronically signed by: Himadri Dasgupta M.D. 05/28/2013 @ 1:18 PM

D: T:05/28/2013
2411 he suddenly

05/28/2013

05/28/2013

SEE ATTACHED

Winfrey, Clarence B #M002010261**Admission Info: Inpatient (Adm: 05/28/13)****Hospital Account: 200044872****Description: 50 y.o. M****Primary Service: Med/Surg****Unit Info: Surg 4thNT****Consult Notes****Consults signed by Jeffrey Allen Travis, MD at 05/29/13 0629**

Author:	Jeffrey Allen Travis, MD	Service:	(none)	Author	Physician
Filed:	05/29/13 0629	Note	05/28/13 1553	Type:	
		Time:		Trans ID:	3M926468
Trans	Available				
Status:					
Dictation	05/28/13 1553	Trans	05/28/13 1612	Trans	Consult Note
Time:		Time:		Doc	
				Type:	

REQUESTING PHYSICIAN: Dr. Lide**REASON FOR CONSULTATION: Consideration for CABG and repair of VSD.****HISTORY OF PRESENT ILLNESS:** The patient is a 50-year-old white male who states on Wednesday he

was working on some electrical equipment and got a shock. He went home from work and experienced significant chest pain as well as back and shoulder pain. This persisted through the weekend and he really did not do much over the weekend other than sit around and watch TV and experienced pain. Due to the persistence of the pain he presented to an Urgent Care Center today where his EKG was abnormal and he was sent to the hospital. He was taken to the Cath Lab emergently where he was found to have occlusion of his posterior descending coronary artery, severe 3-vessel coronary disease, and a VSD. I have been asked to see him for evaluation and management.

PAST MEDICAL HISTORY: None.**PAST SURGICAL HISTORY: None.****HOME MEDICATIONS: None.****ALLERGIES: No known drug allergies.****SOCIAL HISTORY:** The patient is a pack per day smoker for the last 35 years. The patient drinks about a 12-pack per week but does not drink beer on a daily basis. Denies any illicit drug use. He does maintenance type work for grocery stores like Publix.**REVIEW OF SYSTEMS:** A 10-point review of systems otherwise negative other than listed in the HPI.**PHYSICAL EXAMINATION****GENERAL:** The patient is a well-developed white male in no apparent distress.**HEENT:** Atraumatic, normocephalic. Extraocular movements intact. Pupils equal, round and react to light. Oropharynx is clear. Sclerae nonicteric.**NECK:** No JVD. No carotid bruits.**CARDIOVASCULAR:** Regular S1, S2. He is very tachycardic. There is a 3/6 systolic murmur heard throughout the precordium.**LUNGS:** Clear to auscultation bilaterally. Good chest expansion bilaterally.**ABDOMEN:** Soft, nontender, nondistended. No hernias or masses.**MUSCULOSKELETAL:** Full range of motion. There is no clubbing, cyanosis, or edema. He has 2+ pulses throughout his vascular exam.**NEUROLOGIC:** Intact. Moves all 4 extremities, 5/5 strength. Sensation is intact.**DIAGNOSTIC STUDIES:** I reviewed his cardiac catheterization. He has very severe diffuse 3-vessel disease. On the left side his LAD is diseased but most of this is distally. There is no proximal

obstructive disease. He has a ramus with about an 80-90% proximal lesion. It is graftable. His circumflex vessels again are thready as they get to the distal portions but I do not see a graftable vessel. His right coronary artery is free of proximal disease. His PDA is occluded and has TIMI-2 flow. This is obviously the infarct artery. His ejection fraction looks mildly reduced. It is a little bit difficult to fully ascertain given the tachycardia. He has an obvious VSD with quick filling of the right ventricle and pulmonary artery on ventriculogram.

His laboratory values show his BUN to be 20, creatinine 1. White count is elevated slightly at 17, hemoglobin 15, hematocrit 48. Chest x-ray is pending.

IMPRESSION: Severe 3-vessel coronary disease with acute post-infarct ventral septal defect (VSD).

RECOMMENDATIONS: I think the patient needs to be considered for coronary artery bypass grafting surgery. Right now, he is hemodynamically stable with no evidence of end-organ perfusion difficulties. We will obtain a chest x-ray. Although he has good room air SATs, it does not appear he is in overt failure. We will also get an echo. Certainly if he develops hemodynamic compromise, we will place a balloon pump and speed up the timing of surgery. Right now, I think we have a few moments to better evaluate him and consider him for reparative surgery. Discussed all this with the patient who has no family members at the time to convene with per his report.

T: 05/28/2013 04:12 P/bds

Signed by Jeffrey Allen Travis, MD on 05/29/13-0629

Consult Orders

Consult to Social Work - Equipment (DME) [17195308]		Discontinued	
Ordering user:	Victor A. Gomez, PA-C 06/05/13 0720	Ordering provider:	Victor A. Gomez, PA-C
Authorized by:	Steven W. Marra	Frequency:	Once 06/05/13 1052 - 1 Occurrences
Electronically signed by:	Victor A. Gomez, PA-C 06/05/13 0720		
Electronically cosigned by:	Steven W. Marra 06/05/13 1134 for Ordering		
Released by:	Erin Sullivan Sisk, RN 06/05/13 1051	Discontinued by:	Automatic Discharge Provider 06/07/13 1736 [Patient Discharge]
Questions:	Reason For Social Work Consult Equipment (DME) Comment - please arrange for him to be fitted for a LifeVest		

Consult to Cardiology [17029085]		Discontinued	
Ordering user:	Catherine S Gallier, RN 06/01/13 1150	Ordering provider:	Steven W. Marra
Authorized by:	Steven W. Marra	Frequency:	Once 06/01/13 1142 - 1 Occurrences
Electronically signed by:	Catherine S Gallier, RN 06/01/13 1150		
Electronically cosigned by:	Steven W. Marra 06/05/13 1134 for Discontinue on Transfer		
Discontinued by:	Victor A. Gomez, PA-C 06/05/13 1051		
Questions:	Reason for Consult? VT. Did you call the consulting provider? Yes Comment - 7943950		
Comments:	Answering service called. Consult placed for pt to be seen today. M Patel on call and notified.		

Consult to Nutrition Services [16901901]	Completed

Ordering user:	Jeffrey Allen Travis, MD 05/29/13 1827	Ordering provider:	Jeffrey Allen Travis, MD
Authorized by:	Jeffrey Allen Travis, MD	Frequency:	Once 05/29/13 2018 - 1 Occurrences
Electronically signed by:	Jeffrey Allen Travis, MD 05/29/13 1827		
Released by:	Mitzi K Stewart, RN 05/29/13 2017		
Questions:	Reason for Nutrition Consult? Medical Nutrition Therapy Is this a Doctor's Order? Yes		

Pastoral/spiritual care consult [16834606] Completed

Ordering user:	Jeffrey Allen Travis, MD 05/28/13 1722	Ordering provider:	Jeffrey Allen Travis, MD
Authorized by:	Jeffrey Allen Travis, MD	Frequency:	Once 05/28/13 1720 - 1 Occurrences
Electronically signed by:	Jeffrey Allen Travis, MD 05/28/13 1722		
Questions:	Reason for Consult? Pre-operative support		

Consult to Cardiovascular Surgery [16825697] Discontinued

Ordering user:	Lanneau D Lide, MD 05/28/13 1456	Ordering provider:	Lanneau D Lide, MD
Authorized by:	Lanneau D Lide, MD	Frequency:	Once 05/28/13 1529 - 1 Occurrences
Electronically signed by:	Lanneau D Lide, MD 05/28/13 1456		
Released by:	Angela K Mayo, RN 05/28/13 1528	Discontinued by:	Jeffrey Allen Travis, MD 05/30/13 0147 [Patient Transfer]
Questions:	Reason for Consult? 3 vessel CAD, IMIQ, VSD Did you call the consulting provider? Yes Preferred Group if no MD previously selected? Lexington Cardiovascular 803-936-7095		

Consult to Cardiovascular Surgery [16825701] Discontinued

Ordering user:	Lanneau D Lide, MD 05/28/13 1456	Ordering provider:	Lanneau D Lide, MD
Authorized by:	Lanneau D Lide, MD	Frequency:	Once 05/28/13 1529 - 1 Occurrences
Electronically signed by:	Lanneau D Lide, MD 05/28/13 1456		
Released by:	Angela K Mayo, RN 05/28/13 1528	Discontinued by:	Jeffrey Allen Travis, MD 05/30/13 0147 [Patient Transfer]
Questions:	Reason for Consult? 3 vessel CAD, IMIQ, VSD Did you call the consulting provider? Yes Preferred Group if no MD previously selected? Lexington Cardiovascular 803-936-7095		

1. [Illegible text]

2. [Illegible text]

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99. [Illegible text]

100. [Illegible text]



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J. Kevin Baugh, MD, FACC
Barry J. Feldman, MD, FACC, FACP
Jennifer A. Feldman, MD, FRACP
J. Kyle Hewett, MD, FSCAI

Guillermo Pineda, MD, FACC
Vince M. Vismara, MD, FSCAI
Grace Kludo, RN, MSN, ACNP
Phyllis Williamson, MSN, ACNP, CLS

Eric S. Shoup, MS, PAC, CLS
Sandi VanHooser, PA-C

04 November 13

To Whom It May Concern:

Re: Clarence Winfrey v. Archway Services (Claim No: 22209963)

Dear Sirs:

I am writing to summarize my professional impression after review of the hospital records from Mr. Clarence Winfrey. Mr. Winfrey appears to have presented with a delayed myocardial infarction approximately five days from his initiation of chest pain. He underwent a semi-emergent heart catheterization which demonstrated an occluded right posterior descending artery. This appeared to be a relatively fresh occlusion according to his angiographic report. He was also found to have a VSD in the inferior lateral portion of his ventricular septum which was consistent with this acute occlusion.

His heart appeared to have a focal area of necrosis in the anatomical distribution of this occluded artery consistent with an acute inferior infarct. Overall his ejection fraction was preserved in the 50% range at this time.

In my opinion with reasonable certainty the highest likelihood was that his VSD was acquired from his acute myocardial infarction. His diagnostic arteriogram demonstrated extensive coronary artery disease with the only vessel that could be grafted being a moderate sized ramus intermedius branch.

It is coincidental that he happened to have a myocardial infarction that appears to have occurred the same evening of the day he had an electrocution event. It is possible that this was a spontaneous plaque rupture which had no relation to the electrical shock. This is of the highest certainty since there is no clear cut correlation between plaque ruptures and electrical shocks.

The description of pericardial inflammation is most likely consistent with a possible post MI Dresslers syndrome. It was also noted to have thickened plaque which was calcified in the pericardium which most likely is chronic. The odds of having electrical shock to account for the VSD are quite low given the anatomical relationship of his VSD to his occluded PDA vessel.

If I can shed any further light or offer any additional opinion regarding this case please feel free to contact me personally at any time.

Sincerely yours,

Barry J. Feldman, MD, FACC, FACP, FSCAI

Statement: Bobby Ruppe

RE: Clarence Winfrey

On May 22, 2012 Clarence called me and said a wire in the rotisserie was broken. Clarence had not seen the wire. While tracing out light wires he got shocked. He jerked his neck to get away and hurt his neck. I told him that if he needed to go to the doctor to go, that worker's compensation would pay. He did not want to go to the doctor because of money and said he would be okay in a few days. I told him if he got hurt at work, worker's compensation would pay. He was told this by me several times. He did go to the doctor on the Tuesday the 27th, and they said it was not his neck, it was his heart. He was sent to the hospital and they performed surgery on him that day.

Bobby Ruppe

Service Manager

09-23-2013

Bobby Ruppe

From: Clarence Winfrey
Sent: Monday, May 27, 2013 12:27 PM
To: Bobby Ruppe
Subject: Re: They can't do anything

Wire in rotisserie broken did not see traced out light wire and got hit by power jerked my neck to get away from rotisserie I do not want to lose my job from being hurt

Sent from my iPad

On May 27, 2013, at 12:21 PM, "Bobby Ruppe" <Bobby.Ruppe@asi-cfc.com> wrote:

> If you did it at work workers comp should pay we will have to talk to Susan tomorrow go ahead and do me a letter on what happened and email it to me

>

> Sent from my iPhone

>

> On May 27, 2013, at 11:52 AM, "Clarence Winfrey" <clarence.winfrey@asi-cfc.com> wrote:

>

>> They can't do anything for neck pain I've been trying to stay away med help do to money but if I have to go to hospital that's means I'm hurt I'm trying to avoid

>>

>> Sent from my iPad

>>

>> On May 27, 2013, at 11:47 AM, "Bobby Ruppe" <Bobby.Ruppe@asi-cfc.com> wrote:

>>

>>> What did they say

>>>

>>> Sent from my iPhone

>>>

>>> On May 27, 2013, at 11:15 AM, "Clarence Winfrey" <clarence.winfrey@asi-cfc.com> wrote:

>>>

>>>>

>>>>

>>>> <photo.JPG>

>>>>

>>>>

>>>>

>>>> Sent from my iPad

5-23-13

DRIVERS DAILY LOG

START TIME: 5:30

END TIME: 1:30

DATE: 5/22/2013

DRIVER: HI57

BEGINNING MILEAGE: 03011.9

ENDING MILEAGE: 03187.3

Store Name and Number: Publix 0067

Mileage Start: 03011.9

Mileage End: 03031.6

Activity: Driving

Activity: On Duty

Start Time: 5:30

End Time: 6:00

Start Time: 6:00

End Time: 7:45

Notes: Found big problem and I got shocked hard

Store Name and Number: Wall mart 514

Mileage Start: 03031.6

Mileage End: 03097.4

Activity: Driving

Activity: On Duty

Start Time: 7:45

End Time: 9:00

Start Time: 9:00

End Time: 10:15

Notes:

Store Name and Number: Wall mart 881

Mileage Start: 03097.4

Mileage End: 03147.5

Activity: Driving

Activity: On Duty

Start Time: 10:15

End Time: 11:30

Start Time: 11:30

End Time: 12:15

Notes:

Store Name and Number:

Mileage Start:

Mileage End:

Activity:

Activity:

Start Time:

End Time:

Start Time:

End Time:

Notes:

Store Name and Number:

Mileage Start:

Mileage End:

-100-

DRIVERS DAILY LOG

START TIME: 8:00

END TIME: 3:30

DATE: 5/23/2013

Clearance
Winfy

DRIVER: H157

BEGINNING MILEAGE: 03189.6

ENDING MILEAGE: 03257.9

Store Name and Number: Wall mart 881			
Mileage Start: 03189.6		Mileage End: 03196.4	
Activity: Driving		Activity: On Duty	
Start Time: 8:00	End Time: 8:30	Start Time: 8:30	End Time: 3:30
Notes: Went to whaleys two times then get call none of The fryers are working go back they lost power going to fryers			

Store Name and Number:			
Mileage Start:		Mileage End:	
Activity:		Activity:	
Start Time:	End Time:	Start Time:	End Time:
Notes:			

Store Name and Number:			
Mileage Start:		Mileage End:	
Activity:		Activity:	
Start Time:	End Time:	Start Time:	End Time:
Notes:			

Store Name and Number:			
Mileage Start:		Mileage End:	
Activity:		Activity:	
Start Time:	End Time:	Start Time:	End Time:
Notes:			

Store Name and Number:			
Mileage Start:		Mileage End:	
Activity:		Activity:	
Start Time:	End Time:	Start Time:	End Time:
Notes:			

Store Name and Number:			
Mileage Start:		Mileage End:	
Activity:		Activity:	
Start Time:	End Time:	Start Time:	End Time:
Notes: I'm going to a friend doctor wants to look at my neck he says sounds like wipe lash			

Lunch Hours: _____ Driving Hours: 1 Labor Hours: 7

Standby Hours: _____

DECISION AND ORDER
OF
T. SCOTT BECK, COMMISSIONER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

SCWCC FILE NO.: 1306305

Clarence Winfrey,

Claimant

v.

Archway Services, Inc.,

Employer, and

Liberty Mutual Ins. Co.,

Carrier, Defendants.

Hearing held in Richland County,
South Carolina on November 13th, 2013
Per notice timely and properly served upon all Parties of Interest.

Appearances: Preston F. McDaniel, Esquire, for Claimant

Landon L. Hughey, Esquire, and Brett H. Bayne, Esquire for
Defendants

Filed: December 5, 2013

STIPULATIONS

Prior to the Hearing, the parties stipulated to the following:

1. The South Carolina Workers' Compensation Commission has jurisdiction of this claim;
2. Venue, set in Richland County, South Carolina, is proper;
3. Claimant and Employer were both subject to the South Carolina Workers' Compensation Act at all times relevant to this claim;
4. The sole purpose of the Hearing requested by Claimant pursuant to his Form 15, Section III is for the Commission to determine whether Defendants properly terminated workers' compensation benefits in accordance with § 42-9-260(B)(3); and
5. No documentary evidence dated after September 13th, 2013 would be considered by the undersigned in the adjudication of the issues in dispute.

STATEMENT OF THE CASE

This matter was set for a Hearing at the request of the Claimant pursuant to a Form 15, Section III, filed on September 23rd, 2013. Claimant alleges he suffered an injury by accident arising out of and in the course of his employment with Defendants when he sustained an electrical shock on May 22nd, 2013, resulting in an injury to his heart, left hand/arm/shoulder, neck, head (brain), and chest. Claimant asserts that Defendants accepted the claim and began paying temporary total disability benefits and medical treatment, but terminated all benefits on or about September 12th, 2013, citing § 42-9-260(B)(3) as authority to do so. Claimant asserts this termination of benefits was improper under the statute, and that Defendants should be assessed penalties provided for in § 42-9-260(G). Claimant asserts that he has filed a Form 50 Hearing request asking the Commission to award workers' compensation benefits, and that the sole purpose of the Hearing is to determine whether Defendants properly terminated benefits in accordance with § 42-9-260.

Defendants allege that Employer was aware Claimant suffered a medical emergency and began providing workers' compensation benefits, as a precaution to mitigate future damages should the claim be found compensable, to allow Defendants an opportunity to conduct a thorough investigation of the alleged incident to determine if it was a compensable workers' compensation claim. Defendants assert that on or about September 12th, 2013, it properly terminated workers' compensation benefits, following a good faith investigation by Employer that revealed grounds for denial of the claim. Defendants assert that this termination was lawful and proper by action of § 42-9-260(B)(3) and that therefore it should not be subject to sanctions under § 42-9-260(G).

Prior to the Hearing the parties filed a number of Motions with the Commission. These Motions were considered at the Hearing and were addressed by a separate Order issued by the undersigned on December 5th, 2013, which is incorporated herein by reference.

Following the resolution of the Motions, the parties addressed the merits of the claim raised on Claimant's Form 15, Section III. Both parties offered APA Submissions and Exhibits. Claimant renewed his objection first raised in his letter to the Commission dated November 7th, 2013 objecting to the submission of Defendant's Pre-Hearing Brief, Notice of Witnesses, APA Submissions and Exhibits as untimely. Claimant was offered the opportunity to have the Hearing postponed in order to allow him adequate time to respond to the Defendant's Pre-Hearing Brief, Notice of Witnesses, APA Submissions and Exhibits. Claimant declined to postpone the Hearing, and the following records were received into evidence, with the stipulation that no evidence dated after the date Claimant had actual notice of the denial, September 13th, 2013, would be reviewed or considered by the undersigned:

CLAIMANT'S APA SUBMISSIONS AND EXHIBITS

1. Dr. Lanneau Lide, SC Heart Center, 09/16/13- 10/04/2013, p. 1-2.
2. Dr. Jeffery Travis, Lexington Cardiovascular Assoc., 09/30/13, p. 3.
3. Lexington Medical Center, 05/28/2013 – 05/29/2013, p. 4-8.
4. Dr. Karen Greenfield, Doctors' Care, 05/28/2013 – 09/17/2013, p. 9-16.
5. Kristy Thompson, RN, Genex Services, Inc., 07/22/2013, p. 17-20.

6. "Correspondence", 07/30/2013- 08/07/2013, p. 21-25.

DEFENDANT'S APA SUBMISSIONS AND EXHIBITS

1. Doctors' Care, 05/28/2013, p. 1.
2. South Carolina Heart Center, 05/28/2013, p. 2-4.
3. Jeffrey A. Travis, M.D., Lexington cardiovascular Surgery, 05/28/2013, p. 5-7.
4. Statement of Bobby Ruppe, 09/23/2013, p. 8.
5. Emails between Bobby Ruppe and Claimant, 05/27/2013, p. 9.
6. Driver's Daily Log, 05/22/2013- 05/23/2013, p. 10-11.
7. Letter from Preston McDaniel to Defense Counsel, 10/16/2013, p. 12.
8. Motion to Quash the Deposition of the Adjuster, 09/27/2013, p. 13-21.
9. Motion to Compel Deposition and For Costs, 10/21/2013, p. 22-24.
10. Motion for Continuance, 10/21/2013, p. 25-30.
11. Summons and Complaint filed by Preston McDaniel, 09/27/2013, p. 31-48.
12. Temporary Restraining Order, 10/01/2013, p. 49-51.

FINDINGS OF FACT

Based on my consideration of the relevant evidence submitted into the record, excluding all evidence dated after September 13th, 2013, as well as the testimony of the Claimant offered at the Hearing, I make the following findings of fact:

1. Claimant suffered an incident while working on electrical equipment at work that he believed to be an electrical shock on May 22nd, 2013. This is based on the testimony of the Claimant as well as the medical records submitted by the Claimant from Lexington Medical Center.
2. Claimant suffered a myocardial infarction on May 28th, 2013. This is based on the medical records submitted by the Claimant from Lexington Medical Center.

3. Claimant alleged that he suffered an injury by accident arising out of and in the course and scope of his employment to his heart, left hand/arm/shoulder, neck, head (brain), and chest, and filed a claim for workers' compensation benefits. This is based on the Form 50 Employee's Notice of Claim filed by Claimant on June 6th, 2013.

4. Defendants began providing Claimant with temporary total disability benefits beginning on June 1st, 2013 and continuing through September 14th, 2013. This is based on the Form 19 Status Report and Compensation Receipt filed by Defendants on September 12th, 2013.
5. Defendants also provided Claimant with medical treatment between the alleged date of injury and September 12th, 2013. This is based on the Form 19 Status Report and Compensation Receipt filed by Defendants on September 12th, 2013.
6. Defendants terminated Claimant's workers' compensation benefits 114 days after employer could have had notice of his alleged injury, on September 12th, 2013. The termination was based on a denial of the claim following an investigation. This is based on the Form 15, Section II dated September 12th, 2013.
7. The Form 15, Section II was received by the Commission no later than September 18th, 2013. This is based on the records in the Commission's file and the Form 15, Section III filed by the Claimant.
8. The Form 15, Section II documented that the reason for termination was that the employee fails to meet the burden of a compensable injury under the S.C. Workers' Compensation Act. This is based on the Form 15, Section II dated September 12th, 2013.
9. Claimant received the Form 15, Section II in a timely manner and was able to exercise his rights under § 42-9-260(C) and R.67-504(C). This is based on the Form 15, Section III filed by the Claimant. Claimant alleged that the Form 15, Section II was not served on him properly pursuant to R.67-504(A) because he was only served with one copy of the Form 15, Section II and the documented reason for termination was printed on the Form 15 under Section II, rather than on an attached document. However, Claimant was in no way prejudiced from exercising his rights under the Act by the manner of service of the Form 15, Section II. This is evident by the fact that Claimant filed a Form 15, Section III asserting his rights shortly after receiving the Form 15, Section II. Claimant had the benefit of counsel at the time he was served with the Form 15, Section II,

rendering the requirement to provide him with two copies unnecessary. Therefore, Defendants alleged failure to provide Claimant with a second copy of the Form 15, Section II, and including the reasons for denial on the form itself rather than on a separate attachment are not grounds to find the termination of benefits was improper.

10. Claimant did not provide any evidence at the Hearing to indicate that Defendants acted in anything other than good faith during the investigation and eventual denial of the claim. This is based on the evidence (or lack thereof) submitted by the Claimant at the Hearing.
11. I find the Claimant's argument that the apparent failure of Defendants to interview Claimant prior to the denial of the claim as evidence of bad faith is unpersuasive. Claimant is alleging a medically complex condition resulting from an injury by accident. Defendants have not denied that Claimant suffered an incident he believed to be an electrical shock on May 22nd, 2013. The causal relation between Claimant's alleged electrical shock and his current medical condition is one that can best be determined by review of the expert medical reports, to which Defendants had access by operation of § 42-15-95. Claimant's statement would have been of little value to Defendants in attempting to determine whether his heart condition was causally related to the alleged electrical shock.

RULINGS OF LAW

Based on the foregoing, I make the following rulings of law:

1. The Workers' Compensation Act provides "[o]nce temporary disability payments are commenced, the payments may be terminated or suspended immediately at any time within the one hundred fifty days if . . . a good faith investigation by the employer reveals grounds for denial of the claim." § 42-9-260(B)(3).
2. Defendants properly terminated Claimant's workers' compensation benefits on September 12th, 2013 by meeting all the required elements for termination under § 42-9-260(B)(3).
 - a. Benefits were commenced on or about June 1st, 2013. *See* Finding of Fact No. 4.

- b. Benefits were terminated on or about September 12th, 2013, well within 150 days after the employer could have received notice of the injury. *See* Finding of Fact No. 6.
 - c. Defendants represented to the Commission they conducted a good faith investigation of the claim. *See* Form 15, Section II dated September 12th, 2013.
 - d. Claimant did not provide any evidence that Defendants conducted their investigation in anything other than good faith. *See* Finding of Fact Nos. 10-11
 - e. Defendants represented the grounds for denial revealed during their investigation was a good faith belief that "Claimant fails to meet the burden of a compensable injury under the SC Workers' Compensation Act". *See* Form 15, Section II, dated September 12th, 2013. Under the Act, Claimant bears the burden of proving by a preponderance of the evidence that it is more likely than not that Claimant suffered an injury by accident arising out of and in the course of his or her employment resulting in disability. *See* § 42-1-160; *Hall v. Desert Aire, Inc.*, 376 S.C. 338, 656 S.E.2d 753 (S.C. App. 2009) ("A claimant has the burden of proving facts sufficient to allow recovery under the Workers' Compensation Act"); *Fowler v. Abbott Motor Co.*, 236 S.C. 226, 113 S.E.2d 737 (1960) ("The burden rests upon claimants to show by competent testimony, not only the fact of injury, but that it occurred in connection with the employment of the deceased; and to furnish evidence from which the inference can logically be drawn that the injury arose out of and in the course of the employment." (*Internal citations omitted*)); *S.C. Second Injury Fund v. Liberty Mut. Ins. Co.*, 353 S.C. 117, 576 S.E.2d 119 (S.C. App. 2003) ("The burden lies with the workers' compensation claimant to demonstrate causation by a preponderance of the evidence.").
 - f. Therefore, a belief of Defendants formed following a good faith investigation that Claimant had not met his burden of proving compensability is adequate grounds for denial of the claim by the Defendants.
3. § 42-9-260(C) and R.67-504(C) provide a mechanism for a Claimant whose temporary disability benefits have been terminated by action of § 42-9-260(B)(3) to have an Order issued reinstating benefits following a Hearing held pursuant to a request made by Claimant on a Form 15, Section III. Counsel for Claimant stipulated on the record that

the sole purpose of the Hearing he had requested was to determine whether Defendants properly stopped benefits under § 42-9-260.

4. Based on the foregoing, I find that Defendants properly stopped benefits under § 42-9-260 on September 12th, 2013. Defendants terminated benefits on the justification that a good faith investigation reveals grounds for the denial of the claim. *See* Finding of Fact # 8. This is a permissible ground for termination under the statute. *See* § 42-9-260(B)(3). At the time Defendants terminated Claimant's benefits on September 12th, 2013, Defendants had access to Claimant's medical records by operation of § 42-15-95 and had knowledge of the course of Claimant's treatment through its Nurse Case Manager. *See* Claimant's APA Submission # 5, p. 17. It is possible for Defendants to have drawn a conclusion in good faith based on Claimant's medical records that he suffered from pre-existing medical conditions unrelated to his employment that could be contributing to his current symptoms that would justify denying the claim. *See e.g.* Claimant's APA Submission #3, p.4 ("Discharge Diagnosis(es) . . . 3. Coronary artery disease[,] . . . 5. Hypertension[,] 6. Congestive heart failure."). The fact that there also exists evidence that was available to Defendants that could lead to the conclusion that Claimant's current condition is causally related to a compensable injury by accident does not lead me to conclude that Defendant's termination of benefits was improper. Claimant bears the ultimate burden of proving his claim is compensable and he has requested the Commission provide him an opportunity to do so.
5. Specifically, Claimant has requested a Hearing on the merits of whether Claimant sustained a compensable injury by accident and is entitled to benefits by operation of the Form 50 Employee's Request for Hearing filed on October 21st, 2013. Therefore, the question of whether Claimant sustained a compensable injury by accident and is entitled to benefits under the Act will be decided by the Commission at the Hearing set pursuant to Claimant's Form 50 Request for Hearing.
6. Claimant has availed himself of all relief available under § 42-9-260 and R.67-504 and, therefore, these provisions of the Workers' Compensation Act are no longer in contention in Claimant's claim for benefits against Defendants.

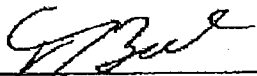
ORDER

IT IS THEREFORE ORDERED that Defendants properly terminated benefits under § 42-9-260 on September 12th, 2013.

IT IS FURTHERMORE ORDERED that Claimant's request for sanctions against Defendants under § 42-9-260(G) for failure to comply with the provisions of that statute is **DENIED**.

IT IS FURTHERMORE ORDERED that all other issues in contention, specifically including the question of whether Claimant sustained an injury by accident arising out of and in the course of his employment with Defendants resulting in compensable disability is preserved for adjudication at the Hearing set pursuant to Claimant's October 21st, 2013 Form 50 Employee's Request for Hearing.

AND SO IT IS ORDERED!



T. Scott Beck, Commissioner

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or by depositing a copy hereof, postage paid, in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

December 5, 2013

By: Amy Bracy, Administrative Assistant to Commissioner Beck

South Carolina Workers' Compensation

1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675 www.wcc.sc.gov



WCC File #: 1306305
Carrier File #: 22209963
Carrier Code #: 00475
Employer FEIN #: 510663955

Claimant's Name: Clarence Winfrey

SSN: [REDACTED]

Employer's Name: Archway Services Inc

Address: [REDACTED]

Address: [REDACTED]

Home Phone: [REDACTED]

Work Phone: [REDACTED]

Insurance Carrier: American Fire & Casualty Insurance Company c/o Liberty Mutual GroupPreparer's Name: Landon HugheyLaw Firm: McAngus Goudelock & CouriePreparer's Phone Number: (803) 227-2261**REQUEST FOR COMMISSION REVIEW**Request for Commission Review by ☐ Claimant ☒ Employer (check one) Date of Injury or Illness: May 22, 2013 (m/d/yyyy)

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

SEE ATTACHED

(Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

☐ Mediation☐ Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.Questions regarding mediation may be submitted to mediation@wcc.sc.gov.I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Preston F. McDaniel, Esquire, The McDaniel Law Firm1315 Elmwood Avenue
Address Columbia, South Carolina 29201

on

the

6th day of March20 14by ☒ first class postage ☐ certified mail ☐ personal service.[Signature]
Preparer's SignatureAttorney for Employer/Carrier

Title

rhughey@mgclaw.com

Email

March 6, 2014

Date

Check this box if you are not represented by an attorney. ☐

Questions about the use of this form should be directed to the Judicial Department at 803.737.5675 or appeals@wcc.sc.gov. If the claimant appeals and is not represented by counsel, the Judicial Department will properly serve this form pursuant to Reg. 67-607 C. Pursuant to Reg. 67-205 and Reg. 701, the appeal must be postmarked no later than 14 days from the date of service of the Decision and Order of the Hearing Commissioner along with the filing fee. Attach a Form 32, if you are unable to pay the filing fee. Refer to Reg. 67-211 and Reg. 67-701 through 711.

WCC FORM #30
revised 7/13**30****REQUEST FOR COMMISSION REVIEW**

000215

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1306305

CLARENCE WINFREY,

Employee,

Claimant,

vs.

ARCHWAY SERVICES INC,

Employer,

AND

AMERICAN FIRE & CASUALTY
INSURANCE COMPANY C/O LIBERTY
MUTUAL GROUP

Carrier,

Defendants.

**FORM 30 EXCEPTIONS TO SINGLE
COMMISSIONER'S DECISION AND
ORDER**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND PRESTON
F. MCDANIEL, ESQUIRE:

1. Did the Single Commissioner err in holding the hearing over Defendants' objections because, by conducting the hearing and ruling on material compensability issues, the Single Commissioner operated in an appellate capacity without proper jurisdiction?
2. Did the Single Commissioner err in holding the hearing over Defendants' objections when specific rulings from a prior Single Commissioner Decision and Order may become the law of the case and, if upheld in that proceeding, would render any decision by the Single Commission to be in error?
3. Did the Single Commissioner err in failing to find a date on which Claimant suffered a plaque rupture in Claimant's heart?

4. Did the Single Commissioner err in failing to find what caused the plaque rupture in Claimant's heart?
 5. Did the Single Commissioner err in failing to find a date on which Claimant suffered a myocardial infarction?
-
6. Did the Single Commissioner err in relying on Dr. Travis' written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts his written medical opinion?
 7. Did the Single Commissioner err in relying on Dr. Lide's written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts his written medical opinion?
 8. Did the Single Commissioner err in relying on Dr. Greenfield's written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts her written medical opinion?
 9. Did the Single Commissioner err in failing to deny compensability for a brain injury because Claimant presented no evidence of any brain injury even though Claimant specifically included a brain injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
 10. Did the Single Commissioner err in failing to deny compensability for a head injury because Claimant presented no evidence of any head injury even though Claimant specifically included a head injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
 11. Did the Single Commissioner err in failing to deny compensability for a left hand injury because Claimant presented no evidence of any left hand injury even though Claimant

specifically included a left hand injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?

12. Did the Single Commissioner err in failing to deny compensability for a left arm injury because Claimant presented no evidence of any left arm injury even though Claimant

specifically included a left arm injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?

13. Did the Single Commissioner err in failing to deny compensability for all other organs, members, and bodily parts because Claimant presented no evidence of any injury to any organs, members, or bodily parts even though Claimant specifically included other organs, members, and bodily parts on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?

14. Did the Single Commissioner err in Finding of Fact #1 in that the Finding is limited only to Claimant alleging an injury to his heart when the record is clear that Claimant alleged injuries to his head, brain, left hand, left arm, and all other organs, members, and bodily parts?

15. Did the Single Commissioner err in Finding of Fact #6 by finding that Claimant believed the actual voltage to be 480 volts when Claimant's own testimony refutes that finding?

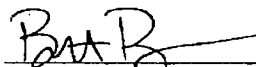
16. Did the Single Commissioner err in Finding of Fact #6 that Defendants had access to the rotisserie oven when the record is clear that the oven belonged to a third party and Defendants did not own or control the oven?

17. Did the Single Commissioner err in Finding of Fact #7 by finding that Claimant began sweating the night of the electrical shock when Claimant's own testimony refutes that finding?

18. Did the Single Commissioner err in Finding of Fact #9 that three physicians have opined the electrical shock resulted in Claimant's heart attack regardless of the date on which the heart attack occurred?

