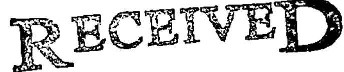
THE STATE OF SOUTH CAROLINA
In The Court of Appeals



JAN 10 2017
SC Court of Appeals

APPEAL FROM RICHLAND COUNTY
Civil Court

23055

Robert E. Hood, Circuit Court Judge

Case No. 2013-CP-40-01259
Appellate Case No. 2016-000429

Phillip Durrett, Appellant

v.

Palmetto Health Alliance d/b/a Palmetto Richland Memorial and W. Ross, M.D., Respondents.

Record on Appeal

Melvin D. Bannister
Post Office Box 6833
Columbia, South Carolina 29260
(803) 782-8688
Attorney for the Appellant
sctriallawyer@bellsouth.net

R. Gerald Chambers, Jr.
Carmello B. Sammataro
TURNER PADGET GRAHAM & LANEY, P.A.
Post Office Box 1473
Columbia, SC 29202
(803) 254-2200
Attorneys for Respondent

INDEX

Order dated May 25, 2011 1

Form 4 Order dated April 3, 2012 6

Order dated January 8, 2014 8

Order dated December 3, 2014 10

Order on Motion to Reconsider, dated January 26, 2016 17

Transcript of Record, August 25, 2011 30

Transcript of Record, July 22, 2014 36

Transcript of Record, January 25, 2016 49

Notice of Intent, dated August 5, 2009 66

Statement of Case, August 5, 2009 67

Motion to Dismiss Notice of Intent dated September 22, 2009 70

Medications List, Medication Information 72

Plaintiff's Motion to Reconsider dated June 3, 2011 107

Complaint dated February 28, 2013 109

Defendants' Answer to Complaint dated June 21, 2013 113

Affidavit of Plaintiff dated February 18, 2010	122
Stipulation of Dismissal dated April 9, 2014	125
Amended Motion for Summary Judgment dated July 17, 2014	126
Memorandum in Support of Amended Motion for Summary Judgment dated July 17, 2014, with exhibits	130
Defendant's Motion to Reconsider dated December 8, 2014	202
Defendant's Memorandum in Support for Reconsideration dated January 25, 2016	206
Plaintiff's Return to Motion for Reconsideration dated January 25, 2016	219
Transcript of Deposition of Michael Charpia, March 12, 2014	227
Deposition Excerpts of Matt Hancock, June 13, 2014	236
EMS Run Sheet, August 9, 2006	239
Certificate of Counsel	240

STATE OF SOUTH CAROLINA	)	IN THE COMMON PLEAS COURT
	)	
COUNTY OF RICHLAND	)	CASE NO.: 09-CP-40-5568
PHILLIP DURRETT,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	
	)	**ORDER OF DISMISSAL**
PALMETTO HEALTH ALLIANCE d/b/a PALMETTO RICHLAND MEMORIAL, and W. ROSS, M.D.,	)	
	)	
Defendants.	)	

2011 MAY 25 AM 11:56
JEANETTE W. McBRIDE
C.C.P. & G.S.
FILED

This matter came before the Court for oral argument on the motion of Defendants Palmetto Health Alliance d/b/a Palmetto Richland Memorial ("Defendant Hospital") and W. Ross M.D. ("Defendant Ross") (collectively "Defendants") to dismiss the Notice of Intent to File Suit and any claims that have been or could be alleged by Plaintiff Phillip Durrett ("Plaintiff") against Defendants. Present on behalf of Plaintiff was Melvin D. Bannister. Present for Defendants was R. Gerald Chambers, Jr. of Turner Padget Graham & Laney, P.A. The motion was argued before The Honorable L. Casey Manning. After considering the written submissions and argument of the parties, the Court hereby grants Defendants' motion and dismisses this matter for the reasons set forth herein.

FACTUAL AND PROCEDURAL BACKGROUND

Plaintiff initiated this medical malpractice action with the filing of his original Notice of Intent to File Suit ("Original Notice") in the Richland County Court of Common Pleas on August 5, 2009. In his Original Notice, Plaintiff alleged he was transferred to Defendant Hospital shortly after sustaining physical injuries in an automobile accident on August 9, 2006. Original Notice ¶¶ 2-3. Upon arrival, Plaintiff informed Defendants that he was allergic to anesthetic and

sedative drugs and asked that such drugs not be administered to him. Original Notice ¶¶ 5-6. Plaintiff then alleges his warnings to Defendants were disregarded, he was administered said drugs, and as a result he suffered cardiac and respiratory arrest followed by a coma or catatonic like state for approximately nine days. Original Notice ¶¶ 7-10. Plaintiffs also had to receive additional medical treatment and incurred greater expense as a result of Defendants' alleged conduct. Original Notice ¶ 11. Based on these allegations Plaintiff claims Defendants were negligent and thus liable for his damages. Original Notice ¶¶ 12-13. In addition to the Original Notice Plaintiff also submitted an affidavit signed by Plaintiff's attorney, Melvin Bannister, stating that Plaintiff's Original Notice was filed within ten days of the expiration of the statute of limitations for Plaintiff's injuries. Bannister Aff. ¶2. He affirms that time constraints prevented the preparation of an expert affidavit and further that an expert affidavit was not required under the South Carolina Code of Laws section 15-36-100(C) (2) and per the factual allegations of the claim. Bannister Aff. ¶3. Bannister agreed to file an expert affidavit to supplement a Complaint within forty five days of its filing and a determination by the Court that an expert affidavit is required. Id.

For all of the reasons stated in greater detail below, Plaintiff failed to follow the filing requirements for this medical malpractice action by not filing an expert affidavit with the Original Notice. Accordingly, Plaintiff's claims against Defendants are dismissed pursuant to 12(b) (1) and 12(b) (6) of the South Carolina Rules of Civil Procedure.

LEGAL STANDARD

A motion to dismiss on the pleadings based on failure to state a claim and lack of subject matter jurisdiction is the proper vehicle for challenging compliance with the filing requirements of a medical malpractice action. S.C. R. Civ. P. 12(b) (1), 12(b) (6); S.C. Code Ann. §15-36-

100(F). "In considering the motion to dismiss a complaint based on a failure to state facts sufficient to constitute a cause of an action, a trial court must base its ruling solely on allegations set forth in the complaint." Doe v. Marion, 373 S.C. 390, 395, 645 S.E.2d 245, 247 (2007). A Rule 12(b) (6) motion must be sustained where the facts alleged and inferences reasonably deducible therefrom would not entitle plaintiff to relief under any theory of recovery. *Id.*

ANALYSIS

South Carolina law requires Plaintiff to file an expert affidavit contemporaneously with his Notice of Intent to File Suit, this medical malpractice action against Defendants. S.C. Code Ann. §15-79-125(A) (referencing section 15-36-100 for specifications of filing the affidavit). Section 15-36-100(C) (2) provides an exception to this rule: "the contemporaneous filing requirement...is not required to support a pleaded specification of negligence involving subject matter that lies within the ambit of common knowledge and experience, so that no special learning is needed to evaluate the conduct of the defendant." S.C. Code Ann. §15-36-100(C) (2).

Plaintiff wrongly relies on *Hickman v. Sexton Clinic, P.A* to argue that an expert affidavit is not needed to support his cause of action. In *Hickman*, an unsupervised hygienist "ram[med] something sharp into the plaintiff's mouth, causing pain, cutting her tongue and necessitating stitches. 295 S.C. 164, 166, 367 S.E.2d 453 (Ct. App. 1988). The court found that this testimony alone, from the non-expert plaintiff, alleged a sufficient causal connection rising above mere speculation or conjecture that a duty was breached. Id. at 168, 367 S.E.2d 453. Plaintiff's case is not so clear. The complaint alleges that "certain anesthetic and sedative drugs" were administered to Plaintiff, causing cardiac arrest, respiratory arrest, and a coma or catatonic state for approximately 9 days. Pl. Compl. ¶¶7, 9, 10. These conditions are not the same as a sharp object cutting a mouth requiring stitches; the complexities of cardiac arrest, respiratory arrest, a

coma or catatonic state, and the makeup, side effects, dosages, and administration of particular drugs certainly require special learning to evaluate Defendants' conduct as a potential cause of Plaintiff's injuries. Ross Aff. ¶4. Even Plaintiff recognizes this complexity by attaching voluminous and wordy materials to his Return to Motion to Dismiss. Plaintiff's alleged facts do not match *Hickman*. Rather, *Hickman* advocates the necessity of an expert affidavit in this case, where causation is not simple and direct.

Plaintiff also wrongly relies on *Stallings v. Ratliff*. In *Stallings* the plaintiff's malpractice theory was that the doctor breached his duty to inform the plaintiff about the potential risks related to the procedure he performed. 292 S.C. 349, 356 S.E.2d 414 (Ct. App. 1987). In reviewing the case after trial, the Court of Appeals found the *expert* testimony presented by the plaintiff was sufficient enough to go to the jury on the standard of care and that there was a breach of that standard. Id. at 352-54, 356 S.E.2d 414. Plaintiff is correct to state that failure to inform of potential risks can be a basis for a malpractice suit. However, Plaintiff is incorrect to suggest that no expert testimony is needed to make that conclusion. *Stallings* clearly states the opposite, making the decision based on the expert testimony provided. Id.

Furthermore, Plaintiff has failed to provide an expert affidavit within the forty-five day grace period in section 15-36-100(C) (1). When an action is filed within ten days of the statute of limitation expiration and the plaintiff alleges an expert affidavit could not be prepared due to time constraints, the court allows the plaintiff an extra forty-five days from the filing to submit the affidavit. S.C. Code Ann. §15-36-100(C) (1). "Upon motion, the trial court, after hearing and for good cause, may extend the time as the court determines justice requires." Id. Plaintiff's Notice of Intent to File Suit and affidavit were filed August 5, 2009. Plaintiff made no motion

before the court to extend the forty-five day grace period. Again, Plaintiff's claim fails and is dismissed

Lastly, even if the Medical Malpractice Reform Act and its provisions under section 15-79-125 do not apply Plaintiff is still required to file an expert affidavit in compliance with the South Carolina Frivolous Civil Proceedings Sanctions Act, section 15-36-100. Section 15-36-100(B) states, "...in an action for damages alleging professional negligence against a professional licensed by or registered with the State of South Carolina and listed in subsection (G) or against any licensed health care facility...the plaintiff must file as part of the complaint an affidavit of an expert witness which must specify at least one negligent act or omission claimed to exist and the factual basis for each claim." S.C. Code Ann. §15-36-100(B). Subsection (C) again provides the forty-five day grace period. Plaintiff has not complied with either of these provisions.

This case involves issues beyond common knowledge and experience, Plaintiff was required to file an expert affidavit with his Notice of Intent to File Suit. Plaintiff failed to do so and further failed to file such affidavit within the forty-five day grace period; he likewise did not move to request from the Court more than forty-five days to file an expert affidavit. Because he did not comply with these provisions under the Medical Malpractice Reform Act or the South Carolina Frivolous Civil Proceedings Sanctions Act, this Court grants Defendant's Motion to Dismiss.

AND IT IS SO ORDERED.

The Honorable L. Casey Manning
Presiding Judge

Columbia, South Carolina
May 25, 2010

FORM 4

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

JUDGMENT IN A CIVIL CASE

CASE NO. 2009 -CP- 4005568

Durrett, Phillip

PLAINTIFF(S)

Palmetto Health Alliance, et al

DEFENDANT(S)

Submitted by:	Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

RICHLAND COUNTY FILED
2012 APR -3 AM 11:51
JEANETTE W. McBRIDE C.C.P. G.S.

IT IS ORDERED AND ADJUDGED: ☑ See attached order (formal order to follow) ☐ Statement of Judgment by the Court: Motion to Reconsider Granted. Formal order to follow.

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.
Additional Information for the Clerk :

INFORMATION FOR THE JUDGMENT INDEX
Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details.**

[signature]	2061	4-2-12
Circuit Court Judge	Judge Code	Date

SCRCP Form 4C (12/2011)

SCANNED

For Clerk of Court Office Use Only

This judgment was entered on the ________ day of __________, 20__ and a copy mailed first class or placed in the appropriate attorney's box on this 3 day of April, 2018 to attorneys of record or to parties (when appearing pro se) as follows:

______________________________	______________________________
______________________________	______________________________
ATTORNEY(S) FOR THE PLAINTIFF(S)	ATTORNEY(S) FOR THE DEFENDANT(S)

Jeanette W. McBride
CLERK OF COURT

Court Reporter: ______________________________

SCRCP Form 4C (12/2011)

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF RICHLAND)

IN THE FIFTH CIRCUIT

Phillip Durrett,

PLAINTIFF,

VS

Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,

DEFENDANT.

ORDER GRANTING PLAINTIFF'S MOTION FOR RECONSIDERATION
09-CP-40-5568

RICHLAND COUNTY
FILED
2014 JAN -8 PM 3:01
JEANETTE W. McBRIDE
C.C.P., G.S.

This matter came before the Court for a hearing on Plaintiff's Motion for Reconsideration on August 25, 2011.

A review of the status of the case is as follows:

The Plaintiff filed a medical malpractice action against the Defendants by filing a Notice of Intent to File Suit, Statement of Case (Complaint) on August 5, 2009. The Defendants filed a Motion to Dismiss on September 22, 2009. A hearing on Defendants' Motion to Dismiss was heard on March 2, 2010. An Order granting the dismissal of the action was filed May 25, 2010. Plaintiff timely filed a Motion for Reconsideration on June 6, 2011.

Based upon the pleadings, affidavits and supporting documents, and argument of counsel, I find the following:

Upon the commencement of the action, the Plaintiff did not file an affidavit of an expert witness, which would support the allegations of medical malpractice. Instead, Plaintiff's counsel filed an affidavit, which indicated an expert's affidavit was not required under the South Carolina Code of Laws, section 15-36-100 (C) (2). This Court originally

 SCANNED

granted the Order of Dismissal based upon Plaintiff's failure to file an expert witness affidavit.

After reconsideration, I find that Order of Dismissal (May 25, 2011) should be vacated.

Pursuant to section 15-79-125 of the South Carolina Code of Laws, I further find that the parties shall participate in a mediation conference within 90 days of this Order. In the event the matter cannot be resolved through mediation, the Plaintiff may file the civil action by filing a summons and complaint.

WHEREFORE, IT IS ORDERED that the Order of Dismissal (May 25, 2011) is hereby vacated.

It is further ordered that the parties shall participate in a mediation conference within 90 days of the execution of this Order.

AND IT IS SO ORDERED.

L. Casey Manning, Judge
Court of Common Pleas for the
Fifth Judicial Circuit

Columbia, South Carolina
7 day of Jan, 2013

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
Phillip Durrett,	)	IN THE FIFTH CIRCUIT
PLAINTIFF,	)	
VS	)	
Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,	)	ORDER DENYING MOTION FOR SUMMARY JUDGMENT 13-CP-40-1259
DEFENDANT.	)	

RICHLAND COUNTY FILED
2014 DEC -3 AM 11:52
JEANETTE W. McBRIDE C.C.P.&G.S.

The medical malpractice action is before the Court on the amended motion by Defendants for summary judgment. The Court heard oral argument of Defendants' motion, filed July 17, 2014, on July 22, 2014. Present at the hearing were Melvin D. Bannister, Esquire, for Plaintiff Phillip Durret (Durrett) and Carmelo B. "Sam" Sammataro, of Turner Padget Graham & Laney, P.A. on behalf of Defendants. After hearing oral argument and reviewing the parties' submissions, the court hereby denies the motion in its entirety for the reasons set forth below in greater detail.

LEGAL STANDARD

South Carolina juris prudence makes clear that in medical malpractice actions such as this, summary judgment "is appropriate when there is no genuine issue of material fact such that the moving party must prevail as a matter of law." *David v. McLeod Regional Medical Center,* 367 S.C. 242, 626 S.E.2d 1 (2006).

DISCUSSION

The Defendants' amended motion for summary judgment is based mainly on Defendants' argument that Plaintiff was required under S.C. Code Ann. 15-79-125 (A)

("prior to filing or initiating a civil action alleging injury or death as a result of medical malpractice, the plaintiff shall contemporaneously file a Notice of Intent to File Suit and an affidavit of an expert witness, **subject to the affidavit requirements established in Section 15-36-100...** " emphasis added)

Section 15-36-100 states in pertinent part: "(C)(2) The contemporaneous filing requirement of subsection (B) is not required to support a pleaded specification of negligence involving subject matter that lies within the ambit of common knowledge and experience, so that no special training is needed to evaluate the conduct of the defendant." S.C. Code Ann. 15-36-100(C)(2).

Recently in *Brouwer, Appellant, v. Sisters of Charity Providence Hospitals, South Carolina ENT, Allergy and Sleep Medicine, P.A.; Robert Puchalski, M.D.; Jane Does and John Does, Defendants, Of whom South Carolina ENT, Allergy and Sleep Medicine, P.A.; Robert Puchalski, M. D. and Francine K. Moring, M.D. are, Respondents*, Opinion No. 27427, Heard March 5, 2014-Filed August 6, 2014, the Supreme Court agreed that section S.C. Code Ann. 15-79-125 (A) incorporates section 15-36-100 in its entirety, including the common-knowledge and experience exception codified in 15-36-100(C)(2).

I find that the Plaintiff herein has successfully invoked this exception and, thus, was not required to file an expert witness affidavit.

In *Brouwer* the plaintiff was admitted to the (Providence Hospital). She was treated and suffered an allergic reaction. She attributed the reaction to her latex allergy that was disclosed to medical personnel on her forms for Pre-Anesthesia Evaluation.

In the present case, plaintiff asserts in his affidavit, which was previously filed with the Court, that he informed Defendants that he was allergic to anesthetic drugs and that he should not be given any such drugs. The Defendants disregarded his instructions. The same instructions were given to Richland County EMT personnel upon their arrival at the accident scene. The EMT personnel followed his instructions and did not supply any medications to the plaintiff.

The Plaintiff further contends that the Defendants were not aware of the material/instructions for the provision of certain drugs to the Plaintiff, or the material/instructions were ignored.

The Plaintiff has alleged negligence on the part of the Defendants in providing to the Plaintiff certain drugs, against his instructions, failing to monitor the Plaintiff in the provision of certain drugs, providing drugs which were contra-indicated, and overdosing the Plaintiff.

Where the evidence permits the jury to recognize or infer a breach of duty without the aid of expert testimony, such testimony is not required in order for the case to go to the jury. *Hickman v. Sexton Clinic, P.A.*, 295 S.C. 164, 367 S.E.2d 453 (Ct.App. 1988), *Stallings v. Ratliff*, 292 S.C. 349, 356 S.E.2d 414 (Ct.App. 1987), *Welch v. Whitaker,* 282 S.C. 251, 317 S.E.2d 758 (Ct.App. 1984)

A plaintiff in a medical malpractice case must prove the proximate cause as well as negligence and proof of proximate cause must be established by expert testimony where the origin of the injury is obscure and not readily apparent to a layman, or there are several equally probable causes of the condition. When expert testimony is not relied upon to establish proximate cause, the plaintiff must offer evidence that rises

above mere speculation or conjecture. And when considering whether to direct a verdict in favor of the defendant in a medical malpractice case, the court must view the evidence and all reasonable inferences arising there from in the light most favorable to the plaintiff. *Stallings v. Ratliff*, 292 S.C. 349, 356 S.E.2d 414 (Ct.App. 1987), *Welch v. Whitaker,* 282 S.C. 251, 317 S.E.2d 758 (Ct.App. 1984)

In the *Hickman* case the Court held that allowing an unsupervised dental assistant to ram a sharp object into her mouth is evidence rising above mere speculation or conjecture.

In the present case the Defendants failed to monitor the Plaintiff before administering lethal doses of medication. The Defendants' failure to monitor is shown on the medical records, which were submitted to the Court by the Plaintiff. In particular, the additional provision(s) of the drugs, which were given at different times and which were administered by different individuals, indicates that the Plaintiff was not monitored. Further, in the present case, the Defendants rammed a sharp object (needle) into the Plaintiff and provided medications, which caused the Plaintiff to go into cardiac and respiratory arrest and to go into a coma for several days.

In the *Stallings* case the court held that the failure of the doctor (defendant) to inform the plaintiff of the possible risks of a procedure prior to obtaining the plaintiff's consent was a violation of the standard of care.