19. Did the Single Commissioner err in Finding of Fact #14 that Claimant specifically requested a finding of compensability for the heart when there is no evidence in the record the hearing was limited in scope to the heart, when Claimant's own Form 50 and Form 58 demanded a hearing on compensability of the left hand, arm, shoulder, neck, head, brain, chest, and all organs, members, and bodily parts determined to be related and when the Notice of Hearing from the Commission included a determination of compensability for the left hand, arm, shoulder, neck, head, brain, chest and all organs, members, and bodily parts determined to be related?

20. Did the Single Commissioner err by not making any findings of fact or conclusions of law related to an aggravation of a pre-existing heart condition as alleged by Claimant?



LANDON HUGHEY
BRETT H. BAYNE
MCANGUS GOUDELOCK & COURIE, L.L.C.
Post Office Box 12519, Capitol Station
Meridian, 1320 Main Street, 10th Floor
Columbia, South Carolina 29211-2519
(803) 779-2300
Attorneys for the Employer/Carrier

Columbia, South Carolina
March 6, 2014

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1306305

CLARENCE WINFREY,

Employee,

Claimant,

vs.

ARCHWAY SERVICES INC,

Employer,

AND

AMERICAN FIRE & CASUALTY
INSURANCE COMPANY C/O LIBERTY
MUTUAL GROUP,

Carrier,

Defendants.

**CERTIFICATE
OF
SERVICE**

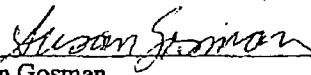
The undersigned certifies that she is an employee at MCANGUS GOUDELOCK & COURIE, and that she has served, on the date set forth below, a copy of the document described below, in the above entitled action to the following persons, pursuant to Section 15-9-930 and Section 15-9-940 of the Code of Laws of South Carolina, 1976, by depositing a copy of same in the United States Mail, postage prepaid, addressed to:

TO: Preston F. McDaniel, Esquire
The McDaniel Law Firm
1315 Elmwood Avenue
Columbia, South Carolina 29201

South Carolina Worker's Compensation Commission
1333 Main Street, Suite 500 · Post Office Box 1715
Columbia, South Carolina 29202-1715
VIA HAND DELIVERY

DOCUMENT: Form 30

DATE OF Mailing: March 6, 2014


Susan Gosman

Legal Assistant to Landon Hughey

000220

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO.: 5/22/2013

C LARENCE WINFREY,

Employee,

Claimant,

vs.

ARCHWAY SERVICES INC,

Employer,

AND

AMERICAN FIRE & CASUALTY
INSURANCE COMPANY C/O LIBERTY
MUTUAL GROUP

Carrier,

Defendants.

**DEFENDANT-APPELLANTS' BRIEF
TO THE FULL COMMISSION**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND PRESTON
F. MCDANIEL, ESQUIRE:

STATEMENT OF THE CASE

This claim arises out of an alleged accident on May 22, 2013. On that date, Claimant contends he was momentarily shocked by a rotisserie oven he was working on. Following the accident, Claimant continued to work for the remainder of the day and the following day. Claimant had scheduled time off after May 23, 2013. On May 28, 2013—six days after the accident—Claimant presented to Doctor's Care and Lexington Medical Center with severe three vessel coronary disease as well as an acute myocardial infarction which caused an acute ventricular septal defect. At Doctor's Care, Claimant reported he was having no chest pressure and had started sweating that morning (May 28th). At Lexington Medical Center, Claimant

indicated he was not having chest pain but had been sweating. Following the diagnosis, Claimant underwent surgery to repair the ventricular septal defect caused by the myocardial infarction. The medical records in the case revealed that Claimant has a distinct family history of coronary disease with his father passing away at a similar age from coronary disease and a myocardial infarction. Further, the medical records indicated that Claimant was a 35 year pack-a-day smoker and drank a case of beer per week. Based on all of the medical records available to Carrier, this claim was ultimately denied by verbal communication to Claimant on September 13, 2013.

Immediately following the denial of benefits, Claimant filed a Form 15, Section III requesting a hearing as well as a Summons and Complaint in Richland County Circuit Court alleging a bad faith denial of benefits, alleging that S.C. Code Ann. § 42-9-260 is unconstitutional, seeking a temporary restraining order to stop Defendants from denying the claim, and seeking an Order from Judge Lee finding the claim compensable and awarding benefits. Judge Lee issued and then rescinded the temporary restraining order sought by Claimant. A hearing on the merits of Claimant's Complaint has not been set by the Court. After the temporary restraining order was rescinded, the Commission set Claimant's Form 15, Section III for a hearing before Commissioner Beck. In addition, Defendants filed several motions with the Commission including a Motion to Quash the deposition of the adjuster, a Motion to Quash discovery of the adjuster's claim file, and a Motion to Postpone the Hearing.

A hearing on all of the motions and on Claimant's Form 15, Section III was set on September 30, 2013 for November 11, 2013. Prior to the hearing, Commissioner Beck conducted a standard pre-hearing conference as well as a Motions Hearing wherein Commissioner Beck ruled on all outstanding issues raised by the motions including Defendants' Motion to Postpone. Each of these motions affected the ability to conduct the Form 15 hearing and were necessary to

have prior to the hearing. Commissioner Beck gave Claimant the opportunity to postpone the Form 15 hearing in order to spend time preparing for each of the motions that were timely served. Claimant turned down that opportunity. At the hearing, all parties agreed that the only issue for Commissioner Beck was to determine whether or not Defendants had conducted a good faith investigation. In order to make that determination, Commissioner Beck limited the review of evidence to only those documents produced prior to the date of denial – September 13, 2013. Following the hearing, Commissioner Beck issued a Decision and Order on December 5, 2013 finding that Defendants had conducted a good faith investigation. Thereafter, Claimant timely filed a Form 30 and that portion of the claim is currently before the Full Commission.

On October 22, 2013, after the Form 15 hearing was set by the Commission, Claimant filed a Form 50 requesting a hearing on compensability for alleged injuries to his head, brain, left hand, left arm, chest, heart, and all other organs, members, and bodily parts. A hearing notice for the Form 50 hearing was sent by the Commission on December 6, 2013 with explicit instructions that the hearing would be to determine compensability of Claimant's alleged injuries to his head, brain, left hand, left arm, chest, heart, and all other organs, members, and bodily parts. The Form 50 hearing was held before the Single Commissioner on January 13, 2014. Following the hearing, the Single Commissioner issued a Decision and Order on February 27, 2014. Defendants timely filed a Form 30 based on legal errors contained in the Single Commissioner's Decision and Order.

LEGAL ISSUES RAISED BY DEFENDANT-APPELLANTS

- I. Did the Single Commissioner err in holding the hearing over Defendants' objections because, by conducting the hearing and ruling on material compensability issues, the Single Commissioner operated in an appellate capacity without proper jurisdiction?

- II. Did the Single Commissioner err in holding the hearing over Defendants' objections when specific rulings from a prior Single Commissioner Decision and Order may become the law of the case and, if upheld in that proceeding, would render any decision by the Single Commission to be in error?
-
- III. Did the Single Commissioner err in failing to find a date on which Claimant suffered a plaque rupture in Claimant's heart?
- IV. Did the Single Commissioner err in failing to find what caused the plaque rupture in Claimant's heart?
- V. Did the Single Commissioner err in failing to find a date on which Claimant suffered a myocardial infarction?
- VI. Did the Single Commissioner err in relying on Dr. Travis' written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts his written medical opinion?
- VII. Did the Single Commissioner err in relying on Dr. Lide's written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts his written medical opinion?
- VIII. Did the Single Commissioner err in relying on Dr. Greenfield's written medical opinion when the evidence presented at the hearing and deposition testimony directly contradicts her written medical opinion?
- IX. Did the Single Commissioner err in failing to deny compensability for a brain injury because Claimant presented no evidence of any brain injury even though Claimant specifically included a brain injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?

- X. Did the Single Commissioner err in failing to deny compensability for a head injury because Claimant presented no evidence of any head injury even though Claimant specifically included a head injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
-
- XI. Did the Single Commissioner err in failing to deny compensability for a left hand injury because Claimant presented no evidence of any left hand injury even though Claimant specifically included a left hand injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
- XII. Did the Single Commissioner err in failing to deny compensability for a left arm injury because Claimant presented no evidence of any left arm injury even though Claimant specifically included a left arm injury on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
- XIII. Did the Single Commissioner err in failing to deny compensability for all other organs, members, and bodily parts because Claimant presented no evidence of any injury to any organs, members, or bodily parts even though Claimant specifically included other organs, members, and bodily parts on his Form 50 and Form 58 as an issue to be determined at the hearing before the Single Commissioner?
- XIV. Did the Single Commissioner err in Finding of Fact #1 in that the Finding is limited only to Claimant alleging an injury to his heart when the record is clear that Claimant alleged injuries to his head, brain, left hand, left arm, and all other organs, members, and bodily parts?
- XV. Did the Single Commissioner err in Finding of Fact #6 by finding that Claimant believed the actual voltage to be 480 volts when Claimant's own testimony refutes that finding?

- XVI. Did the Single Commissioner err in Finding of Fact #6 that Defendants had access to the rotisserie oven when the record is clear that the oven belonged to a third party and Defendants did not own or control the oven?
- XVII. Did the Single Commissioner err in Finding of Fact #7 by finding that Claimant began sweating the night of the electrical shock when Claimant's own testimony refutes that finding?
- XVIII. Did the Single Commissioner err in Finding of Fact #9 that three physicians have opined the electrical shock resulted in Claimant's heart attack regardless of the date on which the heart attack occurred?
- XIX. Did the Single Commissioner err in Finding of Fact #14 that Claimant specifically requested a finding of compensability for the heart when there is no evidence in the record the hearing was limited in scope to the heart, when Claimant's own Form 50 and Form 58 demanded a hearing on compensability of the left hand, arm, shoulder, neck, head, brain, chest, and all organs, members, and bodily parts determined to be related and when the Notice of Hearing from the Commission included a determination of compensability for the left hand, arm, shoulder, neck, head, brain, chest and all organs, members, and bodily parts determined to be related?
- XX. Did the Single Commissioner err by not making any findings of fact or conclusions of law related to an aggravation of a pre-existing heart condition as alleged by Claimant?

MEDICAL EVIDENCE OF THE CASE

Claimant notified Employer he was shocked while working on a rotisserie oven on May 22, 2013. (Def. APA p. 8). Employment records of Claimant indicate that he continued working the remainder of the day and the entire following day. (Def. APA p. 10-11). An email from

Claimant to Employer indicates that he was experiencing only neck pain on May 27, 2013 (5 days post-accident). (Def. APA p. 9). Claimant first presented to Doctor's Care on May 28, 2013 (6 days post-accident) complaining that he woke up sweating that morning (6 days post-accident). (Def. APA p. 1). Doctor's Care noted that Claimant had some tenderness in his shoulder and neck area. Id. Further, Doctor's Care noted that Claimant did **not** complain of any chest pressure. Id. Claimant was referred to and saw Dr. Dasgupta at the South Carolina Heart Center. Dr. Dasgupta also noted sweating and noted that Claimant **denied** chest pain but did have minimal left shoulder pain. (Def. APA p. 2). Dr. Dasgupta diagnosed Claimant with an acute myocardial infarction. Id. Dr. Dasgupta indicated that Claimant had a prior history of hypertension, tobacco abuse, as well as a significant family history for heart disease (Claimant's father passed away from coronary disease and myocardial infarction). (Def. APA p. 2-3). Dr. Dasgupta also noted that Claimant appeared to have a ventricular septal defect as a possible completion of his myocardial infarction. (Def. APA p. 2). Dr. Dasgupta referred Claimant to Lexington Medical Center where he underwent surgery to repair an acute ventricular septal defect that formed following the myocardial infarction. (Def. APA p. 5-7).

LEGAL ANALYSIS

I. THE SINGLE COMMISSIONER ERRED BY HOLDING THE HEARING OVER DEFENDANTS' OBJECTIONS BECAUSE, BY CONDUCTING THE HEARING AND RULING ON MATERIAL COMPENSABILITY ISSUES, THE SINGLE COMMISSIONER OPERATED IN AN APPELLATE CAPACITY WITHOUT PROPER JURISDICTION.

Claimant has alleged an injury arising out of an electrical shock accident on May 22, 2013. Prior to the hearing held by the Single Commissioner, Commissioner Beck issued a Decision and Order on December 5, 2013 finding that Defendants had conducted a good faith investigation. In addition, in that Decision and Order, Commissioner Beck made a correct

finding based on the medical evidence submitted that Claimant suffered a myocardial infarction on May 28, 2013 (6 days post-accident). That finding, along with many others from that order, was appealed by Claimant in a properly filed Form 30. At the time of this underlying hearing before the Single Commissioner, the Full Commission had not yet conducted a hearing on Commissioner Beck's Decision and Order and, therefore, each of the exceptions to his order were on appeal—including the May 28, 2013 date of the myocardial infarction.

A review of the medical evidence and deposition testimony reveals that Claimant's ventricular septal defect was caused by his acute myocardial infarction/plaque rupture¹. In other words, the medical evidence is clear that the electrical shock did not directly cause the ventricular septal defect. Rather, the acute myocardial infarction caused the ventricular septal defect. Further, there is no dispute between the parties that the cause of the ventricular septal defect is the acute myocardial infarction. The question of compensability before the Single Commissioner for Claimant's chest and/or heart condition therefore was simply "what caused Claimant's acute myocardial infarction?"

In order to make that determination and answer that question, the Single Commissioner was required to make findings related to when the acute myocardial infarction occurred. The Single Commissioner expressly refused to make that finding. It was Defendants position that an acute myocardial infarction occurring 6 days post-accident cannot be causally related to the work-accident itself. Defendants' position is that Claimant's pre-existing conditions, family history, lifestyle choices, and mere coincidence in time are the causative factors of his acute myocardial infarction occurring 6 days post-accident. When all of Claimant's conditions are

¹ The medical records and testimony indicate the plaque rupture was contemporaneous with the acute myocardial infarction and that it was either caused by the acute myocardial infarction or the acute myocardial infarction was caused by the plaque rupture. The doctors' testimony indicates that it is not possible to know which occurred first. For continuity and clarity throughout, acute myocardial infarction will be used in this brief.

viewed together, the evidence clearly supports a finding that the acute myocardial infarction in relation to the work-accident is nothing more than an unfortunately timed coincidence.

However, Defendants' position as to compensability aside, the Single Commissioner was required to make a finding indicating when Claimant suffered an acute myocardial infarction in order for there to be legal support for a finding of a causal connection between the acute ventricular septal defect and the electrical shock². Absent a requirement to make a finding of when the causative injury occurred (in this case the acute myocardial infarction), the door would be opened to find compensability for injuries that occur 1 month, 6 months, 1 year or more from the date of an alleged accident.

In the Decision and Order, the Single Commissioner, by choosing to expressly refuse to find the date on which the acute myocardial infarction occurred, implicitly made findings that result in one of two things: (1) an affirmation of Commissioner Beck's finding of the May 28, 2013 date of acute myocardial infarction or (2) a reversal of Commissioner Beck's finding of the May 28, 2013 date of acute myocardial infarction³. Either way, the Single Commissioner sat in an unlawful appellate capacity when she both heard this claim and rendered her Decision and Order by either implicitly affirming or reversing Commissioner Beck's findings as compensability of the acute ventricular septal defect cannot be determined absent a finding of when the acute myocardial infarction occurred.

For the foregoing reasons, the Single Commissioner's Decision and Order should be vacated in its entirety as the underlying hearing could not have been held and by holding the

² As noted throughout, the causative chain at issue is whether the (1) Electrical Shock caused the (2) Acute Myocardial Infarction/Plaque Rupture which then caused the (3) Ventricular Septal Defect. If the acute myocardial infarction was not caused by the electrical shock then the ventricular septal defect is not compensable.

³ In other words, the Single Commissioner, by not ruling on the timing of the acute myocardial infarction, either acknowledges the acute myocardial infarction occurred May 28 (6 days post-accident) and finds that it is still causally related to the electrical shock (which is addressed below) OR the Single Commissioner determined the acute myocardial infarction occurred earlier in time and simply refused to enumerate that finding of fact so as to

hearing the Single Commissioner sat in an unlawful appellate capacity. Further, this claim should be remanded for a new hearing at the Single Commissioner level with instructions that the hearing cannot be conducted until the first appeal of Commissioner Beck's Decision and Order has been allowed to run its course and the issues related to the date of the acute myocardial infarction are resolved.

II. THE SINGLE COMMISSIONER ERRED BY HOLDING THE HEARING OVER DEFENDANTS' OBJECTIONS WHEN SPECIFIC RULINGS FROM A PRIOR SINGLE COMMISSIONER DECISION AND ORDER MAY BECOME THE LAW OF THE CASE AND, IF UPHELD IN THAT PROCEEDING, WOULD RENDER ANY DECISION BY THE SINGLE COMMISSION TO BE IN ERROR.

This exception tracks closely with the previous exception. Defendants contend that the Single Commissioner erred by conducting the hearing because, if Commissioner Beck's Decision and Order is upheld, the Single Commissioner's Decision and Order will be in error and the Full Commission will be required to remand the claim for a new hearing consistent with findings in Commissioner Beck's Decision and Order. Defendants contend the Form 50 hearing conducted by the Single Commissioner was premature in light of judicial economy when certain merits of the claim directly affecting compensability were already on appeal to the Full Commission.

For the foregoing reasons, the Single Commissioner's Decision and Order should be vacated in its entirety as the underlying hearing should not have been held based on the underlying ongoing appeal to the Full Commission on issues that directly affect compensability of the claim. Further, this claim should be remanded for a new hearing at the Single Commissioner level with instructions that the hearing cannot be conducted until the first appeal of Commissioner Beck's Decision and Order has been allowed to run its course and the issues related to the date of the acute myocardial infarction are resolved.

avoid inherent conflict with Commissioner Beck's prior Decision and Order that is on appeal.

III. THE SINGLE COMMISSIONER ERRED BY FAILING TO FIND A DATE ON WHICH CLAIMANT SUFFERED A PLAQUE RUPTURE IN CLAIMANT'S HEART.

The sequence of medical events in this claim is not disputed. Claimant suffered an electrical shock at work on May 22, 2013. Sometime between May 23, 2013 and May 28, 2013 Claimant suffered an acute myocardial infarction/plaque rupture⁴. The acute myocardial infarction/plaque rupture led to Claimant developing an acute ventricular septal defect. The ventricular septal defect developed as a result of the acute myocardial infarction/plaque rupture required surgical intervention on May 29, 2013.

As previously noted, the key to determining whether or not Claimant's ventricular septal defect is compensable is determining whether or not the plaque rupture was caused by the electrical shock. If the electrical shock did not cause the plaque rupture then the ventricular septal defect **cannot** be found to be compensable as it was directly caused by the plaque rupture. In order to find that the plaque rupture was caused by the electrical shock, the Single Commissioner must find the date on which the plaque rupture occurred. Absent a finding of when Claimant suffered the injury (the plaque rupture) that led to his ventricular septal defect, the Single Commissioner's Decision and Order is speculative, conjecture, and without any support in the evidence.

In Cross v. Concrete Materials, 236 S.C. 440, 114 S.E.2d 828 (1960), the Supreme Court stated that "Under other authority, the rule of liberal construction of the compensation acts in favor of the employee...does not dispense with the necessity of evidence to support the award, or of making proof prerequisite to recovery, **does not permit a court to award compensation where the requisite proof is lacking**, and...does not to apply to the evidence offered, or

⁴ Defendants position, consistent with the medical records and Commissioner Beck's Decision and Order is that the acute myocardial infarction/plaque rupture occurred on May 28, 2013.

required, to establish the claim, or to the function of the commission in hearing evidence or in resolving conflicts in the testimony, and does not operate to distort the proofs or to make the facts other than as they are. A liberal construction of the evidence cannot be substituted for failure of proof of any essential element of the claim..." (emphasis added). The Supreme Court went on to state "It has been mistakenly said in one or more of our decisions...that doubt of causal connection between injury and death or disability should be resolved in favor of compensability. That is error because it would found a conclusion of fact upon doubt whereas **such finding must be upon evidence, not doubt...** There is no sound reason for the translation of the rule of liberal construction of the law to the finding of the facts to the end that doubt with respect to the latter shall be resolved in favor of the claimant. Doubt, as the foundation of a factual finding, can hardly be distinguished from surmise, speculation and conjecture which countless cases have condemned as a substitute for facts and legitimate inferences. **Conviction, not doubt, is the proper basis of a conclusion of fact.**" (emphasis added).

A finding of compensability for the ventricular septal defect without first finding when the plaque rupture occurred in relation to the electrical shock constitutes a finding that is based on surmise, conjecture, and speculation. Pursuant to Cross, the Single Commissioner must make findings based upon "evidence, not doubt." The Single Commissioner was required to make findings of fact based on the evidence of when the plaque rupture occurred and that the plaque rupture was caused by the electrical shock. Absent these findings, the Single Commissioner cannot make a finding that the ventricular septal defect is a compensable injury.

Therefore, the Single Commissioner's Decision and Order should be reversed. The Full Commission should either enter a finding that the ventricular septal defect is not compensable based on the evidence presented or this claim should be remanded for a new hearing with

instructions that the Single Commissioner shall enter findings not inconsistent with a finding that the ventricular septal defect is not compensable. Alternatively, this claim should be remanded for a new hearing on the merits of compensability.

IV. THE SINGLE COMMISSIONER ERRED BY FAILING TO FIND WHAT CAUSED THE PLAQUE RUPTURE IN CLAIMANT'S HEART.

The sequence of medical events in this claim is not disputed. Claimant suffered an electrical shock at work on May 22, 2013. Sometime between May 23, 2013 and May 28, 2013 Claimant suffered an acute myocardial infarction/plaque rupture⁵. The acute myocardial infarction/plaque rupture led to Claimant developing a ventricular septal defect. The ventricular septal defect developed as a result of the acute myocardial infarction/ plaque rupture required surgical intervention on May 29, 2013.

As previously noted, the key to determining whether or not Claimant's ventricular septal defect is compensable is determining whether or not the plaque rupture was caused by the electrical shock. If the electrical shock did not cause the plaque rupture then the ventricular septal defect cannot be found to be compensable as it was directly caused by the acute myocardial infarction and plaque rupture. The Single Commissioner failed to make a finding related to what caused the plaque rupture in Claimant's heart. Absent a finding of what caused Claimant's plaque rupture that led to his ventricular septal defect, the Single Commissioner's Decision and Order is speculative, conjecture, and without any support in the evidence.

In Cross v. Concrete Materials, 236 S.C. 440, 114 S.E.2d 828 (1960), the Supreme Court stated that "Under other authority, the rule of liberal construction of the compensation acts in favor of the employee...does not dispense with the necessity of evidence to support the award, or of making proof prerequisite to recovery, **does not permit a court to award compensation**

⁵ Defendants position, consistent with the medical records and Commissioner Beck's Decision and Order is that the

where the requisite proof is lacking, and...does not to apply to the evidence offered, or required, to establish the claim, or to the function of the commission in hearing evidence or in resolving conflicts in the testimony, and does not operate to distort the proofs or to make the facts other than as they are. A liberal construction of the evidence cannot be substituted for failure of proof of any essential element of the claim..." (emphasis added). The Supreme Court went on to state "It has been mistakenly said in one or more of our decisions...that doubt of causal connection between injury and death or disability should be resolved in favor of compensability. That is error because it would found a conclusion of fact upon doubt whereas **such finding must be upon evidence, not doubt**...There is no sound reason for the translation of the rule of liberal construction of the law to the finding of the facts to the end that doubt with respect to the latter shall be resolved in favor of the claimant. Doubt, as the foundation of a factual finding, can hardly be distinguished from surmise, speculation and conjecture which countless cases have condemned as a substitute for facts and legitimate inferences. **Conviction, not doubt, is the proper basis of a conclusion of fact.**" (emphasis added).

A finding of compensability for the ventricular septal defect without first finding what caused the plaque rupture in relation to the electrical shock constitutes a finding that is based on surmise, conjecture, and speculation. Pursuant to Cross, the Single Commissioner must make findings based upon "evidence, not doubt." The Single Commissioner was required to make findings of fact based on the evidence of what caused the plaque rupture and that the plaque rupture was caused by the electrical shock. Absent these findings, the Single Commissioner cannot make a finding that the ventricular septal defect is a compensable injury.

Therefore, the Single Commissioner's Decision and Order should be reversed. The Full Commission should either enter a finding that the ventricular septal defect is not compensable

based on the evidence presented or this claim should be remanded for a new hearing with instructions that the Single Commissioner shall enter findings not inconsistent with a finding that the ventricular septal defect is not compensable. Alternatively, this claim should be remanded for a new hearing on the merits of compensability.

V. THE SINGLE COMMISSIONER ERRED BY FAILING TO FIND A DATE ON WHICH CLAIMANT SUFFERED A MYOCARDIAL INFARCTION.

The sequence of medical events in this claim is not disputed. Claimant suffered an electrical shock at work on May 22, 2013. Sometime between May 23, 2013 and May 28, 2013 Claimant suffered an acute myocardial infarction/ plaque rupture⁶. The acute myocardial infarction/plaque rupture led to Claimant developing a ventricular septal defect. The ventricular septal defect developed as a result of the acute myocardial infarction required surgical intervention on May 29, 2013.

As previously noted, the key to determining whether or not Claimant's ventricular septal defect is compensable is determining whether or not the acute myocardial infarction was caused by the electrical shock. If the electrical shock did not cause the acute myocardial infarction then the ventricular septal defect cannot be found to be compensable as it was directly caused by the acute myocardial infarction and resulting plaque rupture. The Single Commissioner failed to make a finding related to what caused the acute myocardial infarction in Claimant's heart. Absent a finding of what caused Claimant's acute myocardial infarction that led to his ventricular septal defect, the Single Commissioner's Decision and Order is speculative, conjecture, and without any support in the evidence.

In Cross v. Concrete Materials, 236 S.C. 440, 114 S.E.2d 828 (1960), the Supreme Court stated that "Under other authority, the rule of liberal construction of the compensation acts in

⁶ Defendants position, consistent with the medical records and Commissioner Beck's Decision and Order is that the

favor of the employee...does not dispense with the necessity of evidence to support the award, or of making proof prerequisite to recovery, **does not permit a court to award compensation where the requisite proof is lacking**, and...does not to apply to the evidence offered, or required, to establish the claim, or to the function of the commission in hearing evidence or in resolving conflicts in the testimony, and does not operate to distort the proofs or to make the facts other than as they are. A liberal construction of the evidence cannot be substituted for failure of proof of any essential element of the claim..." (emphasis added). The Supreme Court went on to state "It has been mistakenly said in one or more of our decisions...that doubt of causal connection between injury and death or disability should be resolved in favor of compensability. That is error because it would found a conclusion of fact upon doubt whereas **such finding must be upon evidence, not doubt**...There is no sound reason for the translation of the rule of liberal construction of the law to the finding of the facts to the end that doubt with respect to the latter shall be resolved in favor of the claimant. Doubt, as the foundation of a factual finding, can hardly be distinguished from surmise, speculation and conjecture which countless cases have condemned as a substitute for facts and legitimate inferences. **Conviction, not doubt, is the proper basis of a conclusion of fact.**" (emphasis added).

A finding of compensability for the ventricular septal defect without first finding what caused the acute myocardial infarction in relation to the electrical shock constitutes a finding that is based on surmise, conjecture, and speculation. Pursuant to Cross, the Single Commissioner must make findings based upon "evidence, not doubt." The Single Commissioner was required to make findings of fact based on the evidence of what caused the acute myocardial infarction and that the acute myocardial infarction was caused by the electrical shock. Absent these findings, the Single Commissioner cannot make a finding that the ventricular septal defect is a

compensable injury.

Therefore, the Single Commissioner's Decision and Order should be reversed. The Full Commission should either enter a finding that the ventricular septal defect is not compensable based on the evidence presented or this claim should be remanded for a new hearing with instructions that the Single Commissioner shall enter findings not inconsistent with a finding that the ventricular septal defect is not compensable. Alternatively, this claim should be remanded for a new hearing on the merits of compensability.

VI. THE SINGLE COMMISSIONER ERRED BY RELYING ON DR. TRAVIS' WRITTEN MEDICAL OPINION WHEN THE EVIDENCE PRESENTED AT THE HEARING AND DEPOSITION TESTIMONY DIRECTLY CONTRADICTS HIS WRITTEN MEDICAL OPINION.

The Single Commissioner erred in relying on Dr. Travis' written medical opinion for two reasons: (1) Dr. Travis' opinion that the electrical shock caused Claimant's heart condition is based solely on the relationship in time between the shock and the acute myocardial infarction as well as the presence of a plaque on Claimant's heart; and (2) Dr. Travis' opinion is based on the fact that Claimant was shocked by 480 volts of electricity which is clearly contradicted by the evidence.

First, the extent of Dr. Travis opinion is grounded solely in the relationship in time between the electrical shock and the heart condition as well as a plaque on Claimant's heart. Dr. Travis described the mechanism of Claimant's injury as being a plaque rupture that caused a myocardial infarction that caused the ventricular septal defect. (Dr. Travis Depo. Tr. 13:24 – 14:2). However, Dr. Travis indicated that plaque ruptures can be caused by many things including getting up the wrong way from a couch, strenuous activity, stressful events in your personal life, emotional stresses, and many other things. (Dr. Travis Depo. Tr. 14:3-11). Further, Dr. Travis was asked "...other than the timing of the heart attack...there's no way to know for

certain the plaque rupture was caused by the electrical shock, is that correct?" (Dr. Travis Depo. Tr. 14:12-15). Dr. Travis response was that "[i]s there a definitive way to—collate one to another **absolutely not**." (Dr. Travis Depo. Tr. 14:16-18) (emphasis added). Dr. Travis also stated that "the [electrical shock] **could**⁷ of started the whole domino effect." (Dr. Travis Depo. Tr. 29:23-24). Finally, Dr. Travis indicated that the neck pain Claimant experienced—and that Claimant's deposition testimony reveals was the **only** pain he experienced through at least two days post-accident—"could be just neck pain [unrelated to a heart condition]. (Dr. Travis Depo. Tr. 30:12-16).

Dr. Travis also indicated that part of his opinion formed because of the presence of a plaque on Claimant's heart. However, Dr. Travis stated that this was his first open heart surgery on a patient who had received an electrical shock. (Dr. Travis Depo. Tr. 29:2-5). Further, Dr. Travis stated that he had **never** "read about or seen anything" related to whether or not the plaque he observed is related to electrical shock or whether or not the plaque he observed is common in electrical shock. (Dr. Travis Depo. Tr. 29:6-12). The testimony indicates that Dr. Travis essentially guessed that the plaque he observed was related to an electrical shock based solely on the fact that Claimant suffered an electrical shock a week prior. This is clearly an insufficient basis on which to ground a medical opinion as it related to causation under the Act.

Second, Dr. Travis' written medical opinion should not be given weight because the specific underlying causation (e.g. 480 volts of electricity) in his written medical statement is clearly contradicted by the evidence. Dr. Travis' written statement indicates that Claimant's condition was caused by 480 volts of electricity. In his deposition, Dr. Travis was asked to confirm his written opinion about whether he believed that Claimant's "...condition was brought about by electrical shock of 480 volts..." (Dr. Travis Depo. Tr. 8:20-22). Dr. Travis answered

⁷ "Could" is insufficient to support a finding of medical causation under the Act.

"I believe it, absolutely, had cause (sic) the defect on presentation." (Dr. Travis Depo. Tr. 8:23-24). However, **Dr. Travis admitted that he does not have any idea what amount of voltage actually shocked Claimant.** (Dr. Travis Depo. Tr. 9:3-4). Further, Dr. Travis admitted that the entire basis of his opinion related to voltage of the shock causing Claimant's condition came from Claimant himself. (Dr. Travis Depo. Tr. 9:5-8).

At the Hearing, Claimant could not testify to the exact voltage of the machine. Claimant stated that the voltage into the machine "...was at 240. I mean, it's 240 or above..." (Hr'g Tr. 24:25). Further, Claimant could only state the machine was "high voltage" and "at least 240 volts." (Hr'g Tr. p. 54:16-24). Mark Warren also testified at the hearing. His testimony revealed that the machine Claimant was using was rated for a maximum 480 volts but that it could run on 208 volt. (Hr'g Tr. 58:24-25). Further, Mr. Warren testified that the machine should be running at 208 volts per leg. (Hr'g Tr. 59:2-4).

The evidence in the record clearly establishes that there is no basis for a finding by Dr. Travis, any other doctor, or the Commission that Claimant suffered a shock of 480 volts. Because Dr. Travis' written opinion is based upon a shock of 480 volts, which is clearly contradicted by the evidence, weight cannot be given to his written medical opinion.

For the foregoing reasons, the Single Commissioner erred in giving any weight to Dr. Travis' written medical opinions. It is clear from the evidence that Dr. Travis' opinion is based on speculation, conjecture, surmise, and incorrect information. Further, Dr. Travis' opinion is based solely on a time relationship inasmuch as Claimant suffered an electrical shock and 6 days later presented with an acute myocardial infarction. Additionally, Dr. Travis' opinion related to plaque on Claimant's heart amount to, at best, a guess and Dr. Travis readily indicated he had no idea whether or not the plaque he observed was caused by electrical shock. Because the Single

Commissioner clearly relied on this report in finding this claim to be compensable, the Full Commission must either enter new findings of fact finding this claim to be not compensable or remand this claim to the Single Commissioner with instructions that Dr. Travis' written opinion is to be given no weight and to enter findings of fact consistent with the testimony and medical evidence—namely that Claimant did not suffer a compensable injury to his chest and/or heart.

VII. THE SINGLE COMMISSIONER ERRED BY RELYING ON DR. LIDE'S WRITTEN MEDICAL OPINION WHEN THE EVIDENCE PRESENTED AT THE HEARING AND DEPOSITION TESTIMONY DIRECTLY CONTRADICTS HIS WRITTEN MEDICAL OPINION.

The Single Commissioner erred in relying on Dr. Lide's written medical opinion for two reasons: (1) Dr. Lide's opinion that the electrical shock caused Claimant's heart condition is based solely on the relationship in time between the shock and the acute myocardial infarction; and (2) Dr. Lide's opinion is based on the fact that Claimant was shocked by 480 volts of electricity which is clearly contradicted by the evidence.

First Dr. Lide bases his opinion on the relationship in time inasmuch as Claimant suffered an electrical shock and 6 days later presented with an acute myocardial infarction. In his deposition, Dr. Lide stated that no one knows what causes a plaque rupture in the heart. (Dr. Lide Depo. Tr. 17:13-15). Dr. Lide agreed with the statement that "...we don't really know what causes plaque rupture." (Dr. Lide Depo. Tr. 17:22). Dr. Lide also testified that **"I don't know whether the electrical shock caused the plaque rupture..."** (Dr. Lide Depo. Tr. 18:14-15). Further, Dr. Lide testified that **he is not familiar with any research and he has not conducted any research on whether an electrical shock can cause a myocardial infarction or a ventricular septal defect.** (Dr. Lide Depo. Tr. 22:13 – 23:1). Dr. Lide also indicated that the longer in time the heart condition develops from the precipitating event (in this case an electrical shock), the less likely it is the heart condition is related to the electrical shock. (Dr. Lide Depo.

Tr. 23:2-6). Finally, Dr. Lide stated his overwhelming evidence that the electrical shock caused Claimant's condition was "proximity in time." (Dr. Lide Depo. Tr. 24:20-21).

Second, Dr. Lide bases his opinion on the fact that Claimant was shocked by 480 volts of electricity. However, at his deposition, Dr. Lide stated "[t]he details of the shock are beyond me..." and "...I did not investigate the scene. I do not know what equipment he was working on...and I certainly have no data to indicate to me whether 480 volts would be strong enough to cause the problem that 120 volts wouldn't cause...I have done no research on this."

At the Hearing, Claimant could not testify to the exact voltage of the machine. Claimant stated that the voltage into the machine "...was at 240. I mean, it's 240 or above..." (Hr'g Tr. 24:25). Further, Claimant could only state the machine was "high voltage" and "at least 240 volts." (Hr'g Tr. p. 54:16-24). Mark Warren also testified at the hearing. His testimony revealed that the machine Claimant was using was rated for a maximum 480 volts but that it could run on 208 volt. (Hr'g Tr. 58:24-25). Further, Mr. Warren testified that the machine should be running at 208 volts per leg. (Hr'g Tr. 59:2-4).

The evidence in the record clearly establishes that there is no basis for a finding by Dr. Lide, any other doctor, or the Commission that Claimant suffered a shock of 480 volts. Because Dr. Lide's written opinion is based upon a shock of 480 volts, which is clearly contradicted by the evidence, weight cannot be given to his written medical opinion.

For the foregoing reasons, the Single Commissioner erred in giving any weight to Dr. Lide's written medical opinions. It is clear from the evidence that Dr. Lide's opinion is based on speculation, conjecture, surmise, and incorrect information. Dr. Lide indicated in his testimony that there is no known way to determine what causes a plaque rupture. Further, Dr. Lide

indicated that he knows of no research connecting an electrical shock to a myocardial infarction or a ventricular septal defect. Finally, Dr. Lide admitted that he based his opinion on proximity in time. In addition, Dr. Lide's written opinion related to the electrical shock is invalid based on the clear evidence presented by Claimant and Mr. Warren that the voltage of the machine was less than 480 volts. Because the Single Commissioner clearly relied on this report in finding this claim to be compensable, the Full Commission must either enter new findings of fact finding this claim to be not compensable or remand this claim to the Single Commissioner with instructions that Dr. Lide's written opinion is to be given no weight and to enter findings of fact consistent with the testimony and medical evidence—namely that Claimant did not suffer a compensable injury to his chest and/or heart.

VIII. THE SINGLE COMMISSIONER ERRED BY RELYING ON DR. GREENFIELD'S WRITTEN MEDICAL OPINION WHEN THE EVIDENCE PRESENTED AT THE HEARING AND DEPOSITION TESTIMONY DIRECTLY CONTRADICTS HER WRITTEN MEDICAL OPINION.

The Single Commissioner erred in relying on Dr. Greenfield's written medical opinion for two reasons: (1) Dr. Greenfield's opinion that the electrical shock caused Claimant's heart condition is based solely on the relationship in time between the shock and the myocardial infarction; and (2) Dr. Greenfield's opinion is based on the fact that Claimant was shocked by 480 volts of electricity which is clearly contradicted by the evidence.

Dr. Greenfield testified in her deposition that the testing she conducted could not give any indication as to when Claimant suffered the myocardial infarction. Specifically, Dr. Greenfield stated that the myocardial infarction "...could have been 5 days ago..." and further **admitted that the acute myocardial infarction could have occurred the evening of May 27 or the morning of May 28.** (Dr. Greenfield Depo Tr. 12:10 – 13:8). Further, Dr. Greenfield indicated that she based portions of her opinion on articles that she read relating to electrocution

from lightning strikes. When asked about these articles, Dr. Greenfield admitted the voltage involved in those articles was 10,000,000 volts—an amount that is 20,000-40,000 times higher than the voltage involved in this claim. (Dr. Greenfield Depo. Tr. 28:19 – 29:4). Additionally, Dr. Greenfield stated that Claimant presented without any chest pain. (Dr. Greenfield Depo. Tr. 16:5-9, 24:3-8). Dr. Greenfield also noted the pain in Claimant's arm and shoulder was not indicative of having sustained a myocardial infarction. (Dr. Greenfield Depo. Tr. 16:13-25).

Second, Dr. Greenfield bases her written opinion on the fact that Claimant was shocked by 480 volts of electricity. However, in her deposition, Dr. Greenfield was asked about this opinion and she stated “[Claimant] told me it was 480.” (Dr. Greenfield Depo. Tr. 7:11). Dr. Greenfield admitted that she did not run any tests to determine voltage and when asked if she had any personal knowledge of the actual voltage of the machine, she responded “I would not have the foggiest [idea].” (Dr. Greenfield Depo. Tr. 7:12-23).

At the Hearing, Claimant could not testify to the exact voltage of the machine. Claimant stated that the voltage into the machine “...was at 240. I mean, it's 240 or above...” (Hr'g Tr. 24:25). Further, Claimant could only state the machine was “high voltage” and “at least 240 volts.” (Hr'g Tr. p. 54:16-24). Mark Warren also testified at the hearing. His testimony revealed that the machine Claimant was using was rated for a maximum 480 volts but that it could run on 208 volt. (Hr'g Tr. 58:24-25). Further, Mr. Warren testified that the machine should be running at 208 volts per leg. (Hr'g Tr. 59:2-4).

The evidence in the record clearly establishes that there is no basis for a finding by Dr. Greenfield, any other doctor, or the Commission that Claimant suffered a shock of 480 volts. Because Dr. Greenfield's opinion is based upon a shock of 480 volts, which is clearly contradicted by the evidence, weight cannot be given to her written medical opinion.

For the foregoing reasons, the Single Commissioner erred in giving any weight to Dr. Greenfield's written medical opinions. It is clear from the evidence that Dr. Greenfield's opinion is based on speculation, conjecture, surmise, and incorrect information. She stated in her deposition that there was no way for her determine when the myocardial infarction occurred and that it was possible it occurred on the night of May 27—5 days post-accident—or the morning of May 28—6 days post-accident. Further, Dr. Greenfield based her opinion on articles that have no relevance to the claim at hand (namely an article about lightning strikes containing voltage over 20,000-40,000 times higher than the voltage in this claim).

In addition, Dr. Greenfield's written opinion related to the electrical shock is invalid based on the clear evidence presented by Claimant and Mr. Warren that the voltage of the machine was less than 480 volts. Because the Single Commissioner clearly relied on this report in finding this claim to be compensable, the Full Commission must either enter new findings of fact finding this claim to be not compensable or remand this claim to the Single Commissioner with instructions that Dr. Greenfield's written opinion is to be given no weight and to enter findings of fact consistent with the testimony and medical evidence—namely that Claimant did not suffer a compensable injury to his chest and/or heart.

IX. THE SINGLE COMMISSIONER ERRED BY FAILING TO DENY COMPENSABILITY FOR A BRAIN INJURY BECAUSE CLAIMANT PRESENTED NO EVIDENCE OF ANY BRAIN INJURY EVEN THOUGH CLAIMANT SPECIFICALLY INCLUDED A BRAIN INJURY ON HIS FORM 50 AND FORM 58 AS AN ISSUE TO BE DETERMINED AT THE HEARING BEFORE THE SINGLE COMMISSIONER.

Claimant filed a Form 50 on October 21, 2013 alleging injuries to his "heart, left hand/arm/shoulder, neck, head (brain), chest." Thereafter, Defendants filed a Form 51 on or about November 19, 2013 denying every alleged injury and stated that "Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the

Act.” This matter was set for a hearing on January 13, 2013 by a Notice of Hearing issued on December 6, 2013. That Notice of Hearing specifically stated that the purpose of the hearing was to “determine issues as set forth on Forms 50 and 51.” Claimant’s Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are “heart, left hand/arm/shoulder, neck, head (brain), chest.”

There is no question that Claimant alleged a brain injury on his Form 50. There is no question that the Notice of Hearing indicated that all issues on the Form 50 would be determined at the hearing. There is no question that Claimant had sufficient notice of this hearing and what was contained on his Form 50. There is no question that Claimant filed a Pre-Hearing brief indicating that he was seeking compensation for a brain injury. There is no question that Defendants filed a Pre-Hearing Brief denying compensability of this claim. There is no question that Claimant did not withdraw his allegations related to a brain injury prior to or at the hearing. And, likewise, there is no question that Claimant did not present any evidence at the hearing to substantiate his alleged brain injury.

The Single Commissioner, in Finding of Fact #14, explicitly found that Claimant failed to present any evidence that he sustained or may have sustained a head or brain injury. However, the Single Commissioner indicated that benefits would only be denied “at this juncture.” This was improper. Claimant raised the issue of suffering a brain injury in every single one of his filings. Claimant chose to proceed at the hearing on his Form 50 without modification. Therefore, pursuant to the Act, Claimant had the absolute burden of proving the right to compensation for each and every injury alleged on the Form 50. If Claimant failed to present evidence, as he did in this claim, then his right to compensation for the alleged injury should be denied. To leave the claim open for possibly unlimited future hearings to determine

compensability of presently alleged body parts is grossly prejudicial to Defendants.

Therefore, for the foregoing reasons, the Full Commission should alter or amend the Single Commissioner's Decision and Order by removing the phrase "at this this point" and "at this juncture." Because Claimant failed to present any evidence of a brain injury, the proper course of action is a complete denial of any alleged brain injury.

X. THE SINGLE COMMISSIONER ERRED BY FAILING TO DENY COMPENSABILITY FOR A HEAD INJURY BECAUSE CLAIMANT PRESENTED NO EVIDENCE OF ANY HEAD INJURY EVEN THOUGH CLAIMANT SPECIFICALLY INCLUDED A HEAD INJURY ON HIS FORM 50 AND FORM 58 AS AN ISSUE TO BE DETERMINED AT THE HEARING BEFORE THE SINGLE COMMISSIONER.

Claimant filed a Form 50 on October 21, 2013 alleging injuries to his "heart, left hand/arm/shoulder, neck, head (brain), chest." Thereafter, Defendants filed a Form 51 on or about November 19, 2013 denying every alleged injury and stated that "Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the Act." This matter was set for a hearing on January 13, 2013 by a Notice of Hearing issued on December 6, 2013. That Notice of Hearing specifically stated that the purpose of the hearing was to "determine issues as set forth on Forms 50 and 51." Claimant's Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are "heart, left hand/arm/shoulder, neck, head (brain), chest."

There is no question that Claimant alleged a head injury on his Form 50. There is no question that the Notice of Hearing indicated that all issues on the Form 50 would be determined at the hearing. There is no question that Claimant had sufficient notice of this hearing and what was contained on his Form 50. There is no question that Claimant filed a Pre-Hearing brief indicating that he was seeking compensation for a head injury. There is no question that Defendants filed a Pre-Hearing Brief denying compensability of this claim. There is no question

that Claimant did not withdraw his allegations related to a head injury prior to or at the hearing. And, likewise, there is no question that Claimant did not present any evidence at the hearing to substantiate his alleged head injury.

The Single Commissioner, in Finding of Fact #14, explicitly found that Claimant failed to present any evidence that he sustained or may have sustained a head or brain injury. However, the Single Commissioner indicated that benefits would only be denied "at this juncture." This was improper. Claimant raised the issue of suffering a head injury in every single one of his filings. Claimant chose to proceed at the hearing on his Form 50 without modification. Therefore, pursuant to the Act, Claimant had the absolute burden of proving the right to compensation for each and every injury alleged on the Form 50. If Claimant failed to present evidence, as he did in this claim, then his right to compensation for the alleged injury should be denied. To leave the claim open for possibly unlimited future hearings to determine compensability of presently alleged body parts is grossly prejudicial to Defendants.

Therefore, for the foregoing reasons, the Full Commission should alter or amend the Single Commissioner's Decision and Order by adding a Finding of Fact denying compensability for an alleged head injury. In the alternative, this claim should be remanded to the Single Commissioner for additional findings consistent with Claimant's failure to present any evidence related to a head injury. Because Claimant failed to present any evidence of a head injury, the proper course of action is a complete denial of any alleged head injury.

XI. THE SINGLE COMMISSIONER ERRED BY FAILING TO DENY COMPENSABILITY FOR A LEFT HAND INJURY BECAUSE CLAIMANT PRESENTED NO EVIDENCE OF ANY LEFT HAND INJURY EVEN THOUGH CLAIMANT SPECIFICALLY INCLUDED A LEFT HAND INJURY ON HIS FORM 50 AND FORM 58 AS AN ISSUE TO BE DETERMINED AT THE HEARING BEFORE THE SINGLE COMMISSIONER.

Claimant filed a Form 50 on October 21, 2013 alleging injuries to his "heart, left

hand/arm/shoulder, neck, head (brain), chest.” Thereafter, Defendants filed a Form 51 on or about November 19, 2013 denying every alleged injury and stated that “Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the Act.” This matter was set for a hearing on January 13, 2013 by a Notice of Hearing issued on December 6, 2013. That Notice of Hearing specifically stated that the purpose of the hearing was to “determine issues as set forth on Forms 50 and 51.” Claimant’s Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are “heart, left hand/arm/shoulder, neck, head (brain), chest.”

There is no question that Claimant alleged a left hand injury on his Form 50. There is no question that the Notice of Hearing indicated that all issues on the Form 50 would be determined at the hearing. There is no question that Claimant had sufficient notice of this hearing and what was contained on his Form 50. There is no question that Claimant filed a Pre-Hearing brief indicating that he was seeking compensation for a left hand injury. There is no question that Defendants filed a Pre-Hearing Brief denying compensability of this claim. There is no question that Claimant did not withdraw his allegations related to a left hand injury prior to or at the hearing. And, likewise, there is no question that Claimant did not present any evidence at the hearing to substantiate his alleged left hand injury.

The Single Commissioner failed to make any Findings of Fact related to an alleged left hand injury. Therefore, for the foregoing reasons, the Full Commission should alter or amend the Single Commissioner’s Decision and Order by adding a Finding of Fact denying compensability for an alleged left hand injury. In the alternative, this claim should be remanded to the Single Commissioner for additional findings consistent with Claimant’s failure to present any evidence related to a left hand injury. Because Claimant failed to present any evidence of a left hand

injury, the proper course of action is a complete denial of any alleged left hand injury.

XII. THE SINGLE COMMISSIONER ERRED BY FAILING TO DENY COMPENSABILITY FOR A LEFT ARM INJURY BECAUSE CLAIMANT PRESENTED NO EVIDENCE OF ANY LEFT ARM INJURY EVEN THOUGH CLAIMANT SPECIFICALLY INCLUDED A LEFT ARM INJURY ON HIS FORM 50 AND FORM 58 AS AN ISSUE TO BE DETERMINED AT THE HEARING BEFORE THE SINGLE COMMISSIONER.

Claimant filed a Form 50 on October 21, 2013 alleging injuries to his "heart, left hand/arm/shoulder, neck, head (brain), chest." Thereafter, Defendants filed a Form 51 on or about November 19, 2013 denying every alleged injury and stated that "Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the Act." This matter was set for a hearing on January 13, 2013 by a Notice of Hearing issued on December 6, 2013. That Notice of Hearing specifically stated that the purpose of the hearing was to "determine issues as set forth on Forms 50 and 51." Claimant's Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are "heart, left hand/arm/shoulder, neck, head (brain), chest."

There is no question that Claimant alleged a left arm injury on his Form 50. There is no question that the Notice of Hearing indicated that all issues on the Form 50 would be determined at the hearing. There is no question that Claimant had sufficient notice of this hearing and what was contained on his Form 50. There is no question that Claimant filed a Pre-Hearing brief indicating that he was seeking compensation for a left arm injury. There is no question that Defendants filed a Pre-Hearing Brief denying compensability of this claim. There is no question that Claimant did not withdraw his allegations related to a left arm injury prior to or at the hearing. And, likewise, there is no question that Claimant did not present any evidence at the hearing to substantiate his alleged left arm injury.

The only notations in the record related to a left arm injury are as a result of medical

records and deposition taken of Dr. Greenfield. Dr. Greenfield indicated that Claimant had tenderness in his left arm and shoulder. There was no medical evidence presented that indicated Claimant actually sustained any physical injury to his left arm or shoulder. In Schurlknight v. City of N. Charleston, 325 S.C. 175, 178, 574 S.E.2d 194, 195 (2002), the Supreme Court stated

that “[n]othing in the Act suggests our legislature intended to compensate an employee for aches, pains, or other conditions that do not interfere with his ability to do his job, even if those conditions are work-related.” Simple aches and pains connected to the job do not constitute compensable injuries. In this case, tenderness in the arm and shoulder region following Claimant bumping into a rotisserie oven does not constitute a compensable injury by accident.

The Single Commissioner failed to make any Findings of Fact related to an alleged left arm injury other than the notations of Dr. Greenfield. Therefore, for the foregoing reasons, the Full Commission should alter or amend the Single Commissioner’s Decision and Order by adding a Finding of Fact denying compensability for an alleged left arm injury. In the alternative, this claim should be remanded to the Single Commissioner for additional findings consistent with Claimant’s failure to present any evidence related to a left arm injury. Because Claimant failed to present any evidence of a left arm injury, the proper course of action is a complete denial of any alleged left hand injury.

XIII. THE SINGLE COMMISSIONER ERRED BY FAILING TO DENY COMPENSABILITY FOR ALL OTHER ORGANS, MEMBERS, AND BODILY PARTS BECAUSE CLAIMANT PRESENTED NO EVIDENCE OF ANY INJURY TO ANY ORGANS, MEMBERS, OR BODILY PARTS EVEN THOUGH CLAIMANT SPECIFICALLY INCLUDED OTHER ORGANS, MEMBERS, AND BODILY PARTS ON HIS FORM 50 AND FORM 58 AS AN ISSUE TO BE DETERMINED AT THE HEARING BEFORE THE SINGLE COMMISSIONER.

Claimant filed a Form 50 on October 21, 2013 alleging injuries to his “heart, left hand/arm/shoulder, neck, head (brain), chest.” Thereafter, Defendants filed a Form 51 on or

about November 19, 2013 denying every alleged injury and stated that "Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the Act." This matter was set for a hearing on January 13, 2013 by a Notice of Hearing issued on December 6, 2013. That Notice of Hearing specifically stated that the purpose of the hearing was to "determine issues as set forth on Forms 50 and 51." Claimant's Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are "heart, left hand/arm/shoulder, neck, head (brain), chest."

There is no question that Claimant alleged injuries to all other organs, members and bodily parts on his Form 50. There is no question that the Notice of Hearing indicated that all issues on the Form 50 would be determined at the hearing. There is no question that Claimant had sufficient notice of this hearing and what was contained on his Form 50. There is no question that Claimant filed a Pre-Hearing brief indicating that he was seeking compensation for injuries to all other organs, members and bodily parts. There is no question that Defendants filed a Pre-Hearing Brief denying compensability of this claim. There is no question that Claimant did not withdraw his allegations related to injuries to all other organs, members and bodily parts prior to or at the hearing. And, likewise, there is no question that Claimant did not present any evidence at the hearing to substantiate his alleged injuries to all other organs, members and bodily parts.

There is only one mention in the record related to any other body parts, organs, or members. The Single Commissioner noted that Dr. Lide recorded numbness in Claimant's great toe and suggested that this was a neurologic symptom related to the electrical shock. However, every doctor denied that the electrical shock, if any passed through his body, ever exited through Claimant's foot and/or toe based on a lack of exit wound on the foot. Further, the Single Commissioner readily notes that Dr. Lide does not have the expertise to diagnose or evaluate any

neurologic symptoms. Claimant was clearly in possession of Dr. Lide's suggestion prior to the underlying hearing and chose not to seek evaluation, treatment, or other diagnoses. Claimant further failed to present any evidence linking an alleged numbness in the great toe to an alleged electrical shock at the hearing. The only evidence presented is a single note from Dr. Lide who lacks the experience or expertise to diagnose this type of injury.

The Single Commissioner failed to make any Findings of Fact related to any other alleged injuries to all other organs, members and bodily parts. Therefore, for the foregoing reasons, the Full Commission should alter or amend the Single Commissioner's Decision and Order by adding a Finding of Fact denying compensability for alleged injuries to all other organs, members and bodily parts. In the alternative, this claim should be remanded to the Single Commissioner for additional findings consistent with Claimant's failure to present any evidence related to injuries to all other organs, members and bodily parts. Because Claimant failed to present any evidence of injuries to all other organs, members and bodily parts, the proper course of action is a complete denial of any alleged injuries to all other organs, members and bodily parts.

XIV. THE SINGLE COMMISSIONER ERRED IN FINDING OF FACT #1 IN THAT THE FINDING IS LIMITED ONLY TO CLAIMANT ALLEGING AN INJURY TO HIS HEART WHEN THE RECORD IS CLEAR THAT CLAIMANT ALLEGED INJURIES TO HIS HEAD, BRAIN, LEFT HAND, LEFT ARM, AND ALL OTHER ORGANS, MEMBERS, AND BODILY PARTS.

This issue has been thoroughly briefed above, but for the purpose of preserving this exception, it will be briefed again here. Claimant filed a Form 50 on October 21, 2013 alleging injuries to his "heart, left hand/arm/shoulder, neck, head (brain), chest." Thereafter, Defendants filed a Form 51 on or about November 19, 2013 denying every alleged injury and stated that "Claimant has failed to meet his burden of proving that he sustained a compensable injury or

illness pursuant to the Act.” This matter was set for a hearing on January 13, 2013 by a Notice of Hearing issued on December 6, 2013. That Notice of Hearing specifically stated that the purpose of the hearing was to “determine issues as set forth on Forms 50 and 51.” Claimant’s Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are “heart, left hand/arm/shoulder, neck, head (brain), chest.”

There is no question that Claimant alleged injuries to his heart, left hand/arm/shoulder, neck, head (brain), chest, and all other organs, members and bodily parts on his Form 50. There is no question that the Notice of Hearing indicated that all issues on the Form 50 would be determined at the hearing. There is no question that Claimant had sufficient notice of this hearing and what was contained on his Form 50. There is no question that Claimant filed a Pre-Hearing brief indicating that he was seeking compensation for alleged injuries to his heart, left hand/arm/shoulder, neck, head (brain), chest, and all other organs, members and bodily parts. There is no question that Defendants filed a Pre-Hearing Brief denying compensability of this claim. There is no question that Claimant did not withdraw his allegations related to alleged injuries to his heart, left hand/arm/shoulder, neck, head (brain), chest, and all other organs, members and bodily parts prior to or at the hearing. And, likewise, there is no question that Claimant did not present any evidence at the hearing to substantiate his alleged injuries to his heart, left hand/arm, head (brain), chest, and all other organs, members and bodily parts.

Therefore, for the foregoing reasons, the Full Commission should alter or amend the Single Commissioner’s Decision and Order in Finding of Fact #1 by including all the body parts alleged by Claimant for the purposes of the Form 50 hearing.

XV. THE SINGLE COMMISSIONER ERRED IN FINDING OF FACT #6 BY FINDING THAT CLAIMANT BELIEVED THE ACTUAL VOLTAGE TO BE 480 VOLTS WHEN CLAIMANT'S OWN TESTIMONY REFUTES THAT FINDING.

At the Hearing, Claimant could not testify to the exact voltage of the machine. Claimant stated that the voltage into the machine "...was at 240. I mean, it's 240 or above..." (Hr'g Tr. 24:25). Further, Claimant could only state the machine was "high voltage" and "at least 240 volts." (Hr'g Tr. p. 54:16-24). Mark Warren also testified at the hearing. His testimony revealed that the machine Claimant was using was rated for a maximum 480 volts but that it could run on 208 volt. (Hr'g Tr. 58:24-25). Further, Mr. Warren testified that the machine should be running at 208 volts per leg. (Hr'g Tr. 59:2-4).

This finding is clearly in error based on the testimony presented at the hearing. Because this erroneous finding of 480 volts not only factored into the Single Commissioner's Decision and Order but also underlies every physician's written medical opinion, the Full Commission must either enter findings of fact consistent with the evidence and determine Claimant's chest and/or heart condition is not compensable or it must remand this claim to the Single Commissioner with instructions to render new findings of fact based on the evidence that would result in a denial of compensability for the alleged chest and/or heart condition.

XVI. THE SINGLE COMMISSIONER ERRED IN FINDING OF FACT #6 THAT DEFENDANTS HAD ACCESS TO THE ROTISSERIE OVEN WHEN THE RECORD IS CLEAR THAT THE OVEN BELONGED TO A THIRD PARTY AND DEFENDANTS DID NOT OWN OR CONTROL THE OVEN.

There is no evidence in the record to support a finding that Defendants had access or control of the oven which Claimant alleges shocked him. The record establishes that the premises where Claimant alleges his injuries occurred is a Publix Supermarket that is not owned by Defendants. Further, the record establishes that the machine Claimant alleged shocked him is

not owned by Defendants. There is absolutely no evidence in the record to support Finding of Fact #6.

Because the Single Commissioner based her entire Decision and Order, in part, on the Defendants ability to investigate the machine that Claimant alleged shocked him—and because that Finding of Fact is clearly in error—the entire Decision and Order must be vacated and this claim must be remanded for a new hearing on the evidence previously submitted. There is no way to know from the Decision and Order what weight the Single Commissioner gave to this evidence and therefore allowing the Decision and Order to stand would be prejudicial to Defendants.

XVII. THE SINGLE COMMISSIONER ERRED IN FINDING OF FACT #7 BY FINDING THAT CLAIMANT BEGAN SWEATING THE NIGHT OF THE ELECTRICAL SHOCK WHEN CLAIMANT'S OWN TESTIMONY AND THE MEDICAL EVIDENCE REFUTES THAT FINDING.

The medical and testimonial evidence clearly do not support a finding that Claimant began sweating the night of the electrical shock.

Claimant notified Employer he was shocked while working on a rotisserie oven on May 22, 2013. (Def. APA p. 8). Employment records of Claimant indicate that he continued working the remainder of the day and the entire following day. (Def. APA p. 10-11). An email from Claimant to Employer indicates that he was experiencing only neck pain on May 27, 2013 (5 days post-accident). (Def. APA p. 9). Claimant first presented to Doctor's Care on May 28, 2013 (6 days post-accident) complaining that **he woke up sweating that morning (6 days post-accident)**. (Def. APA p. 1). Doctor's Care noted that Claimant had some tenderness in his shoulder and neck area. Id. Further, Doctor's Care noted that Claimant did not complain of any chest pressure. Id. Claimant was referred to and saw Dr. Dasgupta at the South Carolina Heart Center. Dr. Dasgupta also noted sweating and noted that Claimant denied chest pain but did have

minimal left shoulder pain. (Def. APA p. 2). Dr. Dasgupta diagnosed Claimant with an acute myocardial infarction. Id. Dr. Dasgupta indicated that Claimant had a prior history of hypertension, tobacco abuse, as well as a significant family history for heart disease (Claimant's father passed away from coronary disease and myocardial infarction). (Def. APA p. 2-3). Dr.

Dasgupta also noted that Claimant appeared to have a ventricular septal defect as a possible completion of his myocardial infarction. (Def. APA p. 2). Dr. Dasgupta referred Claimant to Lexington Medical Center where he underwent surgery to repair an acute ventricular septal defect that formed following the myocardial infarction. (Def. APA p. 5-7). Further, even in light of the medical records, Claimant testified at the hearing that he actually began sweating the morning after the electrical shock. (Hr'g Tr. 49:21-24).

The testimony and medical records are clear that Claimant did not begin sweating the night of the electrical shock. The Single Commissioner clearly relied on this fact in forming her Decision and Order related to compensability of the chest and/or heart condition. Because this basis of her Decision and Order is clearly erroneous in light of the evidence and testimony, the Full Commission should enter its own finding of facts denying compensability for the chest and/or heart condition. In the alternative, this claim should be remanded to the Single Commissioner for findings not inconsistent with this evidence and entry of a denial of compensability for the chest and/or heart condition.

XVIII. THE SINGLE COMMISSIONER ERRED IN FINDING OF FACT #9 THAT THREE PHYSICIANS HAVE OPINED THE ELECTRICAL SHOCK RESULTED IN CLAIMANT'S HEART ATTACK REGARDLESS OF THE DATE ON WHICH THE HEART ATTACK OCCURRED.

The Single Commissioner erred by ignoring the issue of when the acute myocardial infarction occurred and, instead, relying solely on a portion of the written opinions in finding this claim to be compensable. The date and/or timing of the acute myocardial infarction is

paramount to the compensability of the acute myocardial infarction. If the timing of an injury can be ignored and otherwise considered not relevant to the inquiry of compensability, then the door is open to allow any injury from any time following a work-related accident to be found compensable simply because the injury happened after the work-related accident. Each of the doctors' opinions as set out previously in this brief—and the Single Commissioner's Finding of Fact—can be boiled down as follows: A is followed by B, therefore A caused B. The Workers' Compensation Act requires more than just a sequence of events or coincidence in time for a claim to be found compensable. The Act specifically requires a distinct causal relationship between events. Absent that causal relationship, there can be no compensable claim. The doctors' written opinions all follow the formula laid out above. Each of their deposition transcripts reveal that their main basis for determining compensability is that an electrical shock (A) happened and, sometime after the electrical shock happened, an acute myocardial infarction (B) happened, therefore the electrical shock (A) caused the acute myocardial infarction (B)—that is simply insufficient to support a finding of compensability under the Act. It is particularly insufficient when there is no evidence to determine and no medical testimony to support when the acute myocardial infarction even occurred⁸.

To make a finding that the alleged injuries are compensable regardless of when the alleged injuries occurred in relation to the alleged causative event would be improper and grounds for reversal. Therefore, the Full Commission should enter its own findings of facts denying compensability for the chest and/or heart condition. In the alternative, the Full Commission should remand this claim to the Single Commissioner for additional findings not inconsistent with this evidence and an order to deny compensability for the chest and/or heart

⁸ With the exception of the hospital admittance records on May 28 showing Claimant was admitted with an acute myocardial infarction. In other words, the most likely date of the myocardial infarction is the May 28 date of

conditions.

XIX. THE SINGLE COMMISSIONER ERRED IN FINDING OF FACT #14 THAT CLAIMANT SPECIFICALLY REQUESTED A FINDING OF COMPENSABILITY FOR THE HEART WHEN THERE IS NO EVIDENCE IN THE RECORD THE HEARING WAS LIMITED IN SCOPE TO THE HEART, WHEN CLAIMANT'S OWN FORM 50 AND FORM 58 DEMANDED A HEARING ON COMPENSABILITY OF THE LEFT HAND, ARM, SHOULDER, NECK, HEAD, BRAIN, CHEST, AND ALL ORGANS, MEMBERS, AND BODILY PARTS DETERMINED TO BE RELATED AND WHEN THE NOTICE OF HEARING FROM THE COMMISSION INCLUDED A DETERMINATION OF COMPENSABILITY FOR THE LEFT HAND, ARM, SHOULDER, NECK, HEAD, BRAIN, CHEST AND ALL ORGANS, MEMBERS, AND BODILY PARTS DETERMINED TO BE RELATED.

This issue has been thoroughly briefed above, but for the purpose of preserving this exception, it will be briefed again here. Claimant filed a Form 50 on October 21, 2013 alleging injuries to his "heart, left hand/arm/shoulder, neck, head (brain), chest." Thereafter, Defendants filed a Form 51 on or about November 19, 2013 denying every alleged injury and stated that "Claimant has failed to meet his burden of proving that he sustained a compensable injury or illness pursuant to the Act." This matter was set for a hearing on January 13, 2013 by a Notice of Hearing issued on December 6, 2013. That Notice of Hearing specifically stated that the purpose of the hearing was to "determine issues as set forth on Forms 50 and 51." Claimant's Pre-Hearing Brief filed on December 23, 2013 clearly states that the types of injury and body parts to be determined at the January 13, 2013 hearing are "heart, left hand/arm/shoulder, neck, head (brain), chest."

There is no question that Claimant alleged injuries to his heart, left hand/arm/shoulder, neck, head (brain), chest, and all other organs, members and bodily parts on his Form 50. There is no question that the Notice of Hearing indicated that all issues on the Form 50 would be determined at the hearing. There is no question that Claimant had sufficient notice of this hearing

admittance.

and what was contained on his Form 50. There is no question that Claimant filed a Pre-Hearing brief indicating that he was seeking compensation for alleged injuries to his heart, left hand/arm/shoulder, neck, head (brain), chest, and all other organs, members and bodily parts. There is no question that Defendants filed a Pre-Hearing Brief denying compensability of this claim. There is no question that Claimant did not withdraw his allegations related to alleged injuries to his heart, left hand/arm/shoulder, neck, head (brain), chest, and all other organs, members and bodily parts prior to or at the hearing. And, likewise, there is no question that Claimant did not present any evidence at the hearing to substantiate his alleged injuries to his heart, left hand/arm, head (brain), chest, and all other organs, members and bodily parts.

Therefore, for the foregoing reasons, the Full Commission should alter or amend the Single Commissioner's Decision and Order in Finding of Fact #14 by including all the body parts alleged by Claimant for the purposes of the Form 50 hearing. Further, the Full Commission should add a Finding of Fact denying compensability for all body parts for which no evidence was presented at the hearing pursuant to Claimant's Form 50, Form 58, and the Notice of Hearing.

XX. THE SINGLE COMMISSIONER ERRED BY NOT MAKING ANY FINDINGS OF FACT OR CONCLUSIONS OF LAW RELATED TO AN AGGRAVATION OF A PRE-EXISTING HEART CONDITION AS ALLEGED BY CLAIMANT.

The Single Commissioner, in Finding of Fact #17, finds that Claimant alleges an "aggravation" of his pre-existing conditions resulting in an injury to his heart. There is absolutely no medical evidence in the record that indicates any of the events Claimant alleges happened resulted in an aggravation of the pre-existing condition of his heart. Claimant presented absolutely no evidence to support a finding of an "aggravation" of a pre-existing condition. Because no evidence was presented related to an aggravation of a pre-existing condition, the

Single Commissioner's Decision and Order should be reversed and the Full Commission should enter findings of facts consistent with the evidence—namely that Claimant's alleged injuries are not compensable. In the alternative, this claim should be remanded to the Single Commissioner for further findings related to an alleged "aggravation" and any reference to the pre-existing conditions being aggravated should be removed from the Single Commissioner's Decision and Order as there is no evidence in the record to support it.

CONCLUSION

For all the foregoing reasons, the Single Commissioner's Decision and Order should be altered or amended to reflect that Claimant did not sustain any compensable injuries to his head, brain, left arm, left hand, chest, heart, and all other organs, members or bodily parts. In the alternative, this claim should be remanded for a new hearing with instructions for the Single Commissioner to issue a new Decision and Order not inconsistent with those findings.

Additionally, the Decision and Order should be vacated in its entirety because the Single Commissioner lacked jurisdiction to sit and hear the claim while key compensability issues were on appeal to the Full Commission.



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Columbia, South Carolina
April 23, 2014

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 5/22/2013

CLARENCE WINFREY,

Employee,

Claimant,

vs.

ARCHWAY SERVICES INC,

Employer,

AND

AMERICAN FIRE & CASUALTY INSURANCE
COMPANY C/O LIBERTY MUTUAL GROUP,

Carrier,

Defendants.

**CERTIFICATE
OF
SERVICE**

The undersigned certifies that she is an employee at MCANGUS GOUDELOCK & COURIE, and that she has served, on the date set forth below, a copy of the document described below, in the above entitled action to the following persons, pursuant to Section 15-9-930 and Section 15-9-940 of the Code of Laws of South Carolina, 1976, by depositing a copy of same in the United States Mail, postage prepaid, addressed to:

TO: Preston F. McDaniel, Esquire
The McDaniel Law Firm
1315 Elmwood Avenue
Columbia, South Carolina 29201

VIA HAND DELIVERY

South Carolina Worker's Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715

DOCUMENT: Other - Defendant/Appellants' Brief to The Full Commission

DATE OF Mailing: April 23, 2014

MAILING:



Jessica M. Morell

Legal Assistant to Brett H. Bayne

McDANIEL LAW FIRM
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Proudly representing injured workers
for over 25 years.