In the present case, the Plaintiff alleges, not only did the Defendants fail to inform the Plaintiff of the possible risks of cardiac arrest, respiratory arrest, coma, nor any other possible side effects, after the Plaintiff gave the Defendants specific instructions not to provide any sedative or anesthetic drugs to the Plaintiff the Defendants ignored

the Plaintiff's specific instructions. The Plaintiff further informed the Defendants that he was allergic to said drugs. He further stated that if any said drugs were to be administered, he would go to another hospital.

According to the Plaintiff's allegations, the Defendants ignored the Plaintiff's instructions and administered a minimum of 4 different drugs over a period of time, without monitoring the Plaintiff. The administration of the said drugs caused the Plaintiff to suffer cardiac and respiratory arrest and to induce a coma for the Plaintiff, which lasted at least 8 days.

An individual with common knowledge and experience is aware that medications have possible side effects. An individual will see numerous advertisements on the television, newspapers, magazines, mail, and on the internet. The advertisements will list possible side effects. The advertisers are required by federal law to inform the public of the possible side effects. The Plaintiff in this case was aware of the possible side effects; therefore, he instructed the Defendants not to provide the medications.

I find that it is clear that no special learning is needed to evaluate the conduct of the defendants. In particular, the Defendants' failure to abide by the Plaintiff's specific instructions, in providing the medications to the Plaintiff without monitoring the Plaintiff and in failing to consider the possible lethal side effects of the medications to the Plaintiff.

In comparing the present case to the Welch case, it is clear that the Plaintiff has evidence, which this Court must view and all the reasonable inferences arising there from in the light most favorable to the Plaintiff in determining whether an expert witness is required in this case.

I find that the Court and/or jury will not need expert testimony to use its common knowledge and experience to determine the medical malpractice of the Defendants and the injuries caused to the Plaintiff.

The Defendants at the hearing on the motion for summary judgment also argued that Plaintiff's claim should be barred for failing to institute the action in a timely manner. Section 15-79-125 provides, in part, as follows: "Filing the Notice of Intent to File Suit tolls all applicable statutes of limitations." The Plaintiff timely filed the NOI, thereby tolling the statute of limitations. The Plaintiff timely filed the Complaint in this action.

As noted in the Defendant's Amended Notice of Motion and Amended Motion for Summary Judgment, the Plaintiff filed a Notice of Intent to File Suit on or about August 5, 2009. On September 22, 2009, the Defendants filed a Motion to Dismiss Plaintiff's Notice of Intent to File, based upon the failure to the Plaintiff to file an expert witness affidavit. Judge Manning initially ruled in favor to the Defendants in his Order of Dismissal on May 25, 2010. (Defendants' Exhibit 9) However, Judge Manning vacated the Order of Dismissal based in part on an affidavit that an expert witness affidavit was not required under South Carolina Code of Laws, section 15-36-100 (C) (2). It should be noted that Judge Manning's Order Granting Plaintiff's Motion for Reconsideration, did not require the Plaintiff to file an expert witness affidavit.

Judge Manning's Order Granting Plaintiff's Motion for Reconsideration, dated January 7, 2013 should be considered as "the law in this case".

Judge Manning's Order was not appealed.

Based upon the foregoing, I agree with Judge Manning's Order, which has the ultimate effect of allowing this action to proceed without the necessity of filing an expert witness affidavit.

THREFORE, IT IS ORDERED that the Defendants' Amended Motion for Summary Judgment is hereby denied.

AND IT IS SO ORDERED.

Robert E. Hood, Judge
Court of Common Pleas for the
Fifth Judicial Circuit

Columbia, South Carolina
1 day of Dec, 2014

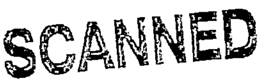
STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	Civil Action No.: 2013-CP-40-01259
Phillip Durrett, Plaintiff, vs. Palmetto Health Alliance d/b/a Palmetto Richland Memorial and W. Ross, M.D., Defendants.	)	**ORDER ON MOTION TO RECONSIDER BY DEFENDANT PALMETTO HEALTH ALLIANCE d/b/a PALMETTO RICHLAND MEMORIAL**

2016 JAN 27 AM 10:32
JEANETTE W. McBRIDE
C.C.P. & G.S.
RICHLAND COUNTY
FILED

This matter is before the Court on the motion by Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial ("Palmetto Richland") for reconsideration of the Court's Order denying summary judgment. After careful consideration the Court grants Palmetto Richland's motion for the reasons stated in greater detail, below, and directs that summary judgment be entered on each and every allegation asserted in Plaintiff's Complaint on file in this action.

BACKGROUND

Plaintiff Phillip Durrett ("Durrett") sustained physical injury in a multi-vehicle collision that occurred August 7, 2006. Specifically, Durrett, who was cited for driving too fast for conditions, failed to observe the flashing lights of an ambulance parked in the eastbound median of Interstate 20 to assist another motorist, struck the ambulance in the rear, and became entrapped in his own vehicle for approximately 15-20 minutes. (August 7, 2006 South Carolina Traffic Collision Report Form (Ex. 1 to Def.'s Mot. for Summ. J.)) Durrett sustained "incapacitating injuries", was extricated from his vehicle, and transported from the scene by paramedics with Richland County EMS. (*Id.*; DHEC Patient Care Form (Ex. 2 to Def.'s Mot. for



Summm. J.)) According to the DHEC Patient Care Form, Durrett was agitated but remained stable during transport to Palmetto Richland. (Ex. 2 to Def.'s Mot. for Summm. J.) No medication, other than saline, was administered.

According to Palmetto Richland Emergency Department documentation, Durrett was "awake, alert, and oriented . . . upon arrival" in the ER, displayed a "very aggressive, violent nature", and "was on a back board and C-collar, complaining of left leg pain." (August 9, 2006 record (PRMH 0497-98) (Ex. 3 to Def.'s Mot. for Summm. J.)) He denied tobacco, alcohol, or illicit drug use,[1] and his chart indicates he is allergic to Morphine. (*Id.*) During examination, Durrett "was verbal, cussing, noncompliant, and very uncooperative." (*Id.*) For his protection, and to facilitate his medical examination, Durrett was sedated, intubated, examined, and prepped for further radiologic studies to confirm initial impressions of left leg fracture and abdominal injuries. (*Id.*) During his course of treatment in the Emergency Department, Durrett was started on propofol, became hypotensive, and underwent two precordial thumps[2] prior to returning to sinus tachycardia. (August 10, 2006 Consult (PRMH 0501) (Ex. 4 to Def.'s Mot. for Summm. J.)) Durrett remained at Palmetto Richland until discharged on August 23, 2006. (August 21, 2006 Progress Note and Discharge Summary (PRMH 00513-515) (Ex. 5 to Def.'s Mot. for Summm. J.))

In his Notice of Intent filed August 5, 2009, Durrett alleged Defendant Palmetto Richland and others were negligent in disregarding his instructions and administering "certain (but unspecified) anesthetic and sedative drugs" to him in the emergency room, which caused him to go into cardiac arrest. (Notice of Intent, ¶¶ 7-12) These allegations are repeated essentially

---

[1] Durrett's urine drug screen was positive for amphetamines. (August 11, 2006 Consult Note (PRMH 0502) (Ex. 6 to Def.'s Mot. for Summm. J.))

[2] "Hypotensive" refers to abnormally low blood pressure. "In a precordial thump, a provider strikes with a single blow of the fist to the middle of a persons [sic] sternum. The intent is to interrupt a potentially life-threatening rhythm." http://en.wikipedia.org/wiki/Precordial_thump (last accessed July 16, 2014).

verbatim in Durrett's Complaint filed February 28, 2013. (Plaintiff's Compl., ¶¶ 6-8) Defendants filed their Answer on or about June 24, 2013, in which they asserted a general denial and numerous substantive defenses, including expiration of the statute of limitations, comparative fault, and Durrett's failure to file the required expert affidavit. (Defs.' Answer, ¶¶ 1, 6, 14, and 15)

LEGAL STANDARD

1. Rule 59(e)

The South Carolina Supreme Court has held that "it is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court 'alter or amend the judgment,' but also a vehicle to seek 'reconsideration' of issues and arguments. . . . Consequently, a party usually is allowed to ask the court to reconsider its decision even if it means rehashing all or part of an argument previously presented." *Elam v. S.C. DOT*, 361 S.C. 9, 22, 602 S.E.2d 772, 778-779 (2004).

2. Summary Judgment

South Carolina jurisprudence makes clear that in medical malpractice actions such as this, summary judgment "is appropriate when there is no genuine issue of material fact such that the moving party must prevail as a matter of law." *David v. McLeod Regional Medical Center*, 367 S.C. 242, 626 S.E.2d 1 (2006) (citing SCRCP 56(c)). In order to establish a genuine issue of material fact, Plaintiff must adduce evidence demonstrating "(1) the generally recognized and accepted practices and procedures that would be followed by average, competent practitioners in the defendants' field of medicine under the same or similar circumstances, and (2) that the defendants departed from the recognized and generally accepted standards." *Id.*, 367 at 248-247, 626 S.E.2d at 4 (citing *Pederson v. Gould*, 288 S.C. 141, 143-144, 341 S.E.2d 633, 634 (1986) (additional citation omitted)). Further, Plaintiff must establish that the breach of the applicable

standard of care proximately caused his injuries and damages. *Id.* (citing *Green v. Lilliewood*, 272 S.C. 186, 193, 249 S.E.2d 910, 913 (1978)).

Plaintiff also must "provide expert testimony to establish both the required standard of care and that defendants' failure to conform to that standard, unless the subject matter lies within the ambit of common knowledge so that no special learning is required to evaluate the conduct of the defendants." *Id.*, 367 S.C. at 248, 626 S.E.2d at 4 (citing *Pederson*, 288 S.C. at 143, 341 S.E.2d at 634). In recognition of these requirements, the South Carolina General Assembly has seen fit to impose the requirement that plaintiffs in medical malpractice actions must, prior to the filing of a summons and complaint, file a "Notice of Intent to File Suit and an affidavit of an expert witness, subject to the requirements established in Section 15-36-100. . . ." S.C. Code Ann. § 15-79-125(A); *see also* S.C. Code Ann. § 15-36-100.

ARGUMENT

I. PLAINTIFF'S NOTICE OF INTENT TO FILE SUIT AND COMPLAINT ARE SUBJECT TO SUMMARY DISMISSAL GIVEN HIS FAILURE TO FILE THE TIMELY AFFIDAVIT OF AN EXPERT WITNESS AS REQUIRED BY APPLICABLE STATUTORY PROVISIONS.

The legal issues in this case are simple. Durrett's case is subject to dismissal because he did not file the affidavit of an expert witness in support of his Notice of Intent to File Suit or his Complaint, which is a prerequisite to the filing or initiating of a civil action alleging injury as a result of medical malpractice. *See* S.C. Code Ann. 15-79-125(A) ("Prior to filing or initiating a civil action alleging injury or death as a result of medical malpractice, the plaintiff shall contemporaneously file a Notice of Intent to File Suit and an affidavit of an expert witness. . . ."). Instead, he relied upon the affidavit of his attorney, which expressly relied upon inapplicable provisions of S.C. Code Ann. 15-36-100(C)(2) in an attempt to excuse his failure to comply with the affidavit requirement. As such, Durrett's Notice of Intent to File Suit was procedurally

defective, and his claims are barred by the statute of limitations. Even assuming, without conceding, that Durrett's claims are procedurally viable, he has adduced no competent evidence establishing a genuine issue for trial. As such, summary judgment is appropriate.

A. Procedural Background

Durrett filed his Notice of Intent to File Suit pursuant to S.C. Code Ann. § 15-79-125 on or after August 5, 2009. In that Notice of Intent, Durrett alleged he sustained injuries and damages during his course of medical treatment at Palmetto Richland following his August 9, 2006 automobile accident. Of particular relevance here, Durrett alleges the administration of certain medications by Palmetto Richland personnel caused him to go into cardiac arrest, thereby causing him to sustain injuries and damages.

Durrett's Notice of Intent did not include the affidavit of an expert witness as required pursuant to S.C. Code Ann. § 15-79-125(A). Instead, Durrett submitted the Affidavit of his attorney, Melvin Bannister ("Bannister"), and contended he was not required to submit an affidavit in light of the provisions of S.C. Code Ann. § 15-36-100(C)(2) (excusing the filing of an affidavit with the complaint "to support a pleaded specification of negligence involving subject matter that lies within the ambit of common knowledge and experience, so that no special learning is needed to evaluate the conduct of the defendant."). In his Affidavit, Bannister acknowledged Durrett's notice was filed within ten days of expiration of the statute of limitations and pledged to "file an expert's affidavit to supplement the filing of a Complaint in this matter within forty five (45) days of the filing of such a pleading and a determination by the Court of Common Pleas that such an affidavit is required." (Bannister Aff. (Ex. 7 to Def.'s Mot. for Summ. J.), p. 2, ¶ 3) Durrett never filed the affidavit required by §15-79-125(A) (Notice of Intent

to File Suit) or the affidavit contemplated by § 15-36-100 (complaint alleging professional negligence).

Defendants filed a motion to dismiss Durrett's Notice of Intent pursuant to S.C. Code Ann. §§ 15-79-125 and 15-36-100, as well as Rules 12(b)(1) and 12(b)(6), SCRCP, on or after September 22, 2009. Defendants' motion was based upon: (a) Durrett's failure to follow the statutory conditions precedent to the filing of a medical malpractice action as set forth in § 15-79-125; and (b) Durrett's failure to provide an expert affidavit within 45 days of the filing of a complaint as provided for in § 15-36-100(C). Defendants supported their motion with the Affidavit of William Ross, M.D., who opined to a reasonable degree of medical certainty, and without contradiction, that Defendants did not deviate from the applicable standard of care and that administration of the types of drugs at issue in Durrett's Complaint "is not within the common knowledge of the ordinary lay person and expert testimony is required." (Aff. of W. Ross, M.D., (Ex. 8 to Def.'s Mot. for Summ. J.), ¶¶ 3-4)

The Court of Common Pleas for Richland County filed its order dismissing Durrett's Notice of Intent to File Suit on May 25, 2011. In its order, the court concluded this case involves complex interactions with drugs allegedly resulting in cardiac arrest and other medical complications. (May 25, 2011 Order (Ex. 9 to Def.'s Mot. for Summ. J.), pp. 3-4) Further, the court concluded Durrett ran afoul of S.C. Code Ann. §§ 15-36-100(C)(1) and 15-79-125(A) because he did not file a timely expert affidavit in support of medical malpractice allegations. (*Id.*, pp. 4-5) Durrett moved for reconsideration, and, via Form 4 Order filed April 3, 2012, the court ruled the "[m]otion to reconsider granted. Formal order to follow." (April 3, 2012 Form 4 Order (Ex. 10 to Def.'s Mot. for Summ. J.)) In an order filed nearly 18 months later – on January 8, 2014 – the court noted that "after consideration," the earlier order should be vacated

but provided no additional discussion or analysis of the substantive issues presented[3]. (January 8, 2014 Order (Ex. 11 to Def.'s Mot. for Summ. J.), p. 2) Further, the court determined, pursuant to § 15-36-100(C)(2), that no affidavit was required because Durrett's claims fell within the ambit of common knowledge and ordered the parties to engage in mediation. (*Id.*, pp. 1-2)

Durrett filed his Summons and Complaint on or after February 28, 2013, in which he largely re-asserted the allegations set forth in the Notice of Intent. Defendants answered with a general denial and asserted numerous substantive defenses, including expiration of the statute of limitations, comparative fault, and Durrett's failure to file the required expert affidavit. Thereafter, on July 17, 2014, Palmetto Richland moved for summary judgment on the bases that (1) Durrett failed to support his medical malpractice allegations with the required expert affidavit; and (2) Durrett failed to adduce any evidence to support his claims and that those claims relied entirely upon insufficient conjecture and speculation. Palmetto Richland's motion was heard July 22, 2014, and denied via written order entered December 3, 2014. Palmetto Richland moved to reconsider, and that motion was heard January 25, 2016.

B. Legal Analysis

Section 15-79-125(A) addresses the notice of intent as a prerequisite to filing an action for medical malpractice and requires the plaintiff to file, contemporaneously with his notice of intent, "an affidavit of an expert witness, subject to the affidavit requirements[4] established in Section 15-36-100 . . . ." Turning to Section 15-36-100, that provision sets forth certain

[3] The January 8, 2004 Order only addressed Durrett's Notice of Intent and did not pass upon the sufficiency (or insufficiency) of the matters asserted in his Complaint. Given the absence of meaningful discussion or analysis underlying the January 8, 2014 Order, the undersigned does not consider itself bound thereby. Even setting aside the expert affidavit issue, Durrett's Complaint fails for the additional reasons set forth herein.

[4] These requirements are set forth in § 15-36-100(A)(1)-(3) and address issues such as, but not necessarily limited to, licensure and other relevant credentials and experience.

requirements for complaints alleging professional negligence and the requirement that such complaints be supported by the contemporaneously filed affidavit of an expert witness. Specifically, Section 15-36-100(B) makes clear that "in an action for damages alleging professional negligence against . . . any licensed health care facility . . . the plaintiff must file as part of the complaint an affidavit of an expert witness which must specify at least one negligent act or omission claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit." Subsection (C)(1) affords plaintiffs an additional 45 days to file the required affidavit where "the period of limitation will expire, or there is a good faith basis to believe it will expire on a claim stated in the complaint, within ten days of the date of filing and, because of the time constraints, the plaintiff alleges that an affidavit of an expert could not be prepared." Subsection (C)(2) excuses the contemporaneous affidavit requirement where the alleged negligent act or omission involves subject matter that lies with the ambit of common knowledge and experience. Finally, Subsection (D) makes clear that "[t]his section does not extend an applicable period of limitation . . . ." absent an exception that does not apply in this case.

Durrett failed to file an affidavit of any expert as required pursuant to the statutory provisions addressed in the preceding paragraph. As such, his Notice of Intent to File Suit and Complaint are subject to summary dismissal, and the statute of limitations bars him from seeking recovery against Palmetto Richland. To the extent Durrett relies upon *Ranucci v. Crain*, 409 S.C. 493, 763 S.E.2d 189 (2014) or *Grier v. AMISUB of South Carolina, Inc.*, 397 S.C. 532, 725 S.E.2d 693 (2012), to compel a different result, his reliance is misplaced. *Ranucci* addressed the interplay between §§ 15-79-125 and 15-36-100 at the *pre-suit* phase and affirmed the legislative intent that those provisions be read in harmony. *Grier* addressed (and rejected) the contention

that the plaintiff's *pre-suit* expert affidavit is required to contain an opinion as to proximate cause. Unlike Durrett, the plaintiffs in both of those cases ultimately proffered the affidavit of an expert witness to bolster their medical malpractice claims.

Inasmuch as Durrett failed to comply with the clear requirements of S.C. Code § 15-79-125(A) by filing the required affidavit contemporaneously with his Notice of Intent or at any point thereafter, Durrett's filings are procedurally defective and must be dismissed. The Bannister Affidavit does nothing to change this result. If anything, the Bannister Affidavit is an implicit recognition on Durrett's part that he would be required at some point to support his claims with competent expert testimony. The procedural defects in Durrett's Notice of Intent to File Suit and his Complaint warrant dismissal with prejudice, and his claims are now barred by the statute of limitations.

II. DEFENDANT IS ENTITLED TO SUMMARY JUDGMENT ON THE ADDITIONAL BASIS THAT PLAINTIFF HAS FAILED TO ADDUCE ANY COMPETENT EVIDENCE DEMONSTRATING A GENUINE ISSUE OF MATERIAL FACT FOR TRIAL.

In addition to Durrett's failure to file the affidavit of an expert witness, Palmetto Richland is entitled to summary judgment given Durrett's failure to adduce any competent evidence, expert or otherwise, demonstrating an issue of fact for trial. Specifically, Durrett has not come forward with any evidence to support the allegations in his Complaint that agents of Palmetto Richland disregarded his instructions, administered "anesthetic and sedative drugs" to which he claims to be allergic, and that the administration of these unspecified "anesthetic and sedative drugs" caused him to sustain injuries and damages. (Plaintiff's Compl., ¶¶ 6, 8, 12-15) To the contrary, the only medical evidence of causation in this case demonstrates that Durrett's alleged injuries and damages stem from the interaction of medically necessary medications with the illegal methamphetamine that was present in Durrett's body at the time of his underlying

automobile accident. Furthermore, this case clearly falls outside of the common knowledge exception found in § 15-36-100(C)(2) given the complicated nature of drug interaction, both with other drugs and with the human body. As such, Palmetto Richland is entitled to summary adjudication in its favor on all claims asserted against it in this action.

Pursuant to South Carolina law, "medical malpractice actions require a greater showing than generic allegations and conjecture." *David v. McLeod Regional Medical* Center, 367 S.C. 242, 249, 626 S.E.2d 1, 4 (2006). Indeed, as the South Carolina Supreme Court has observed, "if the patient receives allegedly negligent professional medical care, then expert testimony as to the standard of that type of care is necessary, and the action sounds in medical malpractice." *Dawkins v. Union Hospital District*, 408 S.C. 171, 758 S.E.2d 501 (2014), *reh'g denied* (June 11, 2014) (internal citations omitted). In the uncontroverted opinion of one of Durrett's treating physicians, "[t]he subject matter of this lawsuit involves the use and administration of various anesthetic and/or sedative medications as well as contraindications for various anesthetic and/or sedative medications . . . . [, and] that the utilization of these medications is not within the common knowledge of the ordinary lay person and expert testimony is required." (Ross Aff., (Ex. 8 to Def.'s Mot. for Summ. J.) at ¶ 4) Here, Durrett relies solely upon "generic allegations and conjecture" in support of his claims and has not produced evidence or testimony from any expert who will testify to a reasonable degree of medical certainty on his behalf.

According to Durrett's own testimony, he was anesthetized and therefore unable to provide any medical history to hospital personnel shortly after his admission at Palmetto Richland. (March 12, 2014 deposition of Phillip Scott Durrett (Ex. 12 to Def.'s Mot. for Summ. J.), p. 44, lines 14-20; p. 45, lines 19-20) He further testified that from the time he presented in the emergency room, it "[m]ight have been a minute" that he remained conscious and that he

does not remember anything else until waking up days later. (*Id.*, p. 47, lines 5-21) Along these lines, Durrett could not identify by name any medical provider associated with Palmetto Richland, including the physician he named as a defendant in this lawsuit and later dismissed with prejudice. (*Id.*, p. 50, lines 8-23; p. 54, lines 19-24) Similarly, he did not have any knowledge of what medications he actually received while a patient at Palmetto Richland or what made him vomit following his sedation in the emergency room. (*Id.*, p. 50, lines 6-24) At the same time, he testified he did not tell EMS or Palmetto Richland about any allergies to anesthetic or sedative medications. (*Id.*, p. 65, lines 18-25)

Durrett simply had no memory of what treatment he received or anything specific he discussed with his doctors regarding his treatment. (Durrett Dep., p. 53, lines 4-15) Durrett also candidly admitted he did not recall giving ***any*** medical history to anyone at the hospital, including his alleged allergy to anesthetic and/or sedative medications. (*Id.*, p. 60, lines 9-15) Further, when questioned about which medications he received, Durrett himself acknowledged the medically complex nature of drug interaction when he testified "I have no idea. My getting sick from that stuff like that is kind of hard to research." (*Id.*, p. 65, lines 12-15) Nevertheless, Durrett has failed to identify any expert who will opine that his injuries and damages stem from Palmetto Richland's administration of medications to which he now claims to be allergic, relying instead upon inadmissible hearsay statements attributed to a prior treating physician.

The only medical expert who has offered a causation opinion in this case is Palmetto Richland's retained expert witness, Dr. Robert Clodfelter ("Dr. Clodfelter"). Dr. Clodfelter is board certified in emergency medicine and serves as the Medical Director of the Emergency Department of the Hilton Head Hospital. (June 11, 2014 deposition of Robert Clodfelter, M.D., (Ex. 13 to Def.'s Mot. for Summ. J.), p. 5, lines 5-12) In his review of the relevant medical

records, Dr. Clodfelter noted Durrett arrived at Palmetto Richland in an uncooperative and combative state and, therefore, was given a paralytic agent and a sedative in order to facilitate a "very rapid trauma assessment." (*Id.*, p. 6, lines 12-23)

Dr. Clodfelter also noted that medical records indicate Durrett admitted ingesting methamphetamine the day before the accident, that Durrett's urine drug screen yielded a positive result for that substance, and that Durrett is allergic to morphine and codeine[5]. (*Id.*, p. 19, lines 1-8) Further, the methamphetamines were still present in Durrett's system because that drug metabolizes quickly and would not have been detectible in a urine screen twenty-four hours after it had been ingested. (*Id.*, p. 23, line 16 – p. 24, line 1) In Dr. Clodfelter's opinion, the methamphetamine in Durrett's system could interact adversely with everything and anything given to the patient, resulting in symptoms including altered mental status, cardiac dysrhythmia, and tachycardia. (*Id.*, p. 22, line 25 – p. 23, line 9)

Turning to the paralytic agents hospital staff actually administered (Norcuron and Anectine), Dr. Clodfelter testified these medications are not indicated to have caused Durrett's cardiac issues. (Clodfelter Dep., Ex. 13, p. 26, line 24 – p. 27, line 4) Instead, Dr. Clodfelter agreed with Durrett's treating cardiologist that Durrett's cardiac issues likely resulted from a combination of the methamphetamines in his system, the administration of propofol, and a sharp drop in blood pressure. (*Id.*, p. 27, lines 5-10; August 11, 2006 consult record) Specifically, Dr. Clodfelter opined that Durrett's "cardiac problems were related to dysrhythmia, which means an abnormal cardiac rhythm due to hypotension and the effects of amphetamines." (*Id.*, p. 27, line 25 – p. 28, line 2)

---

[5] Neither morphine nor codeine was administered during Durrett's course of treatment at Palmetto Richland.

The dearth of evidence substantiating Durrett's allegations of medical malpractice plainly demonstrates the absence of any genuine material issue of fact for trial. Moreover, Durrett is nothing like the plaintiff in *Brouwer v. Sisters of Charity Providence Hosps.*, 409 S.C. 514, 522, 763 S.E.2d 200, 203-204 (2014) (plaintiff with a known latex allergy noted on pre-procedure paperwork successfully invoked common knowledge exception at the pre-suit phase). In comparison to plaintiffs in *Brouwer* and related cases, complex issues relating to drug interactions and Durrett's concession that he never conveyed *any* medical history, including known allergies, to hospital staff, prevent him from invoking the common knowledge exception. Given Durrett's reliance on supposition and conjecture, and his failure to come forward with competent expert testimony in support of his claims, Palmetto Richland is entitled to an order granting it summary judgment on each and every allegation asserted against it in this lawsuit.

CONCLUSION

For all of the reasons stated herein, the undersigned has reconsidered the briefing and argument presented by the parties and finds that no genuine issue of act exists with regard to Plaintiff Phillip Durrett's medical malpractice allegations. Therefore, Defendant Palmetto Richland's motion to reconsider is granted, and Palmetto Richland is entitled to summary judgment on each and every allegation directed against it in Plaintiff's Complaint.

AND IT IS SO ORDERED.

RoHood

The Honorable Robert E. Hood
Circuit Judge

1/26, 2016
Columbia, South Carolina

1 STATE OF SOUTH CAROLINA) IN COMMON PLEAS
2 COUNTY OF RICHLAND) COURT
3)
4 PHILLIP DURRETT,)
5) TRANSCRIPT
6 -V-) OF
7) RECORD
8 PALMETTO HEALTH ALLIANCE,) 2013-CP-40-01259
9 DEFENDANT.)
10
11 AUGUST 25, 2011
12 RICHLAND, SOUTH CAROLINA
13
14 B-E-F-O-R-E:
15 HONORABLE L. CASEY MANNING, JUDGE;
16
17 A-P-P-E-A-R-A-N-C-E-S:
18 FOR THE PLAINTIFF:
19 MR. BANNISTER, ESQ.
20
21
22 FOR THE DEFENDANT:
23 MR. CHAMBERS, ESQ.
24
25

1 I-N-D-E-X

2 PG.

3 MOTION: 3

4

5 CERTIFICATION OF REPORTER: 7

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 (The following proceedings were held on
2 August 25, 2011.)
3 THE COURT: This is the case of Phillip Durrent
4 vs. Palmetto Health doing business as Palmetto Richland
5 Memorial Hospital and W. Ross, M.D. It's a motion to
6 reconsider, a 59(e), I do believe?
7 MR. BANNISTER: That's correct.
8 THE COURT: We had a hearing some time ago and I
9 granted the motion to dismiss; is that right?
10 MR. BANNISTER: Correct, Your Honor.
11 THE COURT: And this is your motion for me to
12 reconsider?
13 MR. BANNISTER: It is, Your Honor.
14 THE COURT: I'll hear some brief arguments. I've
15 already made up my mind after reading all the motions and
16 everything, but we need to put it on the record.
17 Go ahead.
18 MR. BANNISTER: Your Honor, you may remember, this
19 is a medical mal case.
20 THE COURT: Uh-huh.
21 MR. BANNISTER: You dismissed this case because an
22 expert witness was not provided -- or an expert witness
23 affidavit was not provided at the time of the filing of the
24 complaint. And we felt that this was under the common
25 knowledge theory that a jury would be able to to determine

1 that there was medical malpractice using their common
2 knowledge.
3 And I've cited several cases to support the theory
4 that in citing a motion for a directed verdict -- and I
5 don't know if this is similar to a motion for a directed
6 verdict, all reasonable inferences which can be drawn
7 therefrom must be viewed in the light most favorable to the
8 nonmoving party.
9 THE COURT: Yes, sir.
10 MR. BANNISTER: And if the evidence supports --
11 THE COURT: Well, first of all, this is a new
12 statute that I don't think there's any one case on by our
13 own supreme court. And I can't remember how long the
14 statute has been in play, a year or so, but everything's a
15 first impression, even this issue that's been raised by my
16 granting of the motion to dismiss. So I'm on the same track
17 with you. I understand your position. Thank you, sir.
18 Be happy to hear from you now.
19 MR. CHAMBERS: Thank you, Your Honor. We move,
20 obviously, Your Honor, that an expert affidavit is required
21 in this case pursuant to the statute which this falls
22 within. It does not fall within a common knowledge
23 exception. According to the Plaintiff's own notice of
24 intent, this case involves the use, administration and
25 effects of anesthetic and sedative drugs that's clearly set

1 out in paragraphs five, seven, eight, nine and ten of this
2 paragraph. We've also alluded to this in our reply for the
3 Plaintiff's motion for reconsideration. And not only for
4 the duty of negligence, but for the proximate cause issues
5 because if they're alleging that the use of this medication
6 caused the Plaintiff to have a cardiac respiratory arrest
7 and eventually go into a coma, we just plead there are
8 numerous medical issues involved here that require expert
9 testimony.
10 THE COURT: All right. I don't necessarily
11 disagree with any of y'all's positions, but I think since it
12 is a matter of first impression, out of an abundance of
13 caution, I've decided after some thought -- obviously, I
14 gave thought to the proposed orders, the new statute and
15 everything, I'm going to grant the 59(e) motion and let
16 y'all proceed.
17 In making this decision, everybody's rights still
18 preserved, even yours for purposes of appeal. I hate to put
19 anybody in the position when you think you've won, you
20 didn't win, but I think these issues should be flushed out
21 at another level. That's the reason for me changing my
22 decision in this case.
23 I'll do a little short order. I'll be happy to
24 talk to y'all in chambers and try to figure out something
25 logistically if that's necessary. But, essentially, after

1 due reflection and out of an abundance of caution, I think
2 probably I should make the decision I've just made.
3 Thank you all so very much. Y'all need two
4 minutes with me in chambers or is everybody okay? Y'all
5 okay?
6 MR. CHAMBERS: Maybe at a later time, we can
7 just --
8 THE COURT: Okay. Sometime in the next three or
9 four days, if y'all need to chitchat. Thank you all so very
10 much.
11
12
13 END OF PROCEEDINGS
14
15
16
17
18
19
20
21
22
23
24
25

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

Phillip Durrett,)
PLAINTIFF,)
VS.)   TRANSCRIPT OF RECORD
)   CASE 2013-CP-40-1259
Palmetto Health Alliance)
d/b/a Palmetto Richland)
Memorial and W. Ross, MD,,)
DEFENDANTS.)

July 22, 2014
Columbia, South Carolina

B E F O R E:

THE HONORABLE ROBERT E. HOOD, JUDGE.

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

MELVIN D. BANNISTER, ESQ.
ATTORNEY FOR THE PLAINTIFF

CARMELO B. SAMMATARO, ESQ.
ATTORNEY FOR THE DEFENDANT

WENDY WISE DERRICK
OFFICIAL COURT REPORTER

1
2
I N D E X

3
4
5

Argument by Mr. Sammataro	3 & 7
Argument by Mr. Bannister	10
Order of The Court	12
Certificate of Reporter	13

6
7
8
9
10
E X H I B I T S

11
No exhibits were presented.

12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 THE COURT: So this is defendant's motion for
2 summary judgment; is that correct?
3 MR. SAMMATARO: That's correct, Your Honor.
4 THE COURT: All right. Be happy to hear from
5 you, sir.
6 MR. SAMMATARO: Thank you, Judge.
7 Your Honor, there is a medical malpractice
8 action that stems from plaintiff Mr. Durrett's
9 August 2006 automobile accident. Mr. Durrett was
10 driving down I-20, didn't notice the blinking lights
11 of an ambulance. Rear ended it and was entrapped in
12 his vehicle for about 15, 20 minutes before they
13 were able to extricate him and transport him
14 emergently to Richland Memorial Hospital here in
15 Columbia. He was combative upon presentation. So
16 hospital personnel made the medical decision that he
17 needed to be sedated and intubated so that he could
18 be examined and forwarded on to radiological
19 imaging.
20 According to the notice of intent that was
21 filed by Mr. Durrett and supporting affidavit of his
22 attorney, Mr. Durrett informed hospital personnel he
23 had allergies to certain sedative medications that
24 aren't specified in that notice. And then he
25 informed Richland Memorial staff not to administer

1 those medications or else he'd go elsewhere.
2 The issue before the Court -- one of the issues
3 is two-prong argument. First is that Mr. Durrett
4 failed to comply with South Carolina Code Section
5 15-79-125 (A) which is the statutory provision
6 dealing with Notice of Intent to file medical
7 malpractice actions and requires the contemporaneous
8 filing of an affidavit of an expert witness to
9 support the Notice of Intent. That affidavit was
10 never filed. We moved to dismiss. And at that
11 time, Judge Manning was hearing the motion. He
12 originally granted the motion. The motion was based
13 on failure to file contemporaneous affidavit. And
14 also by that point a complaint had been filed and
15 it, likewise, was not supported by an expert
16 affidavit as required by South Carolina Code Section
17 15-36-100. Judge Manning concluded inconsistent
18 findings that were in the affidavit of our expert by
19 the administration of medication and effects of
20 those medications are clearly not within the ambit
21 of common knowledge and experience. So an affidavit
22 was required.
23 Fast forward. The plaintiff filed a motion for
24 reconsideration of the Court issued a Form 4 Order
25 granting that motion indicating that a more formal

1 order would be forthcoming. That order was issued
2 in January of this year. It found that the -- the
3 affidavit was not required and that the parties
4 should be -- should mediate the case or directed to
5 mediate the case.
6 But, Your Honor, taking a second look at the
7 affidavit requirement in 15-79-125, it's clear that
8 the affidavit must be filed contemporaneously with
9 the Notice of Intent. That wasn't done here. There
10 is no -- I'm citing to the case of Ranucci versus
11 Crain which is reported at 397 SC 168, 723 S.E.2d
12 242. The Court of Appeals in that case made
13 absolutely clear that the only portion of 15-36-100
14 that applies is that the affidavit filed with the
15 Notice of Intent deals with qualification of the
16 expert and the affidavit as contained. It's
17 absolutely clear under that case law that the
18 affidavit has to be filed at the same time as the
19 Notice of Intent which wasn't done here. And the
20 Ranucci case, the majority of the Court held that
21 the affidavit has to be -- has to be at the same
22 time. Can't come afterward which is what the
23 plaintiff's facts was in that case. She filed it
24 more than 45 days after her Notice of Intent was
25 filed, and the Court of Appeals said you can't do

1 that. It has to be filed at the same time. I have
2 an extra copy for the Court.
3 THE COURT: No. No. I'm just looking -- they
4 pulled up the statute. So I can look right at it.
5 Thank you.
6 MR. SAMMATARO: So the legal argument that
7 we're making is that because Mr. Durrett never filed
8 that contemporaneous affidavit with his Notice of
9 Intent, that was a procedural defect that's never
10 been cured. It can't be cured. So we're entitled
11 to dismissal of the Notice of Intent.
12 Looking past, that the plaintiff's clearly
13 beyond the statute of limitations as his treatment
14 was in August of 2006, and here we are in 2014.
15 But we also, Your Honor -- even if the Court is
16 not persuaded by the legal argument as it was
17 addressed almost point for point by the Court in
18 Ranucci, taking a look at the facts of the case as
19 they've developed, there's no factual support for
20 Mr. Durrett's claims. Specifically in his
21 deposition testimony Mr. Durrett testified he had no
22 memory and was unable to provide any history to
23 hospital staff. Never gave them any medical history
24 that he was allergic to any medication, let alone
25 the medications that were administered by the

1 hospital. He didn't even tell EMS nurses, doctors,
2 nobody that he had medical allergies. It also sort
3 of pits on the complex nature of what we're talking
4 about. He said it's kind of a mystery to him. He's
5 had trouble researching why certain medications,
6 certain sedative medications make him ill. Just
7 sort of underscores the need for expert testimony in
8 the case.
9 And, Your Honor, the only expert who's
10 testified is the expert from Palmetto Health
11 Richland Memorial Hospital. And what Dr. Clotfelter
12 said is that there was no medical malpractice here.
13 That the medical issues that Mr. Durrett had upon
14 admission at Richland Memorial were a combination of
15 amen methamphetamines that were in his system, low
16 brood pressure, and interaction with this propofol
17 which was administered by hospital staff.
18 That's a pretty quick overshot of our argument,
19 Your Honor. I'd be happy to answer any questions.
20 That's the substance of it. We submitted a
21 memorandum last week.
22 THE COURT: We have it. Thank you. I
23 appreciate that.
24 All right. Mr. Bannister.
25 MR. BANNISTER: Your Honor, an affidavit from

1 the expert witness is not required in this case
2 because the Code says the contemporaneous filing
3 requirements of Subsection B is not required to
4 support a pleadings specification of negligence
5 involving subject matter that lies with the ambit of
6 common knowledge and experience so that no special
7 learning is needed to evaluate the conduct of the
8 defendant.
9 In this case, the defendants supplied sedative
10 medication to my client against his specific
11 instructions. Don't give me any sedative
12 medications. That's shown on his affidavit. That's
13 attached as Exhibit 1 in the materials I just handed
14 up. And it was for this reason that Judge Manning
15 vacated the original order of dismissal because we
16 argued that this would be within the common
17 knowledge of the jury to determine that the
18 defendants committed malpractice by providing these
19 sedative medications to which my client was
20 allergic.
21 So I believe Judge Manning's order -- final
22 order, it should be the law in this case. And they
23 shouldn't get another two, three, four, however many
24 times they want to take to try and get this case
25 dismissed because we did not file an affidavit -- an

1 expert witness affidavit.
2 Attached also to the memorandum or return here
3 are some documents that are basically the readouts
4 concerning the different medications that were
5 supplied or given to my client. And in some of
6 those it's clear that one of the medications was
7 contraindicated. Even if he hadn't been allergic,
8 it's contraindicated due to the multiple traumas
9 that my client suffered in the accident prior to
10 reaching the emergency room. It should be noted
11 that the EMS personnel complied with my client's
12 instructions and did not give him any medication
13 between the time they arrived at the accident scene
14 until they got Mr. Durrett to the defendant's
15 hospital.
16 So I believe we've alleged in here certain
17 factual allegations that would show that we
18 certainly have a jury issues, and that it does not
19 take an expert witness to say that these medications
20 should not have been given to him when he gave
21 specific instructions not to.
22 THE COURT: All right. What about the statute
23 of limitations argument?
24 MR. BANNISTER: Your Honor, this action was
25 filed timely with the Notice of Intent. The Notice