Preston F. McDaniel
Matthew Robertson
OF COUNSEL:
Michael Johnson, P.C.

Telephone (803) 771-7211

RECEIVED

Faxsimile (803) 252-0709

May 8, 2014

MAY 9 2014

Per _____

Virginia L. Crocker, Judicial Director
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

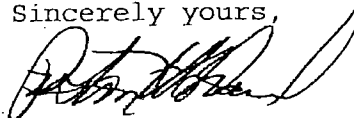
RE: Clarence B. Winfrey, Jr. v. Archway Services, Inc.
WCC File No.: 1306305

Dear Ginger:

Please find enclosed for filing with the Commission the original and three (3) copies of CLAIMANT/RESPONDENT'S BRIEF TO THE FULL COMMISSION. I am, by copy of this letter, serving opposing counsel with a copy of each.

I hope this is sufficient for filing with the Commission, however, if additional information is needed, please feel free to contact me at your convenience.

Sincerely yours,



Preston F. McDaniel

PFM/kth
Enclosures

cc: Brett H. Bayne, Esquire ✓
Mr. Clarence B. Winfrey, Jr.

000262

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION.
WCC FILE NO: 1306305

CLARENCE B. WINFREY, JR.)
Employee-Claimant,)

v.)

ARCHWAY SERVICES, INC.)

As Employer, and)

AMERICAN FIRE & CASUALTY CO.,)

as Carrier,)

Defendants.)

CLAIMANT/RESPONDENT'S BRIEF TO
THE FULL COMMISSION

STATEMENT OF THE CASE

While in the Form 51, the Defendants denied injury by accident and compensable injury; at the Hearing they admitted both. [Commissioner Barden Tr. p. 9, l. 1 and l. 9: "his left shoulder and arm, which are admitted body parts . . . (and) - so he seeks a finding of compensability of not only the neck and the left shoulder, which the Defendants admit . . ."] As to the accident that occurred on May 22nd and the body parts affected, from the Transcript:

By the witness: (the Claimant Clarence Winfrey)

"And when I was moving the wires, that wire moved, and I mean it blew up. I mean not no pow, it went kaboom. And that is when I snatched back real hard, but I would feel it from here (indicated) my neck.

By Commissioner: (Commissioner Barden)

So you're use - - you are indicating your left arm all the way up?

Witness:

Yeah, I got a scar right there."
(Tr. p. 26, ll. 8-17).

"And it went up my arm and from my ears down through my shoulder.

Commissioner:

Is that your middle finger the scar was on?

Witness:

Yes, ma'am.

Commissioner:

Ok. So it went up your arm into your neck?

Witness:

Right through here and run down through here.

Commissioner:

Ok. And you are indicating your chest and up into your head a little bit?

Witness:

Yeah.

Commissioner:

All right.

Witness:

And that's how - - when I called Bobby Ruppe and explained to him they got more problems than a - -

* * *

- - well, first I had to go outside and get my composure back. Then I called Bobby Ruppe."
(Tr. p. 27, l. 9 - p. 28, l. 1 and ll. 5-6).

"By Mr. McDaniel: (hereinafter McDaniel)

- - - Both the Defendants and we have put in Mr. Ruppe's statement confirming Mr. Winfrey's testimony about that that he called Mr. Ruppe.

Commissioner:

OK..

McDaniel:

Page 78.

Commissioner:

And that's R-U-P-P-E. "
(Tr. p. 28, ll. 15-24).

"Q: Did you tell him about the shock?

A: Oh yeah. I told him I was hurt.

Q: Ok.

A: I told him I was hurt. I said, 'I've never been hit this hard before in my life.'
(Tr. p. 29, ll. 8-12). (Emph. added).

After leaving the Publix, Mr. Winfrey tried to continue working but had to leave work after several hours at which time he called Bobby Ruppe and told him,

Witness:

"and told Bobby 'I can't - - I'm done' I couldn't do nothing else, and it was getting worse and worse."
(Tr. p. 49, ll. 13-15).

"Witness:

Yeah. And the next morning when I got up I was just dripping sweat and I tried to work. I went to the Walmart on - - -

Commissioner:

~~When did the sweating occur, the next morning?~~

Witness:

I mean, I was dripping."
(Tr. p. 31, 11.10-17).

"Commissioner:

That's ok.

Witness:

And I was laying on my back because that is the - - you know what I mean? It hurt if I stood up and then on my head so I laid down. I had to go to Whaley's to get some fuses. I drove to Whaley's. It's down the road, came back, put the fuses in. That's when I called Bobby Ruppe, and said, 'man, I can't do it. I am sorry.' I even apologized to the people in the Deli, but I was in too much pain and when I left that Walmart, Bobby had Peggy Duncan call me. She works for the company and said that they just called - - Walmart just called and said all the fryers are down. And I said, 'well, Peggy, I am severely hurt but I will go back because I just left there.' So I went back and they lost power to all the fryers. That's when I called Bobby back and said 'they lost power, and they need an electrician' and I told him 'I can't do nothing else. I have got to go home.' And that is what I did.

McDaniel:

Q: And then what did you do between then and - - we're going to talk about the 27th in just a minute, but between that - - the day that you called Bobby and said 'I can't do it anymore; I am going home' did you - - what did you do between then and when you finally went to I believe we are going to talk about the Minute Clinic in the second?

A: Yeah, that was a Monday. 'That was a holiday."

Q: So what did you do - - over the weekend?

A: Oh, I had - - I went by Walgreen's and bought Motrin and Tylenol, you know, anything to what I thought would help."
(Tr. p. 31, l. 25 - p. 33, l. 8).

"McDaniel:

Q: And it was - - it - - it was in the same place as it was from the - - from the minute of the shock?

A: Yes.

Q: Is that correct?

A: Yes, it was in my arm. It went up to my ear and it dropped like that (indicating). But I just ate Motrin and Tylenol and things like that. Ibuprofen. I was trying to get the pain to go away."
(Tr. p. 33, ll. 18-25).

Finally, in reference to the voltage, the Claimant testified repeatedly that the voltage was at least 240 and as much as 480 volts. (Tr. p. 24, ll. 1-25; p. 54, ll. 14-24). Mr. Wesley Mark Warren who testified on behalf of the Defendants confirmed the Claimant's testimony about the voltage and stated that, "without checking with a meter, I couldn't tell you the actual voltage, but the machine is rated for 480 volt, - - -". (Tr. p. 58, ll. 23-25).

In a report dated September 30th, Dr. Jeffrey A. Travis, M.D., Board Certified Cardiovascular Surgeon (not just a cardiologist and as he testified, the only doctor in this case that actually held the Claimant's heart in his hands), stated:

"Mr. Winfrey is a patient who presented with a very unusual cardiac lesion after suffering a large electrical shock. The lesion, a ventricle septal defect, and normally only seen very rarely in a setting of an acute myocardial infarction. I believe that Mr. Winfrey's electrical shock caused his heart attack and his ventral septal defect.

* * *

Operative photographs confirm a large white patch on both sides of his heart that were almost certainly entrance and exit wounds of the electricity. I have never seen anything like these patches in my 15 years of surgery. I have a photo of the anterior surface of the heart that demonstrates either the entrance or exit site.

* * *

I find it quite unbelievable that his surgery and postoperative course have been considered separate from his electrical injury at work. I see almost no plausible explanation other than a direct cause and effect." (Claimant's APA Submissions, Section 1, p. 1).

In his deposition, Dr. Travis reaffirmed this opinion and also how the electrical shock in his opinion caused a plaque rupture that caused the myocardial infarction that lead to the ventral septal defect. (Highlighted pages of the Deposition Transcript, pp. 12-14; pp. 16-17; and pp. 23-25 are attached as Exhibit "A"). Dr. Lanneau Lide, the Claimant's Board Certified treating cardiologist stated his opinion to a reasonable degree of medical certainty that the symptoms and injuries to his heart stemmed from the electrical shock that he sustained to his left hand and arm on May 22, 2013. He unequivocally reaffirmed that

opinion at p. 39 of his deposition which is attached hereto as highlighted and incorporated herein by reference as Exhibit "B".

Dr. Karen Greenfield, Board Certified in family medicine and the initial treating physician at Doctor's Care stated that it was her opinion to a reasonable degree of medical certainty that the injuries and problems for which she treated him specifically in reference to the heart were caused by the electrical shock. She reaffirmed that opinion at p. 21 of her deposition.

From the Decision of the Hearing Commission in favor of the Claimant that the Claimant had proved by a preponderance of the evidence that he is entitled to the benefits sought which was for reinstatement of temporary compensation and treatment for all causally related medical care, this appeal follows.

ARGUMENTS

I. THE HEARING COMMISSIONER DID NOT ERR BY HOLDING THE HEARING AND RULING ON THE ISSUES BEFORE HER FOR DECISION AND IN SO DOING DID NOT ACT IN AN APPELLATE CAPACITY.

While Claimant's Counsel is very confused over exactly what the Defendants are arguing under Argument I, wherein the Defendants appear to argue that Commissioner Beck's Order concerning a Form 15 Hearing in some way precludes a Hearing on compensability with which Commissioner Barden was charged with deciding but on the other hand or in some way connected, she should have addressed certain issues that they wanted addressed as part of her Decision which are not part of the issues that had to be addressed to reach a decision on compensability. Outside

of containing statements totally outside of the evidence before her, the Argument is like combining vinegar, banana pudding and oregano; they just don't mix and it is nonsensical to mix them. Regardless, the Hearing Commissioner properly heard the issues ~~before her and ruled on those issues making Findings of Fact and~~ Conclusions of Law on those issues in reaching her Decision.

After the Defendants denied compensability on a Form 15, the Claimant filed a Form 50 Request for Hearing requesting that the claim be determined to be compensable and awarding temporary compensation benefits and medical benefits for the injuries which needed treatment at the time of the hearing as stemming from the accident. The Defendants filed a Form 51 and the issues were joined. It was the Claimant's position that the severe injuries to the Claimant's heart for which he was being treated were caused by the electrocution injury that he sustained. Specifically in his Pre-Hearing Brief he delineated the factual issues and his request for benefits as follows:

- "b. The Claimant would submit that the evidence establishes that he sustained a compensable injury and is entitled to reinstatement of temporary compensation benefits . . . ;
- c. Medical care from the date that medical care was stopped being authorized and continuing until the Claimant reaches maximum medical improvement"

Therefore the issues before the Commissioner were whether or not the Claimant had sustained compensable injury, whether or not he was entitled to temporary total disability benefits and whether

or not he is entitled to medical care for all the injuries resulting from that accident. The Commissioner entered a decision appropriately on those issues.

When a claimant filed a request for benefits which is denied ~~and is the moving party before the Commission, it is the law of~~ our State that the Claimant has the burden of proof and must establish by a preponderance of the evidence (facts) that he is entitled to an Award under the Workers' Compensation Act. Walsh v. US Rubber Co., 238 S.C. 411, 120 S.E.2d 685 (1961). Further the Decision of the Commissioner must be based on the facts and cannot be based upon surmise, conjecture or speculation. Solar v. Sunny Slope Farms, 244 S.C. 6, 135 S.E.2d 321 (1964). In this case it was the Claimant's burden of proof to prove by a preponderance of the evidence that the injuries to the Claimant's ~~heart~~ stemmed from the electrocution injury thus entitling him to compensation. The Claimant testified to the facts of the electrocution injury and that from the very minute of that electrocution, he had severe pain in his neck, arm and shoulder than ran as far up as into his head and ear and into the front part of his chest over his collarbone area. His three (3) treating physicians (all treating physicians in fact) testified that in their opinions the injuries to his heart stemmed from the electrocution injury. Clearly there is a preponderance of the evidence to support the Commissioner's Decision finding that the Claimant has sustained compensable injury.

Further, the Hearing Commissioner's Decision had to be based on the evidence before her, and emphasis is placed on "before her", and based on the evidence before her, the Hearing Commissioner found that the Claimant had established a compensable injury stemming from the May 22nd electrocution injury.

In reference to the argument that the Commissioner in some way was acting in an appellate capacity, that is simply wrong. She was charged with the responsibility of hearing the issues and making a decision on the issues raised by the Forms 50 and 51 which she did; and she based that decision on the evidence before her and her analysis of the evidence.

Finally, there is no requirement that the Commissioner make a decision as to when the myocardial infarction occurred. The ~~factual~~ issue upon which she had to make a decision and which was submitted to her for decision was whether or not any and all of the Claimant's heart related problems stemmed from the accident, the electrocution injury that occurred on May 22nd. She appropriately made her Findings of Fact based on the law addressed to that issue.

Finally besides the fact that as to when the myocardial infarction specifically occurred was not paramount to the decision of the issues before the Commissioner, the Defendants while trying to bootstrap Commissioner Beck's dicta decision which is not the law of the case into establishing a fact as to

when the myocardial infarction occurred, the Defendants did not ask any one of the doctors involved as to when in their opinion the myocardial infarction occurred and also did not specifically ask the question "Doctor, in your opinion did the myocardial infarction occur on the 28th?" Having failed to ask that question or present evidence on that point, there was simply no evidence before the Hearing Commissioner, Commissioner Barden, on that issue and for her to make a decision in that regard specifically as to the position of the Defendants, would make her decision be the subject of and be based on surmise, conjecture or speculation. The issue is without merit.

II. THE HEARING COMMISSION DID NOT ERR BY HOLDING A HEARING OVER THE DEFENDANTS' OBJECTIONS ON THE BASIS THAT A SPECIFIC RULING OF A PRIOR SINGLE COMMISSIONER, "MAY" BECOME THE LAW OF THE CASE.

The answer to the Defendants' argument and question raised lies in the actual wording of the argument when the Defendants argue that the finding of Commissioner Beck, "may" become the law of the case. Quoting the black letter law of the State of South Carolina as to the doctrine of the law of the case from Bone v. US Food Service, 399 S.C. 566, 733 S.E.2d 200 (2012) quoting from the Supreme Court's decision in Sloan Constr. Co. v. SouthCo. Grassing, Inc., 395 S.C. 164, 717 S.E.2d 603 (2011):

"Under the law of the case doctrine, a party is precluded from re-litigating, after an appeal, matters that were either not raised on appeal, but should have been or raised on appeal, but expressly rejected by the Appellate Court."

As set forth in the law of the case doctrine and as argued to the Single Commissioner, the Decision by Commissioner Beck at the time this case was heard by Commissioner Barden was not the law of the case because that Decision had been appealed and thus ~~is was not final. The law of the case doctrine does not apply~~ unless and until such time as the case is over, concluded, finished, and all appeals are final. Therefore at the time this case was heard, that doctrine has absolutely no application to the case before Commissioner Barden. Further in the Bone case, supra, the Supreme Court rejected a similar position to the one raised here, that was taken by the employer's carrier in that case that a finding in an interlocutory Order under the Law of the Case doctrine would preclude a later determination of the compensability issue in a final decision in a hearing specifically on that point. Therefore and finally because the Finding was dicta and was an ancillary and irrelevant to the issue before Commissioner Beck and because the specific issue that Commissioner Barden had before her was the issue and a decision on compensability, she appropriately rejected the application of that decision for that reason also. The issue is without merit.

III. COMMISSIONER BARDEN DID NOT ERR BY FAILING TO MAKE A FINDING AS TO THE DATE THAT THE CLAIMANT SUFFERED A PLAQUE RUPTURE.

As is set out in Argument I, there is simply no requirement that the Commissioner make a Finding of Fact as to the time of

the plaque rupture. The Commissioner was charged with making Findings of Fact as to whether or not the Claimant's injuries to his heart stemmed from the work-related accident and as to whether he had sustained compensable injury by accident.

~~It is somewhat ironic that the Defendants would cite the~~
case of Cross v. Concrete Materials, 236 S.C. 440, 114 S.E.2d 828 (1960) in support of this argument in that in the Cross case benefits were denied because there was simply a lack of medical opinion evidence stated to a reasonable degree of certainty that the Claimant's condition stemmed from the accident. The Cross case simply stated black letter law which is that, "when testimony of medical experts is relied upon to establish causal connection between an accident and subsequent disability or death, in order to establish such, the opinion of the experts must be at least that the disability or death 'most probably' resulted from accidental injury." In this case, not only one (1) but three (3) different doctors all testified that in their opinions to a reasonable degree of medical certainty the Claimant's injuries to his heart stemmed from the work-related electrocution injury. There is simply no requirement that the Commissioner make a Finding as to the time when the plaque rupture occurred. The Claimant would also point out that the Commission's review of the evidence before Commissioner Barden will establish that plaque rupturing resulting in a blockage and myocardial infarction which led to the septal defect is only one

of the scenarios that the doctors opined could have resulted from the electrical shock. However there is no question or difference of opinion in any of the doctors' minds, meaning the three (3) doctors who treated the Claimant, and particularly the doctor ~~that did the heart surgery and held the Claimant's heart in hand~~ who witnessed the entrance and exit wounds in his heart, that the electrical shock caused the injuries to his heart. The issue is without merit.

IV. THE HEARING COMMISSIONER DID NOT ERR BY FAILING TO MAKE A FINDING OF WHAT CAUSED THE PLAQUE RUPTURE IN THE CLAIMANT'S HEART.

As set out in Argument I and III, the issue before the Commissioner was whether or not the Claimant proved by a preponderance of the evidence that he had sustained compensable injury by accident and that that injury resulted in the injuries to his heart. Quoting from Commissioner's Finding of Fact No. 9:

"three physicians have all opined to a reasonable degree of medical certainty that the electric shock ultimately resulted in Claimant's heart attack, regardless of the date on which the infarction occurred . . .".

She goes on to quote explicitly from all the doctors' depositions supporting that Finding. The issue is without merit.

V. THE HEARING COMMISSIONER DID NOT ERR BY FAILING TO FIND A DATE ON WHICH THE CLAIMANT SUFFERED A MYOCARDIAL INFARCTION.

For all the reasons as set forth in Argument I, III, and IV, the same legal arguments and factual arguments apply and the issue is without merit.

VI. THE HEARING COMMISSIONER DID NOT ERR BY RELYING ON DR. TRAVIS' MEDICAL OPINIONS AS EXPRESSED BOTH IN WRITTEN DOCUMENTS AND IN HIS DEPOSITION TESTIMONY.

This argument made by the Defendants by pulling "piece-mill" out of Dr. Travis' deposition does not reflect his ~~opinions as expressed in the deposition and as previously~~ expressed in his written report. On p. 22, ll. 20-25, the doctor specifically reiterated that his opinions as expressed in his letter of September 30th represented his opinions concerning the causation of the Claimant's problems. Then on p. 23, l. 1 - p. 25, l. 9, the doctor went through and specifically detailed the sequence of events that occurred and the problems that resulted from the electrical shock leading to all of the injuries to the heart and to his need for treatment, at the end of which on p. 25, l. 6 through l. 9, the doctor again stated his opinion specifically:

"But that electrical shock was the thing that pushed the first domino over and everything that we saw after that followed it. That's just my opinion."

Then again on p. 26, the doctor reiterated again:

"Q: Doctor, this is a report that was issued on September 30th. I believe you dictated that, does that represent your opinions in reference to the causation issue and your opinions about what caused Mr. Winfrey's condition?

A: That is correct.

Q: Is that your opinion to a reasonable degree of medical certainty?

A: It is."

Travis Depo. Tr., p. 26, ll. 6-11, marking
of exhibit 9/30 report and quotation, ll.
12-20.)

The issue is without merit and is a total misstatement of
the doctor's testimony.

VII. THE HEARING COMMISSIONER DID NOT ERR IN RELYING ON THE
WRITTEN MEDICAL OPINION AND THE TESTIMONY OF DR. LIDE IN
MAKING HER FINDINGS AND RULING.

Quoting from Dr. Lide's deposition, p. 39, ll. 6-14:

Q: "But in your opinion, based on this history
and everything you observed and your
conversations with Mr. Winfrey and this
history and development of his problems, is
it your opinion that - - that this
electrical shock, is it still your opinion
that this electrical shock caused all the
problems that lead to him coming to see
you?

A: That is my opinion.

Q: Ok.

A: - - that - - that the electrical shock was
the approximate cause of - - of all this
illness.

Q: Ok and that is stated to a reasonable
degree of medical certainty?

A: As certain as I can be."

The issue is without merit.

VIII. THE HEARING COMMISSIONER DID NOT ERR BY RELYING ON THE
WRITTEN AND TESTIMONIAL OPINIONS EXPRESSED BY DR.
GREENFIELD IN MAKING HER FINDINGS OF FACT THAT THE CLAIMANT
HAD SUSTAINED COMPENSABLE INJURY.

Quoting from p. 21, ll. 2-6, Dr. Greenfield testified:

"Q: Ok. Alright. And the opinion that you were kind enough to write to us, you - - that still remains your opinion to a reasonable degree of medical certainty?

A: Right."

The Hearing Commissioner did not err by relying on the opinions of Dr. Greenfield. The issue is without merit.

IX. THE HEARING COMMISSIONER DID NOT ERR BY FAILING TO DENY COMPENSABILITY OF A BRAIN INJURY WHERE NEITHER THE MEDICAL TREATMENT NOR COMPENSATION BENEFITS REQUESTED AT THE TIME OF THE HEARING WERE BASED ON A BRAIN INJURY.

As is set forth in the Statement of the Case, quoting from the Claimant's Pre-Hearing Brief, the Claimant sought:

1) a determination that he had sustained compensable injury by accident since the injury, after initially being accepted, had been denied by the Defendants in their Form 51 and Pre-Hearing Brief; [Note: while denying an accident occurred in the Form 51, the Defendants actually at the hearing in the Pre-Hearing Conference admitted that an accident had occurred and admitted injury to two (2) body parts, the Claimant's neck and his shoulder. The Claimant would note this because there is a discrepancy between the Defendants' position going into the hearing and what their position actually was at the hearing but they seek to criticize this as to the Claimant]; and

2) the Claimant sought medical treatment for the injuries resulting from the accident until the Claimant reached maximum medical improvement; and 3) temporary compensation benefits to be reinstated.

On the Form 50, the Claimant is required to list all body parts that he believes may be, "affected" as a result of the injury. However, in the Pre-Hearing Brief, the Claimant is specially required to detail the issues that are before the Commission and in that, the Claimant simply asked for medical care for all injuries resulting from the accident. To make sure his position was clarified in the Pre-Hearing Conference as referred to in the Transcript by the Commissioner:

"It is the position of the Claimant that not only did he injure his neck and his left shoulder and arm, which are admitted body parts that he also sustained a myocardial infarction from the shock, which ultimately resulted in V.S.D., or a hole in his heart. He also contends that he suffered a head and possibly a brain injury. But because the focus of his treatment has been just about exclusively on the heart, his head and his - - and possible brain injury have not been explored or properly and thoroughly evaluated. So he seeks a finding a compensability of not only the neck and the left shoulder . . . BUT he also believes and contends and would contend that the medical evidence supports this Finding by more than a greater weight of the evidence standard. . . and he also injured his heart and his head." (Tr. p. 8, l. 24 - p. 9, l. 11; and ll. 13-18.) (Emph. added).

The Claimant was thus not requesting a determination of any compensable injury to the brain nor was he seeking benefits in any form, either temporary total or medical care, for injury to the brain at this time. The Commissioner appropriately did not address this in her Decision other than as she specifically did in Findings of Fact #14 and 15.

Further the Defendants claim that they are in some way

prejudiced by leaving the issue of these or any body parts open for later determination. The Commissioner specifically in her Findings of Fact noted that the Defendants could challenge the compensability and deny treatment for any conditions alleged to be related to the accidental injury. This is the same as it is in any case where an injury is found compensable and then additional body parts, organs or systems are added or are opined by medical professionals to be related and/or the Claimant seeks treatment for those body parts. The Commission at that point makes a determination as to whether or not those body parts, conditions or treatment are related to the original injury and its aftermath. The Commission would be called upon in this case like in every case to make a decision based on the facts and circumstances presented at the time that that issue is raised or becomes an issue. There is simply no justiciable issue or controversy between the parties at this time because no treatment and/or compensation for any such injuries has not been requested. See: Gattis v. Murrell's Inlet VFW No. 10420, 353 S.C. 100, 576 S.E.2d 191 (SC App. 2006) and Brayboy v. Clarke Hearing Co., Inc., 306 S.C. 56, 409 S.E.2d 767 (1991) for the proposition that medical care may be ordered for any condition found to have resulted from the compensable injury unless and until there is or has been a final adjudication on entitlement to compensation for that condition. Also see S.C. Code §42-1-700 requiring a claimant to list all body parts thought to be affected and the right of a

Commissioner to add a body part or condition and further under §42-9-10, 20 and 30 as to a request being made for an award for compensation for permanent disability or loss of use. Temporary compensation for disability and medical are totally different issues from permanency.

X. THE HEARING COMMISSIONER DID NOT ERR BY FAILING TO DENY COMPENSABILITY OF HEAD INJURY, INJURY TO THE LEFT HAND, LEFT ARM, OR ANY OTHER ORGANS, MEMBERS OR BODILY PARTS (ARGUMENTS X THROUGH XIII).

As set forth in the previous Argument IX, the Hearing Commissioner did not err by not addressing these issues since specific benefits for either compensation or medical care were being requested for injuries to the left arm, left hand, head or any other organs or bodily parts.

In the Form 50 in accordance with the Statute, the Claimant specifically listed all of the body parts, organs or members, "affected" by the injury and listed that this was a systemic electrical injury and there may be involvement of other organs, members, or bodily parts and sought only treatment for those members, organs, bodily parts, or conditions opined and determined by the doctors to be related to the injury.

Therefore, since there was no request for a determination of benefits for compensation or medical treatment due to the injury to these members, organs or bodily parts, the Commissioner appropriately made no decision on those.

The Commissioner under Finding of Fact 15 reiterated some

of the evidence that indicated that these organs, members, or bodily parts were, "affected" by the electrical shock injury. For example, she reiterated the records and testimony of the Claimant concerning the problems with the left arm and shoulder and from Dr. Lide's notes, that he had tried the patient on Neurontin because of a possible peripheral neuropathy secondary to the electrocution injury at work and where he noted numbness in the Claimant's great toe and suggested this neurological symptom was due to the electrical shock. The Claimant testified to pain radiating up into his head and around his ear. His testimony reflects the burn injury to the left hand and again both the Claimant's testimony and the deposition testimony of Dr. Greenfield notes the weakness and problems that were probably more related to the electrocution injury than to the actual heart injuries stemming from the accident in reference to the pain and tenderness that he experienced in the left hand, arm and shoulder. The Commissioner then found appropriately that:

"Thus, if any problems are opined to have stemmed from the electrical shock injury which is outside of the area and expertise of Dr. Lide and Dr. Travis, those doctors may request referral for him to other physicians for evaluation and treatment but the Defendants retain the right to contest whether these are related to the accident and to select the physicians for treatment of any causal related problems."

This is in accordance with the dictates of the Act. Again, no treatment has been sought and no compensation has been sought for

any of these body parts, organs, or members and the Commissioner appropriately did not prematurely judge those, either one way or the other. The Defendants are not prejudiced in any way by a decision not being prematurely made on these issues which the Claimant would point out may never result in being issues at all.

There is simply no controversy over any of these body parts at this point in time because the Claimant again has not sought any medical care or compensation for any of these members, organs or bodily parts.

XIV. THE HEARING COMMISSIONER DID NOT ERR IN MAKING FINDING OF FACT #1.

For all the reason as set forth previously, the Hearing Commissioner appropriately addressed in Finding of Fact #1 the injury for which compensation was requested at this hearing. The Defendants are quite disingenuous in making this argument in that in their Form 51, they denied that the Claimant had sustained compensable injury and then only allege that the Claimant alleges injury to his, "neck, left shoulder, and heart". They then state the reason for the denial is that, "Defendants have denied this claim as failing to meet the standards for being a compensable claim". Then under Facts in Controversy in their Form 58, the Defendants list the controversial issue(s) as being only, "The issue for this hearing is whether or not the Claimant can meet his burden of proving a compensable claim pursuant to the Act." Therefore in

neither the Form 51 nor in the Pre-Hearing Brief is there any contest to or issue that is raised and is merged as a controversy for decision by the Commissioner as to any of these body parts by the Defendants. They obviously recognize that the ~~issue was whether or not the Claimant had sustained compensable~~ injury and whether or not he is entitled to medical care and compensation benefits for any injuries stemming from that accident. Again, there has simply been no request for injuries to these various body parts for which the Defendants now want a decision being made. There is no ripe justiciable issue for decision.

XV. THE HEARING COMMISSIONER DID NOT ERR IN MAKING FINDING OF FACT #6.

When the Commission reads the Record, the Commission will find that everybody agrees that this machine was carrying between 240 and 480 volts. The Commissioner notes in the very beginning of Finding of Fact #6 that the Claimant was shocked with between 240 and 480 volts. She then notes appropriately that both the Claimant and the Defense Witness, Mr. Mark Warren, both noted that this machine was rated at 480 volts and that the only way that that could be confirmed would be by testing the machine with an amp meter.

Further, there is absolutely no evidence that the company does not continue to do the work on Publix's equipment. The truth of the matter is that the testimony of Mark Warren

confirms that of the Claimant as to the voltage of this machine. The Claimant would submit that the Commissioner's Finding of Fact #6 is an accurate reflection of the testimony and evidence presented before her. The issue is without merit.

XVI. THE HEARING COMMISSIONER DID NOT ERR IN MAKING FINDING OF FACT #6 AND SPECIFICALLY THAT THE DEFENDANTS HAVE ACCESS TO THE ROTISSERIE OVEN THAT RESULTED IN THE ELECTRICAL SHOCK.

While this issue is really irrelevant, the undisputed evidence is that the Claimant's employer had recently taken over maintenance of all the Publix's Delicatessen electrical equipment and that on the day of the accident he was sent to and was working on the rotisserie at one of the Publix locations. The Defendants' witness, Mr. Mark Warren, was called as a witness and at no time did he testify that they were no longer doing all the maintenance work on the Publix equipment at this location. There is no testimony that they do not have access to this equipment. The Commissioner's finding is a reasonable assumption based on the testimony and the circumstantial evidence in the Record.

XVII. THE HEARING COMMISSIONER DID NOT ERR IN FINDING OF FACT #7 BY FINDING THAT THE CLAIMANT BEGAN SWEATING THE NIGHT OF THE ELECTRICAL SHOCK.

While as set forth below the evidence supports the Commissioner's Finding, before addressing this issue by setting out the evidence that supports the Finding, according to the medical expert testimony whether or not and when the Claimant sweated is totally irrelevant and is absolutely unimportant in

reference to the issues before the Commissioner for decision or in reference to a myocardial infarction. Therefore, this issue is nothing but the Defendants trying to get the Commission to chase rabbits, which is an old saying that comes from fox hunting. When your dogs are on the scent of the fox and you are on the, "hunt", you don't want your dogs to start chasing rabbits and want them to keep their eye on the prize, the fox.

Dr. Lanneau Lide testified:

"Q: And that is a symptom of suffering from a myocardial infarction; is that right?

A: That is a symptom of suffering from illness. Period.

Q: Okay.

A: That is so non-specific a symptom that it doesn't tell you. It doesn't lead you in any - - any specific direction."

* * *

"Q: His sweating didn't start until 24 hours after the electrical shock, would that be indicative of when the myocardial infarction occurred?

A: I don't think that - - I don't think you can time anything by the onset of sweating."

(Tr. p. 20, l. 25 - p. 21, l. 7; p. 21, ll. 19-24).

With that point made, in reference to the Commissioner's Finding, Dr. Karen Greenfield in her deposition at p. 8, ll. 15-18, gave the following answer:

"A: The only thing that I wrote down there was

- - I guess it was on Thursday when he was shocked. And he said he had some sweating issues that evening - - ."

In her report found at Claimant's APA Submissions, Tab 3, p. 66, she recorded:

"Rotisserie shock on Thursday, sweated Thursday PM."

The testimony of the Claimant on sweating was to being drenching wet sweating on Friday morning. The issue is without merit.

XVIII. THE HEARING COMMISSIONER DID NOT ERR IN MAKING FINDING OF FACT #9 THAT ALL THREE (3) TREATING PHYSICIANS HAD OPINED THE ELECTRICAL SHOCK RESULTED IN CLAIMANT'S HEART ATTACHED (ACTUALLY HEART RELATED INJURIES) AND NOT INCLUDING A DATE ON WHICH THE, "HEART ATTACK" OCCURRED.

In this argument, the Defendants make another attempt to change the issue that was before Commissioner Barden and which is now before the Full Commission. The issue was and is did the Claimant sustain compensable injury to his heart as a result of the admitted electrocution injury by accident. The Commissioner properly addressed that in Finding of Fact #9 and one thing that can be said about the Hearing Commissioner is that she makes very copious and detailed reference to the testimony and evidence upon which she relies in making her Findings. The issue before her and her Finding are best summed up from the Commissioner's Order:

"After due and proper consideration of the testimony and evidence presented, I find that Mr. Winfrey has sustained his burden of proof by proving by a preponderance of the evidence that

he sustained compensable injury to include specifically injury to his heart as a result of the electrical shock that occurred on May 22, 2013, and specifically including that the electrical shock resulted in the Claimant's heart attack, myocardial infarction, and ventricular septal defect (VSD), and including the specific entrance and exit wounds and damage to the heart as described by Dr. Travis all being physical injuries to the heart stemming from this accident."

The Defendants again are simply trying to force the Commission into making a decision and a Finding that is not necessary nor required by law and in fact ignoring much of the damage done to the Claimant's heart as a result of the electrocution. Further, Finding of Fact #9 must be read in conjunction with all the other Findings and particularly Finding of Fact #10 where the Commissioner gave great weight to the opinions of Dr. Travis and Dr. Lide who, "both opined that the heart condition is causally related." The issue is patently without merit.

XIX. THE HEARING COMMISSIONER DID NOT ERR IN MAKING FINDING OF FACT #14.

The Defendants are correct in their opening statement of this argument that this issue been thoroughly briefed in the other issues in their Brief. The same arguments from the Claimant apply here, but again, in the Pre-Hearing Brief, the Claimant asked specifically for medical treatment for any and all injuries determined to be related to the accident. On p. 9 of the Transcript, the Full Commission will find that the

Commissioner recites the position of the Claimant and that the focus of his treatment has been almost exclusively on the heart which was the major injury sustained as a result of the injury and which had resulted in the denial by the Defendants. Further on that same page the Commissioner noted that Mr. Winfrey was seeking medical treatment and compensation for the injury to his heart and took the position that the greater weight of the evidence would sustain that position. In addition to these arguments, the Claimant would submit all the previous arguments made on this issue. But again, the issue on which the Defendants stopped payment and the issue that was in contention and the issue which was before the Commissioner for decision and the issue which in reality is the entire focus of this Brief, and which the Defendants that the Defendants are trying to morph is was the Claimant's injuries to his heart caused by the electrocution injury. Nothing more, nothing less. The issue is patently without merit.

XX. THE HEARING COMMISSIONER DID NOT ERR BY MAKING FINDINGS OF FACT AND CONCLUSIONS OF LAW RELATED TO AN AGGRAVATION OF A PRE-EXISTING HEART CONDITION AS ALLEGED BY CLAIMANT.

After reading the Defendants' argument and re-reading the Order of the Hearing Commissioner, Claimant's Counsel has a hard time understanding exactly what the Defendants are arguing the Commissioner did not include in reference to any pre-existing condition that existed in the Claimant's cardiovascular system.