1 of Intent tolls the statute of limitations.
2 THE COURT: So when was that filed?
3 MR. BANNISTER: That was filed in August 5th of
4 2009.
5 THE COURT: All right. What about your
6 client's deposition that he has no memory of telling
7 anybody anything?
8 MR. BANNISTER: Well that's -- obviously,
9 that's something that I normally use to
10 cross-examine and try to impeach him based upon the
11 information that we have provided.
12 THE COURT: All right. Mr. Sammataro.
13 MR. SAMMATARO: Your Honor, just briefly in
14 reply if I might. I would point out, at least based
15 on the documents that we have, I don't believe
16 Mr. Durrett's affidavit was ever actually filed.
17 Even if it was filed, it conflicts with his sworn
18 testimony in his deposition. And he never told EMS
19 or hospital personnel that he was allergic to
20 anything or that he made any verbal instructions to
21 them consistent with what he sets out in that
22 affidavit.
23 Secondly, I think that Mr. Bannister's
24 contraindication argument clearly underscores the
25 need for Mr. Durrett to have an expert to support

1 his version of events. They have three years of
2 litigation. And they haven't done that.
3 Turning to Mr. Bannister's argument about the
4 code sections here. He was reading from, Your
5 Honor, 15-36-100. And the Court of Appeals in this
6 Ranucci case -- I'd be happy to hand it up if Your
7 Honor needs a copy of it -- it's clear that
8 15-36-100, specifically the portions about the
9 45-day window, if they can't get an affidavit filed
10 in time with the complaint and more importantly with
11 the provision that excuses the affidavit
12 requirement, if the substance of lawsuit is within
13 the ambit of common knowledge and experience, those
14 expressly do not apply to 15-79-125. That's the
15 exact point the Court of Appeals makes in the
16 Ranucci case. Ranucci says that in the pre-suit
17 phase the only thing about Section 100 that is
18 applicable is the part about the affidavit from the
19 expert. The expert has to be licensed in relevant
20 field. He has to provide at least one incidence of
21 alleged malpractice or deviation from the standard
22 of care. Subsection A of 100. That's the only part
23 of this section that crosses over and has
24 application in the pre-suit phase because what the
25 Court of Appeals in it's opinion is that there's no

1 choice essentially on the part of the plaintiff in a
2 medical malpractice action which is how this was
3 pled. And for Mr. Bannister to try and take
4 advantage of the 45-day window or the exemption of
5 not having to file an affidavit at all, those
6 clearly are not applicable.
7 And so turning to the notice that was actually
8 filed in the case, it was procedurally defective.
9 So it does nothing to toll the statute of
10 limitations in this case. I can't -- I mean, I
11 couldn't make my argument any better than to stand
12 here and read to the Court under the Ranucci
13 decisions exactly on all fours with the motion that
14 we presented to the Court and Mr. Durrett's lawsuit.
15 THE COURT: All right. We have the Ranucci
16 case.
17 Anything further, Mr. Bannister?
18 MR. BANNISTER: No, Your Honor.
19 THE COURT: Okay. Thank you very much. We'll
20 probably let you know by the end of the week. By
21 the end of the week.
22 MR. SAMMATARO: Thank, Judge.
23 THE COURT: Okay. Thank you.
24
25

1 CERTIFICATE OF REPORTER

2

3

4 STATE OF SOUTH CAROLINA)
)
5 COUNTY OF RICHLAND)

6

7

8 I, Wendy Wise Derrick, Official Court Reporter for
9 the Eleventh Judicial Circuit of the State of South
10 Carolina, do hereby certify that the foregoing is a true,
11 accurate and complete Transcript of Record of the
12 proceedings had and evidence introduced in the trial of
13 the captioned case, relative to appeal, Court of Common
14 Pleas for Richland County, South Carolina, on the 22nd day
15 of July, 2014.
16 I do further certify that I am neither of kin,
17 counsel nor interest to any party hereto.

18

19

20

21

22 [signature]
23 Wendy Wise Derrick, Court Reporter
24 My Commission Expires: 12-30-2024
25

1 State of South Carolina | Court of Common Pleas
2 County of Richland | Fifth Judicial Circuit
3
4 Phillip Durrett,) Transcript of Record
)
5 Plaintiff,)
)
6 vs.) 2013-CP-40-01259
)
7 Palmetto Health Alliance,)
 d/b/a Palmetto Richland)
8 Memorial, et al.,)
)
9 Defendant.)
10
11 January 25, 2016
 Columbia, South Carolina
12
13 B E F O R E:
14 The Honorable Robert E. Hood, Judge
15
16 A P P E A R A N C E S:

COPY

17 Melvin D. Bannister, Esquire
 On behalf of the Plaintiff
18
 Carmelo B. Sammataro, Esquire
19 On behalf of the Defendant
20
21
22 STACY S. JOHNSON
 CIRCUIT COURT REPORTER
23
24
25

1 I N D E X

2 WITNESS PAGE

3 Certificate Of Reporter 17

4

5 E X H I B T S

6 (No exhibits were marked.)

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 (The following proceedings were held on January 25,
2 2016.)
3 **THE COURT:** All right. We're on the record in
4 Phillip Durrett versus Palmetto Health Alliance, doing
5 business as Palmetto Richland Memorial, and W. Ross, M.D.
6 This is Civil Action Number 2013-CP-40-1259. Present for
7 the Plaintiff is Attorney Melvin Bannister. Present for
8 the hospital is Sam Sammataro representing them.
9 Now at some point in time in history we did a summary
10 judgment motion; is that right?
11 **MR. SAMMATARO:** That's right, Your Honor.
12 **THE COURT:** Approximately when was that? Ball park
13 me.
14 **MR. SAMMATARO:** It was late 2014.
15 **THE COURT:** Okay. Late 2014. And did I -- I
16 officially ruled on that; is that correct?
17 **MR. SAMMATARO:** You did, Your Honor. You requested
18 an order from Mr. Bannister and that order was entered.
19 **THE COURT:** Okay. And then subsequent to that you
20 filed a motion to reconsider; is that right?
21 **MR. SAMMATARO:** That's correct, Your Honor.
22 **THE COURT:** And for whatever reason the first time I
23 ever heard about that was within the past thirty days, in
24 December, right before Christmas. So I don't know how
25 that missed me. I apologize. I would have never kept

1 something pending that long.

2 **MR. SAMMATARO:** Well, Your Honor, if it was on our

3 end, we apologize as well.

4 **THE COURT:** Well, and I'm not blaming anybody and

5 that's no slight on any of the attorneys. If I had to

6 bet, it's more likely an issue with the clerk's office

7 than it is anything else, but this wasn't -- we keep a

8 -- we keep a Matters Under Advisement report that we

9 submit to Court Administration on every case that is --

10 we haven't made a decision on that's over thirty days.

11 This one's never even appeared on it because we didn't

12 even know we had it to consider.

13 So I sincerely apologize, first, to the attorneys

14 and, more importantly, to the respective parties who have

15 been waiting on me wondering what in the world I am doing.

16 I assure you I -- it's just not been sitting on my desk

17 and me not doing anything with it. So to the hospital and

18 to the doctor and to Mr. Durrett, I sincerely apologize

19 for the extreme delay. It's inappropriate and if I had

20 known I would have dealt with it much sooner, so I do

21 apologize.

22 Okay. So, Mr. Sammataro, you have filed a motion to

23 reconsider my order on the summary judgment motion; is

24 that correct?

25 **MR. SAMMATARO:** That's correct, Your Honor.

1 **THE COURT:** All right. I'll be happy to hear from
2 you.
3 **MR. SAMMATARO:** Thank you, Your Honor. And I
4 appreciate you taking the time to hear us.
5 **THE COURT:** No, sir. I wanted to get it done and
6 Mr. Bannister was in trial last week, I believe --
7 **MR. BANNISTER:** That's right, Your Honor.
8 **THE COURT:** -- and, so, you know, I told the law
9 clerk whatever we need to do once everybody's available
10 I'll stop whatever else I'm doing to get it resolved.
11 So this is a -- Mr. Durrett went to the hospital.
12 Tell me the --
13 **MR. SAMMATARO:** I can give you the facts, Your Honor.
14 **THE COURT:** Give me a brief play of the facts and
15 let's go from there.
16 **MR. SAMMATARO:** All right. Your Honor, Mr. Durrett
17 back in August of 2006 was travelling on I-20. He
18 encountered a lights and sirens ambulance bus parked in
19 the center median assisting another motorist and collided
20 with that ambulance and was transported emergently to
21 Richland Memorial Hospital. He was administered saline
22 in the back of the ambulance and when he got to Palmetto
23 he was combative, cursing, et cetera, yelling at hospital
24 staff, and so the decision was made to sedate him so that
25 they could do a rapid trauma assessment.

1 During the course of his hospitalization, hospital
2 personnel administered propofol, which our contention is
3 reacted with the methamphetamine that was present in his
4 system, along with a hypotensive state where he had a low
5 heart rate, and he went into cardiac arrest in which he
6 was resuscitated. He had a somewhat lengthy stay at the
7 hospital, I think approximately about a week or a bit
8 longer, and ultimately was discharged from the hospital
9 and as far as I know is doing well.
10 On the eve of the statute of limitations for the
11 required notice of intent to file suit, Mr. Durrett filed
12 the notice that was supported by Mr. Bannister and what
13 Mr. Bannister's affidavit said is we recognize we're up
14 against a time crunch and so as the statute permits we're
15 gonna get an expert affidavit within forty-five days.
16 That affidavit was never forthcoming. There was pretty
17 weird procedural history with regard to the notice of
18 intent.
19 Ultimately, by Form 4 order, Judge Manning allowed
20 the case to proceed without the required expert affidavit
21 and so all that time later we came before the Court, Your
22 Honor, on a motion for summary judgment that was -- the
23 argument was twofold. First was that Mr. Durrett never
24 filed the required expert affidavit to support his
25 allegations of medical malpractice and even if you set

1 that requirement aside, Your Honor, the facts of this
2 case entitle the Defendant to summary judgment.
3 I will say that Dr. Ross, who was the individual
4 named doctor, has long since been dismissed from the case,
5 so it's just the hospital that's the Defendant.
6 **THE COURT:** Okay. Thank you for -- I was just reading
7 the names on there, so I apologize for that.
8 **MR. SAMMATARO:** Sure.
9 **THE COURT:** Dr. Ross is out, so it's just the
10 hospital?
11 **MR. SAMMATARO:** Right.
12 **THE COURT:** Okay.
13 **MR. SAMMATARO:** And so, Your Honor, at summary
14 judgment the basic argument was this case is all about
15 causation, what caused Mr. Durrett to go into cardiac
16 arrest, and Mr. Durrett, relying on a hearsay statement
17 from a prior treating physician, has this theory that he
18 is allergic to sedative medications that would include
19 like morphine, codeine, things like that. Both of those
20 were in his hospital record as an allergy. He wasn't
21 administered those medications. Now if our expert is
22 correct, those medications, including the methamphetamine,
23 the illegal methamphetamine that was in his system, and
24 the interaction with the propofol that was administered to
25 sedate him for the rapid trauma assessment and his low

1 heart rate combined and his reaction to all those things
2 was a side effect. That requires medical causation
3 testimony from a qualified expert, Your Honor.
4 So the argument is, number one, he never filed the
5 required affidavit, so the case should have been dismissed,
6 and he is now barred by the statute of limitations from
7 proceeding on his medical malpractice claims. But even
8 if you disagree on that front, there's absolutely no
9 evidence in this case that some undisclosed, unknown
10 allergy to unidentified sedative medications caused him to
11 go into cardiac arrest.
12 And if you look at the transcript of Mr. Durrett's
13 deposition testimony, he admits he was awake and alert when
14 he got to the hospital. He could have communicated this
15 supposed allergy of his to hospital personnel, but he
16 didn't. Mr. Durrett after the fact looked at his medical
17 records, reviewed his medical records, but didn't -- didn't
18 know what caused him -- didn't know what medicines he took
19 or what medicines supposedly caused him to go into this
20 cardiac episode that he sustained.
21 **THE COURT:** So there were medical records that said
22 he was allergic to medicine that the hospital knew about
23 and the hospital did not administer those medicines?
24 **MR. SAMMATARO:** That's correct, Your Honor. And
25 that's all set out in the memo we filed in support for

1 our motion for summary judgment --

2 **THE COURT:** Okay.

3 **MR. SAMMATARO:** -- and our motion to reconsider. And

4 so in his deposition testimony Mr. Durrett also implicitly

5 acknowledges that these are complicated issues that require

6 somebody with the requisite skill, knowledge and experience

7 to testify to because he says -- when we asked him, you

8 know, what happened, what caused this episode that you

9 have, he says I have no idea, I don't know. It sort of

10 escapes him as to how all this stuff worked together in his

11 system to both get him sick and to recover, I suppose.

12 Now if you compare that to what we brought forward in

13 the case, our testifying expert would say he agrees with

14 the treating cardiologist who said that the cardiac episode

15 was the result of interaction with propofol and the illegal

16 methamphetamines in his system plus his hypotensive state

17 that threw his cardiac rhythm out of whack and he had this

18 reaction to it. You compare that with absolutely no expert

19 testimony on -- on Mr. Durrett's side, he failed to meet

20 his burden of proof both as to the standard of care and as

21 to causation, and so that's -- in a very quick nutshell,

22 that's our argument, Your Honor.

23 **THE COURT:** All right. Mr. Bannister?

24 **MR. BANNISTER:** Your Honor, he was brought into the

25 ER -- well, in the ambulance prior to getting to the ER,

1 he did not take any -- any medication. As Mr. Sammataro
2 says, he received some saline solution, did not take any
3 medication. When he gets into the ER, he's not having any
4 heart problems, he's not having any respiratory problems.
5 They don't -- the hospital agents do not take any history
6 from my client. He tells them if they're gonna sedate him
7 he wants to go to another hospital and he is -- when he
8 arrived in the ER he is loud. I'm not sure combative, but
9 he's very loud requesting that the agents take the strap
10 across his broken leg -- to undo that strap that's causing
11 him so much pain and causing him to be very loud. So
12 against his instruction not to give him anything, whether
13 it's the many -- or additional medications after the
14 propofol that caused him to go into cardiac arrest and
15 pulmonary arrest and into a coma, Mr. Durrett is -- you
16 know, was aware of sedative medications causing him
17 problems, he had had surgeries before, and so he -- he
18 knew that he would have a problem if they gave him any
19 sedation, and that's clear in the deposition testimony.
20 So Judge Manning initially ruled that an expert
21 affidavit would be required on motion for reconsideration.
22 He reversed that and said no expert affidavit would be
23 required to -- with the filing of the notice of intent.
24 If no expert witness affidavit is required for the notice
25 of intent, why would it be required when filing the

1 complaint? The -- and Your Honor ruled in your order of
2 December 14th that an expert witness affidavit would not
3 be required because the jury has enough common knowledge
4 and experience to determine whether or not it was a
5 violation of medical malpractice for the agents to -- the
6 Defendant to give him these medications, one, against his
7 instruction and, two, without ever taking a history from
8 him that -- of what he might be allergic to or to explain
9 the ramifications or consequences of -- the possible
10 consequences for giving these medications to him.
11 There are records that indicate in -- that he is
12 allergic to morphine and codeine, which he was not given,
13 but that -- that information was not given by my client
14 nor do we know when it was given. This -- this history
15 information, we don't know who gave it or when it was given
16 to -- to the Defendant, and so we believe that information
17 -- and if they'd asked him in the history, he would have
18 told them that he was allergic to morphine and codeine, but
19 since they never had talked with him about that, we believe
20 that all of the medications given to him should not have
21 been given. He was coherent, he could -- and under --
22 heart rate was normal, everything was normal, except they
23 knew he had a broken leg and a gash on his arm. That was
24 obvious. And so considering that without any heart
25 problems prior to that we feel the Defendant was negligent

1 -- grossly negligent in supplying these medications to
2 him and because of that that would be under the common
3 knowledge and experience of the jury to know that you're
4 not supposed to give medications to someone who says he
5 don't want them. Thank you.
6 **THE COURT:** Help me with the fact that Judge Manning
7 let the case go forward anyway. I don't really -- how did
8 that come about?
9 **MR. SAMMATARO:** Your Honor, I don't know how it came
10 about either. Judge Manning initially ruled that an expert
11 affidavit was required. I have a feeling, and I don't
12 know, I haven't asked him this question, that it probably
13 had something to do with the statute of limitations. The
14 only thing reversing that decision was a Form 4 order that
15 didn't provide any reasoning for why we switched tack
16 there, just that the motion to dismiss was gonna be denied.
17 We never got a formal order providing any rationale or
18 reasoning behind that.
19 If I could just briefly in rebuttal to some of
20 Mr. Bannister's comments?
21 **THE COURT:** Sure.
22 **MR. SAMMATARO:** And this is in the briefing. When
23 Mr. Durrett was transported to the emergency room at
24 Richland Memorial, he was, quote, awake, alert and
25 oriented, but he, quote, displayed a very aggressive,

1 violent nature. He denied tobacco, alcohol or illicit
2 drug use. So what they did, medical personnel made the
3 decision to sedate him for rapid trauma assessment because
4 he had suspected internal abdominal injuries, plus the
5 obvious fracture of one of -- I believe it was the left
6 leg, I'm not positive about that -- one of the legs. He
7 was verbal, cussing, noncompliant and very uncooperative,
8 but, as Mr. Bannister says, he was coherent. If he had
9 chosen to communicate some medical information about
10 alleged allergies to medicines, he could have done that,
11 but he didn't. He also relies on his own assessment of
12 what it is that he's allergic to. He's not a medical
13 doctor, he has no medical training. He has a high school
14 diploma and he runs -- owns and operates a motorcycle
15 custom repair and building shop. He was only awake for
16 about a minute in the ER when they decided to put him down
17 -- or put him under so that they could do the assessment
18 they needed to do that would hopefully save his life.
19 This -- this business about the prior operations, that's
20 entirely based on hearsay testimony from a treating
21 physician that wasn't identified as a witness or deposed
22 in this case. And by Mr. Durrett's own testimony there
23 are ways to -- that he could be sedated without becoming
24 nauseated, but he didn't share any of that with hospital
25 personnel.

1 And so, you know, I -- I think the main reason we
2 filed this motion to reconsider is we don't think it's
3 right that the hospital be bound by some sort of law of
4 the case that no expert affidavit was required. I think
5 that is a legal determination for the Court and so to the
6 extent that Your Honor denies the motion to reconsider
7 based on that, we certainly understand it, but even setting
8 aside that affidavit issue Mr. Durrett cannot go forward
9 on a medical malpractice case because the interaction to
10 these medications, both medication medication, but also
11 within the human body, just perforce is something that's
12 complicated and is gonna require expert testimony to assist
13 the jurors in the case. None of that has been provided by
14 Mr. Durrett in almost, you know, four years of litigation.
15 Here we are on -- on the morning of trial and we still have
16 nothing from Mr. Durrett that would explain at least from
17 the Plaintiff's perspective what caused him to go into
18 cardiac arrest, so it circles back to what I said when I
19 stood up the very first time. This is a causation case and
20 Mr. Durrett doesn't have any evidence of causation other
21 than what he says about being allergic to medication and
22 we submit to you, Your Honor, that that's not enough.
23 **THE COURT:** Where are you-all on the trial docket
24 this week?
25 **MR. SAMMATARO:** First. We start right after this

1 hearing.

2 **THE COURT:** Okay. All right. And who are you in

3 front of, Judge Lee?

4 **MR. SAMMATARO:** That's correct, Your Honor.

5 **THE COURT:** Okay. All right. Anything else,

6 Mr. Bannister, for the record?

7 **MR. BANNISTER:** Your Honor, it's speculation on

8 Defendant's counsel's part that Judge Manning changed his

9 ruling.

10 **THE COURT:** He admitted it was speculation. He

11 didn't -- but he said there was a Form 4 with no

12 explanation.

13 **MR. BANNISTER:** That's right.

14 **THE COURT:** He didn't say that this is why -- you

15 know, I know for a fact this is why Judge Manning changed

16 his mind. He just -- he said this is what I guess

17 essentially and he said -- I think he said I feel, but,

18 I mean, he wasn't saying it as if it was the law of the

19 case, but he said there was a Form 4 with no basis for the

20 reconsideration. I didn't take it as in that was gospel

21 from Judge Manning.

22 **MR. BANNISTER:** And obviously, Your Honor, Judge

23 Manning could have changed his --

24 **THE COURT:** Right.