Under Finding of Fact #1, after noting that the injury to

the heart resulted from the accident, she found that it aggravated a pre-existing condition and ultimately resulted in the myocardial infarction. Therefore this Finding of Fact refers to the pre-existing condition.

~~Then under Finding of Fact #17 she specifically notes and~~
took into consideration the pre-existing conditions or factors that the Defendants had asked all of the treating physicians in their depositions to consider and raised at the hearing in reference to other possible causes which were simply rejected by the treating physicians. In the Finding she again specifically noted premature coronary artery disease and pre-existing severe three vessel disease on the date of the accident. She then makes the specific Finding in reference to the pre-existing disease and finds that the Claimant was not alleging that his pre-existing disease was caused by the accident; he only alleged that that pre-existing condition was aggravated by the accident resulting in the injury to the heart.

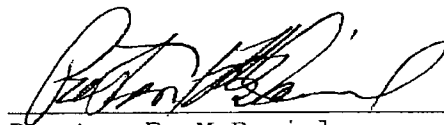
She then further makes the specific Conclusion of Law citing case references finding under that Conclusion of Law first that Claimant's disability and his medical problems stemmed from the physical injury of the electrical shock. Then she quotes the law that any medical condition or disability is compensable that either results directly from the physical injury or which is a, " pre-existing condition that is aggravated, accelerated or caused to become symptomatic by the

physical injury . . . ". Clearly the Hearing Commissioner considered the pre-existing conditions that the Claimant had, the medical and lay testimony on those issues and made Findings of Fact and Conclusions of Law in reference to those. The issue is patently without merit.

CONCLUSION

For all the foregoing reasons, the Decision of the Hearing Commissioner should be affirmed by the Full Commission.

Respectfully submitted,



Preston F. McDaniel
MCDANIEL LAW FIRM
1315 Elmwood Avenue
Columbia, SC 29201
803-771-7211

May 8, 2014

1 high blood pressure, diabetes, elevated cholesterol

2 family history, cigarette smoking.

3 Q. Pretty much the whole gamete.

4 A. Yeah.

5 Q. Okay. And someone ~~so someone~~ for example who

6 smoke a pack a day or a half a pack a day would be an

7 increase risk for that?

8 A. Absolutely.

9 Q. Someone who drank a case a beer a week would be an
10 increase risk to that.

11 A. In general drinking it's not directly correlated to
12 coronary disease.

13 Q. Okay. If someone had a family history of close
14 relatives who suffering from coronary artery disease
15 that would be a risk factor?

16 A. Most likely.

17 Q. Okay. In the medical records it also talks about a
18 occlusion I believe of the coronary artery, is that a
19 condition that resulted from the electrical shock or is
20 that part of the artery disease he had acquire over his
21 life time?

22 A. I think it was related to the electrical shock.
23 Let me explain that just a little bit, you have
24 arterosclerosis or the hardening of the arteries, so you
25 have plaque in your arteries, because there at a base

1 line, based on those things that we talked about and
2 then some, every heart attack is caused by some process
3 causing that plaque to rupture. And so what you have an
4 injury or cut, basically, inside the artery and the body
5 tries to heal that much as it tries to heal a cut on
6 your skin it tries to form a scab, but instead it the
7 scab is forming inside an artery, and so the scab forms
8 and causes that artery to completely occlude. So it
9 doesn't matter if the plaque was ten percent blockage,
10 twenty, thirty, forty, whatever, it goes to 100 percent
11 because the blood begins to clot within the artery. So
12 that's why the artery becomes occluded, that's why
13 people have heart attacks.

14 Q. Okay. And so the -- I guess the question is the
15 plaque build up that was the occlusion. Was that plaque
16 build up directly caused by the electrical shock or did
17 the rupture of that plaque build up?

18 A. The rupture of the plaque is what causes the acute
19 heart attack.

20 Q. Okay.

21 A. The build up happens over years and then it can be
22 any sort of activity that can cause that to rupture.

23 Q. Okay. So for in this scenario if the electrical
24 shock is what caused it, it would be the shock caused
25 the rupture, that then caused the heart attack, and then

1 caused the VSD?

2 A. Correct.

3 Q. Okay. But that plaque rupture could occur as you
4 said, it could occur for many things --

5 A. It can.

6 Q. -- from getting up the wrong way, strenuous
7 activities something like that.

8 A. It can. A stressful event in your life. People
9 that walk in and find a love one dead it can trigger
10 that any type of stress. Or whether it be physical,
11 emotional.

12 Q. And other than the timing of the heart attack, as far
13 as, some time of last week, there's way to know for
14 certain the plaque rupture was caused by the electrical
15 shock, is that correct?

16 A. Is there any definitive way to --

17 Q. Correct.

18 A. -- collate one to another absolutely not.

19 Q. It's more likely not, I guess. This is your
20 opinion on it?

21 A. Correct.

22 Q. Okay. As far as, his treatment goes, what is, I
23 guess once he goes through -- going cardio
24 rehabilitation right now, is that correct? As far as,
25 that treatment goes once he's completed with that care,

1 would present with all the symptoms he had except for
2 what you believed caused by the shock?

3 A. In general, no. In general there ventricular
4 function can be anywhere, again there's a thousand
5 different factors that go into that.

6 Q. In the medical reports I believe in the post
7 surgical report you talked about seeing, I guess white
8 marks on either other side of the heart --

9 A. Correct.

10 Q. -- what, I think your opinion was, that probably
11 caused or most likely caused by an electrical shock,
12 entering and exiting the heart, is that correct?

13 A. Correct.

14 Q. Have you've seen anything like that in your career
15 prior to that point?

16 A. Not with the heart, I've certainly seen electrical
17 injuries, when I took care of burn patients, you would
18 see people that were burn electrically and you would see
19 the type of changes as it entered or exited the
20 extremity which is more common. I've never seen it on a
21 heart, I've never seen anything that looked liked that
22 on the heart.

23 Q. Okay.

24 A. That's what made me think this was related to his
25 electrical injury, certainly, looked like a entry, exit.

1 wound. It's shriveled, drawn up, kind of welded
2 together around the tissues around it, so I have seen it
3 in other locations, I've never seen it in the heart.

4 Q. Would the electricity if that -- if those marks are
5 indicative of that, would that electricity, I guess,

6 going through the heart had caused any issues other than
7 it may have led to the infarction itself?

8 A. It could of rupture the plaque led to the
9 infarction. I don't think it was directly related to
10 the -- I don't think it made a hole in the heart,

11 Q. Okay.

12 A. -- I think the hole in the heart came from the
13 infarction you know muscle dying over time and the hole
14 developing. I do think it could relate to any
15 electrical disturbance in the heart and ventricular
16 function.

17 Q. Okay.

18 A. Those are the things that it could effect.

19 Q. And in examining Mr. Winfrey, I guess prior to and
20 after surgery where you able to determine if there were
21 any exit wounds from the body of the electricity other
22 than what you observed in the heart, so did it come out
23 of his hand, foot?

24 A. I didn't observe any. No, sir.

25 Q. And in your practice have you've been involved -- I

1 Q. I just want to ask you again. I know Mr. Bayne
2 went over this, but just in summary fashion would you
3 just tell me -- I just hand you copy of your optative
4 note, but just specifically -- just tell me -- and you
5 already testified, you haven't seen anything like this
6 before -- just tell me in your own words, basically,
7 what you observed, and just tell me what formulated this
8 opinion, that my opinion, my understanding, you believed
9 everything that caused him, required treatment by you
10 and the open heart surgery stemmed from this electrical
11 shock.

12 A. Right. And so if you mean, your asking me to put
13 together a time line of events. So he's working under
14 goes electrical shock that causes a plaque rupture
15 causing a heart attack. He feels bad all over has some
16 chest pain, pain other places related to that would be
17 typical, goes home and just tries to gut it out sort of
18 speak doesn't get better, finally shows up to the
19 emergency room or urgent care, the signs and symptoms in
20 the EKG changes components is consistence with him
21 having a heart attack. Brought over to the hospital,
22 optimally taken to the CAT lab found that has blockage
23 that we saw where there was 100 percent occluded artery,
24 including VSD, so sometime along that time course this
25 heart attack caused that muscle to die, the blood pushed

1 through that dead muscle caused the VSD. You know when
2 I saw him it would seemed to me that, that was the
3 typical course of what happened. That he had a plaque
4 rupture, artery occluded, the muscle died, VSD presented
5 in that time course, all of that seemed very normal to
6 me. When we operate on him the thing that was different
7 to me, made me think that this was directly related to
8 the electrical shock and not just two events that happen
9 to co-inside was the amount of change that I saw in his
10 heart. Again what was definitely entry and exit wound
11 where the Peri-cardiac was almost fused like you would
12 weld something together and that was Per carditis. It's
13 not a typical Per carditis that people have after a
14 heart attack, that it's global it's every where, it's
15 just kind of a general Per carditis, this was different
16 these were specific areas interior, posterior. We
17 really had to do a lot of work to clean those off to get
18 the Pericardium which is the sack around the heart off
19 the heart, off the heart proper, almost again, welded to
20 it on the front and back so we can pick the heart up to
21 actually work on it, it really took us thirty minutes to
22 get that done before we really start the operation, so
23 it was after operating on him that it seemed to me that
24 this electrical shock was directly related to the
25 primary problem that he presented with even though he

1 might of have a life long condition coronary disease,
2 I'm sure he did or after arteriosclerosis, I'm sure he
3 did, but I was fairly convinced this electrical shock
4 passed through his heart, it was likely the causative
5 event that started the domino effect. Again a lot of
6 things were in place already, but that electrical shock
7 was the thing that pushed the first domino over and
8 everything that we saw after that followed it. That's
9 just my opinion

10 Q. You also used the term soldier plaques.

11 A. Correct.

12 Q. And tell me about those.

13 A. We find sometimes on the heart what are called
14 soldiers plaque again that just kind of a nomenclature
15 that's been pasted down, they'll just be quarter size,
16 silver dollar size, white areas on the heart. That
17 don't have any type of reason or obvious you know
18 causation you find them variable, I don't know one or
19 two percent of hearts that you operate on, you just see
20 this little white -- whitish plaque areas. They are not
21 inflammatory they are not stuck to anything and they
22 have just passed down through -- along people just
23 called soldier plaques. We don't know what causes them,
24 we don't know why they are there, there just there. And
25 so, you know, I dictated that specifically because this

1 infarction leading to the VSD or the heart muscle,
2 as you said, being damaged immediately from the
3 electrical shock. Let's just refer to one of
4 those as being absolutely direct and the other one
5 being indirect cause.

6 But in your opinion, based on this
7 history and everything you observed and your
8 conversations with Mr. Winfrey and this history
9 and development of his problems, is it your
10 opinion that -- that this electrical shock, is it
11 still your opinion that this electrical shock
12 caused all the problems that lead to him coming to
13 see you?

14 A. That is my opinion --

15 Q. Okay.

16 A. -- that -- that the electrical shock was
17 the proximate cause of -- of all this illness.

18 Q. Okay. And that's stated to a reasonable
19 degree of medical certainty?

20 A. As certain as I can be.

21 MR. MCDANIEL: Okay. All right. Doctor,
22 I'm not going to belate anything any further.
23 Thank you very much.

24

25

REEXAMINATION

Veritext Corporate Services

800-567-8658



000301

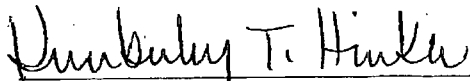
CERTIFICATE OF SERVICE BY MAIL

WCC FILE NO. 1306305

I hereby certify that I have on this day served the following in the matter of Clarence B. Winfrey, Jr. v. Archway Service, Inc. with a copy of the CLAIMANT/RESPONDENT'S BRIEF TO THE FULL COMMISSION by depositing the same in the United States Mail, with adequate postage thereon, addressed as follows:

Virginia Crocker - Judicial Director
SC Workers Compensation Commission
1333 Main Street, Ste. 500
Columbia, South Carolina 29202

Brett H. Bayne, Esquire
McAngus Goudelock & Courie, LLC
P.O. Box 12519
Columbia, SC 29211



Kimberley T. Hinkle
Paralegal to Preston F. McDaniel

SWORN TO BEFORE ME this
8th day of May, 2014.



(L.S.)

Notary Public for South Carolina

My Commission Expires: 10/28/18

Bobbie Moore

From: Hollmon, Eugenia <EHollmon@wcc.sc.gov>
Sent: Friday, June 06, 2014 2:56 PM
To: Brett Bayne; preston@pfmcdlaw.com
Cc: Bobbie Moore
Subject: Winfrey 2

Below is a request for a proposed decision and order.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
REQUEST FOR A PROPOSED DECISION AND ORDER

This document is not a Decision and Order. It is a request for a proposed order. The Commissioners reserve the right to modify and/or delete any or all portions of the submitted Decision and Order.

Clarence Winfrey v Archway Service Inc.
SCWCC: 1306305
Commission Panel: Taylor, James, Wilkerson; Chair
Order Assigned to Commissioner: James
Court Reporter – Cassandra Vance – 803-252-3445

Brett Harris Bayne
Preston F. McDaniel

Defendants/Appellant
Claimant/Respondent

This matter was heard before the South Carolina Workers' Compensation Full Commission Appellate Panel during the last term of Review. The Commissioners considered the matter and **affirm in part and reverse in part** the Decision and Order of the Single Commissioner.

The Panel denies the brain injury based in insufficient evidence.

Mr. Bayne, please prepare a proposed order and submit to the Judicial Department within thirty (30) days of this notice. The proposed order shall be submitted in Word format to appeals@wcc.sc.gov and shared with each Party. Please make sure the Appellate Panel Decision and Order recites the specific Finds of Fact and Rulings of Law of the Single Commissioner's Decision and Order and reflects any comments requested by a Commissioner.

The signature page shall include a signature line for each Commissioner and the first signature should be the name of the Commissioner assigned the case as indicated above.

If you have any questions, please do not hesitate to email me at ehollmon@wcc.sc.gov or call at 803-737-5737

Judicial

Transmitted via email and regular mail this 6 June 2014

South Carolina Workers' Compensation Commission
WCC File No.: 1306305

CLARENCE WINFREY,

Employee,

Claimant,

vs.

ARCHWAY SERVICES, INC.,

Employer,

and

AMERICAN FIRE & CASUALTY
INSURANCE COMPANY C/O LIBERTY
MUTUAL GROUP,

Carrier,

Defendants.

THURSDAY, JANUARY 9, 2014

ORAL DEPOSITION OF KAREN GREENFIELD, MD,
taken at Doctors Care, 100 Jimmy Love Lane,
Columbia, South Carolina, commencing at 2:05 p.m.,
before Deidre Osborne, a Court Reporter and Notary
Public.

Job No. CS1787777

Veritext Corporate Services

800-567-8658

973-410-4040

000304

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4 803-771-7211

kim@pfmcdaniellaw.com

5 Representing the Claimant

6
7 MCANGUS GOUDELOCK & COURIE, LLC

BY: BRETT H. BAYNE, ESQUIRE

8 1320 Main Street, 10th Floor

Post Office Box 12519 (29211)

9 Columbia, South Carolina 29201

803-779-2300

10 brett.bayne@mgclaw.com

Representing the Defendants

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17
18 (INDEX AT REAR OF TRANSCRIPT.)
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25

1 (It is hereby stipulated and agreed by and
2 between counsel for the respective parties
3 that this deposition is being taken in
4 accordance with the South Carolina Workers'
5 Compensation Commission and the Administrative
6 Procedures Act; and that the deponent waives
7 reading and signing of this deposition
8 transcript.)

9
10 KAREN GREENFIELD, MD, after having been
11 first duly sworn, was examined and testified
12 as follows:

13
14 EXAMINATION
15

16 BY MR. BAYNE:

17 Q. Doctor, how are you doing today?

18 A. Good.

19 Q. My name is Brett Bayne. I'm an attorney
20 with McAngus, Goudelock & Courie. We represent
21 Archway Services and the insurance carrier in this
22 claim that Mr. Winfrey has filed. I'm just here
23 to ask you a few questions about the care you
24 provided him. I believe it was on May 28, 2013.
25 But before we begin, can you state your full name

1 for the record and also just go through your
2 background for me.

3 A. Karen G. Greenfield, MD. Undergraduate,
4 Wheaton College, Illinois. Doctor of Medicine,
5 University of Illinois, 1979. Residency and
6 internship at Richland Hospital in family practice
7 finishing in '82, and I've been working at Doctors
8 Care since '82.

9 Q. Okay. And what is it that you do at
10 Doctors Care on a daily basis?

11 A. Staff physician. See whatever illnesses,
12 accidents come in.

13 Q. Just general practitioner?

14 A. Right.

15 Q. Do you have any board certifications or
16 specialties?

17 A. Family practice.

18 Q. Okay. And you've -- have you had an
19 occasion to treat Mr. Clarence Winfrey in this
20 case?

21 A. Yes.

22 Q. And what was it that -- when did you
23 treat him and what did you treat him for?

24 A. It was Tuesday the 28th of May, and he
25 presented to the front desk just as a regular

1 patient, no urgency to it, and had complaints
2 about neck pain and left arm pain, and so when he
3 came in, in talking to him it was ascertained that
4 this was in the line of duty, that a rotisserie
5 had shocked him with 480 volts.

6 I have to admit that we don't see a lot
7 of electrocution things in here. Usually that's
8 emergency room kind of stuff, so I went real quick
9 and read what I could on it, and it said, really,
10 anything over probably 220 can cause some damage.
11 So he was saying that his left arm and shoulder
12 were hurting him and that the shock had kind of
13 jerked his neck down, and that's what he was
14 concerned about.

15 But in just observing him I saw that his
16 pulse was rapid and he was a little short of
17 breath which I actually had questioned him about,
18 but he said he didn't feel short of breath, and
19 then I advised him that it was work-related, that
20 this was going to be an EKG and some other things
21 and that he probably would need to have workmen's
22 comp cover that as opposed to -- because he put
23 himself down as self-pay, didn't have insurance.
24 He was going to just pay for that.

25 And I said, "Well, you better see about

1 workmen's comp on that." So we waited a little
2 while, in the meantime did the EKG and got
3 approval from workmen's comp to go ahead and treat
4 him.

5 Q. When you say he put self-pay, where did
6 he -- where did he put that down?

7 A. Well, where it is on the chart is where
8 it says copay, and S/P means self-pay.

9 Q. Would that have been something he filled
10 out on an intake form?

11 A. Right. Right.

12 Q. Okay. Do you have a copy of his intake
13 form?

14 A. I should because this was before our
15 computer revolution. All I have is his patient
16 information form, and it doesn't have any kind of
17 insurance listed, so if they don't have insurance,
18 by necessity, they're there for self-pay.

19 Q. Is there anywhere on that form to mark
20 whether it was work-related or not?

21 A. No. They don't ask them that at the
22 front desk.

23 Q. That's something you do during your
24 initial --

25 A. Well, I mean, it's obvious if they come

1 in with an authorization to be treated. Then
2 that's fine. And sometimes they'll say it was
3 work-related, but he did not offer that
4 information to start with.

5 Q. Okay. You had mentioned a minute ago
6 that he was shocked with 480 volts of electricity,
7 and I believe you've filled out a questionnaire as
8 well that indicates he was shocked with 480 volts
9 of electricity. Where did that information come
10 from?

11 A. He told me it was 480.

12 Q. So you haven't seen the device he was
13 using?

14 A. No.

15 Q. And you didn't do any testing on it?

16 A. No.

17 Q. Okay. So if it -- 480 volts is correct,
18 it would be because that's where Mr. Winfrey got
19 it from; is that right?

20 A. Right. Uh-huh.

21 Q. Okay. But you don't know for certain?
22 It could have been 240 or 110?

23 A. I would not have the foggiest.

24 Q. Okay. On your -- I believe it is your
25 medical report from that day where you have your

1 handwritten notes on it. You have written that he
2 had no chest pressure. What does that mean?

3 A. He was not complaining of any type of
4 thing that would go along with a heart attack.

5 Q. Okay. So he had no chest pain at that
6 time --

7 A. Right.

8 Q. -- that he was complaining of?

9 A. Right.

10 Q. Did you make any notes at all about
11 whether or not he was complaining of chest pain
12 before May 28th when he came in?

13 A. No.

14 Q. Okay.

15 A. The only thing that I wrote down there
16 was -- I guess it was on Thursday when he was
17 shocked, and he said he had some sweating issues
18 that evening --

19 Q. Okay.

20 A. -- apparently, and then came in on
21 Tuesday because he woke up sweating.

22 Q. Okay. Between the Thursday night
23 sweating and when he came in on Tuesday, did you
24 get any indication from him that he suffered from
25 that sweating or suffered from any chest pain --

1 A. No.

2 Q. -- during that time?

3 A. No.

4 Q. Okay. And you performed an EKG on him;
5 is that correct?

6 A. Yes.

7 Q. And what did that EKG reveal?

8 A. That he was tachycardic, pulse of 122
9 when normal is 60 to 100. He had some ST
10 elevation in the inferior part of his heart as
11 well as depression in the lateral leads which went
12 along with possible cardiac damage and also a
13 bundle branch block which is a widening of the
14 QRS.

15 Q. Okay. And tachycardia is just an
16 elevated heartbeat; is that correct?

17 A. Right. Heart rate. Yeah.

18 Q. And what is -- you said the right bundle
19 branch block. What does that mean?

20 A. The time interval between the time that
21 the impulse of the heart travels, I believe,
22 through the -- from the top of the heart to the
23 bottom of the heart. There's a regular time
24 period that it should be under, and it was wider
25 than that.

1 Q. Okay.

2 A. So it was taking longer to conduct the
3 electricity.

4 Q. And that would be indicative of a
5 blockage of the heart; is that correct?

6 A. No. That was an electrical problem.

7 Q. Okay.

8 A. Yeah.

9 Q. And then I believe it says inferior, you
10 said, ST elevation. And what does that mean?

11 A. ST elevation goes along with part of the
12 heart not getting blood supply to it.

13 Q. Okay. Are you able to tell from the EKG
14 that you performed and the findings that were
15 found what was wrong with his heart at that time?

16 A. Well, it would lead you to think that the
17 lower part of his heart had some lack of blood
18 control to -- or blood supply to it, and the rate,
19 obviously that his heart was struggling to try and
20 do what it needed to do.

21 Q. And when you say the lack of blood
22 supply, are you -- is that, again, an electrical
23 issue or is that --

24 A. No. That would be --

25 Q. -- a blockage?

1 A. -- a blockage probably.

2 Q. Okay. At that time does this EKG reveal
3 whether or not he was -- he was later -- let me

4 rephrase the question. He was later found to have
5 a -- what's called a ventricle septal defect, a
6 hole in his heart.

7 A. Yeah. You can't -- you can't see that
8 on --

9 Q. Okay.

10 A. -- an EKG.

11 Q. That's -- there's no way to know whether
12 or not he was suffering from it at the time of the
13 EKG or not; is that right?

14 A. Well, I guess. I'm not a cardiologist,
15 but the electrical impulse travels through the
16 septum, so if there was a hole in the septum, it
17 may -- that may explain why that was a little
18 longer delay getting there.

19 Q. But the EKG itself wouldn't actually
20 directly reveal that to you?

21 A. No.

22 Q. Okay. And what was your -- by the time
23 you got -- you read the EKG, what was your
24 determination of what was going on with
25 Mr. Winfrey?

1 A. That he needed someone a little bit
2 higher level of medical care than I, so I called a
3 cardiologist. I called Dr. Dasgupta. I spoke
4 with him, and he said, "Well, send him over right
5 now."

6 Q. Did your evaluation of Mr. Winfrey or the
7 EKG you performed give you any indication as to
8 when it was that Mr. Winfrey may have suffered
9 this heart attack?

10 A. No. I mean, it was -- I would say yes in
11 the fact that it's -- it wasn't three years ago.
12 It wasn't three months ago. Three -- it could
13 have been five days ago, but if it was longer than
14 ten days, he probably would not have had the ST
15 elevation.

16 Q. Okay. It was, obviously, sometime before
17 he did the EKG.

18 A. Right.

19 Q. Is there --

20 A. But not months before.

21 Q. Correct.

22 A. Yeah.

23 Q. Correct. And so we're kind of looking at
24 an upper limit of between five and ten days
25 maybe?

1 A. Probably.

2 Q. Okay. Could it have been sooner than
3 that as well?

4 A. What do you mean by "sooner"?

5 Q. In other words, could it have been that
6 morning? It could have been the night before? Or
7 is it --

8 A. I imagine.

9 Q. Okay.

10 A. Yeah.

11 Q. Other than the treatment on May 28th when
12 he presented, have you seen Mr. Winfrey back for
13 any reason?

14 A. Not as a patient.

15 Q. Okay. Have you had a chance to see him
16 in any setting at all?

17 A. He came back after he got out of the
18 hospital and thanked me for saving his life which,
19 of course, I didn't do.

20 Q. I understand. And then just one more
21 time, again, on the written opinion that you
22 issued on September 17, 2013, when you refer to
23 480 volts, that is based on what Mr. Winfrey told
24 you; is that right?

25 A. Yes. Uh-huh.

1 Q. And all your opinions here today are to a
2 reasonable degree of medical certainty?

3 A. Yes.

4 MR. BAYNE: Okay. That's all I have,
5 Preston.

6 - - -
7 EXAMINATION

8 - - -

9 BY MR. MCDANIEL:

10 Q. Let me ask you just a couple questions,
11 Doctor, and, really, it refers to -- would you
12 mind reading in some of the handwritten language.
13 First, up in the part -- and I'm going to refer.
14 This is found at page 66 of our APA Submissions.
15 Up where you've given the information from
16 Mr. Winfrey, all that's typed in, and then there's
17 handwritten notes. I believe there's a "G," but
18 it looks like your -- your initials to the left of
19 Columbia, South Carolina. You see that, Doctor,
20 in that section?

21 A. No. Those aren't mine.

22 Q. Oh, they're not?

23 A. I do everything below the Vital Sign
24 line.

25 Q. Okay.

1 A. And the other thing, I guess I did write
2 "WKC" in there for workmen's comp.

3 Q. Okay.

4 A. So that's mine, but everything else is --

5 Q. All right. Would you mind just
6 publishing just so -- so we can read all this.
7 Starting with "shocked," can you just tell me what
8 that says, all that written hand --

9 A. "Shocked on hand by 480 volts. Jerked
10 neck down to left shoulder."

11 Q. Okay.

12 A. That would have been written by the nurse
13 that put him back, and I'm trying to think of who
14 that is. Whoever signed the bottom left there.

15 Q. Okay.

16 A. Bax. We don't have a -- I don't know who
17 that is. Sorry.

18 Q. That's okay. That's all right. Now,
19 let's go down. You said you would have filled in
20 all the Physical.

21 A. Right.

22 Q. Would you just read what that says into
23 the record for me.

24 A. Okay. Well, the Complaint is on the
25 right side. 480 volts rotisserie shock on

1 Thursday. Sweated Thursday night. Woke up
2 sweating this morning, which would have been
3 Tuesday. Complained of pain in his left neck and
4 no chest pressure.

5 Now, that was after I asked him if he'd
6 had any discomfort in his chest.

7 Q. Okay.

8 A. So he did not offer that, really, and I
9 didn't write down there, but I do remember he was
10 really -- he was rubbing his arm, and he was like,
11 "My arm hurts." Of course, you have electricity
12 go through it --

13 Q. And that's the left arm and --

14 A. Right. Left arm.

15 Q. Okay. And is that also a common
16 presentation for having sustained a heart attack?

17 A. Yes. Well, you will have pain in your
18 arm but not pain to touch.

19 Q. Okay. And -- but he had actual pain --
20 to your recollection, he had pain to touch.

21 A. Well, yeah. I didn't write anything
22 about the arm, but I did put "tenderness in his
23 left trapezius," and that's the upper -- the
24 muscle up here in the neck, so he was -- he was
25 sore there.

1 Q. Okay. All right. And then in reference
2 to the other side, to the left --

3 A. Oh, okay. Well, the -- "well-developed,
4 well-nourished white male. No acute distress.

5 Appears short of breath but denies." Appears to
6 be. That's a --

7 Q. Okay.

8 A. "Entry wound." He had a entry on the --
9 the back of his third left finger. I didn't say
10 whether it was proximally or distally, but I do
11 remember that there.

12 Q. Okay.

13 A. "Trapezius -- tenderness, left
14 trapezius." And then when I listened to his heart
15 he had a grading of three over six murmur, and
16 his -- his rate was -- was high.

17 Q. All right. Grade three --

18 A. Over six.

19 Q. -- over six.

20 A. Yeah.

21 Q. What does that mean?

22 A. We grade heart murmurs from one to six.

23 Six is if I was sitting next to you without a
24 stethoscope I could hear your heart --

25 Q. Okay.

1 A. -- murmur. One is like you got to think
2 real hard, is that a heart murmur or not. So a
3 three is like a medical student could figure that
4 one out real easy.

5 Q. Okay. And then so that's the --

6 A. That would actually go along with the
7 ventral -- the septal -- excuse me. VSD, the
8 ventricular septal.

9 Q. It would --

10 A. Because you don't get murmurs from heart
11 attacks. You get murmurs either through blood
12 going over the valves or blood going from one side
13 of the heart to the other.

14 Q. Okay. So that would be further support
15 in reference to the EKG of that he was having --

16 A. Well, not --

17 Q. -- blood not going where it was supposed
18 to.

19 A. No. This would say the blood was -- was
20 turbulent going through some place, so it would
21 either be a valve or the hole between the right
22 side and the left side.

23 Q. Okay.

24 A. But it doesn't say anything about blood
25 getting to all the area of the heart.

1 Q. Right. Exactly. But, in other words,
2 it -- it's further support that the VSD was there
3 at that time.

4 A. Right.

5 Q. Okay. And then those -- I guess those
6 numbers are just diagnostic codes?

7 A. Right.

8 Q. Okay.

9 A. Yeah. For tachycardia, electric shock
10 and muscle shock.

11 Q. Then --

12 A. Okay.

13 Q. -- you discuss --

14 A. So discuss with Dr. Dasgupta at South
15 Carolina Heart Lexington, and he said, "Oh, send
16 him over." Of course, then when he got over
17 there, he said, "I'm calling an ambulance. You're
18 going to the hospital."

19 It's like, "Whoops."

20 Q. Okay. And then -- and so that's in
21 reference to your follow-up now?

22 A. Yeah. That he was to go now. Yeah.

23 Q. Okay. All right.

24 A. And then, depending on what happened, I
25 gave him some muscle relaxers and some pain

1 reliever for -- for what he perceived that he came
2 in here for.

3 Q. You know, your testimony goes along
4 exactly with -- in reference to five, no more than
5 ten days. Tell me what the -- why you said that
6 about the EKG in reference to, I believe -- was it
7 the STV or the ST?

8 A. ST elevation.

9 Q. The ST elevation.

10 A. Right. Yeah.

11 Q. Correct.

12 A. During the -- a heart attack, the ST
13 level grade will go up higher, and then as the
14 heart attack resolves, it comes down.

15 Q. Okay.

16 A. So the cardiologist will be able better
17 to tell you at what point it goes from being up to
18 being down or to being low. I'm not sure about
19 the evolution of time on that one.

20 Q. Okay. But it -- based on your background
21 and training, I believe you said that
22 normally that --

23 A. It's an acute injury.

24 Q. -- it's an acute injury, meaning within
25 the last ten days.

1 A. Oh, at least. Yeah.

2 Q. Okay. All right. And the opinion that
3 you were kind enough to write to us, you -- that

4 still remains your opinion to a reasonable degree
5 of medical certainty?

6 A. Right.

7 MR. MCDANIEL: All right. Nothing
8 further.

9 THE WITNESS: Well, not having any
10 previous information on any of his medical
11 status.

12 MR. MCDANIEL: Uh-huh. Uh-huh.

13 THE WITNESS: I mean, you know, if he was
14 seeing a cardiologist for three years and had
15 documented heart disease, that would be
16 another story, but ...

17 BY MR. MCDANIEL:

18 Q. Right. But in other words --

19 A. Just based on the one time.

20 Q. You said you did some brief research?

21 A. Yeah. The -- really, I was looking for
22 the VSD, and I couldn't find anything anywhere
23 about VSDs, but apparently there's some attorney
24 in Florida or in California that loves to do
25 electrical stuff, but on this -- you know,

1 V-fib -- of course, abnormal heart rhythm is the
2 greatest risk for an acute electrical injury
3 because the electricity goes through your heart,
4 just fritzes out your own heart's electrical
5 activity.

6 So V-fib and A-fib are the biggest things
7 that happen on that one, but this goes ahead and
8 says that the shock can actually cause myocardial
9 damage, can cause bundle branch blocks.

10 Q. And where is that from?

11 A. Medscape. Actually, there's another one
12 here. Electrical Injuries and Lightning Strikes
13 under -- this is a UK site. "Cardiac system," it
14 says "Ventricular fibrillation is the usual cause
15 of immediate death. Other arrhythmias have been
16 reported: right bundle branch block, nonspecific
17 ST and T-wave changes" which is that ST thing we
18 were talking about.

19 "Supraventricular tachycardia, atrial
20 fib. Acute myocardial infarction has been
21 reported. It's worth noting cardiac markers will
22 be raised." That's the blood work. To diagnose a
23 heart attack you need either the symptoms, changes
24 in EKG and the blood work to go along with that
25 or, if you don't have the symptoms, those other

1 two things would be adequate. And "delayed
2 arrhythmias are extremely rare, tend to be found
3 in patients with a previous history of EKG
4 abnormality."

5 So, you know, acutely, that's when they
6 need to go to the emergency room, and five days
7 later, I was, frankly, surprised that he would
8 come in, but I was really concerned about his
9 heart findings.

10 Q. Let me -- you know, just one question.
11 Of course, he was obviously reporting these
12 problems that would be associated with --

13 A. Muscle injury.

14 Q. -- muscle from -- from the electrical
15 shock.

16 A. Right. Right.

17 Q. And that would be -- but also that's in
18 the same exact area that many people report pain
19 and --

20 A. When they're having a heart attack.

21 Q. -- discomfort and have -- well, would it
22 be your opinion that there's a substantial
23 likelihood that the electrical shock and where it
24 occurred and the path it took would have masked
25 him -- like -- in other words, saying like, "Well,

1 I've just got to get over this electrical shock,"
2 versus, "I've had a heart attack."

3 A. Well, I don't know about certainty issues
4 because without any pressure in his chest or a
5 heaviness in his chest, by itself, pain in the
6 left arm, I would be concerned about if he came in
7 and said, "I have left arm pain, but I'm fine
8 here."

9 Q. Uh-huh.

10 A. Especially with a EKG. But you're saying
11 with electrical shock pain, he may have confused
12 any pain that might have come from a heart attack
13 in his left arm with that.

14 Q. Correct.

15 A. Yeah. I mean, you can't separate those
16 two out.

17 Q. Okay. All right. Let me ask you -- and
18 you said this came -- and, of course, it says it
19 came off of Medscape. What is Medscape?

20 A. It's just a Web site with usually medical
21 information on it.

22 Q. Okay. Is that something y'all regularly
23 use when you've got --

24 A. No. I did that at home yesterday.

25 Q. Oh, okay.

1 A. No. I didn't do it at the time. I was
2 just doing it to be prepared for today.

3 Q. Okay. All right.

4 A. If you want this, too, you can have
5 that. We can make copies for both of you.

6 MR. MCDANIEL: Would you mind if we make
7 a copy of that?

8 MR. BAYNE: No.

9 MR. MCDANIEL: Okay.

10 THE WITNESS: This one -- I mean, I just
11 summarize it on the side there, but under
12 "Cardiac system" down there it has it.