25 **MR. BANNISTER:** -- opinion based upon the matter that

1 was put before him and that he felt that a jury using
2 their common knowledge and experience could determine
3 whether malpractice was committed in this case.
4 **THE COURT:** Okay. All right. I'll -- I'm gonna go
5 discuss what I'm gonna do with Judge Lee and we'll let
6 you-all know quickly because I know you-all are up on the
7 trial docket.
8 **MR. BANNISTER:** Thank you, Judge.
9 **THE COURT:** Thank you.
10 (Whereupon, the proceedings were concluded at
11 10:10 AM.)
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 C E R T I F I C A T E

2

3 I, Stacy S. Johnson, Official Court Reporter for

4 the Eleventh Judicial Circuit of the State of South

5 Carolina, do hereby certify that the foregoing is a true,

6 accurate and complete transcript of record of all the

7 proceedings had and the evidence introduced in the hearing

8 of the captioned case in Circuit Court on the 25th day of

9 January, 2016.

10 This transcript may contain quoted material. Such

11 material is reproduced as read by the speaker.

12 I do further certify that I am neither of kin,

13 counsel, nor have an interest to any party hereto.

14

15 April 20, 2016

16

17 Stacy S. Johnson

STACY S. JOHNSON

18 CIRCUIT COURT REPORTER

19

20

21

22

23

24

25

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
Phillip Durrett,	)	IN THE FIFTH CIRCUIT
PLAINTIFF,	)	NOTICE OF INTENT TO FILE SUIT
VS	)	
Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,	)	
DEFENDANT.	)	

RICHLAND COUNTY
FILED
2009 AUG -5 PM 4:53
JEANETTE W. McBRIDE
C.C.P. & G.S.

Pursuant to S.C. Code Ann. 15-79-125, Plaintiff files this Notice of Intent to File Suit. Attached, as Exhibit A, is Plaintiff's short and plain statement of the facts. The short and plain statement of facts is styled as a complaint. Attached, as Exhibit B, is the affidavit from the attorney in this case attesting that this case is within 10 days of the statute of limitations. An Affidavit of an expert is not required under the South Carolina Code of Laws § 15-36-100 (C) (2). Attached as Exhibit C are answers to Standard Interrogatories as set forth in S.C.R.C.P. 33 (b).

Melvin D. Bannister
5115 Forest Drive Suite G-1
Post Office Box 6833
Columbia, South Carolina 29260
(803) 782-8688
(803) 782-8677 Facsimile
sctriallawyer@bellsouth.net

Columbia, South Carolina

August 4, 2009

EXHIBIT A

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
Phillip Durrett,	)	IN THE FIFTH CIRCUIT
PLAINTIFF,	)	
VS	)	
Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,	)	STATEMENT OF CASE
DEFENDANT.	)	

RICHLAND COUNTY
FILED
2009 AUG -5 PM 4:43
JEANETTE W. McBRIDE
C.C.P. & G.S.

The Plaintiff would show the following:

1. The Plaintiff is a resident of Lexington County, South Carolina; the Defendant Palmetto Health Alliance (hereinafter referred to as Richland) is a corporation and is doing business in Richland County, South Carolina; on information and belief, the Defendant, W. Ross, M.D., is a resident of Richland County, South Carolina.
2. On August 9, 2006, the Plaintiff was involved in an automobile accident.
3. The Plaintiff received physical injuries as a result of the said automobile accident.
4. The Plaintiff was transported to the hospital, which is owned and operated by the Defendant Richland by Emergency Medical Services personnel.
5. Upon the Plaintiff's arrival at the hospital operated by the Defendant Richland, the Plaintiff informed the medical personnel and agents of the Defendant Richland that he was allergic to anesthetic and sedative drugs and that the personnel were not to provide, administer, and/or treat the Plaintiff with any said drugs.

6. The Plaintiff further stated to the agents of Defendant Richland and to Defendant Ross that if any said drugs were to be administered that the Plaintiff would go to another hospital.
7. The Defendants disregarded the Plaintiff's specific instructions and administered certain anesthetic and sedative drugs to the Plaintiff.
8. The Defendants and their agents, including other medical personnel, failed to monitor the Plaintiff after the administration of the said drugs and administered more of the said drugs to the Plaintiff.
9. As a result of the administration of the said drugs, the Plaintiff suffered cardiac and respiratory arrest.
10. As a result of the administration of the said drugs, the Plaintiff went into a coma and/or catatonic like state for approximately 9 days.
11. The Plaintiff had to receive additional medical treatment and expense as a result to the actions of the Defendants.
12. That the Defendants were negligent, grossly negligent, willful, wanton, and careless, at the time and place above-mentioned in the following particulars:
    a. In disregarding the specific instructions of the Plaintiff concerning the Plaintiff's medical treatment, including, specifically, the administration of certain drugs;
    b. In the administration of certain drugs;
    c. In failing to monitor the Plaintiff before administering certain drugs;
    d. In failing to comply with the statutory laws of the State of South Carolina;

e. In failing to use the degree of care and caution that a reasonably prudent person would have used under the circumstances then and there prevailing;

All of which were the direct and proximate cause of the injuries and damages suffered by the Plaintiff herein, said acts being in violation of the Statute laws of the State of South Carolina.

13. The Plaintiff is informed and believes that he is entitled to judgment against the Defendants in a reasonable sum as actual damages, and for punitive damages in an appropriate amount.

WHEREFORE, Plaintiff prays for a judgment against the Defendants in a reasonable sum as actual damages, together with punitive damages in an appropriate amount, for the costs of this action, and for such other and further relief as the Court may deem just and proper.

Melvin D. Bannister
~~5115~~ Forest Dr., Suite G
Post Office 6833
Columbia, South Carolina 29260
(803) 782-8688
Attorney for the Plaintiff

4th day of August, 2009.

JURY TRIAL DEMANDED

STATE OF SOUTH CAROLINA	)	IN THE COMMON PLEAS COURT
COUNTY OF RICHLAND	)	CASE NO.: 09-CP-40-5568
PHILLIP DURRETT, Plaintiff,	)	
vs.	)	**NOTICE OF MOTION AND MOTION TO DISMISS**
PALMETTO HEALTH ALLIANCE d/b/a PALMETTO RICHLAND MEMORIAL, and W. ROSS, M.D., Defendants.	)	

TO: MELVIN D. BANNISTER, ESQUIRE, ATTORNEY FOR PLAINTIFF:

The Defendants hereby move for an order from the Court dismissing Plaintiff's Notice of Intent to File Suit and the claims raised against them. This motion is made pursuant to Rules 12(b)(1) and 12(b)(6) of the South Carolina Rules of Civil Procedure, and §15-79-125 and §15-36-100, Code of Laws of South Carolina, as amended.

As grounds for the motion, Defendants would show that Plaintiff's Notice of Intent to File Suit sets forth a cause of action for medical malpractice against them in their capacity as a licensed healthcare facility and practicing medical doctor, but that Plaintiff has failed to follow the requirements as set forth in S.C. Code Ann. § 15-79-125. Specifically, Plaintiff has failed to file an expert affidavit, prior to filing his Notice of Intent to File Suit, as required by statute. Section 15-79-125(A) states in part, "[p]rior to filing or initiating a civil action alleging injury or death as a result of medical malpractice, the plaintiff shall contemporaneously file a Notice of Intent to File Suit and an affidavit of an expert witness, subject to the affidavit requirements established in Section 15-36-100...." Plaintiff did not comply with the provisions of this statute by filing an expert affidavit. Plaintiff further failed to provide an expert affidavit within the 45

day provision of Section 15-36-100(C)(1). Therefore, Defendants' Motion to Dismiss should be granted.

Furthermore, even if Plaintiff claims that this case does not fall within the purview of the Medical Malpractice Reform Act, Plaintiff has still failed to comply with the expert affidavit requirements of §15-36-100, contained within the South Carolina Frivolous Civil Proceedings Sanctions Act. Section 15-36-100(B) states, "[e]xcept as provided in Section 15-79-125, in an action for damages alleging professional negligence against a professional licensed by or registered with the State of South Carolina and listed in subsection (G) or against any licensed health care facility...the plaintiff must file as part of the complaint an affidavit of an expert witness which must specify at least one negligent act or omission claimed to exist and the factual basis for each claim." Since the Complaint alleges causes of action against a profession and entity contemplated under this statute and since Plaintiff did not serve the required expert affidavit, the Notice of Intent to File Suit should be dismissed.

For these reasons, Defendants move to dismiss Plaintiff's Notice of Intent to File Suit. This motion is based upon the pleadings, relevant statutes and authorities, and any affidavits and memorandum that may be submitted.

TURNER, PADGET, GRAHAM & LANEY, P.A.

R. Gerald Chambers, Jr.
1901 Main Street, 17th Floor (29201)
Post Office Box 1473
Columbia, SC 29202
Telephone: (803) 227-4201
Facsimile: (803) 799-3957
Attorneys for Defendants

Columbia, South Carolina
September 22, 2009

COLLOID/CRYSTALLOID/INTAKE

TIME BEGUN	#	SOLUTION AMOUNT	SITE	AMOUNT INFUSED	INIT
	PREHOSPITAL INTAKE				
PTA	#1	NS	(L) HAND	100ML D/C'D By	CR, RN
1440	#2	WARM NS 1L	(L) AC	1000	CR

BLOOD COMPONENTS

TIME	TYPE	#	AMOUNT	INITIALS
	PREHOSPITAL INTAKE			

HOURLY OUTPUT

TIME	URINE	NG / EMESIS	CT	CT	OTHER

REVISED TRAUMA SCORE

GLASCOW COMA SCORE	SYSTOLIC BP	RESPIRATORY RATE	CODE VALUE
13 - 15	> 89	10 - 29	4
9 - 12	76 - 89	> 29	3
6 - 8	50 - 75	6 - 9	2
4 - 5	1 - 49	1 - 5	1
3	0	0	0

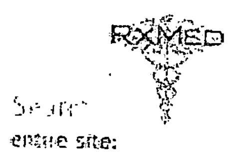
TOTAL TRAUMA ROOM

INTAKE		OUTPUT	
CRYSTALLOID		URINE	
COLLOID		NG	
		CHEST	
		EMESIS	
TOTAL ▶		TOTAL ▶	

TIME	MED / DOSE / ROUTE / SITE	BY	TIME	MED / DOSE / ROUTE / SITE	BY
1452	NORCURON / 1 MG / IVP / (R) AC	CR			
1453	VERSED / 5MG / IVP / (R) AC	CR			
1455	SUCCINYLCHOLINE / 200MG / IVP (R) AC	CR			
1500	NORCURON / 9MG / IVP / (R) AC	CR			
1500	SUCCINYLCHOLINE / 100MG / IVP / (R) AC	CB			
1505	VERSED / 5MG / IVP / (R) HAND	CB			
1534	Norcuron 10mg IVP (Rt) AC	[illegible]			
1625	Ativan 2mg IVP (Rt) AC	[illegible]			
1630	Norcuron 10mg IVP (Rt) AC	[illegible]			
1745	Ativan gtts @ 1mg/hr.	[illegible]			

X-RAYS

TIME		TIME		TIME		TIME		TIME	
	☐ C-SPINE		☐ ABDOMEN		☐ UPPER EXTREMITY		☐ SKULL		☐ CT SCAN
	☐ LATERAL		☐ PELVIS		☐ R		☐ FACIAL BONES		☐ HEAD
	☐ COMPLETION		☐ T-SPINE		☐ L		☐ IVP		☐ NECK
	☐ CHEST		☐ L-SPINE		☐ LOWER EXTREMITY		☐ ANGIOGRAM		☐ CHEST
	☐ SUPINE		☐ OTHER		☐ R		☐ CYSTOGRAM		☐ ABD
	☐ UPRIGHT				☐ L				☐ PELVIS
									☐ OTHER



Search entire site:

The comprehensive resource for physicians, drug and illness information

NORCURON®

Organon

Vecuronium Bromide

Nondepolarizing Neuromuscular Blocking Agent

Action And Clinical Pharmacology: Vecuronium is a nondepolarizing neuromuscular blocking agent possessing all of the characteristic curariform pharmacological actions of this class of drugs. It acts by competing for cholinergic receptors at the motor end-plate. The antagonism to acetylcholine is inhibited and neuromuscular block is reversed by acetylcholinesterase inhibitors such as neostigmine, edrophonium, and pyridostigmine. Vecuronium is about a third more potent than pancuronium; the duration of neuromuscular blockade produced by vecuronium is shorter than that of pancuronium at initially equipotent doses. The time to onset of paralysis decreases and the duration of maximum effect increases with increasing vecuronium doses. The use of a peripheral nerve stimulator is of benefit in assessing the degree of muscular relaxation.

The ED90 (dose required to produce 90% suppression of the muscle twitch response while under balanced anesthesia) has averaged 0.057 mg/kg (0.049 to 0.062 mg/kg in various studies). An initial vecuronium dose of 0.08 to 0.10 mg/kg generally produces first depression of twitch in approximately 1 minute, good or excellent intubation conditions within 2.5 to 3.0 minutes, and maximum neuromuscular blockade within 3 to 5 minutes of injection in most patients. Under balanced anesthesia, the time to 25% recovery of the control twitch response (clinical duration) is approximately 25 to 40 minutes after injection and recovery is usually 95% complete approximately 45 to 65 minutes after injection of an intubating dose.

The neuromuscular blocking action of vecuronium is slightly enhanced in the presence of potent inhalation anesthetics. If vecuronium is first administered more than 5 minutes after the start of the inhalation of enflurane, isoflurane, or halothane, or when steady state has been achieved, the intubating dose of vecuronium may be decreased by approximately 15% (see Dosage).

Prior administration of succinylcholine may enhance the neuromuscular blocking effect of vecuronium and its duration of action. With succinylcholine as the intubating agent, initial doses of 0.04 to 0.06 mg/kg of vecuronium will produce complete neuromuscular block with clinical duration of action of 25 to 30 minutes. If succinylcholine is used prior to vecuronium, the administration of vecuronium should be delayed until the patient starts recovering from succinylcholine-induced neuromuscular blockade. The effect of prior use of other nondepolarizing neuromuscular blocking agents on the activity of vecuronium has not been studied (see Precautions, Drug Interactions).

Repeated administration of maintenance doses of vecuronium has little or no cumulative effect on the duration of neuromuscular blockade. Therefore, repeat doses can be administered at relatively regular intervals with predictable results. After an initial dose of 0.08 to 0.10 mg/kg under balanced anesthesia, the first maintenance dose of 0.010 to 0.015 mg/kg is generally required within 25 to 40 minutes; subsequent maintenance doses, if required, may be administered at approximately 12 to 15 minute intervals. Halothane anesthesia increases the clinical duration of the maintenance dose only slightly. Under enflurane, a maintenance dose of 0.010 mg/kg is approximately equal to a 0.015 mg/kg dose under balanced anesthesia.

The recovery index (time from 25% to 75% recovery) is approximately 15 to 25 minutes under balanced or halothane anesthesia. When recovery from vecuronium neuromuscular blocking effect begins, it proceeds more rapidly than recovery from pancuronium. Once spontaneous recovery has started, the neuromuscular block produced by vecuronium is readily reversed with various anticholinesterase agents, e.g., pyridostigmine, neostigmine, or edrophonium in conjunction with an anticholinergic agent such as atropine or glycopyrrolate. There have been no reports of recurarization following satisfactory reversal of vecuronium induced neuromuscular blockade; rapid recovery is a finding consistent with its short elimination half-life.

Pharmacokinetics: At clinical doses of 0.04 to 0.10 mg/kg, 60 to 80% of vecuronium is usually bound to plasma protein. The distribution half-life following a single i.v. dose (range 0.025 to 0.280 mg/kg) is approximately 4 minutes. Elimination half-life over this same dosage range is approximately 65 to 75 minutes in healthy surgical patients and in renal failure patients undergoing transplant surgery. In late pregnancy, elimination half-life may be shortened to approximately 35 to 40 minutes. The volume of distribution at steady state is approximately 300 to 400 mL/kg; systemic rate of clearance is approximately 3 to 4.5 mL/minute/kg. In man, urinary recovery of vecuronium varies from 3 to 35% within 24 hours. Data derived from patients requiring insertion of a T-tube in the common

bile duct suggest that 25 to 50% of a total i.v. dose of vecuronium may be excreted in bile within 42 hours. Only unchanged vecuronium has been detected in human plasma following clinical use. One metabolite, 3-deacetyl vecuronium, has been recovered in the urine of some patients in quantities that account for up to 10% of the injected dose; 3-deacetyl vecuronium has also been recovered by T-tube in some patients accounting for up to 25% of the injected dose. This metabolite has been judged by animal screening (dogs and cats) to have 50% or more the potency of vecuronium, equipotent doses are of approximately the same duration as vecuronium in dogs and cats.

Limited data derived from the patients with cirrhosis or cholestasis and in the elderly, suggest that some measurements of recovery may be doubled in such patients. In patients with renal failure, measurements of recovery do not differ significantly from similar measurements in healthy patients. Studies involving routine hemodynamic monitoring in good risk surgical patients reveal that the administration of vecuronium in doses up to 3 times that needed to produce clinical relaxation (0.15 mg/kg) did not produce clinically significant changes in systolic, diastolic or mean arterial blood pressure. The heart rate remained unchanged in some studies and was lowered by a mean of up to 8% in other studies. A large dose of 0.28 mg/kg administered during a period of no stimulation, while patients were being prepared for coronary artery bypass grafting, was not associated with alterations in rate-pressure-product or pulmonary-capillary-wedge pressure. Systemic vascular resistance was lowered slightly and cardiac ouput was increased insignificantly. (The drug has not been studied in patients with hemodynamic dysfunction secondary to cardiac valvular disease).

Limited clinical experience in 3 patients with pheochromocytoma has shown that administration of this drug during surgery is not associated with changes in blood pressure or heart rate. Unlike other nondepolarizing skeletal muscle relaxants, vecuronium has no clinically significant effects on hemodynamic parameters and will not counteract those hemodynamic changes or known side effects produced by or associated with anesthetic agents.

In one clinical study, the duration of action of vecuronium was increased 5-fold during hypothermic cardiopulmonary bypass.

Preliminary data on histamine assay in 16 patients and available clinical experience in more than 600 patients indicate that hypersensitivity reactions such as bronchospasm, flushing, redness, hypotension, tachycardia, and other reactions commonly associated with histamine release are unlikely to occur.

Indications And Clinical Uses: As an adjunct to general anesthesia, to facilitate endotracheal intubation and to provide skeletal muscle relaxation during surgery or mechanical ventilation.

Contra-Indications: Hypersensitivity to the drug. Pregnant and lactating women, since reproductive studies in animals have not yet been performed (see Warnings). tag_WarningWarnings

Manufacturers' Warnings In Clinical States: General: Vecuronium should be administered in carefully adjusted dosage by or under the supervision of experienced clinicians who are familiar with its actions and the possible complications that might occur following its use. The drug should not be administered unless facilities for intubation, artificial respiration, oxygen therapy, and reversal agents are immediately available. The clinician must be prepared to assist or control respiration. A peripheral nerve stimulator should be employed to monitor drug response, need for additional relaxant, and adequacy of spontaneous recovery or anticholinesterase antagonism.

Intensive Care Unit: To reduce the possibility of prolonged neuromuscular blockade and other complications that might occur following long-term use in the ICU, vecuronium or any other neuromuscular blocking agent should be administered in carefully adjusted doses by or under the supervision of experienced clinicians who are familiar with its actions and with appropriate peripheral nerve stimulator muscle monitoring techniques.

Neuromuscular Disease: In patients who are known to have myasthenia gravis or the myasthenic (Eaton-Lambert) syndrome, small doses of vecuronium may have profound effects. In such patients, a peripheral nerve stimulator and use of a small test dose may be of particular value in assessing and monitoring dosage requirements.

Precautions: General: Limited data on histamine assay and available clinical experience indicate that hypersensitivity reactions such as bronchospasm, flushing, redness, hypotension, tachycardia and other reactions commonly associated with histamine release are unlikely to occur.

Cardiovascular: As vecuronium has no significant effects on heart rate in the recommended dosage range, it will not counteract the bradycardia produced by many anesthetic agents or vagal stimulation.

Renal Failure: Vecuronium is well-tolerated without clinically significant prolongation of neuromuscular blocking effect in patients with renal failure who have been optimally prepared for surgery by dialysis. Under emergency conditions in anephric patients some prolongation of neuromuscular blockade may occur; therefore, if anephric patients cannot be prepared for non-elective surgery, a lower initial dose of vecuronium should be considered.

Hepatic Disease: Limited experience in patients with cirrhosis or cholestasis has revealed prolonged recovery time in keeping with the role the liver plays in vecuronium metabolism and excretion (see Pharmacology, Pharmacokinetics). Data currently available do not permit dosage recommendations in patients with impaired liver function.

Increased Volume of Distribution: The onset of action of neuromuscular blocking agents may be delayed in patients who have increased volumes of distribution as a result of old age, edematous states, or cardiovascular disease. More time should be permitted for the drug to achieve its maximal effect in these patients. Dosage should not be increased.

Long-term Use in ICU: Limited information if available concerning the efficacy and safety of long-term (days to weeks) i.v. vecuronium infusion to facilitate mechanical ventilation in the intensive care unit. In rare cases, long-term use of neuromuscular blocking drugs to facilitate mechanical ventilation in ICU settings may be associated with prolonged paralysis and/or skeletal muscle weakness, that may be first noted during attempts to wean patients from ventilator. Typically, such patients have received other drugs such as broad spectrum antibiotics, narcotics and/or steroids and may have electrolyte imbalances and diseases which lead to electrolyte imbalances, hypoxic episodes of varying duration, acid-base imbalance and extreme debilitation any of which may enhance the actions of a neuromuscular blocking agent. Additionally, patients immobilized for extended periods frequently develop symptoms consistent with disuse muscle atrophy. The recovery picture may vary from regaining movement and strength in all muscles to initial recovery of movement of the facial and small muscles of the extremities then to the remaining muscles. In rare cases recovery may be over an extended period of time and may even, on occasion, involve rehabilitation. Therefore, when there is a need for long-term mechanical ventilation the benefits-to-risk ratio of neuromuscular blockade must be considered.

Continuous infusion or intermittent bolus dosing to support mechanical ventilation, has not been studied sufficiently to support dosage recommendations.

Whenever the use of vecuronium or any neuromuscular blocking agent is contemplated in the ICU, it is recommended that neuromuscular transmission be monitored continuously during administration and recovery with the help of a nerve stimulator. Additional doses of vecuronium or any other neuromuscular blocking agent should not be given before there is a definite response to T1 or to the first twitch. If no response is elicited, infusion administration should be discontinued until a response returns.

Severe Obesity or Neuromuscular Disease: Patients with severe obesity or neuromuscular disease may pose airway and/or ventilatory problems requiring special care before, during and after the use of neuromuscular blocking agents such as vecuronium.

Malignant Hyperthermia: Many drugs used in anesthetic practice are suspected of being capable of triggering a potentially fatal hypermetabolism of skeletal muscle known as malignant hyperthermia. There are insufficient data derived from screening in susceptible animals (swine) to establish whether or not vecuronium is capable of triggering malignant hyperthermia.

CNS: Vecuronium has no known effect on consciousness, pain threshold or cerebration. Administration must be accompanied by adequate anesthesia or sedation.

Hypothermia: Hypothermia (25 to 28°C) has been associated with a decreased requirement for nondepolarizing neuromuscular blocking agents.

Burns: Resistance to nondepolarizing neuromuscular blocking agents may develop in patients with burns, depending upon the time elapsed since the injury and the size of the burn.

Pregnancy and Lactation: Animal studies have not been conducted with vecuronium. It is not known whether vecuronium can cause fetal harm when administered to a pregnant woman, or if it can affect reproductive capacity. It is not known whether vecuronium is secreted in breast milk and therefore is not recommended in lactating women.

Obstetrics: It is not known whether muscle relaxants administered during vaginal delivery have immediate or delayed adverse effects on the fetus, or increase the likelihood that resuscitation of the newborn will be necessary. The possibility that a forceps delivery will be necessary may increase.

The possibility of respiratory depression in the newborn infant should always be considered following cesarean section during which a neuromuscular blocking agent has been administered.

Children: Infants under 1 year of age but older than 7 weeks also tested under halothane anesthesia, are moderately more sensitive to vecuronium on a mg/kg basis than adults and take about 1 1/2 times as long to recover. Information presently available does not permit recommendations for usage of vecuronium in neonates.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have not been performed to evaluate carcinogenic or mutagenic potential or impairment of fertility.

Drug Interactions: Succinylcholine: Prior administration of succinylcholine may enhance the neuromuscular blocking effect of vecuronium and its duration of action. If succinylcholine is used before vecuronium, the administration of vecuronium should be delayed until the succinylcholine effect shows signs of wearing off. With succinylcholine as the intubating agent, initial doses of 0.04 to 0.06 mg/kg of vecuronium may be administered to produce complete neuromuscular block with clinical duration of action of 25 to 30 minutes (see Pharmacology).

The use of vecuronium before succinylcholine, in order to attenuate some of the side effects of succinylcholine, has not been sufficiently studied. Other nondepolarizing neuromuscular blocking agents (pancuronium, d-tubocurarine, metocurine and gallamine) act in the same fashion as does vecuronium; therefore, these drugs and vecuronium may manifest an additive effect when used together. There are insufficient data to support concomitant use of vecuronium and other competitive muscle relaxants in the same patient.

Inhalation Anesthetics: Use of volatile inhalational anesthetics such as enflurane, isoflurane, and halothane with vecuronium will enhance neuromuscular blockade. Potentiation is most prominent with the use of enflurane and isoflurane.

With the above agents the initial doses of vecuronium may be the same as with balanced anesthesia unless the inhalational anesthetic has been administered for a sufficient time at a sufficient dose to have reached clinical equilibrium (see Pharmacology).

Antibiotics: Parenteral/intraperitoneal administration of high doses of certain antibiotics may intensify or produce a neuromuscular block on their own. The following antibiotics have been associated with various degrees of paralysis: aminoglycosides (such as neomycin, streptomycin, kanamycin, gentamicin, and dihydrostreptomycin); tetracyclines; bacitracin; polymyxin B; colistin; and sodium colistimethate. If these or other newly introduced antibiotics are used in conjunction with vecuronium during surgery, unexpected prolongation of neuromuscular block should be considered a possibility.

Other: Experience concerning injection of quinidine during recovery from use of other muscle relaxants suggests that recurrent paralysis may occur. This possibility must also be considered for vecuronium. Vecuronium induced neuromuscular blockade has been counteracted by alkalosis and enhanced by acidosis in experimental animals (cat). Electrolyte imbalance and diseases which lead to electrolyte imbalance, such as adrenal cortical insufficiency, have been shown to alter neuromuscular blockade. Depending on the nature of the imbalance, either enhancement or inhibition may be expected. Magnesium salts, administered for the management of

toxemia of pregnancy, may enhance neuromuscular blockade.

Adverse Reactions: The most frequent adverse reaction to nondepolarizing blocking agents as a class consists of an extension of the drug's pharmacological action beyond the time period needed for surgery and anesthesia. This may vary from skeletal muscle weakness to profound and prolonged skeletal muscle paralysis resulting in respiratory insufficiency or apnea.

Inadequate reversal of the neuromuscular blockade, although not yet reported, is possible with vecuronium as with all curariform drugs. These adverse reactions are managed by manual or mechanical ventilation until recovery is judged adequate. Little or no increase in intensity of blockade or duration of action of vecuronium is noted from the use of thiobarbiturates, narcotic analgesics, nitrous oxide, or droperidol. See Overdose for discussion of other drugs used in anesthetic practice which also cause respiratory depression.

Symptoms And Treatment Of Overdose: Symptoms and Treatment: There has been no experience with vecuronium overdosage. The possibility of iatrogenic overdosage can be minimized by carefully monitoring muscle twitch response to peripheral nerve stimulation.

Excessive doses of vecuronium can be expected to produce enhanced pharmacological effects. Residual neuromuscular blockade beyond the time period needed for surgery and anesthesia may occur with vecuronium as with other neuromuscular blockers. This may be manifested by skeletal muscle weakness, decreased respiratory reserve, low tidal volume, or apnea. A peripheral nerve stimulator may be used to assess the degree of residual neuromuscular blockade and help to differentiate residual neuromuscular blockade from other causes of decreased respiratory reserve.

Respiratory depression may be due either wholly or in part to other drugs used during the conduct of general anesthesia such as narcotics, thiobarbiturates and other CNS depressants. Under such circumstances the primary treatment is maintenance of a patent airway and manual or mechanical ventilation until complete recovery of normal respiration is assured.

Pyridostigmine, neostigmine, or edrophonium, in conjunction with atropine or glycopyrrolate will usually antagonize the skeletal muscle relaxant action of vecuronium. Satisfactory reversal can be judged by adequacy of skeletal muscle tone and by adequacy of respiration. A peripheral nerve stimulator may also be used to monitor restoration of twitch height.

Failure of prompt reversal (within 30 minutes) may occur in the presence of extreme debilitation, carcinomatosis, and with concomitant use of certain broad spectrum antibiotics, or anesthetic

agents and other drugs which enhance neuromuscular blockade or cause respiratory depression on their own. Under such circumstances the management is the same as that of prolonged neuromuscular blockade. Ventilation must be supported by artificial means until the patient has resumed control of his respiration. Prior to the use of reversal agents, reference should be made to the specific package insert of the reversal agent.

Dosage And Administration: Vecuronium is for i.v. use only. This drug should be administered by or under the supervision of experienced clinicians familiar with the use of neuromuscular blocking agents. Dosage must be individualized in each case.

The dosage information which follows is derived from studies based upon units of drug per unit of body weight and is intended to serve as a guide only, especially regarding enhancement of neuromuscular blockade of vecuronium by volatile anesthetics and by prior use of succinylcholine (see Precautions, Drug Interactions).

To obtain the maximum clinical benefits of vecuronium and to minimize the possibility of overdosage, the monitoring of muscle twitch response to peripheral nerve stimulation is advised.

The recommended initial dose of vecuronium is 0.08 to 0.10 mg/kg (1.4 to 1.75 times the ED90) given as an i.v. bolus injection. This dose can be expected to produce good or excellent non-emergency intubation conditions in 2.5 to 3.0 minutes after injection. Under balanced anesthesia, clinically required neuromuscular blockade lasts approximately 25 to 30 minutes, with recovery to 25% of control achieved approximately 25 to 40 minutes after injection and recovery to 95% of control achieved approximately 45 to 65 minutes after injection. In the presence of potent inhalation anesthetics, the neuromuscular blocking effect of vecuronium is enhanced. If vecuronium is first administered more than 5 minutes after the start of administration of an inhalation agent, or when steady state has been achieved, the initial vecuronium dose may be reduced by approximately 15%, to 0.060 to 0.085 mg/kg.

Prior administration of succinylcholine may enhance the neuromuscular blocking effect and duration of action of vecuronium. If intubation is performed using succinylcholine, a reduction of the initial dose of vecuronium to 0.04 to 0.06 mg/kg with inhalation anesthesia and 0.05 to 0.06 mg/kg with balanced anesthesia may be required. The administration of vecuronium should be delayed until the succinylcholine effect shows signs of wearing off.

During prolonged surgical procedures, maintenance doses of 0.010 to 0.015 mg/kg of vecuronium are recommended. After the initial vecuronium injection, the first maintenance dose will generally be required within 25 to 40 minutes. However, clinical criteria should

be used to determine the need for maintenance doses. Since vecuronium lacks clinically important cumulative effects, subsequent maintenance doses, if required, may be administered at relatively regular intervals for each patient, ranging approximately from 12 to 15 minutes under balanced anesthesia, slightly longer under inhalation agents. (If less frequent administration is desired, higher maintenance doses may be administered.)

Should there be reason for the selection of larger doses in individual patients, initial doses ranging from 0.15 mg/kg up to 0.28 mg/kg have been administered during surgery under halothane anesthesia without ill effects to the cardiovascular system being noted as long as ventilation is properly maintained (see Pharmacology).

The recovery index (time from 25% to 75% recovery) is approximately 15 to 25 minutes under balanced or halothane anesthesia. When recovery from vecuronium neuromuscular blocking effect begins, it proceeds more rapidly than recovery from pancuronium. Once spontaneous recovery has started, the neuromuscular block produced by vecuronium is readily reversed with various anticholinesterase agents, e.g., pyridostigmine, neostigmine, or edrophonium in conjunction with an anticholinergic agent such as atropine or glycopyrrolate.

Use by Infusion: Following the administration of a recommended initial bolus dose of vecuronium, a diluted solution of vecuronium can be administered by continuous infusion to adults for maintenance of neuromuscular blockade during extended surgical procedures. Long-term i.v. infusion to support mechanical ventilation in the intensive care unit has not been studied sufficiently to support dosage recommendations (see Precautions).

Infusion of vecuronium should be individualized for each patient. The rate of administration should be adjusted according to the patient's response as determined by peripheral nerve stimulation.

Infusion of vecuronium should be initiated only after early evidence of spontaneous recovery from the bolus dose (typically 10 to 20% recovery of the initial twitch response). During balanced anesthesia, an initial infusion rate of 1 µg/kg/min is recommended with subsequent rate adjustments to maintain a 90% suppression of the twitch response.

Individual infusion rates may range from 0.6 to 1.8 µg/kg/min.

Inhalation anesthetics, particularly enflurane and isoflurane may enhance the neuromuscular blocking action of nondepolarizing muscle relaxants. In the presence of steady-state concentrations of enflurane or isoflurane, it may be necessary to use infusion rates which are 25 to 60% lower than those recommended during balanced anesthesia. Reduced infusion rates may not be required

during halothane anesthesia.

Spontaneous recovery and reversal of neuromuscular blockade following discontinuation of vecuronium infusion may be expected to proceed at rates comparable to those following single bolus doses (see Pharmacology).

Infusion solutions of vecuronium can be prepared by mixing vecuronium with an appropriate infusion solution such as 5% dextrose injection, USP; 0.9% sodium chloride injection, USP; 5% dextrose and 0.9% sodium chloride injection, USP; or lactated Ringer's injection, USP. Use within 24 hours of mixing with the above solutions. Unused portions of infusion solutions should be discarded.

Children: Older children (10 to 17 years of age) have approximately the same dosage requirements (mg/kg) as adults and may be managed the same way. Younger children (1 to 10 years of age) may require a slightly higher initial dose and may also require supplementation slightly more often than adults. Infants under 1 year of age but older than 7 weeks are moderately more sensitive to vecuronium on a mg/kg basis than adults and take about 1 1/2 times as long to recover. See also subsection of Precautions titled Children. Information presently available does not permit recommendation on usage in neonates (see Precautions).

Reconstitution: Reconstitute each vial with 10 mL of bacteriostatic water for injection or 10 mL of compatible diluent to obtain a solution containing 1 mg/mL vecuronium bromide. Compatible diluents include: 0.9% sodium chloride injection, USP, 5% dextrose injection, USP, 5% dextrose and 0.9% sodium chloride injection, USP, sterile water for injection, USP and lactated Ringer's injection, USP. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

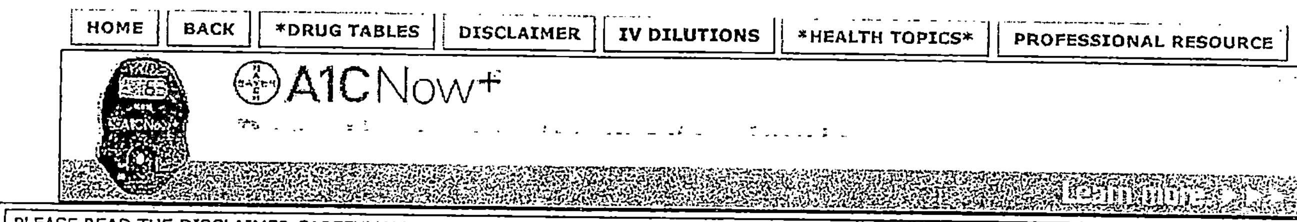
When reconstituted with bacteriostatic water for injection, use within 5 days. When reconstituted with recommended diluents, use within 24 hours. Single dose vial. Discard unused portion.

Availability And Storage: Sterile freeze-dried buffered cake of very fine microscopic crystalline particles for i.v. injection only. Nonmedicinal ingredients: citric acid, mannitol, phosphoric acid, sodium hydroxide and sodium phosphate dibasic. Vials of 10 mL. Boxes of 10. Protect from light. Store at 15 to 30°C.

Google Search

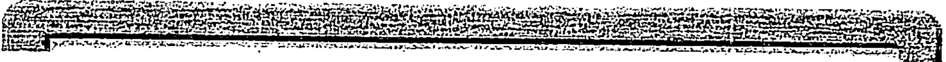
Web www.globalrph.com

HOME | BACK | *DRUG TABLES | DISCLAIMER | IV DILUTIONS | *HEALTH TOPICS* | PROFESSIONAL RESOURCE



PLEASE READ THE DISCLAIMER CAREFULLY BEFORE ACCESSING OR USING THIS SITE. BY ACCESSING OR USING THIS SITE, YOU AGREE TO BE BOUND BY THE TERMS AND CONDITIONS SET FORTH IN THE DISCLAIMER. References Disclaimer

Ads by Google IV Infusion IV Stability IV Training IV Therapy Dosage System



Midazolam
Versed ®

Usual Diluents

D5W, NS

Standard Dilutions [Amount of drug] [Infusion volume] [Infusion rate]

ICU only
[25 mg] [50 ml] [Titrate]
[50 mg] [100 ml] [Titrate]

Concentration: 0.5 mg/ml

Stability / Miscellaneous

EXP: 1 DAY (RT).
Usual dose requested: 1 to 5 mg/hr

Status epilepticus: 0.1 to 0.35 mg/kg load, followed by continuous infusion: 0.05 to 1.08 mg/kg/hr (possibly up to 2? Based on EEG).

Mechanical ventilator patient: usually 0.05 to 0.2 mg/kg/hr for sedation.

DOSAGE AND ADMINISTRATION
Midazolam hydrochloride injection is a potent sedative agent that requires slow administration and individualization of dosage. Clinical experience has shown midazolam hydrochloride to be 3 to 4 times as potent per mg as diazepam. BECAUSE SERIOUS AND LIFE-THREATENING CARDIORESPIRATORY ADVERSE EVENTS HAVE BEEN REPORTED, PROVISION FOR MONITORING, DETECTION AND CORRECTION OF THESE REACTIONS MUST BE MADE FOR EVERY PATIENT T0 WHOM MIDAZOLAM HYDROCHLORIDE INJECTION IS ADMINISTERED, REGARDLESS OF AGE OR HEALTH STATUS. Excessive single doses or rapid intravenous administration may result in respiratory depression, airway obstruction and/or arrest. The potential for these latter effects is increased in debilitated patients, those receiving concomitant medications capable of depressing the CNS, and patients without an endotracheal tube but undergoing a procedure involving the upper airway such as endoscopy or dental (see package insert for Boxed WARNING and WARNINGS).

Reactions such as agitation, involuntary movements, hyperactivity and combativeness have been reported in adult and pediatric patients. Should such reactions occur, caution should be exercised before continuing administration of midazolam hydrochloride.

Midazolam hydrochloride injection should only be administered IM or IV.

Care should be taken to avoid intra-arterial injection or extravasation.

Midazolam Hydrochloride Injection may be mixed in the same syringe with the following frequently used premedications: morphine sulfate, meperidine, atropine sulfate or scopolamine. Midazolam, at a concentration of 0.5 mg/mL, is compatible with 5% dextrose in water and 0.9% sodium chloride for up to 24 hours and with lactated Ringer's solution for up to 4 hours. Both the 1 mg/mL and 5 mg/mL formulations of midazolam may be diluted with 0.9% sodium chloride or 5% dextrose in water.

Monitoring: Patient response to sedative agents, and resultant respiratory status, is variable. Regardless of the intended level of sedation or route of administration, sedation is a continuum; a patient may move easily from light to deep sedation, with potential loss of protective reflexes. This is especially true in pediatric patients. Sedative doses should be individually titrated, taking into account patient age, clinical status and concomitant use of other CNS depressants. Continuous monitoring of respiratory and cardiac function is required (i.e., pulse oximetry).

Adults and Pediatrics: Sedation guidelines recommend a careful presedation history to determine how a patient's underlying medical conditions or concomitant medications might affect their response to sedation/analgesia as well as a physical examination including a focused examination of the airway for abnormalities. Further recommendations include appropriate presedation fasting.

Titration to effect with multiple small doses is essential for safe administration. It should be noted that adequate time to achieve peak central nervous system effect (3 to 5 minutes) for midazolam should be allowed between doses to minimize the potential for oversedation. Sufficient time must elapse between doses of concomitant sedative medications to allow the effect of each dose to be assessed before subsequent drug administration. This is an important consideration for all patients who receive intravenous midazolam.