13 I mean, this says, "This PatientPlus
14 article is written for healthcare
15 professionals so the language may be more
16 technical than the condition leaflets."

17 MR. MCDANIEL: Let me ask. Brett, do you
18 want to take a look at those?

19 MR. BAYNE: Yeah. Just --

20 THE WITNESS: And they were like eight
21 pages long, but I just --

22 MR. MCDANIEL: We can just make those an
23 exhibit to the deposition. Do you have any
24 objection to that?

25 THE WITNESS: And then this one was just

1 a summary of radiation on electrical injury in
2 terms of circulation, which is cardiac
3 disease. It says, "Cardiac complications of
4 electrocution (apropos of a case of myocardial
5 infarction after lightning electrocution.)"

6 Now, I don't know how lightening and 480
7 volts compare, so -- and it's just a
8 bibliography. It doesn't have any information
9 on there. Yeah. Physics wasn't my greatest
10 thing, so volts and amperes and all those
11 things.

12 MR. MCDANIEL: Okay. I don't have any
13 further questions, just subject to us
14 attaching those to -- as --

15 MR. BAYNE: Yeah. Just --

16 MR. MCDANIEL: We can attach them as one
17 of three or however many pages if you want to,
18 Brett.

19 THE WITNESS: Yeah. I was kind of
20 looking for the VSD because that's amazing,
21 but then when you read what Travis said, you
22 know, it looked like burn marks or something.
23 Now, I -- like I said, I wasn't sure whether
24 that was burn marks on the septum or burn
25 marks on the heart, but ...

1 MR. MCDANIEL: Okay. All right. Thank
2 you, Doctor. I don't have any further
3 questions. Let's just see if -- I don't know
4 if Mr. Bayne has any.

5 MR. BAYNE: Can we go off the record real
6 quick?

7 MR. MCDANIEL: Yeah.

8 (A discussion was held off the record.)

9 - - -

10 REEXAMINATION

11 - - -

12 BY MR. BAYNE:

13 Q. Doctor, I just wanted to ask a couple
14 follow-up questions. You said that Mr. Winfrey's
15 pain in his left arm was pain to touch; is that
16 right?

17 A. It was tender to touch.

18 Q. Tender to touch.

19 A. Yeah.

20 Q. You indicated that pain in the left arm
21 that is typically associated with a heart attack
22 is not tender to the touch.

23 A. Yeah.

24 Q. Is that right?

25 So at least based on your observation of

1 him on that day it would not have led you to
2 believe that that pain was related to a heart
3 attack; is that correct?

4 A. Yes.

5 Q. Okay. On the electrical articles that
6 you've referenced that are going to be put into
7 the record in just a second, you indicated that it
8 talked about an electrical shock, lightening; is
9 that right?

10 A. I would have to look at that.

11 MR. MCDANIEL: I think she was referring
12 to --

13 THE WITNESS: Well, the title says both.

14 MR. MCDANIEL: And I have no objection to
15 that page, Brett, if you wanted to put it in.

16 THE WITNESS: Yes. This one says
17 lightening.

18 BY MR. BAYNE:

19 Q. My quick question was, on the second page
20 which is labeled page 2 of 8 on the top right, it
21 does talk about lightening right there. About a
22 third of the way down it indicates lightening is
23 about 10 million volts; is that correct?

24 A. That's what it says.

25 Q. Okay.

1 A. I don't know.

2 Q. And you'd agree that 10 million is more
3 than 480; is that right?

4 A. Right. Uh-huh.

5 Q. And in the other -- the Medscape article
6 that you -- you printed off -- and I'll hand it
7 back to you real quick. It doesn't indicate on
8 there when it's talking about -- I believe you
9 circled a part about heart damage relating --

10 A. Right.

11 Q. -- from electrocution. It doesn't --

12 A. Right.

13 Q. It doesn't refer to the number of volts
14 that would be required or --

15 A. It doesn't say --

16 Q. -- would be typical?

17 A. -- what was causing it. Not of the
18 source. Yeah.

19 Q. Okay. In your notes on 10/28, one thing
20 I wanted to touch on I forgot about, you noted
21 that he had an entry wound --

22 A. Right.

23 Q. -- on his left hand. Is that a term of
24 art, so to speak, or was there an actual wound?

25 A. No. He actually had a wound there.

1 Yeah.

2 Q. Do you recall what it looked like?

3 A. I think it was a little brownish. It

4 was -- I mean, since it was five days old, I think
5 it was just like a resolving burn.

6 Q. Okay. So it looked -- at the time it
7 looked like a resolving burn?

8 A. Uh-huh.

9 Q. And then you said something about --
10 Mr. McDaniel asked you about the opinion that you
11 had filled out, the questionnaire you'd filled
12 out, and asked if that had changed at all, and I
13 think you said something about depending on his
14 history.

15 A. Oh. No. I mean, it -- my opinion from
16 then until now hasn't changed because I don't have
17 any other history.

18 Q. Okay.

19 A. Yeah.

20 Q. Would the fact that Mr. Winfrey had, for
21 example, a family history of this type of heart
22 condition, would that in any way change your
23 opinion as to what caused --

24 A. No.

25 Q. -- his symptoms?

1 A. Huh-uh.

2 Q. And, in fact, I believe when he did
3 arrive at the hospital finally and Dr. Travis saw
4 him, he did diagnose him with severe three vessel
5 disease. Does that at all change any of your
6 opinions in this case?

7 A. Not as far as what precipitated it, no.

8 MR. BAYNE: Okay. That's all I have.

9 MR. MCDANIEL: Nothing further.

10 - - -

11 (Medical Web Site Documents marked
12 Greenfield Exhibit Number 1, for
13 identification.)

14 - - -

15 (Witness excused.)

16 - - -

17 (Deposition concluded at 2:30 p.m.)

18 - - -

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CERTIFICATE OF REPORTER

I, Deidre Osborne, Court Reporter and
Notary Public for the State of South Carolina at

Large, do hereby certify:

That the proceedings and evidence are
contained fully and accurately in the notes taken
by me in the above cause and that it is a correct
transcript of the same.

I further certify that I am neither
related to nor counsel for any party to the cause
pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my
official seal this 9th day of January, 2014, at
Lexington County, South Carolina.

Deidre Osborne,
Court Reporter
Notary Public
State of South Carolina at Large
My Commission Expires:
June 12, 2019

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South Carolina Workers' Compensation Commission
WCC File No.: 1306305

CLARENCE WINFREY, :

Employee, :

Claimant, :

vs. :

ARCHWAY SERVICES, :

Employer, :

and :

AMERICAN FIRE & CASUALTY
INSURANCE, :

Carrier, :

Defendants. :

Thursday, January 23, 2014

ORAL DEPOSITION OF DR. LANNEAU D. LIDE,
JR., taken at South Carolina Heart Center, 2001
Laurel Street, Columbia, South Carolina,
commencing at 7:52 a.m., before Deidre Osborne, a
Court Reporter and Notary Public.

Job No. CS1795646

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18 (INDEX AT REAR OF TRANSCRIPT.)

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1 (It is hereby stipulated and agreed by and
2 between counsel for the respective parties
3 that this deposition is being taken in
4 accordance with the South Carolina Workers'
5 Compensation Commission and the Administrative
6 Procedures Act; and that the deponent waives
7 reading and signing of this deposition
8 transcript.)

9 - - -
10 DR. LANNEAU D. LIDE, JR., after having
11 been first duly sworn, was examined and
12 testified as follows:

13 - - -
14 EXAMINATION
15 - - -

16 BY MR. BAYNE:

17 Q. Dr. Lide, how are you doing today?

18 A. Fine. Thank you.

19 Q. My name's Brett Bayne. I'm an attorney
20 with McAngus Goudelock & Courie. We represent the
21 defendants in this workers' compensation claim,
22 and I'm here today just to ask you a few questions
23 about some opinions that you've -- you've issued
24 as well as the medical records related to
25 Mr. Clarence Winfrey's heart case.

1 Can we start with -- just give me a brief
2 background of your medical qualifications, that
3 type of stuff.

4 A. I'm a cardiologist. I've been in
5 practice here in Columbia since 1981. I've been
6 board-certified since 1981 in cardiology. I've
7 been in practice continually.

8 Q. All right. And how did you get involved
9 in this case?

10 A. Mr. Winfrey went to see his -- to see a
11 doctor and was referred to my partner,
12 Dr. Dasgupta, who saw him in the office, and
13 Dr. Dasgupta realized that Mr. Winfrey was sick
14 and admitted him to the hospital for a heart
15 catheterization and other treatment.

16 Q. And --

17 A. And I did the heart catheterization.

18 Q. And your records reflect that he
19 presented on May 28th, 2013?

20 A. If you say so.

21 Q. And --

22 A. I won't challenge it.

23 Q. That's fine.

24 A. I know that's the date of the heart
25 catheterization, May 28th.

1 Q. And the -- the process of Mr. Winfrey's
2 treatment, I think you -- you mentioned was that
3 he went to a doctor. He was referred to

4 Dr. Dasgupta, and then eventually he ended up with
5 you before moving on to Dr. Travis. Is that
6 correct?

7 A. Yes.

8 Q. Okay. And the visit with you as the
9 cardiologist was to, I guess, run some tests,
10 observe Mr. Winfrey and determine whether or not
11 additional treatment was needed. Is that right?

12 A. Well, Dr. Dasgupta admitted him to the
13 hospital.

14 Q. Okay.

15 A. And Dr. Dasgupta is my partner, and --
16 and I did the heart catheterization.

17 Q. And then after you did the
18 catheterization, did you refer him to Dr. Travis?

19 A. Yes. Yes.

20 Q. Okay. Let's step back for a second. You
21 have a patient history, I believe. There's a
22 catheterization report that we'll enter as Exhibit
23 1 for this deposition purposes.

24 MR. BAYNE: Do you want to tag it real
25 quick?

1 THE COURT REPORTER: Yes, please.

2 MR. BAYNE: And this is a document that
3 neither Mr. McDaniel or myself, we believe,
4 have seen before today, but we're going to
5 enter it into the record.

6 - - -
7 (Catheterization Report Dated 5/28/2013
8 marked Lide Exhibit Number 1, for
9 identification.)

10 - - -

11 BY MR. BAYNE:

12 Q. When Mr. Winfrey presented to
13 Dr. Dasgupta and then to you, what history did you
14 have at that time before you took a history from
15 him? In other words, were you provided with
16 any -- with any background on this case or did you
17 take an initial history when you first saw him?

18 A. Well, I -- of course, I spoke to the
19 patient before we did the -- the procedure. The
20 history that would have been given to me was the
21 history that Dr. Dasgupta had from the office.

22 Q. Okay.

23 A. And I should have a copy of that here on
24 this computer, but you should also have it.

25 Q. If you can just give me a brief rundown

1 of what the history that -- that Dr. Dasgupta gave
2 you was, I would appreciate it.

3 A. I'm going to pull up Dr. Dasgupta's
4 office note on the computer. You want me to read
5 this?

6 Q. If you can, just -- what I'm looking for
7 is what symptoms he complained of to
8 Dr. Dasgupta --

9 A. Okay.

10 Q. -- and then what your understanding of
11 the history was.

12 A. All right. Well, he says that
13 Mr. Winfrey was 50 years old and been found to
14 have an abnormal EKG and a heart murmur when he
15 went to see Dr. Greenfield, that he had an
16 electric shock five days before, complained of
17 pain in his shoulder going into the left scapula
18 region, left side of the neck, left upper
19 extremity, et cetera, been sweaty, been short of
20 breath with exertion and that he'd gotten some
21 relief with Tylenol and Motrin, had no -- no
22 previous heart history.

23 And Dr. Dasgupta did an echocardiogram in
24 the office, and he saw that the -- the inferior
25 segment of the left ventricle was not moving and

1 that there was a defect in the interventricular
2 septum with blood flowing abnormally from the left
3 ventricle to the right ventricle through that
4 defect.

5 Q. Did Dr. Dasgupta make any notes about any
6 complaints of chest pain at that time?

7 A. I don't see anything in -- in this about
8 pain in the chest itself.

9 Q. Did he make any notes about any history
10 of chest pain leading up to his admission to the
11 hospital that day?

12 A. I don't see it in here, but --

13 Q. Have you -- in addition to Dr. Dasgupta's
14 notes, were you ever given the opportunity to
15 review Dr. Greenfield's notes who was the
16 referring physician to your office?

17 A. I probably did not see any notes from
18 Dr. Greenfield.

19 Q. And just referencing her notes, if her
20 notes indicated that he did not have any chest
21 pain on both presentation and leading up to coming
22 to the office, would you have any reason to
23 dispute that he was not having any chest pain?

24 A. I don't have any -- any reason to dispute
25 it based on what you say. Although, I do see my

1 little note here in which I reference chest pain.

2 Q. And that -- that was my next question,
3 Doctor. In Exhibit 1 you mentioned that he's
4 complained of chest pain, I believe, since the
5 accident. Do you know where that particular note
6 came from?

7 A. Well, this -- this note would have been
8 the note that I generated as part of the -- the
9 cardiac catheterization report.

10 Q. Right. Did that come -- if you recall,
11 was that something that Mr. Winfrey told you or
12 was that something that came from another doctor?

13 A. It would have been what he told me.

14 Q. Okay. If Mr. Winfrey had told
15 Dr. Dasgupta he was having chest pain, would that
16 have been in Dr. Dasgupta's notes to your
17 knowledge?

18 A. Probably. However, I can't speak for
19 what everybody else is going to think and put in
20 their notes.

21 Q. Certainly. Doctor, Mr. Winfrey was
22 ultimately diagnosed with -- I think you said a
23 ventricular septal defect. And that was caused by
24 a myocardial infarction; is that correct?

25 A. Well, we say it was caused -- cause by a

1 myocardial infarction. I mean, we do blood tests
2 and EKGs and all that, and I can't say it wasn't
3 caused by -- by an electrical shock. I don't know
4 how we would tell the difference.

5 Q. Well, you -- the VSD could have been
6 caused by an electrical shock or the --

7 A. Sure.

8 Q. -- heart attack could have been caused by
9 the electrical shock?

10 A. I mean, an electrical shock creates a
11 burn.

12 Q. And so in your opinion it's possible that
13 an electrical shock actually just punched a hole
14 in the heart?

15 A. Possibly.

16 Q. Okay. Is -- typically, a ventricular
17 septal defect is caused by a myocardial infarction;
18 is that correct?

19 A. Well, most ventricular septal defects are
20 congenital.

21 Q. Okay.

22 A. I mean, they're not caused by -- by
23 anything. They're just a developmental
24 abnormality. You can end up with a ventricular
25 septal defect by being shocked through the heart,

1 which you have other injuries, and -- but I guess
2 the most common cause for an acquired ventricular
3 septal defect would be a myocardial infarction.

4 Q. Okay. And a myocardial infarction, it's,
5 I believe, in this case and, according to
6 Dr. Travis, was caused by what's called a plaque
7 rupture. Are you aware of his opinion on that?

8 A. I -- I don't know that we could -- you
9 know, a myocardial infarction is damage to heart
10 muscle due to lack of blood flow, so I don't know
11 how you separate that out from damage due to a
12 burn in a case like this.

13 Q. Correct. My -- my question --

14 A. We don't have specific tests. We don't
15 have chemical tests that tell us that damage was
16 due to -- to a burn instead of -- instead of lack
17 of blood flow. You know, all our tests are
18 focused on the common disease of myocardial
19 infarction due to the lack of blood flow.

20 Q. So there's no way to know for sure
21 whether or not any of the injuries to his heart
22 were from electrical shock or were from just, I
23 guess, a congenital defect or from a poor heart
24 condition. Is that --

25 A. Oh, it's not a congenital defect.

1 Q. Okay.

2 A. A congenital defect causing a ventricular
3 septal defect would -- would have been known. I
4 mean, that -- he would have had a -- a murmur from
5 birth.

6 Q. Okay.

7 A. And that would have been diagnosed long
8 ago.

9 Q. But it would either -- so it would either
10 be something that would have been developed over
11 time such as coronary artery disease that would
12 have caused this or it would be the electrical
13 shock. Is that what your opinion is?

14 A. I guess so.

15 Q. In other words --

16 A. Yeah.

17 Q. -- your statement was --

18 A. Yeah.

19 Q. -- that we can't know whether it was
20 shock. He did have three vessel artery disease,
21 so it's possible it was that. It's possible it
22 was electrical shock. Is that a correct
23 statement?

24 A. He had -- he had heart muscle damage
25 which resulted in -- in -- in this rupture of the

1 septum which means -- which is the wall between
2 the left ventricle and the right ventricle.

3 Q. And what causes heart muscle damage?

4 A. Well, he had the electrical shock. We
5 know that. And it's also true that we saw that
6 the artery going into that area was blocked.

7 Q. And can you --

8 A. But it's hard to know which came first.

9 Q. Okay. So the artery block can cause
10 heart muscle damage. The electrical shock can
11 cause heart muscle damage. Is that right?

12 A. That's right.

13 Q. Okay. In your written opinion that you
14 issued, it was a questionnaire you filled out, you
15 indicated that it was your opinion that the
16 electrical shock caused the symptoms that
17 Mr. Winfrey was suffering from, and you indicated
18 that it was when he was shocked with 480 volts of
19 electricity. Where did that information come
20 from?

21 A. I'm sure I had nothing in any note that I
22 generated about 400 volts.

23 Q. Okay. So when you --

24 A. That's not something I would have known.

25 Q. When you indicated that it was caused by

1 a 480-volt shock, that information would have come
2 from Mr. Winfrey, I guess?

3 A. I don't know what document you're
4 referring to.

5 Q. I apologize. I'll show you. There's a
6 questionnaire that you filled out, Dr. Lide, that
7 asked for your medical opinion, and you checked
8 the box that indicated this was caused by 480
9 volts of electricity.

10 A. I imagine that part was probably -- I
11 don't know whether that was generated by workers'
12 comp or whatever, but I -- I don't see any way
13 that we can say that that is not secondary to the
14 shock.

15 Q. Okay.

16 A. The details of the shock are beyond me.

17 Q. And I understand that. My -- my question
18 was -- was, getting to the amount of the shock
19 that your opinion indicates caused this -- the
20 symptoms Mr. Winfrey's suffering from, do you have
21 any evidence or do you have any research you've
22 done that indicates it was actually 480 volts that
23 he suffered electrical shock from?

24 A. I don't -- I don't -- I did not
25 investigate the scene. I don't know what

1 equipment he was working on. I'm taking everybody
2 else's word for it that he had an electrical
3 shock, and I certainly would have no data to

4 indicate to me whether 480 volts would be strong
5 enough to cause the problem that 120 volts
6 wouldn't cause.

7 Q. Okay. What about 10 volts?

8 A. I have no -- I have done no research on
9 this.

10 Q. Okay. And in your day-to-day practice as
11 a cardiologist, you use electrical current to
12 stimulate the heart or stop a heart murmur or
13 apply electrical shock to hearts; is that correct?

14 A. Occasionally, yes.

15 Q. How many volts are you using when you do
16 that?

17 A. It can be as much as 360 joules, but
18 physics at this point in my life is not my strong
19 suit. And I can't tell you exactly how that
20 translates into volts. I can tell you it's a very
21 brief shock. If someone has an electrical shock
22 for -- for a termination of a cardiac arrhythmia,
23 it's typically given over one millisecond or less.

24 Q. Okay. And those shocks, have you ever
25 caused a myocardial infarction by applying those

1 shocks?

2 A. Not that I know of.

3 Q. Have you ever caused a ventricular septal

4 defect by providing those shocks?

5 A. No.

6 Q. In your practice have you ever had the
7 chance to look at the heart -- actually look at
8 the heart after providing those electrical shocks?

9 A. I suspect I probably have seen some
10 autopsy hearts after patients have had cardiac
11 arrests.

12 Q. And in those cases have you ever
13 discovered what would be called entrance and exit
14 wounds on either side of the heart from that
15 electrical current that you've provided?

16 A. I have not. But I am quite sure I would
17 not be able to recognize them.

18 Q. Have you had a chance to review
19 Dr. Travis's medical records in the course of
20 providing care to Mr. Winfrey both of the surgery
21 and of the follow-up that he provided before he, I
22 believe, returned him back to you for care?

23 A. We have -- we probably have received
24 some -- some limited notes from Dr. Travis.

25 Q. And I'll -- my question is, Dr. Travis's

1 opinion, at least the mechanism of injury, is that
2 Mr. Winfrey suffered a plaque rupture in his
3 coronary artery that caused a myocardial

4 infarction that caused the ventricular septal
5 defect. And I think we talked a minute ago about
6 what can cause the damage in the heart. Would
7 that be a -- would that be a correct order of
8 events that would cause the damage in
9 Mr. Winfrey's heart?

10 A. I think it's one of the possibilities.

11 Q. Okay. And a plaque rupture occurs --
12 what causes a plaque rupture?

13 A. Would you like to win the Nobel Prize?

14 Q. I would love to win the Nobel Prize.

15 A. Well, explain that then.

16 Q. And that was -- that was, I believe,
17 Dr. Travis's opinion and Dr. Feldman's opinion.
18 Their statements were, "We don't really know what
19 causes plaque rupture. There's no way to test for
20 it."

21 Is that an accurate statement?

22 A. That's -- that's correct.

23 Q. And -- and their opinion was that the
24 electrical shock caused -- or Dr. Travis's opinion
25 was that the electrical shock caused the plaque

1 rupture. Dr. Feldman's opinion was that it was
2 not. And, again, we -- we don't know for sure
3 whether or not electrical shock caused the plaque
4 rupture or not. Is that right?

5 MR. MCDANIEL: I'm going to object on --
6 and I don't think that's an accurate statement
7 of Dr. Feldman's testimony. But with that ...

8 MR. BAYNE: That's fine.

9 BY MR. BAYNE:

10 Q. The question is, we don't know for sure
11 whether or not electrical shock can cause a plaque
12 rupture or did cause a plaque rupture in this
13 case. Is that right?

14 A. I don't know whether the electrical shock
15 caused the plaque rupture. I don't know which
16 came first, whether -- whether -- because it does
17 seem to me this could have all started off as a
18 burn injury, and I can tell you that for decades
19 after people began to have myocardial infarctions,
20 there was a -- a big debate about which came
21 first, blood clot in the coronary artery or the
22 injury of the -- of the tissue, and I think that
23 if you have -- it does seem to me if you had badly
24 damaged tissue, you're not going to have perfect
25 blood flow through there.

1 This doesn't apply only to the heart, and
2 you'll end up with the artery to the area being
3 blocked, so I don't know which came first.

4 Q. Okay. In your review of Mr. Winfrey, I
5 think it's not disputed that he touched a wire
6 with his left hand, and -- and the question is
7 what happened with the electricity; did it go into
8 his neck, heart.

9 Did you ever find an exit wound on
10 Mr. Winfrey's body where the electricity would
11 have exited?

12 A. I did not look for an exit wound.

13 Q. Okay. Has he ever reported that he has
14 an exit wound to you from the electricity leaving
15 his body?

16 A. I don't know why he would report that to
17 me.

18 Q. As far as the VSD or the heart attack,
19 the plaque rupture, whatever came first in this
20 case, when would -- following the electrical
21 shock, when would he have first started
22 experiencing symptoms of the actual heart
23 condition that he suffered from? In other words,
24 if -- if he -- if he suffers this shock that goes
25 into his heart, is there going to be an immediate

1 "I've got a problem with my heart" or is it
2 something that may develop over several days where
3 he later starts realizing he's got a problem with
4 his heart?

5 A. Well, he probably felt worse when he
6 developed the VSD. And VSDs, after myocardial
7 infarction, they can occur in the first 24 hours.
8 They can occur any time up to a week later.

9 Q. Would he have felt any or noticed any
10 symptoms of the myocardial infarction following
11 electrical shock or would it have been the VSD
12 that triggered him to know something was wrong?

13 A. I think after he developed VSD and after
14 it became large enough for him to have significant
15 flow, he would have become more short of breath.

16 Q. Okay.

17 A. Now, that may not have occurred in a few
18 seconds. It may have been hours before that --
19 before that occurred.

20 Q. In Dr. Dasgupta's notes, on the day he
21 was admitted he talks about -- I believe it was
22 diaphoresis. And that is intense sweating; is
23 that right?

24 A. It's sweating.

25 Q. And that is a symptom of suffering from a

1 myocardial infarction; is that right?

2 A. That is a symptom of suffering from
3 illness, period.

4 Q. Okay.

5 A. That is so non-specific a symptom that it
6 doesn't tell you. It doesn't lead you in any --
7 any specific direction.

8 Q. If the sweating was a -- was a symptom of
9 the myocardial infarction he experienced, when
10 would you expect that sweating to start as a
11 result of the myocardial infarction?

12 A. Well, it could start right away.

13 Q. Would it start before he suffered the
14 myocardial infarction?

15 A. He could have been sweating because he
16 had an electric shock. He could have been
17 sweating because he had an electric shock and he
18 was frightened.

19 Q. If the sweating didn't start until 24
20 hours after the electrical shock, would that be
21 indicative of when the myocardial infarction
22 occurred?

23 A. I don't think that -- I don't think you
24 can time anything by the onset of sweating.

25 Q. Can --

1 A. Maybe his temperature went up a little
2 bit a day after he had the shock.

3 Q. Are you able to time when the myocardial
4 infarction occurred based on any of the tests you
5 were able to run?

6 A. No. Some time after the shock.

7 Q. Is there -- is there any -- any window
8 that we're looking at or it's just sometime
9 between when he suffered the shock and when he was
10 entered -- admitted into the hospital?

11 A. I think we'd be on safer ground
12 considering that to be the window.

13 Q. Okay. Are you -- in your work as a
14 cardiologist and any research you've done, do you
15 have any -- any information about electrical
16 shocks causing a myocardial infarction or causing
17 a VSD and the time period related to that as far
18 as how soon after the shock do these things
19 occur? Can they occur a week later? A month
20 later? What are we looking at as far as timeline
21 with an electrical shock?

22 A. I have not done any research on this, and
23 I'm not -- I don't know of -- of specific
24 research. Somebody's probably done some. The --
25 so, no, I don't have any specific information on

1 that.

2 Q. Would it be safe to say that the farther
3 we get away from the event, the less likely it is
4 that the -- the heart condition is related to that
5 event?

6 A. Yes. I think that's right. I think
7 that -- that it would be unlikely for him to pop
8 up with a VSD a month after having the -- the
9 original injury or a myocardial infarction.

10 Q. In other words, it's more likely that he
11 would suffer a heart attack an hour later than it
12 is a day later, than it is a week later, than it
13 is a month later. The farther we get removed from
14 it, the less likely the odds become that that was
15 the precipitating event.

16 A. I -- I think to the extent that the heart
17 muscle was damaged by the electric shock, that
18 would have occurred immediately.

19 Q. Okay.

20 A. Now, at what point later the
21 interventricular septum gave way and he actually
22 had the defect allowing blood to flow from the
23 left ventricle to the right ventricle, that could
24 have been any time.

25 Q. And related to -- you mentioned, and you

1 said it previously as well, that the -- the shock
2 caused the heart muscle damage. You did say --

3 A. It could have.

4 Q. Could have caused it.

5 A. It could have, yeah.

6 Q. But there's no way to know for sure
7 whether or not his -- the condition his heart was
8 in caused that damage or whether the shock caused
9 that damage; is that right?

10 A. I don't have any way that I can say that
11 the shock was not related to the injury.

12 Q. Okay.

13 A. There's no way I can say that.

14 Q. You don't have any way to say it was not
15 related or that it was related?

16 A. I don't have any way to say that it was
17 not related to it.

18 Q. Do you have any way to say that it was
19 related other than the proximity in time?

20 A. No. The proximity in time is -- is -- is
21 overwhelming evidence as far as I'm concerned.

22 Q. And that's the sole evidence that -- that
23 shock caused the heart damage; is that right?

24 A. Well, that and Dr. Travis's description.

25 Q. And which description are you referring

1 to from Dr. Travis?

2 A. That what he saw in the operating room
3 was, and I think he's given this to you in a

4 deposition, something to the effect that -- that
5 he saw tissue that looked like it had been burned.

6 Q. Okay. And are you referring to the white
7 patches that I think he called plaques on either
8 side of the heart?

9 A. I'm just referring to -- to -- no. I --
10 I can't -- I can't relate that back to anything
11 specific, just that I think he's given you that
12 opinion in a -- in a deposition.

13 Q. So it's -- your opinion's based on the
14 timing and then Dr. Travis's -- what you
15 understand Dr. Travis's opinions to be.

16 A. Right. That's right.

17 Q. Okay. As far as providing Mr. Winfrey
18 care after the surgery, what -- what ongoing care
19 are you providing him at this time?

20 A. I have seen him a few times in the
21 office, and he's on some medications. He's -- I
22 think he's been through -- he's been involved in
23 the cardiac rehab program.

24 Q. What is the cardiac rehab program?

25 A. Basically it's supervised exercise.

1 Q. And is that part of a standard program to
2 be able to return him to, hopefully, the life he
3 was living before --

4 A. Yes.

5 Q. -- he suffered this event?

6 In your experience is that a -- does that
7 program usually work as far as getting people back
8 to what they were doing beforehand?

9 A. It usually results in improvement in
10 functional status. Now, whether it's enough
11 improvement to get somebody back to work depends
12 on the individual case.

13 Q. Have you -- at this point do you have
14 any -- any idea or any opinion about where
15 Mr. Winfrey's going to end up once he completes
16 all of his cardiac rehab or is it too early to
17 tell?

18 A. It may be too early to tell, but I -- I
19 don't know that he's going to be able to get back
20 to work.

21 Q. In general or work as an electrician?

22 A. In general.

23 Q. Okay. And other than here today at this
24 deposition, have you had any -- any contact with
25 Mr. McDaniel or Mr. Winfrey outside of the

1 appointments that -- that Mr. Winfrey comes to?

2 A. Had no contact with Mr. Winfrey except
3 here in the office, and I've not had any contact
4 with Mr. McDaniel.

5 Q. Other than the -- the questionnaire
6 that --

7 A. Yes.

8 Q. That you filled out.

9 A. Yes.

10 MR. BAYNE: Okay. I have no further
11 questions.

12 - - -
13 EXAMINATION

14 - - -
15 BY MR. MCDANIEL:

16 Q. Doctor, let me ask you a few questions.
17 Let's just -- I believe that I sent you a copy of
18 a report that Dr. Travis -- it was briefly after
19 the report that you were kind enough to fill out
20 whenever --

21 A. Uh-huh.

22 Q. -- causation became a question in
23 September, and, first, I'm going to -- this has
24 been put into evidence, and I'm going to ask you
25 if you can look at that --

1 A. If I can look at this? Uh-huh.

2 Q. -- of Dr. Travis and if you -- if that
3 is, in fact, a copy of a report that you have in
4 your records that I sent to you after we received
5 it.

6 A. I think this is, yes.

7 Q. And just in reference to -- Counsel asked
8 you some questions about what Dr. Travis had found
9 and the information. If you would -- does it not
10 refer to the -- his observations during surgery in
11 reference to the entrance and exit wounds in
12 paragraph -- I believe it's paragraph two. You
13 can look at that.

14 A. Uh-huh.

15 Q. Does this concur with what your
16 understanding is in either your discussion with
17 Dr. Travis and/or review of the records and this
18 information?

19 A. I think that Dr. Travis's opinion is
20 probably correct, and I certainly don't have any
21 reason to challenge him.

22 Q. And what I was referring to is, Counsel
23 asked you some questions. In other words, he
24 refers in there that he's never seen anything like
25 this in his 15 years of cardiovascular surgery and

1 that he identified what he -- in his opinion was a
2 clear entrance and exit wound to the heart and
3 damage caused by the electrical shock.

4 Now, I want to look -- ask you a few
5 questions. Counsel back -- bounced back and forth
6 between using the term "VSD" and a "heart attack"
7 in asking his questions in timing. And I want to
8 ask you just a couple questions. We -- you've
9 kindly provided us a report that we should have
10 received from Lexington Medical Center. For some
11 reason we didn't.

12 And if you would, that history -- I know
13 that Counsel asked you about the history that was
14 taken by Dr. Dasgupta, and he specifically asked
15 you about reference to chest pain, and then you've
16 recorded a history there. I know you've stated
17 earlier in your testimony that you reviewed
18 Dr. Dasgupta's history, and you also talked to the
19 patient.

20 A. Yes.

21 Q. Now, is this -- the history that's
22 recorded in this report, is that the history that
23 your -- that you dictated based on both your
24 conversation with Mr. Winfrey and Dr. Dasgupta's
25 report?

1 A. I'm sure this is the only history that I
2 recorded at the time.

3 Q. Right.

4 A. It's -- it was not my role to do a
5 detailed history and physical examination at the
6 time I saw him. I needed no focus on -- on those
7 aspects of the history and the exam that would be
8 relevant for the testing that we were doing.

9 Q. Okay.

10 A. And so, you know, I don't have anything
11 in this little note about how long he had chest
12 pain, where it was, et cetera. It's just a little
13 summary, and as such, I certainly stand by what
14 I've got in this brief paragraph.

15 Q. Okay. And -- and -- and you record in
16 there that he was having left arm, shoulder and
17 chest pain.

18 A. I just have here he had left shoulder and
19 chest pain.

20 Q. Now -- and Counsel asked you about
21 whether Dr. Dasgupta had recorded anything in his
22 history about chest pain. And I'm going to ask
23 you to look at Dr. -- do you have Dr. Dasgupta's
24 on your --

25 A. I should. I do have it here.

1 Q. I've got it right here. I'll just --

2 A. Yeah.

3 Q. -- ask you.

4 MR. BAYNE: It's the May -- the office
5 consultation?

6 MR. MCDANIEL: May 28th.

7 THE WITNESS: May 28th, 2013?

8 BY MR. MCDANIEL:

9 Q. Office consultation. That's would be the
10 report we're referring to.

11 A. Yeah. Uh-huh.

12 Q. Look at the second sentence that begins,
13 "A review of his records today shows."

14 A. Uh-huh.

15 Q. All right. And then after that he goes
16 on. He says, "Since -- since -- he had electrical
17 shock five days ago and since then." So in
18 reference to the symptoms that Dr. Dasgupta -- and
19 him being your partner, records that. And since
20 then he has complained of pain.

21 Would it be your understanding and is it
22 consistent with the history that you took from
23 Mr. Winfrey that everything started after this
24 electrical shock?

25 A. That's my understanding.

1 Q. Okay. All right. Now, let's look at,
2 then, what Dr. Dasgupta recorded. He said, "He
3 has complained of pain in his left shoulder

4 radiating to his left scapula region, the left
5 side of his neck, left infraclavicular region."

6 Am I right that when you refer to the
7 scapula and clavicular region we're talking about
8 the shoulder and front part of the shoulder?

9 A. Well, infraclavicular means below the
10 collarbone.

11 Q. Okay.

12 A. Yeah.

13 Q. So, in other words, if Mr. Winfrey was
14 reporting that his pain was -- after the shock he
15 had pain in his hand, arm, up into his shoulder
16 and when he -- when he uses his hand and would
17 place it in -- with my fingers on top of the
18 shoulder and then my hand extending into the front
19 of the chest, would that be consistent with the
20 description that he's given Dr. Dasgupta there?

21 A. Yes.

22 Q. All right. And then so is that basically
23 the same thing that he's recording here as saying
24 that he's having pain in the upper part of his
25 chest or on the left side?