Immediate availability of resuscitative drugs and age- and size-appropriate equipment and personnel trained in their use and skilled in airway management should be assured.

Pediatrics: For deeply sedated pediatric patients a dedicated individual, other than the practitioner performing the procedure, should monitor the patient throughout the procedure.

Intravenous access is not thought to be necessary for all pediatric patients sedated for a diagnostic or therapeutic procedure because in some cases the difficulty of gaining IV access would defeat the purpose of sedating the child; rather, emphasis should be placed upon having the intravenous equipment available and a practitioner skilled in establishing vascular access in pediatric patients immediately available.

USUAL ADULT DOSE

INTRAMUSCULARLY

For preoperative sedation/anxiolysis/ amnesia (induction of sleepiness or drowsiness and relief of apprehension and to impair memory of perioperative events).

For intramuscular use, midazolam hydrochloride should be injected deep in a large muscle mass.

The recommended premedication dose of midazolam for good risk (ASA Physical Status I & II) adult patients below the age of 60 years is 0.07 to 0.08 mg/kg IM (approximately 5 mg IM) administered up to 1 hour before surgery.

The dose must be individualized and reduced when IM midazolam is administered to patients with chronic obstructive pulmonary disease, other higher risk surgical patients, patients 60 or more years of age, and patients who have received concomitant narcotics or other CNS depressants (see ADVERSE REACTIONS). In a study of patients 60 years or older, who did not receive concomitant administration of narcotics, 2 to 3 mg (0.02 to 0.05 mg/kg) of midazolam produced adequate sedation during the

preoperative period. The dose of 1 mg IM midazolam may suffice for some older patients if the anticipated intensity and duration of sedation is less critical. As with any potential respiratory depressant, these patients require observation for signs of cardiorespiratory depression after receiving IM midazolam.

Onset is within 15 minutes, peaking at 30 to 60 minutes. It can be administered concomitantly with atropine sulfate or scopolamine hydrochloride and reduced doses of narcotics.

INTRAVENOUSLY

Sedation/anxiolysis/ amnesia for procedures (See INDICATIONS AND USAGE): Narcotic premedication results in less variability in patient response and a reduction in dosage of midazolam. For peroral procedures, the use of an appropriate topical anesthetic is recommended. For bronchoscopic procedures, the use of narcotic premedication is recommended.

When used for sedation/anxiolysis/amnesia for a procedure, dosage must be individualized and titrated. Midazolam hydrochloride should always be titrated slowly; administer over at least 2 minutes and allow an additional 2 or more minutes to fully evaluate the sedative effect. Individual response will vary with age, physical status and concomitant medications, but may also vary independent of these factors. (See package insert for WARNINGS concerning cardiac/respiratory arrest/airway obstruction/ hypoventilation.)

Midazolam hydrochloride 1 mg/mL formulation is recommended for sedation/anxiolysis/amnesia for procedures to facilitate slower injection. Both the 1 mg/mL and the 5 mg/mL formulations may be diluted with 0.9% sodium chloride or 5% dextrose in water.

1. Healthy Adults Below the Age of 60: Titrate slowly to the desired effect, (e.g., the initiation of slurred speech). Some patients may respond to as little as 1 mg. No more than 2.5 mg should be given over a period of at least 2 minutes. Wait an additional 2 or more minutes to fully evaluate the sedative effect. If further titration is necessary, continue to titrate, using small increments, to the appropriate level of sedation. Wait an additional 2 or more minutes after each increment to fully evaluate the sedative effect. A total dose greater than 5 mg is not usually necessary to reach the desired endpoint.

If narcotic premedication or other CNS depressants are used, patients will require approximately 30% less midazolam than unpremedicated patients.

2. Patients Age 60 or Older, and Debilitated or Chronically Ill Patients: Because the danger of hypoventilation, airway obstruction, or apnea is greater in elderly patients and those with chronic disease states or decreased pulmonary reserve, and because the peak effect may take longer in these patients, increments should be smaller and the rate of injection slower.

Titrate slowly to the desired effect, (e.g., the initiation of slurred speech). Some patients may respond to as little as 1 mg. No more than 1.5 mg should be given over a period of no less than 2 minutes. Wait an additional 2 or more minutes to fully evaluate the sedative effect. If additional titration is necessary, it should be given at a rate of no more than 1 mg over a period of 2 minutes, waiting an additional 2 or more minutes each time to fully evaluate the sedative effect. Total doses greater than 3.5 mg are not usually necessary.

If concomitant CNS depressant premedications are used in these patients, they will require at least 50% less midazolam than healthy young unpremedicated patients.

3. Maintenance Dose: Additional doses to maintain the desired level of sedation may be given in increments of 25% of the dose used to first reach the sedative endpoint, but again only by slow titration, especially in the elderly and chronically ill or debilitated patient. These additional doses

should be given only after a thorough clinical evaluation clearly indicates the need for additional sedation.

Induction of Anesthesia:

For induction of general anesthesia, before administration of other anesthetic agents.

Individual response to the drug is variable, particularly when a narcotic premedication is not used. The dosage should be titrated to the desired effect according to the patient's age and clinical status.

When midazolam is used before other intravenous agents for induction of anesthesia, the initial dose of each agent may be significantly reduced, at times to as low as 25% of the usual initial dose of the individual agents.

Unpremedicated Patients: In the absence of premedication, an average adult under the age of 55 years will usually require an initial dose of 0.3 to 0.35 mg/kg for induction, administered over 20 to 30 seconds and allowing 2 minutes for effect. If needed to complete induction, increments of approximately 25% of the patient's initial dose may be used; induction may instead be completed with inhalational anesthetics. In resistant cases, up to 0.6 mg/kg total dose may be used for induction, but such larger doses may prolong recovery.

Unpremedicated patients over the age of 55 years usually require less midazolam for induction; an initial dose of 0.3 mg/kg is recommended. Unpremedicated patients with severe systemic disease or other debilitation usually require less midazolam for induction. An initial dose of 0.2 to 0.25 mg/kg will usually suffice; in some cases, as little as 0.15 mg/kg may suffice.

Premedicated Patients: When the patient has received sedative or narcotic premedication, particularly narcotic premedication, the range of recommended doses is 0.15 to 0.35 mg/kg.

In average adults below the age of 55 years, a dose of 0.25 mg/kg, administered over 20 to 30 seconds and allowing 2 minutes for effect, will usually suffice.

The initial dose of 0.2 mg/kg is recommended for good risk (ASA I & II) surgical patients over the age of 55 years.

In some patients with severe systemic disease or debilitation, as little as 0.15 mg/kg may suffice.

Narcotic premedication frequently used during clinical trials included fentanyl (1.5 to 2 mcg/kg IV, administered 5 minutes before induction), morphine (dosage individualized, up to 0.15 mg/kg IM), and meperidine (dosage individualized, up to 1 mg/kg IM). Sedative premedications were hydroxyzine pamoate (100 mg orally) and sodium secobarbital (200 mg orally). Except for intravenous fentanyl, administered 5 minutes before induction, all other premedications should be administered approximately 1 hour prior to the time anticipated for midazolam induction.

Injectable midazolam hydrochloride can also be used during maintenance of anesthesia, for surgical procedures, as a component of balanced anesthesia. Effective narcotic premedication is especially recommended in such cases.

Incremental injections of approximately 25% of the induction dose should be given in response to signs of lightening of anesthesia and repeated as necessary.

CONTINUOUS INFUSION

For continuous infusion, midazolam hydrochloride 5 mg/mL formulation is recommended diluted to a concentration of 0.5 mg/mL with 0.9% sodium chloride or 5% dextrose in water.

Usual Adult Dose: If a loading dose is necessary to rapidly initiate sedation, 0.01 to 0.05 mg/kg (approximately 0.5 to 4 mg for a typical adult) may be given slowly or infused over several minutes. This dose may be repeated at 10 to 15 minute intervals until adequate sedation is achieved. For maintenance of sedation, the usual initial infusion rate is 0.02 to 0.1 mg/kg/hr (1 to 7 mg/hr). Higher loading or maintenance infusion rates may occasionally be required in some patients. The lowest recommended doses should be used in patients with residual effects from anesthetic drugs, or in those concurrently receiving other sedatives or opioids.

Individual response to midazolam is variable. The infusion rate should be titrated to the desired level of sedation, taking into account the patient's age, clinical status and current medications. In general, midazolam should be infused at the lowest rate that produces the desired level of sedation.

Assessment of sedation should be performed at regular intervals and the midazolam infusion rate adjusted up or down by 25% to 50% of the initial infusion rate so as to assure adequate titration of sedation level. Larger adjustments or even a small incremental dose may be necessary if rapid changes in the level of sedation are indicated. In addition, the infusion rate should be decreased by 10% to 25% every few hours to find the minimum effective infusion rate. Finding the minimum effective infusion rate decreases the potential accumulation of midazolam and provides for the most rapid recovery once the infusion is terminated. Patients who exhibit agitation, hypertension, or tachycardia in response to noxious stimulation, but who are otherwise adequately sedated, may benefit from concurrent administration of an opioid analgesic. Addition of an opioid will generally reduce the minimum effective midazolam hydrochloride infusion rate.

PEDIATRIC PATIENTS

UNLIKE ADULT PATIENTS, PEDIATRIC PATIENTS GENERALLY RECEIVE INCREMENTS OF MIDAZOLAM HYDROCHLORIDE ON A MG/KG BASIS. As a group, pediatric patients generally require higher dosages of midazolam hydrochloride (mg/kg) than do adults. Younger (less than six years) pediatric patients may require higher dosages (mg/kg) than older pediatric patients, and may require close monitoring (see tables below). In obese PEDIATRIC PATIENTS, the dose should be calculated based on ideal body weight. When midazolam is given in conjunction with opioids or other sedatives, the potential for respiratory depression, airway obstruction, or hypoventilation is increased. For appropriate patient monitoring, see Boxed WARNING, WARNINGS, and DOSAGE AND ADMINISTRATION, Monitoring. The health care practitioner who uses this medication in pediatric patients should be aware of and follow accepted professional guidelines for pediatric sedation appropriate to their situation.

OBSERVER'S ASSESSMENT OF ALERTNESS/SEDATION (OAA/S)				
Assessment Categories				
Responsiveness	Speech	Facial Expression	Eyes	Composite Score
Responds readily to name spoken in normal tone	normal	normal	clear, no ptosis	5 (alert)
Lethargic response to name spoken in normal tone	mild slowing or thickening	mild relaxation	glazed or mild ptosis (less than half the eye)	4
Responds only after name is called loudly and/or	slurring or	marked relaxation	glazed and marked	3

repeatedly	prominent slowing	(slack jaw)	ptosis (half the eye or more)	
Responds only after mild prodding or shaking	few recognizable words	–	–	2
Does not respond to mild prodding or shaking	–	–	–	1 (deep sleep)

HOW SUPPLIED
Package configurations containing preservative-free midazolam hydrochloride equivalent to 1 mg midazolam/mL:

List Number	Container Description	Fill Volume	Total Midazolam (per container)
2305	Fliptop Vial	2 mL	2 mg
2305	Fliptop Vial	5 mL	5 mg

Package configurations containing preservative-free midazolam hydrochloride equivalent to 5 mg midazolam/mL:

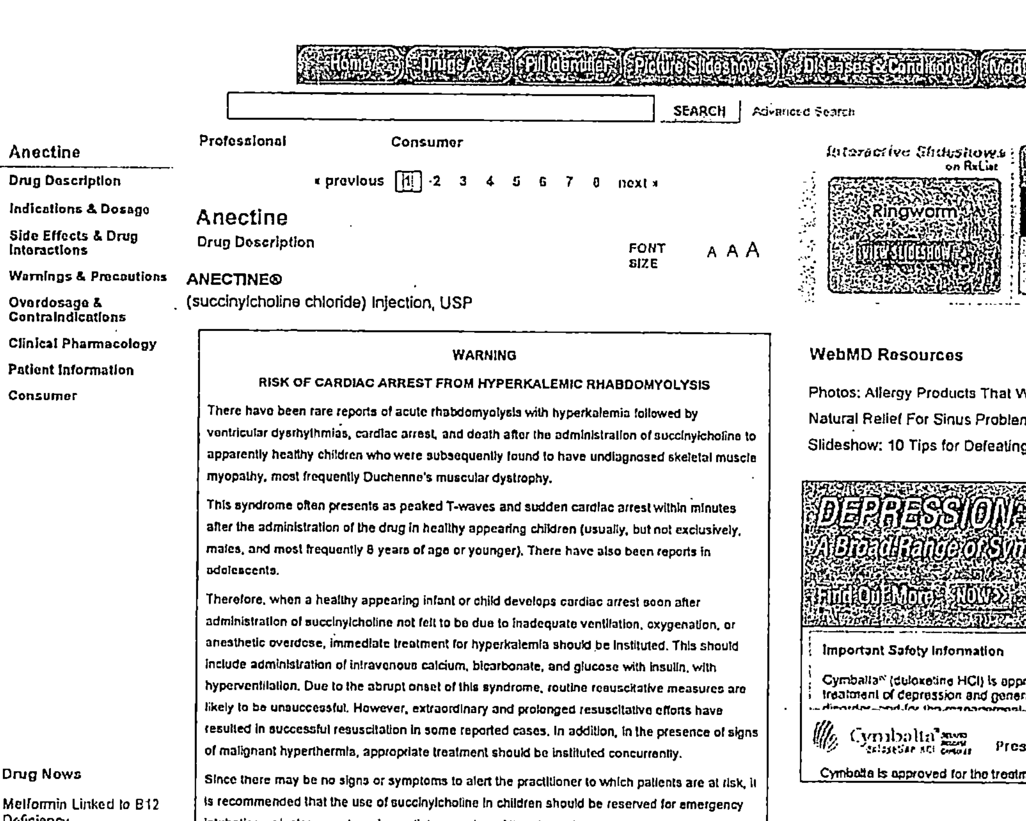
List Number	Container Description	Fill Volume	Total Midazolam (per container)
2308	Fliptop Vial	1 mL	5 mg
2308	Fliptop Vial	2 mL	10 mg

Store at 20 to 25°C (68 to 77°F). [See USP Controlled Room Temperature.]

Discard unused portion.
December, 2004
©Hospira 2004EN-0680
HOSPIRA, INC., LAKE FOREST, IL 60045 USA

This document Copyright © 1993-2009 GlobalRPh Inc., All Rights Reserved. **Do Not Copy, Distribute or otherwise Disseminate without express permission.**

> Physicians: Test your knowledge



Home | Drugs A-Z | Pill Identifier | Picture Slideshows | Diseases & Conditions | Medical Dictionary

SEARCH | Advanced Search

Anectine
Drug Description
Indications & Dosage
Side Effects & Drug Interactions
Warnings & Precautions
Overdosage & Contraindications
Clinical Pharmacology
Patient Information
Consumer

Professional   Consumer

« previous 1 2 3 4 5 6 7 8 next »

Anectine

Drug Description

FONT SIZE A A A

ANECTINE®
(succinylcholine chloride) Injection, USP

WARNING

RISK OF CARDIAC ARREST FROM HYPERKALEMIC RHABDOMYOLYSIS

There have been rare reports of acute rhabdomyolysis with hyperkalemia followed by ventricular dysrhythmias, cardiac arrest, and death after the administration of succinylcholine to apparently healthy children who were subsequently found to have undiagnosed skeletal muscle myopathy, most frequently Duchenne's muscular dystrophy.

This syndrome often presents as peaked T-waves and sudden cardiac arrest within minutes after the administration of the drug in healthy appearing children (usually, but not exclusively, males, and most frequently 8 years of age or younger). There have also been reports in adolescents.

Therefore, when a healthy appearing infant or child develops cardiac arrest soon after administration of succinylcholine not felt to be due to inadequate ventilation, oxygenation, or anesthetic overdose, immediate treatment for hyperkalemia should be instituted. This should include administration of intravenous calcium, bicarbonate, and glucose with insulin, with hyperventilation. Due to the abrupt onset of this syndrome, routine resuscitative measures are likely to be unsuccessful. However, extraordinary and prolonged resuscitative efforts have resulted in successful resuscitation in some reported cases. In addition, in the presence of signs of malignant hyperthermia, appropriate treatment should be instituted concurrently.

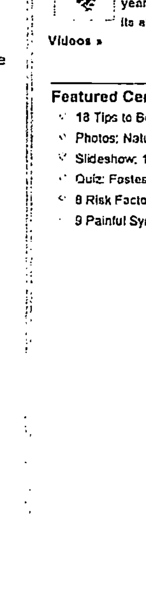
Since there may be no signs or symptoms to alert the practitioner to which patients are at risk, it is recommended that the use of succinylcholine in children should be reserved for emergency intubation or instances where immediate securing of the airway is necessary, e.g., laryngospasm, difficult airway, full stomach, or for intramuscular use when a suitable vein is inaccessible (see PRECAUTIONS: Pediatric Use and DOSAGE AND ADMINISTRATION).

This drug should be used only by individuals familiar with its actions, characteristics, and hazards.

DRUG DESCRIPTION

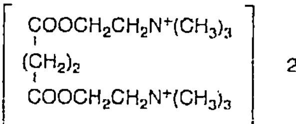
ANECTINE (succinylcholine chloride) is an ultra short-acting depolarizing-type, skeletal muscle relaxant for intravenous (IV) administration.

Succinylcholine chloride is a white, odorless, slightly bitter powder and very soluble in water. The drug is unstable in alkaline solutions but relatively stable in acid solutions, depending upon the concentration of the solution and the storage temperature. Solutions of succinylcholine chloride should be stored under refrigeration to preserve potency. ANECTINE Injection is a sterile nonpyrogenic solution for IV injection, containing 20 mg succinylcholine chloride in each mL and made isotonic with sodium chloride. The pH is adjusted to 3.5 with hydrochloric acid.



Methylparaben (0.1%) is added as a preservative.

The chemical name for succinylcholine chloride is 2,2'-[(1,4-dioxo-1,4-butanediyl)bis(oxy)]bis[*N,N,N*-trimethylethanaminium] dichloride, and the structural formula is:



$$\left[\begin{array}{l} COOCH_2CH_2N^+(CH_3)_3 \\ (CH_2)_2 \\ COOCH_2CH_2N^+(CH_3)_3 \end{array}\right] \quad 2\ Cl^-$$

Last updated on RxList: 6/3/2008

« previous 1 2 3 4 5 6 7 8 next »

Report Problems to the Food and Drug Administration

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit the FDA MedWatch website or call 1-800-FDA-

Drug News
Metformin Linked to B12 Deficiency
Avandia & Heart Risk Debate
New Use for Ingredient of Cialis
View More »

Search the Medical Dictionary for Health Definitions & Medical Abbreviations

Updated & New
News & Features

Identify Your Drugs: Use the RxList Pill Identifier Tool

Add RxList Search to Your Website

Google Subscribed Links & RxList

Popular Searches
Allegra
Byetta
Cymbalta
Esirng
Lantus
MiraLAX
Plan B
Risperdal
Tylenol
Zelia

Interactive Slideshows on RxList
Ringworm
View slideshow
Angry, Sad, Unfocused?
When Is It Depression?
Start Here

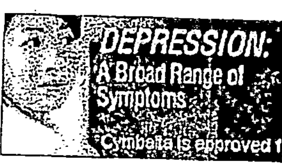
WebMD Resources
Photos: Allergy Products That Work
Natural Relief For Sinus Problems
Slideshow: 10 Tips for Defeating Heartburn

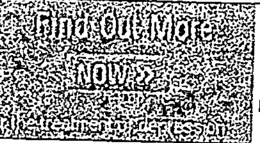
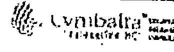
DEPRESSION A Broad Range of Symptoms Find Out More Now
Important Safety Information
Cymbalta (duloxetine HCl) is approved for the treatment of depression and generalized anxiety
Cymbalta
Safety Information and Boxed Warning
Prescribing Information
Medication Guide
Cymbalta is approved for the treatment of depression.

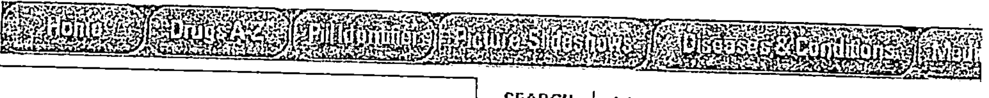
Health Extras
Drug User Reviews Now on RxList
The Secret to Losing Weight from WebMD!
Healthy Recipes for Health & Living on MedicineNet.