1 A. It's all consistent.

2 Q. Okay. I just wanted to clarify that
3 because -- because of just the word -- the very

4 detailed description Dr. Dasgupta gave versus just
5 simply saying "chest pain." Now ...

6 A. I will also tell you that the next person
7 to take a history gets a different history.

8 Q. Right. Actually, as a matter of fact,
9 Doctor, I use that. I tell my clients all the
10 time if they -- if I ask them the same thing five
11 different days in a row, they're going to tell me
12 five different things, not because they're trying
13 to lie to me, but because it's just -- it'll be a
14 little different consistency.

15 Let me ask you this. There's been some
16 discussion about 480 volts, and I'm going to show
17 you Dr. Greenfield's note who referred him to
18 Dr. Dasgupta, and I'll just ask you to look at the
19 right side of that note under the history that she
20 took. Do could you see "480 V rotisserie shock"?

21 A. I see that.

22 Q. And it shows that it occurred on
23 Thursday, and I believe it refers to sweating
24 that -- that evening. Is that -- do you see that?

25 A. Well, it may be referring to woke up

1 sweating this a.m.

2 Q. Well, it's also sweating and -- okay.

3 A. It's a little hard to tell --

4 Q. Okay.

5 A. -- what -- what that --

6 Q. Well, she testified that -- that she --
7 what she recorded, the shock on Thursday, sweating
8 Thursday p.m., woke up sweating this a.m.

9 A. Uh-huh.

10 Q. That he had had sweating following the --
11 the evening after the shock. Let me ask you. I
12 don't want to make this -- I'm trying to make this
13 not too long. You referred that when you did the
14 heart catheterization that you took some
15 pictures.

16 A. Yes.

17 Q. Is there anything -- and you say would we
18 like to see them. And my question to you, really,
19 though, is, Dr. Travis has testified that he held
20 this man's heart in his hands. He looked at it.
21 You actually did a heart catheterization and you
22 have pictures. Dr. Feldman said the only thing
23 he's reviewed is records.

24 The -- would -- would those picture that
25 you took lend anything in reference to your

1 opinion in this case as far as, you know -- I
2 mean, is it your opinion that -- that his problems
3 with his heart, based on the history and

4 everything you saw, is it still your opinion that
5 it was caused by this electrical shock?

6 A. It is. We did find -- you know, we did
7 find that he had atherosclerosis as well.

8 Q. Okay. I mean, so Dr. Feldman actually
9 testified that many times a plaque rupture is
10 caused by some type of stress, either physical or
11 emotional stress, there's many, many studies that
12 show that, and that -- that the shock was a
13 possible cause to the stress that caused the
14 sheering force causing the plaque rupture.

15 My question to you is -- here again, I
16 want to go back to the pictures. Are there any --
17 do you think there's anything you could tell that
18 would help us one way or the other in reference to
19 what you saw and what those pictures reveal as far
20 as damage that would, you know, either strengthen
21 or add to your opinion in -- in reference to
22 the -- the electrical shock?

23 A. There's nothing on the pictures that's
24 not reflected in the written report.

25 Q. Okay. And so there's -- is there any

1 question that a plaque rupture can lead to --
2 well, lead to a myocardial infarction which can
3 lead to a VSD? Is that a --

4 A. That -- there's no question that that
5 sequence of events can occur.

6 Q. Okay. All right. And -- and so either
7 the shock in your opinion could have caused the
8 damage that resulted in the myocardial infarction
9 and the VSD or it could have caused the rupture
10 that lead to the blockage, the myocardial
11 infarction which lead to the VSD. Is that a fair
12 statement of --

13 A. I think there's no question that the
14 shock can cause the burn injury that -- that
15 damages the heart muscle and -- and then leads to
16 the VSD. I don't know of any -- I don't know the
17 mechanism --

18 Q. Right.

19 A. -- by which the shock would -- would --
20 would exactly lead to blockage in the coronary
21 artery causing the -- the myocardial infarction in
22 the conventional sense. Certainly there's lots of
23 data indicating that in stressful times they're
24 more myocardial infarctions and more cardiac
25 deaths, and there have been population studies of

1 people after earthquakes and fires and whatever
2 that usually show a slight increase in -- in
3 occurrence.

4 You know, how many people died in South
5 Carolina after Hurricane Hugo. You know, it
6 looked like there was a little blip in the death
7 rate in the next few days, maybe ten extra deaths,
8 something like that.

9 Q. Right.

10 A. But -- but I don't know exactly what the
11 mechanism is -- is for that.

12 Q. Okay. But there's a clear correlation
13 between stress as being a -- a cause of myocardial
14 infarction or, you know, in other words, the
15 plaque rupture and that type of thing.

16 A. There -- there is a temporal association
17 between stressful events and increased risk of
18 myocardial infarction.

19 Q. And the reason I asked you originally
20 about the -- the -- the domino effect, either that
21 the heart attack -- it -- it -- by the way, let me
22 ask you this. Is it unusual that somebody has a
23 heart attack and then they don't show up for like
24 five days later?

25 A. Most people show up before five days but

1 population studies would suggest that perhaps as
2 many as 25 percent of -- of heart attacks that
3 people survive are not recognized immediately. A

4 person who has it doesn't have enough symptoms to
5 recognize that it's a heart attack, doesn't go to
6 the hospital, and it's discovered later and --
7 when they have an EKG or some other test.

8 Q. Of course, in this case we have -- and
9 one of the normal -- a very usual presentation is
10 left hand and arm and shoulder pain for a heart
11 attack, correct?

12 A. (Witness nodding head.)

13 Q. And so -- and we all agree that this
14 man's electrical shock came to his left hand and
15 he immediately and since then up until the time he
16 went to Dr. Greenfield was experiencing hand, arm
17 and shoulder pain.

18 A. Right. Right.

19 Q. Would it -- there -- would there be any
20 way for the patient to distinguish between those
21 two, just an average layperson?

22 A. Probably not.

23 Q. Okay. Now -- now I want to go back to
24 what I was asking you about, the -- the one series
25 of plaque rupture leading to the myocardial

1 infarction leading to the VSD or the heart muscle,
2 as you said, being damaged immediately from the
3 electrical shock. Let's just refer to one of
4 those as being absolutely direct and the other one
5 being indirect cause.

6 But in your opinion, based on this
7 history and everything you observed and your
8 conversations with Mr. Winfrey and this history
9 and development of his problems, is it your
10 opinion that -- that this electrical shock, is it
11 still your opinion that this electrical shock
12 caused all the problems that lead to him coming to
13 see you?

14 A. That is my opinion --

15 Q. Okay.

16 A. -- that -- that the electrical shock was
17 the proximate cause of -- of all this illness.

18 Q. Okay. And that's stated to a reasonable
19 degree of medical certainty?

20 A. As certain as I can be.

21 MR. MCDANIEL: Okay. All right. Doctor,
22 I'm not going to belate anything any further.
23 Thank you very much.

24 - - -

25 REEXAMINATION

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BY MR. BAYNE:

Q. Doctor, I just have a few follow-up questions.

A. Uh-huh.

Q. The left arm and shoulder pain that -- that Mr. Winfrey(sic) just asked you about, in a heart attack case when you're experiencing the left arm and shoulder pain, it is not pain that is tender to the touch or it's not typically pain associated with, for example, running into a door and bashing your shoulder into it, is it?

A. It's typically not pain relieved by changes in position, but people are different. Some people have, you know, as I say, no pain that they recognize as being something serious, and other people have excruciating pain, and it's very variable.

Q. Okay. And Dr. Greenfield, when she observed Mr. Winfrey and when she gave her deposition, she talked about the fact that the left arm pain and shoulder pain that Mr. Winfrey was having was tender to the touch. It was more indicative of an injury to the arm than it was of a heart attack. Would you agree that -- that --

1 would you agree with her assessment, I guess, that
2 when you have pain that's more indicative of an
3 actual injury to the arm that it is not the same
4 type of pain you're going to suffer with a heart
5 attack injury?

6 A. Well, I don't have any opinion about
7 Dr. Greenfield and her assessment of it that was,
8 you know, before me, and I didn't have any
9 specific contact with -- with Dr. Greenfield. I
10 can just say the -- you know, we would probably
11 have expected this patient to have pain related to
12 the shock, and if the shock was in the left upper
13 extremity, it wouldn't surprise me if it involved
14 the arm and shoulder as well as the hand. I can't
15 say anything about any other pain that he had.

16 Q. I think you mentioned that -- that
17 every -- every person who takes a history may get
18 a different -- you know, there may be something
19 added, may be something removed depending on what
20 exactly is going on at that time when they
21 presented to you.

22 Again, going back to Dr. Greenfield
23 briefly, if her testimony and her records indicate
24 that the -- Mr. Winfrey had no chest pressure and
25 that he did not experience any chest pain or heart

1 attack symptoms from Thursday on the day of the
2 shock until he presented that morning, would --
3 would you have any reason to dispute her

4 understanding of his history at that time?

5 A. I don't have any reason to -- to dispute
6 it. Although, as I've said, he's got all this
7 pain in his upper extremity from -- from the
8 shock. If he has pain in the same area from his
9 myocardial infarction, he's not going to be able
10 to tell the difference.

11 Q. But that pain in the upper extremity, you
12 can't say for a certainty that it was caused
13 because of the heart attack versus simply jerking
14 away from the machine and landing against another
15 machine at the facility he was working at.

16 A. I think that's correct. Yeah.

17 Q. Mr. McDaniel had asked you about stress
18 causing the plaque rupture, if the -- if the
19 mechanism of injury was plaque rupture infarction,
20 VSD, that -- that, for example, the stress of the
21 electrical shock can cause that plaque rupture.
22 Is it correct or am I correct in saying that there
23 is no way to know, though, what stress would cause
24 a plaque rupture?

25 A. That is correct.

1 Q. In other words --

2 A. And it's also true -- you know, y'all
3 keep using the term "plaque rupture." That's not
4 the only mechanism by which blood clots in
5 arteries and blocks arteries.

6 Q. Well --

7 A. A lot of these plaques are not ruptured.
8 They're just -- when they have an eroded surface
9 and -- and platelets aggregate on them, and the
10 next thing you know, you have a clot there
11 without -- without plaque rupture. Plaque rupture
12 is not an essential component to -- to coronary
13 thrombosis.

14 Q. Well, for either the -- I guess the
15 plaque rupture or just where you said it erodes
16 away and stops blood flow. Is that right? To
17 the -- certain parts of the heart.

18 A. You may have an erosion of the
19 endothelium, the -- the thin layers of cells that
20 is the innermost lining of the artery such that
21 blood clots there.

22 Q. And would that also be caused by an
23 outside stressor of some sort?

24 A. Hard to know.

25 Q. It could be caused by -- by nothing at

1 all? It could just happen?

2 A. Most of the time when people have
3 myocardial infarctions, we don't -- we're not able
4 to identify any specific stressor most of the
5 time.

6 Q. And in this case there is no way other
7 than, again, the proximity in time to electrical
8 shock to identify any stressor that -- that could
9 have caused his heart condition; is that right?

10 A. I guess that's correct.

11 MR. BAYNE: That's all the questions I
12 have.

13 MR. MCDANIEL: I did forget to ask you a
14 couple of questions. I'm trying to be very
15 brief.

16 (Pause.)

17 Actually, no further questions. No more
18 questions.

19 MR. BAYNE: Thank you, Doctor.

20 - - -

21 (Witness excused.)

22 - - -

23 (Deposition concluded at 8:39 a.m.)

24 - - -

25

CERTIFICATE OF REPORTER

I, Deidre Osborne, Court Reporter and
Notary Public for the State of South Carolina at
Large, do hereby certify:

That the proceedings and evidence are
contained fully and accurately in the notes taken
by me in the above cause and that it is a correct
transcript of the same.

I further certify that I am neither
related to nor counsel for any party to the cause
pending or interested in the events thereof.
Witness my hand, I have hereunto affixed my
official seal this 23rd day of January, 2014, at
Lexington County, South Carolina.

Deidre Osborne,
Court Reporter
Notary Public
State of South Carolina at Large
My Commission Expires:
June 12, 2019

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[words - years]

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STATE OF SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

COUNTY OF RICHLAND

WCC CASE NO.

CLARENCE WINFREY,)

1306305

CLAIMANT/EMPLOYEE,)

-VS-)

ARCHWAY SERVICES, INC.,)

EMPLOYER,)

AMERICAN FIRE and CASUALTY)

INSURANCE,)

INSURER,)

Deposition of JEFFREY TRAVIS, a witness called by
Counsel on behalf of the DEFENDANT, pursuant to the
applicable provisions of the South Carolina Rules of
Civil Procedure, taken before Timothy Robinton, a
Professional Court Reporter and Notary Public in and for
the State of South Carolina, on Monday, December 16,
2013, at The Lexington Cardiovascular Surgery, 2728
Sunset Blvd. Suite 101, Columbia, South Carolina,
commencing at the hour of 7:00 a.m.

Job No. CS1783715

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EXHIBITS

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Plaintiff	
Exhibit No. 1	Letter from Jeffrey A. Travis . . 26

LEGEND OF THE TRANSCRIPT

dashes [--]	intentional or purposeful interruption
[ph]	denotes phonetically written
[sic]	written as said

S T I P U L A T I O N S

It is hereby stipulated and agreed by counsel
for the respective parties that the Witness will
waive the reading and signing of the deposition
transcript, and also that the witness is a expert
in the field.

Whereupon,

JEFFERY A. TRAVIS,
having been first duly sworn,
was examined and testified as follows:

DIRECT EXAMINATION

BY MR. BAYNE:

Q. Doctor Travis, how are you doing today?

A. Good. How are you?

Q. Good. My name is Brad Bayne I am an attorney with
McAngus Goudelock & Courie. I represent Archway
Services and America Fire and Casualty Insurance Company
in this case related to Mr. Clarence Winfrey. At this
time it's a denied claim based on an investigation that
we conducted. It's my understanding that you conducted
or you performed the heart surgery on Mr. Winfrey when
he presented to the hospital so we are here today to ask
a few questions about that. Mostly related to

1 causation, his health history and kind of going forward
2 what needs to be done if the commission determines this
3 claim is dispensable. Do you have any questions before

4 I get started?

5 A. No.

6 Q. Can you give me just a brief run down what your
7 background is, your qualification and everything?

8 A. Sure. Medical Physician finish medical school in
9 1997, attended General Surgeon residency six years at
10 Wake Forest finished fellowship at Wake Forest as
11 Cardiothoracic surgery and been practicing about nine
12 years.

13 Q. And a day to day bases what do you in your
14 practice?

15 A. Open heart surgery, thorastic surgery, including
16 Lung surgery, Esophageal surgery, Vascular surgery,
17 Carotid in pumps and Triple A's.

18 Q. How many heart surgeries have you performed in your
19 nine years plus your fellowship?

20 A. About -- Including fellowship probably about 1500,
21 since I have in private practice about a 1000.

22 Q. Okay. Have you any occasion treat Mr. Winfrey in
23 this case?

24 A. I did.

25 Q. And what did you treat Mr. Winfrey for?

1 A. Specifically had a ventricular septal defect was
2 the primary presenting problem?

3 Q. And what is a ventricular septal defect?

4 A. There is a septum between the two ventricles, the
5 right, left ventricle and because the tissue having died
6 between those two septum hole developed or defect, so
7 blood went from one side to the other which is
8 anatomically incorrect and not compatible with long term
9 survival.

10 Q. Okay. That hole is inside of the heart?

11 A. Correct.

12 Q. Okay. And when Mr. Winfrey presented to you what
13 were his complaints at the time?

14 A. He had chest pain, shortness of breath and he just
15 kind of had full body aches all over for four or five
16 days prior to the presentation.

17 Q. Okay. I believe that day he presented been May
18 28th is that correct?

19 A. If that's what record reflects

20 Q. On that morning -- I guess he didn't present to you
21 first thing that morning, he was referred?

22 A. Correct.

23 Q. And if the medical records from that referral
24 indicate that he did not have any chest pressure would
25 that be consistent with what he presented with that

1 morning or did he have some --

2 A. When I saw him that was not his specific complaint.
3 he did not relate this specifically to -- what he would
4 considered or what we considered a heart attack pain and
5 he said he had kind of total body didn't feel well all
6 over.

7 Q. And is that typical of someone that has suffered
8 from a ventricular septal defect?

9 A. In general, someone who has post in-fart VSD,
10 ventricular septal defect will present with chest pain,
11 other words they do have acute heart attack, that's what
12 causes the ventricular septal defect.

13 Q. Okay. So, usually, they would, but it's not
14 certainty that they'll have chest pain?

15 A. No. Not everybody has chest pain, but a majority,
16 a great majority people will.

17 Q. You said post in-fart, is that a mild cardio
18 infarction your talking about?

19 A. Correct.

20 Q. Okay. And in this case I think the records had
21 indicated they he had a mild cardio infarction, and then
22 -- I think you said a post in-fart VSD is that correct?

23 A. Mostly likely. Yes, sir.

24 Q. Okay. Is that something like, I don't know, how
25 things in current time, is that infarction would occur

1 days before and then the VSD happened or is it
2 essentially the infarction, the VSD and then within
3 seconds kind of thing?

4 A. In general it takes a little bit of time before the
5 VSD fully develops other words you suffer the infarction
6 and sometime within 36 hours after that, depending on
7 the exact presentation. The muscle dies, as the muscle
8 dies it gets weak, the blood pushes through it, creates
9 the defect, --

10 Q. Okay.

11 A. -- usually there's a time lapse there.

12 Q. So based on that are you able to determine when the
13 infarction occurred in this case?

14 A. Not specifically, no.

15 Q. Is there's time - like a -- ballpark time frame
16 that you're able to back up to figure out?

17 A. It happened sometime with in the last week based on
18 his cardio enzymes.

19 Q. Okay. I believe that you've issued a questionnaire
20 in this case, you've indicated that his condition was
21 brought about by electrical shock of 480 volts is that
22 correct?

23 A. I believe it, absolutely, had cause the defect on
24 this presentation.

25 Q. And I wanted to ask specifically about the 480

1 volts, is that something you were able to determine from
2 looking at the equipment or --

3 A. No. I wouldn't have any knowledge of the amount of
4 voltage or the pertinence that.

5 Q. So that would be -- so if that was your opinion
6 that would be based on what you were told by Mr.
7 Winfrey?

8 A. Correct.

9 Q. Okay. Do you have any opinion or knowledge as to
10 what amount of electricity it would take to cause this
11 infarction or is it a case by case, how does that work?

12 A. It would be a case by case bases, it's not a --

13 Q. Okay. What I am asking, generally is, if for
14 example it was 400 volts or 300 volts or 200 volts is
15 there a point at which a shock is so small it's not
16 going to cause an infarction or a point which you hit is
17 becomes more likely and more likely that it's going to
18 cause a mild cardio infarction.

19 A. I think that's known, as far as, a gradation.

20 Q. Okay. And Mr. Winfrey in his deposition, I
21 believe, he indicated that he was at work and he
22 suffered from electrical shock working on a rotisserie
23 oven. Is it your understanding that or your believe
24 that's when the mild cardio infarction occurred, when
25 that shock occurred or something that would have

1 occurred later in the day?

2 A. I think it would of occurred within, you know,
3 minutes, hours after that.

4 Q. Okay. In a immediate aftermath of suffering that
5 infarction, so he gets shocked and it minutes to hours
6 after. What in a typical patient what would he be
7 experiencing as far as pain related symptoms or
8 complaints?

9 A. In general, in most people again as we discussed
10 have chest pain a lot of people will interpret that
11 differently. Certainly people will have shortness of
12 breath as a lot of people presenting symptoms of a heart
13 attack or simply or just I don't feel well, shortness of
14 breath they don't truly describe chest pain some people
15 are dull pain. It can be referred in a lot of different
16 ways. And then again, a lot of people don't have the
17 typical pressure or pain they have other symptomatology,
18 nausea or vomiting.

19 Q. Would some who was experiencing mild cardio
20 infarction be able to continue work that day?

21 A. Sometimes they are.

22 Q. Okay.

23 A. Sometimes they can.

24 Q. What about the next day would they, as it developed
25 and progress, would they be able to return to work that

1 day as well?

2 A. I have seen people you know struggle through mild
3 cardio infarction for one, two, three, four days and
4 just continue to push through their normal live even
5 though --

6 Q. And as in a scenario in which that occurred where
7 they suffered it and worked or kept and stayed at home,
8 work their kids or whatever. Would those symptoms be
9 worsting on a daily bases or is kind of a plateau?

10 A. Most people will plateau with in 36 to 48 hours but
11 not always.

12 Q. Okay.

13 A. And sometimes it continues to conscendo and that's
14 what brings them into the hospital, so that's why we see
15 them at variable times.

16 Q. And in the medical records, I think they were your
17 records related to the surgery you did, you found that
18 he had three vessel, I believe, artery disease, is that
19 something related to this electrical shock or is that a
20 congenital condition he had?

21 A. Well, not a congenital, but an acquire over his
22 life time.

23 Q. Okay. And what would cause someone to acquire that
24 over their life time?

25 A. After a Socratic cardio vascular disease caused by

1 high blood pressure, diabetes, elevated cholesterol
2 family history, cigarette smoking.

3 Q. Pretty much the whole gamete.

4 A. Yeah.

5 Q. Okay. And someone -- so someone for example who
6 smoke a pack a day or a half a pack a day would be an
7 increase risk for that?

8 A. Absolutely.

9 Q. Someone who drank a case a beer a week would be an
10 increase risk to that.

11 A. In general drinking it's not directly correlated to
12 coronary disease.

13 Q. Okay. If someone had a family history of close
14 relatives who suffering from coronary artery disease
15 that would be a risk factor?

16 A. Most likely.

17 Q. Okay. In the medical records it also talks about a
18 occlusion I believe of the coronary artery, is that a
19 condition that resulted from the electrical shock or is
20 that part of the artery disease he had acquire over his
21 life time?

22 A. I think it was related to the electrical shock.
23 Let me explain that just a little bit, you have
24 arterosclerosis or the hardening of the arteries, so you
25 have plaque in your arteries, because there at a base

1 line, based on those things that we talked about and
2 then some, every heart attack is caused by some process
3 causing that plaque to rupture. And so what you have an
4 injury or cut, basically, inside the artery and the body
5 tries to heal that much as it tries to heal a cut on
6 your skin it tries to form a scab, but instead it the
7 scab is forming inside an artery, and so the scab forms
8 and causes that artery to completely occlude . So it
9 doesn't matter if the plaque was ten percent blockage,
10 twenty, thirty, forty, whatever, it goes to 100 percent
11 because the blood begins to clot within the artery. So
12 that's why the artery becomes occluded, that's why
13 people have heart attacks.

14 Q. Okay. And so the -- I guess the question is the
15 plaque build up that was the occlusion. Was that plaque
16 build up directly caused by the electrical shock or did
17 the rupture of that plaque build up?

18 A. The rupture of the plaque is what causes the acute
19 heart attack.

20 Q. Okay.

21 A. The build up happens over years and then it can be
22 any sort of activity that can cause that to rupture.

23 Q. Okay. So for in this scenario if the electrical
24 shock is what caused it, it would be the shock caused
25 the rupture, that then caused the heart attack, and then

1 caused the VSD?

2 A. Correct.

3 Q. Okay. But that plaque rupture could occur as you

4 said, it could occur for many things --

5 A. It can.

6 Q. -- from getting up the wrong way, strenuous
7 activities something like that.

8 A. It can. A stressful event in your life. People
9 that walk in and find a love one dead it can trigger
10 that any type of stress. Or whether it be physical,
11 emotional.

12 Q. And other than the timing of the heart attack, as far
13 as, some time of last week, there's way to know for
14 certain the plaque rupture was caused by the electrical
15 shock, is that correct?

16 A. Is there any definitive way to --

17 Q. Correct.

18 A. -- collate one to another absolutely not.

19 Q. It's more likely not, I guess. This is your
20 opinion on it?

21 A. Correct.

22 Q. Okay. As far as, his treatment goes, what is, I
23 guess once he goes through -- going cardio
24 rehabilitation right now, is that correct? As far as,
25 that treatment goes once he's completed with that care,

1 what is his prognoses or what is his outlook, both for
2 life and for getting back to normal life?

3 A. It certainly most of that depends on ventricular
4 function which is fairly reduced and also depends on his
5 other coronary disease and how stable that stays over
6 time.

7 Q. Okay.

8 A. I'm certainly think he has a short life span and
9 based on his ventricular function difficulty and
10 returning to full activities that he able to
11 accomplished before all this.

12 Q. And is the fact that the coronary disease existed
13 previously that he had acquired, the fact that exist is
14 that something that effects his recovery from the VSD
15 that he suffered?

16 A. It's more related what his ventricular function is
17 going to inhibit his -- I don't know what his
18 ventricular function was prior to all this. We see him
19 at time zero, I don't know what was at t minus one. His
20 ventricular function was normal at that point than
21 certainly this is correlated with his increase of
22 disability, but I don't know what that, that --

23 Q. As a general kind of hypothetical someone presents
24 with type of artery disease that he had absent the VSD
25 is there a reduce ventricular function in a patient that

1 would present with all the symptoms he had except for
2 what you believed caused by the shock?

3 A. In general, no. In general there ventricular
4 function can be anywhere, again there's a thousand
5 different factors that go into that.

6 Q. In the medical reports I believe in the post
7 surgical report you talked about seeing, I guess white
8 marks on either other side of the heart --

9 A. Correct.

10 Q. -- what, I think your opinion was, that probably
11 caused or most likely caused by an electrical shock,
12 entering and exiting the heart, is that correct?

13 A. Correct.

14 Q. Have you've seen anything like that in your career
15 prior to that point?

16 A. Not with the heart, I've certainly seen electrical
17 injuries, when I took care of burn patients, you would
18 see people that were burn electrically and you would see
19 the type of changes as it entered or exited the
20 extremity which is more common. I've never seen it on a
21 heart, I've never seen anything that looked liked that
22 on the heart.

23 Q. Okay.

24 A. That's what made me think this was related to his
25 electrical injury, certainly, looked like a entry, exit

1 wound. It's shriveled, drawn up, kind of welded
2 together around the tissues around it, so I have seen it
3 in other locations, I've never seen it in the heart.

4 Q. Would the electricity if that -- if those marks are
5 indicative of that, would that electricity, I guess,
6 going through the heart had caused any issues other than
7 it may have led to the infarction itself?

8 A. It could of rupture the plaque led to the
9 infarction. I don't think it was directly related to
10 the -- I don't think it made a hole in the heart,

11 Q. Okay.

12 A. -- I think the hole in the heart came from the
13 infarction you know muscle dying over time and the hole
14 developing. I do think it could relate to any
15 electrical disturbance in the heart and ventricular
16 function.

17 Q. Okay.

18 A. Those are the things that it could effect.

19 Q. And in examining Mr. Winfrey, I guess prior to and
20 after surgery where you able to determine if there were
21 any exit wounds from the body of the electricity other
22 than what you observed in the heart, so did it come out
23 of his hand, foot?

24 A. I didn't observe any. No, sir.

25 Q. And in your practice have you've been involved -- I

1 guess you did the surgeries, are you involved in the
2 post cardiac care, as far as, the rehabilitation for
3 returning someone to work or returning someone to their
4 normal live, or do you --

5 A. I am.

6 Q. Okay. As far as, just a generic heart patient
7 someone that came in and had that ventricular defect,
8 that we talked about just kind of what, what based on
9 ventricular function, but, as far as, for example, going
10 back to our is there a level of work no heart patient
11 should go back to or is it a case by case bases?

12 A. It's always a case by case.

13 Q. Okay. And in someone like Mr. Winfrey's case do
14 you have an opinion yet, is to what, whether or not he
15 be able to return to work or is it still to early to
16 tell in his care?

17 A. I think based on his recovery he could return to
18 some form of work. Correct.

19 Q. Do you think he could be able to return being an
20 electrician or is that an area you would advise he
21 avoid?

22 A. I would advise him to avoid that.

23 Q. Is that because of the risk of electrical shock or
24 is that based on the nature of work?

25 A. A little bit of both.

1 Q. Okay. What is a rough time frame of being able to
2 return to work after a surgery like this?

3 A. In general most open heart surgery patients are
4 ready to go back to work in sometimes two to three
5 months. This is a little bit bigger type problem. I
6 could tell you that I've never had anybody who had this
7 particular injury make it back to work, most people
8 don't live through this. It is very uncommon for people
9 to live through this so.

10 Q. Okay. And your referring to the --

11 A. VSD.

12 Q. -- VSD

13 A. Yes, VSD.

14 Q. Is that based on where it was located or just the
15 fact it was as large as it was or --

16 A. Just --

17 Q. Just happened --

18 A. -- difficult problem to fix -- it's hard to fix.

19 Q. All right. Once it's fixed, absence some, for
20 example, another electrical shock or something like
21 that, is it an issue that it's going to remain fix or is
22 he kind of going to always be at risk of that patch that
23 was placed rupturing again?

24 A. I think he is at very low risk.

25 Q. Okay.

1 A. Again most -- I don't know of any people that have
2 been followed for twenty years this problem. I think
3 it's a low risk, once it's fixed it should be fixed.

4 Q. Okay. And just to clarify one thing on the plaque
5 rupture itself, the causation of it. You testified that
6 it's -- I guess it's possible or in practice it's
7 possible that those incur from any number stimuli's via
8 physical activity, stress, you said walking in on a
9 loved one that kind of thing?

10 A. Correct. And some people it could happens in the
11 middle of the night while they are sleeping.

12 Q. It could happen.

13 A. Yes.

14 Q. Okay.

15 MR. BAYNE: I believe that is all I have.

16 Preston, do you have anything.

17 MR. MCDANIEL: I got a few questions.

18 CROSS EXAMINATION

19 MR. MCDANIEL:

20 Q. It's been since May that you, actually, had an
21 opportunity to look back at the actual presented history
22 will that be fair?

23 A. Yes, sir.

24 Q. All right. I wanted to ask you a couple of
25 questions in reference to your operate note and found

1 that he had very significant per carditis --

2 A. Right.

3 Q. --I believe that basically inflammation --

4 A. Correct.

5 Q. -- and that presents as far as symptoms your going
6 to have, that presents jointlage pain.

7 A. Correct.

8 Q. Okay. In looking over that, correct me if I'm
9 wrong. A lot of times as you've already testified
10 people don't have chest pain, but I saw and lived here a
11 lot of times the pain is in the neck and over the
12 trapazees area of the shoulder or into the left arm.

13 A. That's correct.

14 Q. Is that a general presenting type process, or that
15 when sustain a mild cardio infarction?

16 A. It is, again presentation can be varied, I mean
17 some people just get shortness of breath or they fell
18 they have reflux, left arm pain, left jaw pain, neck
19 pain all those common in presenting signs and symptoms
20 for a heart attack.

21 Q. And the reason I am asking that is. And I believe,
22 of course your aware, -- had the history available from
23 the emergency doctor that who saw him at the Doctor's
24 Care, then the Cardiologist's who saw him, then sent him
25 directly by ambulance to the hospital. And does this

1 sound familiar on the based, this be the history that
2 you remember Mr. Winfrey presenting with -- when he said
3 that a fifty year old gentleman who on Wednesday prior
4 to admission was working on some electrical equipment
5 got a large shock, he went home from work and experience
6 significant chest pain as well as back and shoulder
7 pain, persisted through the weekend and he really did
8 not do much of the weekend. Then the doctor at the
9 Doctor's care recorded that, he's working got a
10 rotisserie shock on Thursday, sweated Thursday p.m. he
11 had pain immediately down the left shoulder, in the left
12 arm, and had jerk his neck and shoulder -- neck and
13 shoulder pain, tenderness over the left trapezes and
14 that's the area we referred to earlier, an entrance
15 wound on the third finger of the left hand. Is that
16 typical that left arm, left shoulder, neck pain, again I
17 believe you already said that is typical of
18 presentation.

19 A. It is.

20 Q. All right. So, let me then ask you this. I'm
21 going to show you a report that you were kind enough to
22 -- when you knew the causation was an issue, you issued
23 that report on September 30th. 2013. Does that
24 represent you're opinions and reference to this?

25 A. It does.

1 Q. I just want to ask you again. I know Mr. Bayne
2 went over this, but just in summary fashion would you
3 just tell me -- I just hand you copy of your optative
4 note, but just specifically -- just tell me -- and you
5 already testified, you haven't seen anything like this
6 before -- just tell me in your own words, basically,
7 what you observed, and just tell me what formulated this
8 opinion, that my opinion, my understanding, you believed
9 everything that caused him, required treatment by you
10 and the open heart surgery stemmed from this electrical
11 shock.

12 A. Right. And so if you mean, your asking me to put
13 together a time line of events. So he's working under
14 goes electrical shock that causes a plaque rupture
15 causing a heart attack. He feels bad all over has some
16 chest pain, pain other places related to that would be
17 typical, goes home and just tries to gut it out sort of
18 speak doesn't get better, finally shows up to the
19 emergency room or urgent care, the signs and symptoms in
20 the EKG changes components is consistence with him
21 having a heart attack. Brought over to the hospital,
22 optimally taken to the CAT lab found that has blockage
23 that we saw where there was 100 percent occluded artery,
24 including VSD, so sometime along that time course this
25 heart attack caused that muscle to die, the blood pushed

1 through that dead muscle caused the VSD. You know when
2 I saw him it would seemed to me that, that was the
3 typical course of what happened. That he had a plaque
4 rupture, artery occluded, the muscle died, VSD presented
5 in that time course, all of that seemed very normal to
6 me. When we operate on him the thing that was different
7 to me, made me think that this was directly related to
8 the electrical shock and not just two events that happen
9 to co-inside was the amount of change that I saw in his
10 heart. Again what was definitely entry and exit wound
11 where the Peri-cardiac was almost fused like you would
12 weld something together and that was Per carditis. It's
13 not a typical Per carditis that people have after a
14 heart attack, that it's global it's every where, it's
15 just kind of a general Per carditis, this was different
16 these were specific areas interior, posterior. We
17 really had to do a lot of work to clean those off to get
18 the Pericardium which is the sack around the heart off
19 the heart, off the heart proper, almost again, welded to
20 it on the front and back so we can pick the heart up to
21 actually work on it, it really took us thirty minutes to
22 get that done before we really start the operation, so
23 it was after operating on him that it seemed to me that
24 this electrical shock was directly related to the
25 primary problem that he presented with even though he

1 might of have a life long condition coronary disease,
2 I'm sure he did or after arteriosclerosis, I'm sure he
3 did, but I was fairly convinced this electrical shock
4 passed through his heart, it was likely the causative
5 event that started the domino effect. Again a lot of
6 things were in place already, but that electrical shock
7 was the thing that pushed the first domino over and
8 everything that we saw after that followed it. That's
9 just my opinion

10 Q. You also used the term soldier plaques.

11 A. Correct.

12 Q. And tell me about those.

13 A. We find sometimes on the heart what are called
14 soldiers plaque again that just kind of a nomenclature
15 that's been pasted down, they'll just be quarter size,
16 silver dollar size, white areas on the heart. That
17 don't have any type of reason or obvious you know
18 causation you find them variable, I don't know one or
19 two percent of hearts that you operate on, you just see
20 this little white -- whitish plaque areas. They are not
21 inflammatory they are not stuck to anything and they
22 have just passed down through -- along people just
23 called soldier plaques. We don't know what causes them,
24 we don't know why they are there, there just there. And
25 so, you know, I dictated that specifically because this

1 was very different. This was not just simple soldier
2 plaques that we see sometimes, this was you know a
3 fusing and what you know kind of drawn up area, it was
4 whitish, but it was not soldier plaques that sometimes
5 we see.

6 Q. I'm not going to try and keep you much longer I'm
7 going to just ask you. If you could mark that as
8 Plaintiff's exhibit 1

9 MR. MCDANIEL: Mark that as Exhibit No. 1
10 Whereupon, the below described, Report was
11 marked Plaintiff's Exhibit No. 1

12 Q. Doctor, this is a report that was issued on
13 September 30th I believe you dictated that, does that
14 represent your opinions and reference to the causation
15 issue and you opinions about what caused Mr. Winfrey
16 condition?

17 A. That's correct.

18 Q. Is that your opinion to a reasonable degree of
19 certainty?

20 A. It is.

21 Q. Now, I want to ask you one other thing. One
22 conversation you were very nice enough just to call me
23 in reference to another physicians issued reviewed some
24 records and you made a statement to me I'm not forget.
25 You said I held this man's hand in my heart, his heart

1 in my hand. Tell me about how important you think that
2 is based on your observation and opinions in this case
3 as compared to somebody just reviewing records.

4 A. Well it's specifically was reviewed by a
5 cardiologist who has never done a open heart surgery.
6 He does all his works by looking at x-ray's and images.
7 So you know in this gentleman's case you know somebody
8 that, actually, operated on a heart held it in their
9 hands is very important in determine the causation,
10 again causing an effect here and I think anybody that
11 had been in my shoes that had looked at the heart and,
12 actually, seen it and had seen a thousand other hearts
13 have never looked like this that had this exact problem

14 I don't think you can draw any other conclusion, so
15 I think it's hard for somebody that's never seen a heart
16 that certainly never seen -- and also did not see Mr.
17 Winfrey heart, could just make that assumption based on
18 just records. I don't disagree with that's how most
19 heart attacks happen, that's how most VSD happens,
20 plaque rupture, MI, things rupture, but then to say para
21 partitas just post MI para partitas, when they never saw
22 what I saw and have actually never seen a heart. It's
23 just a little hard to say that you could -- your reading
24 ten percent of the important, you know, facts. A lot
25 of the facts are covered up or not revealed by just

1 reviewing the records I guess that was my point is, you
2 know that cardiologist who, one never seen a heart, two
3 never saw Mr. Winfrey's heart to make those assumptions.

4 I think is just a little bit of leap of faith, I just
5 think they have all the information.

6 Q. How much can you, actually, see, if you actually --
7 I know you filmed the heart, the surgery, is that
8 correct?

9 A. Well I have a picture. We just took a picture we
10 just thought, again something we never seen before.

11 Q. Oh okay. So you actually took a picture. So
12 another cardiovascular surgeon could look at that and
13 they would -- I guess you took it because it was so
14 unusual?

15 A. Correct.

16 Q. All right.

17 A. Which is not uncommon in the operating room, we
18 find things that are different, abnormal, education we
19 tried to report those so that others can learn and
20 experience.

21 Q. All right.

22 MR. MCDANIEL: Thank you very much I think
23 that is all the questions I have.

24 MR. BAYNE: I just have a couple of follow
25 ups Doctor if I may.

RE DIRECT EXAMINATION

Q. In the 1000 to 1500 surgeries you've done. Have you -- was this your first electrocution related open heart surgery or have you had those before?

A. No. It's the first one.

Q. Okay. Are you -- Have you consulted with anyone to find out if the plaques that you saw if that's kind of a normal thing in a electrocution type surgery or is that something or just to you a regular and --

A. Yeah. I never, I never, I didn't discuss this specifically, but I never read about it or seen anything. No.

Q. -- Okay. As far as, I think you said a second ago that the main driver of why you believed to cause this electrical shock was those plaques. Is that correct?

A. Correct.

Q. Okay. And I think you said it has to do with timing but the main thing you got in there, you said these plaques that's what this is, that's why you think it was caused by the electrical shock.

A. Right. Again most of the time we can't identify a specific causative trauma, so to speak, but here there was a specific cause of trauma that could of started again the whole domino effect.

Q. Is it possible that he was shocked and that and he

1 ends up with these plaques on his heart, but that is not
2 what actually caused the mild cardio infarction?

3 A. I think saying that the two things happened at the
4 same time but weren't related. I just don't think that
5 is plausible.

6 Q. Okay. And we were talking earlier, I was kind of
7 asking you about some symptoms he would be experiencing
8 and Mr. McDaniel went into the shoulder and the scapular
9 and the whole body pain, if -- if the record indicated
10 or the testimony indicated, that the only pain he was
11 experiencing until, say Friday, he was shocked on
12 Wednesday say until Friday, was neck pain, would that be
13 consistence with this mild cardio infarction or would
14 you expect more than just neck pain to be experiencing
15 --

16 A. No. It could be just neck pain.

17 Q. -- okay. And one more time your believe or the
18 records indicate that sometime with in the week prior to
19 him presenting to you when that infarction occurred?

20 A. Correct.

21 Q. Okay. Is there a more likely than not, for example
22 the week prior could mean that day before, but is it
23 more likely it occurred Wednesday, Thursday, than it did
24 on Sunday?

25 A. I don't remember specific days but the time frame

1 for a heart attack to lead to VSD is usually thirty six
2 hours.

3 Q. Okay.

4 A. And then any time after that within the next
5 probably two weeks is possible.

6 Q. Okay. So it would at least be thirty six hours old
7 and up to two weeks old?

8 A. Correct.

9 Q. Okay.

10 A. That would be the typical time for a post infarct
11 VSD.

12 Q. Okay.

13 MR. BAYNE: That's all I got.

14 MR. MCDANIEL: Nothing further.

15 MR. BAYNE: All right.

16 RE CROSS

17 MR. MCDANIEL:

18 Q. Doctor Travis, Mr. Bayne asked you about this being
19 the first known electrical open heart shock surgery that
20 you did, electrical shock -- but you testified earlier
21 that you seen many electrical shock patients where
22 you've seen the damage to the tissue and other parts of
23 the body.

24 A. Correct.

25 Q. And I believe you testified earlier of coarse you

1 did in these open heart surgeries you done cardio of all
2 types of thorastic surgery and all that, and worked on
3 burn patients?

4 A. Correct. Part of general surgery training is
5 taking care of trauma and burn patients.

6 Q. Okay. And so you have seen in the tissue damage --
7 type of tissue damage you saw in Mr. Winfrey's heart is
8 reminiscent of the tissue damage that you've seen in
9 other parts of the body?

10 A. Correct.

11 Q. Okay.

12 MR. MCDANIEL: Nothing further.

13 MR. BAYNE: No. I got nothing.

14 *

15 Deposition concluded at 7:40 a.m.

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STATE OF SOUTH CAROLINA
CERTIFICATE

Be it known that I, Timothy Robinton, a
Professional Court Reporter and Notary Public, did have
JEFFREY TRAVIS, appear before me on Monday, December 16,
2013, at 7:00 a.m., at The Lexington Cardiovascular
Surgery, 2728 Sunset Blvd. Suite 101, Columbia, South
Carolina;

That the witness was duly sworn under pains
and penalties of perjury to testify the truth, the whole
truth, and nothing but the truth;

That the foregoing pages constitute a true
and accurate transcription of the testimony given at
that time and place aforesaid to the best of my skill
and ability;

I further certify that I am not counsel or
kin to any of the parties to this cause of action, nor
am I interested in any matter of its outcome.

In Witness whereof, I have hereunto set my
hand and this 30th Day of December 2013.

Timothy M. Robinton,
Notary Public For South Carolina
My Commission Expires May 1, 2023



Jeffrey A. Travis, M.D.

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Lexington Medical Center



September 30, 2013

Re: Clarence Winfrey

To Whom It May Concern:

Mr. Winfrey is a patient who presented with a very unusual cardiac lesion after suffering a large electrical shock. The lesion, a ventricular septal defect, is normally only seen very rarely in a setting of an acute myocardial infarction. I believe that Mr. Winfrey's electrical shock caused his heart attack and his ventricular septal defect.

Operative photos confirm a large white patch on both sides of his heart that were almost certainly entrance and exit wounds of the electricity. I have never seen anything like these patches in my 15 years of surgery. I have a photo of the anterior surface of the heart that demonstrates either the entrance or exit site.

I find it quite unbelievable that his surgery and postoperative course have been considered separate from his electrical injury at work. I see almost no other plausible explanation other than a direct cause and effect.

Sincerely,

Jeffrey A. Travis, MD

&	7:40 32:15	areas 24:16 25:16	bayne 2:14 3:3,5
& 4:18	8	25:20	4:14,17 20:15 23:1
1	803-227-2281 2:18	arm 21:12,18 22:12	28:24 31:13,15,18
1 3:11 26:8,9,11	803-771-7211 2:8	22:16	32:13
33:25	a	arteries 12:24,25	beer 12:9
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101 1:20 33:8	able 8:12,16 9:1	12:24	believe 6:17 8:19,23
10th 2:15	10:20,25 15:10	artery 11:18 12:14	9:21,23 11:18 12:18
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1315 2:6	abnormal 28:18	13:11,12 15:24	22:17 26:13 30:17
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11-13-13 Winfrey

---[P 1]---

SOUTH CAROLINA WORKERS' COMPENSATION HEARING

CLARENCE WINFREY,

Employee

WCC FILE NO.
1306305

-VS-

ARCHWAY SERVICE, INC.,

Employer

and

AMERICAN FIRE AND CASUALTY CO.,

Carrier

Pursuant to Notice of the Workers' Compensation
Hearing taken on the 13th day of November 2013, heard
before the Honorable T. Scott Beck, and commencing at
the hour of 3:50 p.m. in Columbia, South Carolina.

C. Tatum Court Reporting
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---[P 2]---

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---[P 3]---

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dashes [--] intentional or purposeful interruption
[ph] denotes phonetically written
[sic] written as said

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---[P 4]---

Page 4

1 P R O C E E D I N G S

2 COMMISSIONER BECK: Today's date is

3 November 13, 2013. This is Workers' Compensation

4 File Number 1306305. Claimant in this matter is

5 Clarence Winfrey, represented today by Attorney

6 Preston Daniel. The Employer is Archway Service,

7 Inc., the Carrier is American Fire and Casualty

8 Company, they are represented today by Attorney

9 Rocky Hughey and Brett Bayne. Date of accident in

10 this matter is May 29, 2013. We are here today as

11 a result of a Form 15 hearing request filed on

12 behalf of the Claimant pursuant to 42-9-260(c).

13 Either of you gentlemen have APAs to submit?

14 MR. HUGHEY: Yes, your Honor.

15 COMMISSIONER BECK: I will note for the record

16 that there was an objection by the Claimant for me

17 to exclude the APA evidence and/or any witness

18 evidence on behalf of the Defendants as a result of

19 a late filing of their pre-hearing brief and

20 submissions to the Claimant. I'm going to overrule

21 that objection with the caveat that I'm only

22 considering information prior, up to, and including

23 September 13, 2013. That date being the date in

24 which Defendants made a decision to terminate

25 temporary total disability benefits that were

---[P 5]---

Page 5

1 previously being paid to Mr. Winfrey.

2 Mr. Hughey, do you have your APAs?

3 MR. HUGHEY: Sure, your Honor. I just wanted
4 to let Preston know what I'm doing, is withdrawing

5 what was marked Exhibit 1, removing it from our APA
6 submissions.

7 Thank you, your Honor.

8 COMMISSIONER BECK: Other than that are there
9 any other objections to APAs, jurisdiction, venue,
10 or any other matter, Mr. Hughey?

11 MR. HUGHEY: None from the Defendants, your
12 Honor.

13 COMMISSIONER BECK: Mr. McDaniel?

14 MR. McDANIEL: Commissioner, I would
15 interpose, just for the record, a further objection
16 to several of the documents. As for those
17 documents under Exhibit 2 there's been -- and
18 Exhibit 3 there has been no foundation laid for the
19 submission of those records under any evidentiary
20 basis, and in addition to those, they're hearsay.
21 But I just want to note that for the record.
22 Really don't have any, you know, problem with them,
23 but, I mean, they are not properly submitted and
24 the proper foundation has not been laid.

25 I don't -- I think as to five, six, and seven,

---[P 6]---

Page 6

1 and eight, and nine, those are all court documents,
2 but they're all postdated September 13th and I
3 think you've already stated that in reference to
4 any document that's submitted past that date you
5 would not consider that, so I just note that for
6 the record.

7 COMMISSIONER BECK: And I may also note that,
8 at least as it relates to five, six, seven, those
9 issues were the subjects of some Motions Hearings
10 that we had prior to going on the record today and
11 those matters have been ruled upon and an order is
12 being drafted dealing with each of those respective
13 issues.

14 Other than that, Mr. McDaniel, I'm going to
15 allow them in. Again, with the caveat that I'm
16 only considering information up to and including
17 September 13, 2013.

18 Any other objections?

19 MR. McDANIEL: And the -- Commissioner, just
20 for -- Tab -- what has been given to me as Tab --
21 I'm not sure, I believe that's four?

22 MR. HUGHEY: Yeah, we didn't submit that.

23 MR. McDANIEL: You didn't submit it? Okay.
24 That's fine.

25 COMMISSIONER BECK: Mr. Hughey, any

---[P 7]---

Page 7

1 objections?

2 MR. HUGHEY: Not from the Defendants, your
3 Honor.

4 MR. McDANIEL: It's not submitted, so.

5 COMMISSIONER BECK: All right. Without any
6 further objection the Commission File becomes a
7 part of the record with the exception of self-
8 serving declarations or un-stipulated medical
9 reports.

10 Also during the pre-hearing conference the
11 respective position of both the parties was
12 discussed. Parties stipulate that the sole purpose
13 for today's proceeding is to determine whether or
14 not the Defendants properly stopped the Claimant's
15 temporary total disability benefits under Section
16 42-9-260.

17 Mr. Hughey, do you concur with that?

18 MR. HUGHEY: We do, your Honor.

19 COMMISSIONER BECK: Mr. McDaniel?

20 MR. McDANIEL: Yes, your Honor.

21 COMMISSIONER BECK: All right. As a moving
22 party, Mr. Hughey, you may call your first witness
23 and I believe that is Mr. Winfrey.

24 MR. HUGHEY: Thank you, your Honor.

25 *****

---[P 8]---

Page 8

1 Whereupon,

2 CLARENCE WINFREY,

3 having been first duly sworn,

4 was examined and testified as follows:

5 *****

6 MR. McDANIEL: Your Honor -- I'm sorry.

7 COMMISSIONER BECK: Please state your full
8 name for the record.

9 THE WITNESS: Clarence B. Winfrey, Junior.

10 COMMISSIONER BECK: Mr. Winfrey, you can put
11 your hand down. I'm going to ask, if you would,
12 during the course of your testimony, sir, try to
13 keep your voice up a little bit. These recording
14 devices have to be able to pick up everything that
15 you're saying and the court reporter actually has
16 to hear the words come out of your mouth, as well,
17 and I'm a little hard of hearing, okay?

18 WITNESS: I understand.

19 COMMISSIONER BECK: Mr. McDaniel, do you have
20 something?

21 MR. McDANIEL: Yeah, I just wanted to note one
22 thing additional for the record. I noted that they
23 did not give me notice of any witnesses as part of
24 their case. They did not list Mr. Winfrey as a
25 part of their case. However, we are allowing him

---[P 9]---

Page 9

1 to testify on the limited issues concerning prior
2 to September 13th. However, we did list him as a
3 witness in our case.

4 COMMISSIONER BECK: I understand.

5 Mr. Hughey.

6 MR. HUGHEY: Thank you, your Honor.

7 DIRECT EXAMINATION

8 BY MR. HUGHEY:

9 Q. Mr. Winfrey, can you hear me okay?

10 A. Yeah.

11 Q. Okay. You and I haven't met yet. I'm Rocky
12 Hughey, I represent your employer and their
13 insurance carrier on the workers' compensation
14 claim --

15 A. Nice to met you.

16 Q. I just have a few questions for you, all right?
17 Before we went on the record Mr. McDaniel and the
18 Commissioner let you know you can take a break if
19 you feel uneasy at any point. Just let me know and
20 we'll do that, all right?

21 A. (No Response.)

22 Q. Is that okay?

23 A. Yeah.

24 Q. Okay. Be sure you give verbal responses if you
25 can.

---[P 10]---

Page 10

1 A. All right.

2 Q. Mr. Winfrey, I'm going to ask you about some of

3 your medical records. I understand you don't have

4 all of it in front of you. But what I'm going to

5 do is direct the Court to APA four. This is

6 Claimant's APA four.

7 COMMISSIONER BECK: Page four?

8 MR. HUGHEY: APA four, page ten, of the

9 Claimant's APAs.

10 Q. Mr. Winfrey, at some point after your incident at

11 work you went to Doctors Care, is that correct?

12 A. Yes.

13 Q. I'm looking at a report dated May 28, 2013, does

14 that sound like your first visit to Doctors Care?

15 A. I believe so.

16 Q. Okay. And I have a date of injury, or a date of an

17 incident, of May 22, 2013, does that sound about

18 right to you?

19 A. It was the Thursday before.

20 Q. Your accident was the Thursday before this medical

21 visit?

22 A. Yes.

23 Q. Okay. So you don't disagree with your accident

24 date being May 22, 2013?

25 A. I'm not sure about that, my friend.

---[P 11]---

Page 11

1 Q. Did you go to Doctors Care days after your incident
2 at work or did you go to Doctors Care the same day
3 you were hurt?

4 A. It was over the weekend.

5 Q. Okay. So you didn't immediately go to Doctors
6 Care?

7 A. No.

8 Q. I'm looking at this report, says you were shocked,
9 you were complaining of neck pain on that day, is
10 that correct?

11 A. Yes.

12 Q. Did you complain of any chest pressure to the
13 doctor at Doctors Care?

14 A. That was Dr. Greenfield. And my neck was
15 excruciating from my shoulder up and it was so
16 severe I didn't feel nothing else but this.

17 Q. Were you having chest pain on that day?

18 A. If I was I couldn't feel it because of all the pain
19 here (indicating).

20 Q. So you don't have any recollection of feeling chest
21 pain on the day of this visit to Doctors Care?

22 A. No.

23 Q. All right. And just by way of background,
24 Mr. Winfrey, you are, or at least before this
25 accident, were a pack and a half a day smoker, is

---[P 12]---

Page 12

1 that right?

2 A. Yes.

3 Q. And you also drank periodically?

4 A. Beer, yes.

5 Q. And in terms of your family history, not to upset
6 you, but unfortunately your father did have some
7 issues with his heart, is that correct?

8 A. He was an alcoholic, yes.

9 Q. And your father's cause of death, did he have a
10 heart attack?

11 A. Yes.

12 Q. Okay. Looks like on page 14 of the APAs for the
13 diagnosis from Doctors Care, and this is on May
14 28th, they diagnosed you with a cardiac arrhythmia,
15 do you know what that is, Mr. Winfrey?

16 A. No, sir.

17 COMMISSIONER BECK: What page?

18 MR. HUGHEY: This is on page 14, your Honor,
19 of the APAs.

20 COMMISSIONER BECK: Got it.

21 MR. HUGHEY: Page two, your Honor, of the
22 Defendant's APAs.

23 Q. Mr. Winfrey, I'm looking at a report from the South
24 Carolina Heart Center, this is dated May 28, 2013,
25 do you remember being seen there?

---[P 13]---

Page 13

1 A. Doctor Lide.

2 Q. You did see Dr. -- Dr. Lide is the one you saw
3 there?

4 A. Yeah. I'm not sure about the dates.

5 Q. Okay. And it says in this report at the end of the
6 first paragraph, (As Read): At the time of this
7 interview the patient denied any chest pain, but
8 had minimal left shoulder pain.

9 When you went to the South Carolina Heart
10 Center do you remember whether or not you were
11 having chest pain?

12 A. When I went to the heart center I've already been
13 released from the hospital.

14 Q. Well, I'm looking a report, office consult, May 28,
15 2013 on South Carolina Heart Center letterhead, do
16 remember going there?

17 A. The only time I been there is after I got released
18 to visit Dr. Lide.

19 MR. McDANIEL: Your Honor, not to -- it might
20 be -- well, if there were no objection, but it
21 might be a benefit to Mr. Hughey to look at who
22 that report was from and it might help Mr. Winfrey
23 in properly responding to his questions.

24 COMMISSIONER BECK: All right.

25 Q. It looks like you saw a cardiologist there,

---[P 14]---

Page 14

1 Dr. Dasgupta, do you remember seeing her?

2 A. Oh, yeah, that's the one -- I'm sorry. That's the
3 one Dr. Greenfield sent me to over there by
4 Lexington Hospital.

5 Q. And it looks like, down at the bottom of this first
6 page, they counseled you on stopping smoking, do
7 you remember that?

8 A. I was only in there for about an hour. He did an
9 ECHO of my heart and then they rushed me to the
10 hospital in an ambulance.

11 Q. And on page three of the APAs, the second page of
12 this report under Impression and Plan, here it
13 actually says, Chest pain unspecified. On the
14 first page it said you deny chest pain. Do you
15 know if you had chest pain at the time of that
16 visit?

17 A. I was profusely sweating at Dr. Dasgupta's and so
18 he did an ECHO of my heart.

19 Q. Right.

20 A. And then he called the ambulance to take me across
21 the street to the hospital.

22 Q. It looks like they -- part of the impression was
23 obesity. Would you consider yourself overweight at
24 the time of that visit on May 28th?

25 A. I'm overweight, yes.

---[P 15]---

Page 15

1 Q. Okay. Looking at page four of the APAs -- of the
2 Claimant's APAs. This looks like a June 8, 2013
3 report when you were discharged from Lexington
4 Medical Center. Were you there for a period of

5 time, at Lexington Medical Center?

6 A. I think it was two and a half, three weeks, but I
7 might be wrong.

8 Q. I'm looking on page five at about the second
9 sentence down. It says you were found to have an
10 occlusion -- (As Read): He was found to have an
11 occlusion of his posterior descending coronary
12 artery, as well as three vessel coronary disease
13 and a VSD.

14 Did your doctors talk to you about any of
15 that?

16 A. I don't remember.

17 Q. On page six of the APAs, looks like this same visit
18 or this same discharge, under Final Diagnoses they
19 have coronary arteriosclerosis of native coronary
20 artery and they, again, mention tobacco use and
21 alcohol abuse, did they talk to you about those
22 items?

23 A. And this is at Lexington Hospital?

24 Q. Lexington Medical Center, it looks like.

25 A. I don't remember nobody talking about smoking and

---[P 16]---

Page 16

1 drinking at the hospital.

2 Q. It does look like they performed a procedure that
3 involved a coronary artery bypass, is that your
4 understanding of the procedure that was performed?

5 A. All I know is that Dr. Travis told me that I had
6 entrance and exit wounds from electricity in my
7 heart. He has pictures. And far as everything
8 else, I'm not sure of, buddy. I'm sorry.

9 Q. That's fine.

10 MR. HUGHEY: Your Honor, can you bear with me
11 for just one second?

12 COMMISSIONER BECK: Yes, sir.

13 MR. HUGHEY: Thank you, your Honor.

14 Q. Mr. Winfrey, I'm now looking at page eight of the
15 APAs submitted by your attorney, Mr. McDaniel.
16 This appears to be a May 30, 2013 report and this
17 is the op note from Dr. Travis. Dr. Travis is the
18 one that did your surgery, is that correct?

19 A. Yes.

20 Q. And I'm looking at the paragraph running on to that
21 page, on page eight. It says, (As Read): Patient
22 also had very significant pericarditis with large
23 calcific plaques located anteriorly and
24 posteriorly. It goes on to say, (As Read): They
25 were heavily calcified and there was a real

---[P 17]---

Page 17

1 weirdness to the adhesions throughout.

2 Did he talk to you at all about the content or
3 what he found in your heart when he was in there?

4 A. No.

5 Q. And, Mr. Winfrey, you hadn't seen a doctor for your
6 heart in the years leading up to this, is that
7 correct?

8 A. Not to my memory, no.

9 Q. You don't have a regular family doctor that you
10 treat with?

11 A. No, sir, I sure don't.

12 Q. Mr. Winfrey, and finally in conclusion, the day
13 this happened, May 22, 2013, this incident happened
14 at the Publix on Rosewood, is that correct?

15 A. Rosewood Drive, yes.

16 Q. And you finished working that day, is that right?

17 A. Yes.

18 Q. In fact, you traveled somewhere after that, is that
19 correct?

20 A. I went to Aiken and I finished up two rotisseries
21 there and I called Bobby Ruppe and I said I
22 couldn't do no more.

23 Q. You didn't go anywhere else after that that day?

24 A. Well, I went home.

25 Q. Did you work the following day, Friday?

---[P 18]---

Page 18

1 A. I got up and I got dressed and I went on to
2 Wal-Mart on 378, and from there I had to call Bobby
3 Ruppe again and say, I can't do it. Because I was
4 dumping sweat and my neck was killing me 'cause I
5 was trying to hold my head up. I couldn't do it.

6 Q. At the time of that conversation with Mr. Ruppe did
7 you tell him you were having chest pain?

8 A. I told him my neck was killing me.

9 MR. HUGHEY: Thank you, Mr. Winfrey. I don't
10 have anything else for you right now.

11 COMMISSIONER BECK: Mr. McDaniel, do you have
12 any questions, sir?

13 MR. McDANIEL: Very briefly. Your Honor,
14 first off, based on Mr. Winfrey's testimony, which
15 was un-objected to, I would ask the Court for it's
16 consideration of -- Mr. Winfrey testified as to
17 what Dr. Travis told him about the entrance and the
18 exit wounds, your Honor will recall that testimony?

19 COMMISSIONER BECK: Yes.

20 MR. McDANIEL: All right. In confirmation of
21 that I would ask for the Court's consideration of
22 Claimant's Exhibit under Tab two, page three from
23 Dr. Jeffery Travis, the authorized and treating
24 cardio vascular surgeon, as to his confirmation of
25 the entrance and the exit places that he found on

---[P 19]---

Page 19

1 Mr. Winfrey's heart.

2 CROSS-EXAMINATION

3 BY MR. McDANIEL:

4 Q. Mr. Winfrey --

5 MR. HUGHEY: Your Honor, can I reply to that
6 just briefly?

7 COMMISSIONER BECK: Yes, sir.

8 MR. HUGHEY: We'd object to that coming into
9 evidence in that, number one, it's dated September
10 30, 2013, which is outside of your rule. I
11 understand Mr. McDaniel's trying to link the
12 foundation based on what Mr. Winfrey testified to
13 earlier. However, if this report comes in from
14 Dr. Travis we think it's fair game for any evidence
15 from Dr. Felton to come in.

16 COMMISSIONER BECK: Well, the report's in. If
17 I understand your request, Mr. McDaniel, it's only
18 for the purpose of corroborating the testimony I
19 just heard.

20 MR. McDANIEL: Correct.

21 COMMISSIONER BECK: Not for the opinion --

22 MR. McDANIEL: Not any of the rest of it, just
23 as to that limited part in reference to what
24 Dr. Travis stated in his report about what he found
25 as to being corroborative of what the Claimant

---[P 20]---

Page 20

1 testified.

2 COMMISSIONER BECK: Mr. Hughey?

3 MR. HUGHEY: Your Honor, I think the point is
4 that we didn't know anything about that at the time

5 that this was supposedly told to Mr. Winfrey.

6 COMMISSIONER BECK: And that may go to the
7 weight of the evidence.

8 MR. HUGHEY: Sure.

9 COMMISSIONER BECK: But I'll allow it, limited
10 to that specific purpose.

11 MR. HUGHEY: Thank you, your Honor.

12 COMMISSIONER BECK: Any other questions?

13 MR. McDANIEL: Very briefly.

14 Q. Mr. Winfrey, you had an assigned rehab nurse at
15 some point in time, is that correct?

16 A. Yes.

17 Q. All right. And she attended all the appointments
18 with you when you went to your doctors?

19 A. Yes.

20 Q. A couple more questions. Has any adjuster or any
21 person from the insurance company called you and
22 has any way questioned whether or not your injuries
23 stem from your work related accident?

24 A. No.

25 Q. All right. Has at any time anybody from your

---[P 21]---

Page 21

1 employer called you and questioned you or contacted
2 you or questioned you in any way as to whether or
3 not this was related to your electrical shock?

4 A. No.

5 Q. Now, when you saw Dr. Greenfield --

6 MR. McDANIEL: Commissioner, in reference to
7 Claimant's APA number ten, which was also submitted
8 by Mr. Hughey under their APA submissions, which
9 have been objected to, which have been admitted
10 over objection.

11 Q. According to that you advised Dr. Greenfield that
12 you had a 400 -- you were working on a 480 volt
13 rotisserie, shocked on Thursday, does that sound
14 like the history you gave her?

15 A. Yeah, I got shocked in my neck.

16 Q. And when she saw you what did she do, as far as
17 where did she send you?

18 A. Well, when she seen me I just wanted some Flexeril
19 and stuff and I was going to go back to work. She
20 put a thing on my finger and I had like 117 beats
21 per minute and I was only supposed to have 72.
22 That's when she did the ECHO and she said there's a
23 hole in my heart. That's when she sent me to
24 Gupta.

25 Q. Dasgupta?

---[P 22]---

Page 22

1 A. Yeah.

2 MR. McDANIEL: Madam court reporter, it's

3 D-a-s-g-u-p-t-a.

4 Q. Now, when you saw Dr. Dasgupta, I want to ask you

5 if this sounds correct as to the history that you

6 gave him. (As Read): A review of his records

7 today shows that he received an electrical shock in

8 five days ago and since then has complained of pain

9 in his left shoulder radiating into his left

10 scapular region, left side of his neck, left

11 interclavicular region, and left arm.

12 A. Yeah, from the neck, all this right here

13 (indicating).

14 Q. Okay. Now, does that sound correct as to what you

15 told him?

16 A. It sounds it, but I'm not sure.

17 Q. But in other words, when he says that you received

18 an electrical shock five days ago and since then

19 has complained of pain?

20 A. Dr. Greenfield's friends with Dasgupta. She's the

21 one that said, He's my friend, I can send you there

22 or you can go to the emergency room, but you've got

23 to go.

24 Q. And then after that, according to Dr. Dasgupta's

25 records and I believe your testimony, they had EMS

---[P 23]---

Page 23

1 take you across the street from his office to the
2 emergency room?

3 A. Yes.

4 Q. And then you were treated there by Dr. Travis?

5 A. No, I met Dr. Lide.

6 Q. There?

7 A. At the hospital.

8 Q. And then after that Dr. Travis did the surgical
9 work?

10 A. Dr. Travis -- I think, I'm not positive about
11 dates, but he -- I think it was the next day, or
12 the following day, that's when they opened me up.

13 MR. McDANIEL: No further questions, your
14 Honor.

15 COMMISSIONER BECK: Mr. Hughey, anything
16 further?

17 MR. HUGHEY: Very briefly, your Honor.

18 REDIRECT EXAMINATION

19 BY MR. HUGHEY:

20 Q. Mr. Winfrey, do you know whether or not Liberty
21 Mutual contacted Mr. McDaniel about taking your
22 recorded statement at any point in the past?

23 A. I'm not sure.

24 Q. In terms of the specific amount of volts that were
25 involved in this wiring -- and I'm not trying to

---[P 24]---

Page 24

1 give you a hard time -- are you able to say the
2 precise amount of voltage that was involved in this
3 rotisserie --

4 A. It was high voltage, I mean, 240, 480, one of the
5 two.

6 Q. Sure. But you don't know for sure whether it was
7 480 versus 240?

8 A. I've never been hit that hard.

9 MR. HUGHEY: Thank you, Mr. Winfrey. I don't
10 have anything further.

11 COMMISSIONER BECK: Anything further?

12 MR. McDANIEL: Nothing further. Thank you.

13 COMMISSIONER BECK: You may step down, sir.

14 Thank you very much.

15 WITNESS: Thank you.

16 COMMISSIONER BECK: Any other witnesses on
17 behalf the Defendants?

18 MR. HUGHEY: We'll rest, your Honor. We don't
19 have any other witnesses.

20 COMMISSIONER BECK: Any witnesses on behalf
21 the Claimant?

22 MR. McDANIEL: I understand they've rested?

23 None, your Honor.

24 COMMISSIONER BECK: All right. That will
25 conclude this proceeding. I'd like to see --

---[P 25]---

Page 25

1 MR. McDANIEL: Your Honor -- I'm sorry. I
2 would like to put something on the record if I can.
3 We are here on a Form 15 Hearing. They have
4 an obligation to at least put up a Prima facie
5 case. They have not established that any of --
6 even any of the medical records were received by
7 them. They have put up no testimony, no evidence,
8 whatsoever, to establish when and if these -- even
9 these medical records were received by the
10 Defendants. They have miserably failed in
11 submitting any evidence to this Court upon which it
12 can -- there is a foundation been laid to submit
13 any evidence as to this man's condition was not
14 caused by -- that they conducted a Good Faith
15 Investigation. I just put that on the record, your
16 Honor.

17 COMMISSIONER BECK: All right. }
18 Mr. Hughey, anything in reply to that?
19 MR. HUGHEY: Your Honor, just quickly in
20 response, since Mr. McDaniel felt the need to speak
21 on it. I won't summarize all of it. But, again,
22 we think we certainly had evidence in the record,
23 which was evidence in the Carrier file and the
24 medical records documenting a history of drinking,
25 smoking, coronary artery disease noted in the

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1 medical records. No question arrhythmia was
2 diagnosed, but of course winds up with a coronary
3 bypass procedure. By the very language in the
4 medical records we believe it causes -- raises
5 question as to what's related to what. And we
6 certainly would stand by our positions that it was
7 absolutely a Good Faith Denial of benefits, your
8 Honor.

9 COMMISSIONER BECK: All right.

10 MR. McDANIEL: Commissioner, the only thing I
11 would note to you is that in part of Mr. Hughey's
12 discussion he went outside the record and said,
13 Which is obviously in the adjuster's file. And I
14 just ask that to note that that is not into
15 evidence and he has not submitted any evidence of
16 that point.

17 Thank you, your Honor.

18 MR. HUGHEY: We do have medical records that
19 Mr. McDaniel represented to the Court earlier that
20 he'd provided to the Defendants on multiple
21 occasions. So we did have the records from the
22 initial authorized physicians and that we paid for
23 those records -- paid those bills.

24 COMMISSIONER BECK: All right.

25 MR. McDANIEL: Again, I don't want to belabor

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1 the point, but I just make one brief note, and that
2 is, there is nothing that establishes that they had
3 those records between -- before September 13th.

4 COMMISSIONER BECK: All right. That will
5 conclude this proceeding.

6 *****

7 (Whereupon, the hearing concluded at 4:18 p.m.)

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STATE OF SOUTH CAROLINA
CERTIFICATE

Be it known that I, Christine Tatum, a
Professional Court Reporter and Notary Public, did hear
the matter of Clarence Winfrey -vs- Archway Service,
Inc., Workers' Compensation File No. 1306305 on,
Wednesday, November 13, 2013, in Columbia, South
Carolina, before the Honorable T. Scott Beck;

That the witness(s) were duly sworn under
pains and penalties of perjury to testify to the truth,
the whole truth, and nothing but the truth;

That the foregoing pages constitute a true
and accurate transcription of the testimony given at
that time and place aforesaid to the best of my skill
and ability;

I further certify that I am not counsel or
kin to any of the parties to this cause of action, nor
am I interested in any matter of its outcome.

In Witness whereof, I have hereunto set my
hand this 11th Day of December 2013.

Christine Tatum
Notary Public For South Carolina
My Commission Expires December 29, 2021