Videos
Herbal First Aid
Herbal medicine is ancient, but only in recent years have many people started to take notice of its all natural healing powers. See more WebMD Videos »

Featured Centers from WebMD.com
13 Tips to Boost Your Mood & Fight Stress
Photos: Natural Relief for Colds and Allergies
Slideshow: 15 Allergy Products That Work
Quiz: Fastest Ways to Lower Cholesterol
8 Risk Factors for Diabetes Nerve Pain
9 Painful Symptoms of Depression





Safety Information and Boxed Warning
Prescribing Information
Medication Guide
Important Safety Information
Cymbalta® (duloxetine HCl) is approved for the treatment of depression and generalized anxiety disorder, and for the management of diabetic peripheral neuropathic pain and


SEARCH | Advanced Search

Anectine

- Drug Description
- Indications & Dosage
- Side Effects & Drug Interactions
- Warnings & Precautions
- Overdosage & Contraindications
- Clinical Pharmacology
- Patient Information
- Consumer

Professional Consumer

« previous 1 2 3 [4] 5 6 7 8 next »

Anectine

Warnings & Precautions

FONT SIZE A A A

WARNINGS

SUCCINYLCHOLINE SHOULD BE USED ONLY BY THOSE SKILLED IN THE MANAGEMENT OF ARTIFICIAL RESPIRATION AND ONLY WHEN FACILITIES ARE INSTANTLY AVAILABLE FOR TRACHEAL INTUBATION AND FOR PROVIDING ADEQUATE VENTILATION OF THE PATIENT, INCLUDING THE ADMINISTRATION OF OXYGEN UNDER POSITIVE PRESSURE AND THE ELIMINATION OF CARBON DIOXIDE. THE CLINICIAN MUST BE PREPARED TO ASSIST OR CONTROL RESPIRATION.

TO AVOID DISTRESS TO THE PATIENT, SUCCINYLCHOLINE SHOULD NOT BE ADMINISTERED BEFORE UNCONSCIOUSNESS HAS BEEN INDUCED. IN EMERGENCY SITUATIONS, HOWEVER, IT MAY BE NECESSARY TO ADMINISTER SUCCINYLCHOLINE BEFORE UNCONSCIOUSNESS IS INDUCED.

SUCCINYLCHOLINE IS METABOLIZED BY PLASMA CHOLINESTERASE AND SHOULD BE USED WITH CAUTION, IF AT ALL, IN PATIENTS KNOWN TO BE OR SUSPECTED OF BEING HOMOZYGOUS FOR THE ATYPICAL PLASMA CHOLINESTERASE GENE.

Hyperkalemia: (SEE BOX WARNING.) Succinylcholine should be administered with **GREAT CAUTION** to patients suffering from electrolyte abnormalities and those who may have massive digitalis toxicity, because in these circumstances succinylcholine may induce serious cardiac arrhythmias or cardiac arrest due to hyperkalemia.

GREAT CAUTION should be observed if succinylcholine is administered to patients during the acute phase of injury following major burns, multiple trauma, extensive denervation of skeletal muscle, or upper motor neuron injury (see **CONTRAINDICATIONS**). The risk of hyperkalemia in these patients increases over time and usually peaks at 7 to 10 days after the injury. The risk is dependent on the extent and location of the injury. The precise time of onset and the duration of the risk period are undetermined. Patients with chronic abdominal infection, subarachnoid hemorrhage, or conditions causing degeneration of central and peripheral nervous systems should receive succinylcholine with **GREAT CAUTION** because of the potential for developing severe hyperkalemia.

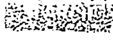
Malignant Hyperthermia: Succinylcholine administration has been associated with acute onset of malignant hyperthermia, a potentially fatal hypermetabolic state of skeletal muscle. The risk of developing malignant hyperthermia following succinylcholine administration increases with the concomitant administration of volatile anesthetics. Malignant hyperthermia frequently presents as intractable spasm of the jaw muscles (masseter spasm) which may progress to generalized rigidity, increased oxygen demand, tachycardia, tachypnea, and profound hyperpyrexia. Successful outcome depends on recognition of early signs, such as jaw muscle spasm, acidosis, or generalized

Drug News

- Metformin Linked to B12 Deficiency
- Avandia & Heart Risk Debate
- New Use for Ingredient of Cialis

View More »

Search the Medical Dictionary for Health Definitions & Medical Abbreviations

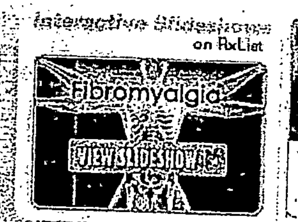


Updated & New
News & Features

Identify Your Drugs: Use the RxList Pill Identifier Tool

Add RxList Search to Your Website

Google Subscribed Links



WebMD Resources

Photos: Allergy Products That W
Natural Relief For Sinus Problen
Slideshow: 10 Tips for Defeatinc

Health Extras

Drug User Reviews Now on RxLis
The Secret to Losing Weight from
Healthy Recipes for Health & Livir

Herbal First Aid
Herbal medicine is ancient years have many people st its all natural healing power

Videos »

Featured Centers from WebM

- 18 Tips to Boost Your Mood & Fight
- Photos: Natural Relief for Colds and
- Slideshow: 15 Allergy Products That
- Quiz: Fastest Ways to Lower Choles
- 8 Risk Factors for Diabetes Nerve P
- 9 Painful Symptoms of Depression

& RxList

Popular Searches
Altace Capsules
Caduet
Darvocet-N
Fioricet
Lasix
Mirapex
Pravachol
Ritalin
Ultracet
Zithromax

rigidity to initial administration of succinylcholine for tracheal intubation, or failure of tachycardia to respond to deepening anesthesia. Skin mottling, rising temperature, and coagulopathies may occur later in the course of the hypermetabolic process. Recognition of the syndrome is a signal for discontinuance of anesthesia, attention to increased oxygen consumption, correction of acidosis, support of circulation, assurance of adequate urinary output, and institution of measures to control rising temperature. Intravenous dantrolene sodium is recommended as an adjunct to supportive measures in the management of this problem. Consult literature references and the dantrolene prescribing information for additional information about the management of malignant hyperthermic crisis. Continuous monitoring of temperature and expired CO_2 is recommended as an aid to early recognition of malignant hyperthermia.

Other: In both adults and children, the incidence of bradycardia, which may progress to asystole, is higher following a second dose of succinylcholine. The incidence and severity of bradycardia is higher in children than in adults. Pretreatment with anticholinergic agents (e.g., atropine) may reduce the occurrence of bradyarrhythmias.

Succinylcholine causes an increase in intraocular pressure. It should not be used in instances in which an increase in intraocular pressure is undesirable (e.g., narrow angle glaucoma, penetrating eye injury) unless the potential benefit of its use outweighs the potential risk.

Succinylcholine is acidic (pH = 3.5) and should not be mixed with alkaline solutions having a pH greater than 8.5 (e.g., barbiturate solutions).

PRECAUTIONS

(SEE BOX WARNING.)

General: When succinylcholine is given over a prolonged period of time, the characteristic depolarization block of the myoneural junction (Phase I block) may change to a block with characteristics superficially resembling a nondepolarizing block (Phase II block). Prolonged respiratory muscle paralysis or weakness may be observed in patients manifesting this transition to Phase II block. The transition from Phase I to Phase II block has been reported in seven of seven patients studied under halothane anesthesia after an accumulated dose of 2 to 4 mg/kg succinylcholine (administered in repeated, divided doses). The onset of Phase II block coincided with the onset of tachyphylaxis and prolongation of spontaneous recovery. In another study, using balanced anesthesia (N_2O/O_2/narcotic-thiopental) and succinylcholine infusion, the transition was less abrupt, with great individual variability in the dose of succinylcholine required to produce Phase II block. Of 32 patients studied, 24 developed Phase II block. Tachyphylaxis was not associated with the transition to Phase II block, and 50% of the patients who developed Phase II block experienced prolonged recovery.

When Phase II block is suspected in cases of prolonged neuromuscular blockade, positive diagnosis should be made by peripheral nerve stimulation prior to administration of any anticholinesterase drug. Reversal of Phase II block is a medical decision which must be made upon the basis of the individual, clinical pharmacology, and the experience and judgment of the physician. The presence of Phase II block is indicated by fade of responses to successive stimuli (preferably "train-of-four"). The use of an anticholinesterase drug to reverse Phase II block should be accompanied by appropriate doses of an anticholinergic drug to prevent disturbances of cardiac rhythm. After adequate reversal of Phase II block with an anticholinesterase agent, the patient should be continually observed for at least 1 hour for signs of return of muscle relaxation. Reversal should not be attempted unless: (1) a peripheral nerve stimulator is used to determine the presence of Phase II block (since anticholinesterase agents will potentiate succinylcholine-induced Phase I block), and (2) spontaneous recovery of muscle twitch has been observed for at least 20 minutes and has reached a plateau with further recovery proceeding slowly;

this delay is to ensure complete hydrolysis of succinylcholine by plasma cholinesterase prior to administration of the anticholinesterase agent. Should the type of block be misdiagnosed, depolarization of the type initially induced by succinylcholine (i.e., Phase I block) will be prolonged by an anticholinesterase agent.

Succinylcholine should be employed with caution in patients with fractures or muscle spasm because the initial muscle fasciculations may cause additional trauma.

Succinylcholine may cause a transient increase in intracranial pressure; however, adequate anesthetic induction prior to administration of succinylcholine will minimize this effect.

Succinylcholine may increase intragastric pressure, which could result in regurgitation and possible aspiration of stomach contents.

Neuromuscular blockade may be prolonged in patients with hypokalemia or hypocalcemia.

Reduced Plasma Cholinesterase Activity: Succinylcholine should be used carefully in patients with reduced plasma cholinesterase (pseudocholinesterase) activity. The likelihood of prolonged neuromuscular block following administration of succinylcholine must be considered in such patients (see **DOSAGE AND ADMINISTRATION**).

Plasma cholinesterase activity may be diminished in the presence of genetic abnormalities of plasma cholinesterase (e.g., patients heterozygous or homozygous for atypical plasma cholinesterase gene), pregnancy, severe liver or kidney disease, malignant tumors, infections, burns, anemia, decompensated heart disease, peptic ulcer, or myxedema. Plasma cholinesterase activity may also be diminished by chronic administration of oral contraceptives, glucocorticoids, or certain monoamine oxidase inhibitors, and by irreversible inhibitors of plasma cholinesterase (e.g., organophosphate insecticides, echothiophate, and certain antineoplastic drugs).

Patients homozygous for atypical plasma cholinesterase gene (1 in 2500 patients) are extremely sensitive to the neuromuscular blocking effect of succinylcholine. In these patients, a 5- to 10-mg test dose of succinylcholine may be administered to evaluate sensitivity to succinylcholine, or neuromuscular blockade may be produced by the cautious administration of a 1-mg/mL solution of succinylcholine by slow IV infusion. Apnea or prolonged muscle paralysis should be treated with controlled respiration.

Carcinogenesis, Mutagenesis, Impairment of Fertility: There have been no long-term studies performed in animals to evaluate carcinogenic potential.

Pregnancy: ***Teratogenic Effects:*** *Pregnancy Category C.* Animal reproduction studies have not been conducted with succinylcholine chloride. It is also not known whether succinylcholine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Succinylcholine should be given to a pregnant woman only if clearly needed.

Nonteratogenic Effects: Plasma cholinesterase levels are decreased by approximately 24% during pregnancy and for several days postpartum. Therefore, a higher proportion of patients may be expected to show increased sensitivity (prolonged apnea) to succinylcholine when pregnant than when nonpregnant.

Labor and Delivery: Succinylcholine is commonly used to provide muscle relaxation during delivery by cesarean section. While small amounts of succinylcholine are known to cross the placental barrier, under normal conditions the quantity of drug that enters fetal circulation after a single dose of 1 mg/kg to the mother should not endanger the fetus. However, since the amount of drug that crosses the placental barrier is dependent on the concentration gradient between the maternal and fetal circulations, residual

neuromuscular blockade (apnea and flaccidity) may occur in the neonate after repeated high doses to, or in the presence of atypical plasma cholinesterase in, the mother.

Nursing Mothers: It is not known whether succinylcholine is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised following succinylcholine administration to a nursing woman.

Pediatric Use: There are rare reports of ventricular dysrhythmias and cardiac arrest secondary to acute rhabdomyolysis with hyperkalemia in apparently healthy children who receive succinylcholine (see **BOX WARNING**). Many of these children were subsequently found to have a skeletal muscle myopathy such as Duchenne's muscular dystrophy whose clinical signs were not obvious. The syndrome often presents as sudden cardiac arrest within minutes after the administration of succinylcholine. These children are usually, but not exclusively, males, and most frequently 8 years of age or younger. There have also been reports in adolescents. There may be no signs or symptoms to alert the practitioner to which patients are at risk. A careful history and physical may identify developmental delays suggestive of a myopathy. A preoperative creatine kinase could identify some but not all patients at risk. Due to the abrupt onset of this syndrome, routine resuscitative measures are likely to be unsuccessful. Careful monitoring of the electrocardiogram may alert the practitioner to peaked T-waves (an early sign). Administration of IV calcium, bicarbonate, and glucose with insulin, with hyperventilation have resulted in successful resuscitation in some of the reported cases. Extraordinary and prolonged resuscitative efforts have been effective in some cases. In addition, in the presence of signs of malignant hyperthermia, appropriate treatment should be initiated concurrently (see **WARNINGS**). Since it is difficult to identify which patients are at risk, it is recommended that the use of succinylcholine in children should be reserved for emergency intubation or instances where immediate securing of the airway is necessary, e.g., laryngospasm, difficult airway, full stomach, or for intramuscular use when a suitable vein is inaccessible.

As in adults, the incidence of bradycardia in children is higher following the second dose of succinylcholine. The incidence and severity of bradycardia is higher in children than in adults. Pretreatment with anticholinergic agents, e.g., atropine, may reduce the occurrence of bradyarrhythmias.

Last updated on RxList: 6/3/2008

« previous 1 2 3 [4] 5 6 7 8 next »

Report Problems to the Food and Drug Administration

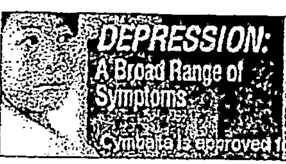
You are encouraged to report negative side effects of prescription drugs to the FDA. Visit the FDA MedWatch website or call 1-800-FDA-1088.

Bookmark this page: SHARE

Privacy Policy

Women's Health
Find out what women really need.

Enter email address SUBMIT



Cymbalta
Safety Information and Boxed Warning
Prescribing Information
Medication Guide
Important Safety Information
Cymbalta® (duloxetine HCl) is approved for the treatment of depression and generalized anxiety disorder, and for the management of diabetic peripheral neuropathic pain and

Anectine

Drug Description
Indications & Dosage
Side Effects & Drug Interactions
Warnings & Precautions
Overdosage & Contraindications
Clinical Pharmacology
Patient Information
Consumer

Anectine

Overdosage & Contraindications

FONT SIZE A A A

OVERDOSE

Overdosage with succinylcholine may result in neuromuscular block beyond the time needed for surgery and anesthesia. This may be manifested by skeletal muscle weakness, decreased respiratory reserve, low tidal volume, or apnea. The primary treatment is maintenance of a patent airway and respiratory support until recovery of normal respiration is assured. Depending on the dose and duration of succinylcholine administration, the characteristic depolarizing neuromuscular block (Phase I) may change to a block with characteristics superficially resembling a nondepolarizing block (Phase II) (see **PRECAUTIONS**).

CONTRAINDICATIONS

Succinylcholine is contraindicated in persons with personal or familial history of malignant hyperthermia, skeletal muscle myopathies, and known hypersensitivity to the drug. It is also contraindicated in patients after the acute phase of injury following major burns, multiple trauma, extensive denervation of skeletal muscle, or upper motor neuron injury, because succinylcholine administered to such individuals may result in severe hyperkalemia which may result in cardiac arrest (see **WARNINGS**). The risk of hyperkalemia in these patients increases over time and usually peaks at 7 to 10 days after the injury. The risk is dependent on the extent and location of the injury. The precise time of onset and the duration of the risk period are not known.

Last updated on RxList: 6/3/2008

Report Problems to the Food and Drug Administration

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit the FDA MedWatch website or call 1-800-FDA-1088.

Bookmark this page: SHARE

Interactive Slideshows on RxList
Ringworm
VIEW SLIDESHOW

WebMD Resources
Photos: Allergy Products That W
Natural Relief For Sinus Problen
Slideshow: 10 Tips for Defeatin

Drug News
Metformin Linked to B12 Deficiency
Avandia & Heart Risk Debate
New Use for Ingredient of Cialis
View More »

Health Extras
Drug User Reviews Now on RxLis
The Secret to Losing Weight from
Healthy Recipes for Health & Livir

Search the Medical Dictionary for Health Definitions & Medical Abbreviations

Updated & New
News & Features

Herbal First Aid
Herbal medicine is ancient years have many people st its all natural healing power
Videos »

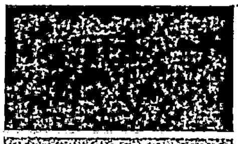
Featured Centers from WebM
18 Tips to Boost Your Mood & Fight
Photos: Natural Relief for Colds and
Slideshow: 15 Allergy Products That
Quiz: Fastest Ways to Lower Choles
8 Risk Factors for Diabetes Nerve P
9 Painful Symptoms of Depression

Identify Your Drugs: Use the RxList Pill Identifier Tool

Women's Health
Find out what women really need.
Enter email address
SUBMIT
Privacy Policy

Add RxList Search to Your Website

Google Subscribed Links



DEPRESSION is not your fault

Anectine

- Drug Description
- Indications & Dosage
- Side Effects & Drug Interactions
- Warnings & Precautions
- Overdosage & Contraindications
- Clinical Pharmacology
- Patient Information
- Consumer

Anectine

Clinical Pharmacology

CLINICAL PHARMACOLOGY

Succinylcholine is a depolarizing skeletal muscle relaxant. As does acetylcholine, it combines with the cholinergic receptors of the motor end plate to produce depolarization. This depolarization may be observed as fasciculations. Subsequent neuromuscular transmission is inhibited so long as adequate concentration of succinylcholine remains at the receptor site. Onset of flaccid paralysis is rapid (less than 1 minute after IV administration), and with single administration lasts approximately 4 to 6 minutes.

Succinylcholine is rapidly hydrolyzed by plasma cholinesterase to succinylmonocholine (which possesses clinically insignificant depolarizing muscle relaxant properties) and then more slowly to succinic acid and choline (see PRECAUTIONS). About 10% of the drug is excreted unchanged in the urine. The paralysis following administration of succinylcholine is progressive, with differing sensitivities of different muscles. This initially involves consecutively the levator muscles of the face, muscles of the glottis, and finally, the intercostals and the diaphragm and all other skeletal muscles.

Succinylcholine has no direct action on the uterus or other smooth muscle structures. Because it is highly ionized and has low fat solubility, it does not readily cross the placenta.

Tachyphylaxis occurs with repeated administration (see PRECAUTIONS).

Depending on the dose and duration of succinylcholine administration, the characteristic depolarizing neuromuscular block (Phase I block) may change to a block with characteristics superficially resembling a nondepolarizing block (Phase II block). This may be associated with prolonged respiratory muscle paralysis or weakness in patients who manifest the transition to Phase II block. When this diagnosis is confirmed by peripheral nerve stimulation, it may sometimes be reversed with anticholinesterase drugs such as neostigmine (see PRECAUTIONS).

Anticholinesterase drugs may not always be effective. If given before succinylcholine is metabolized by cholinesterase, anticholinesterase drugs may prolong rather than shorten paralysis.

Succinylcholine has no direct effect on the myocardium. Succinylcholine stimulates both autonomic ganglia and muscarinic receptors which may cause changes in cardiac rhythm, including cardiac arrest. Changes in rhythm, including cardiac arrest, may also result from vagal stimulation, which may occur during surgical procedures, or from hyperkalemia, particularly in children (see PRECAUTIONS: Pediatric Use). These effects are enhanced by halogenated anesthetics.

Succinylcholine causes an increase in intraocular pressure immediately after its injection and during the fasciculation phase, and slight increases which may

Drug News

Metformin Linked to B12 Deficiency
Avandia & Heart Risk Debate
New Use for Ingredient of Cialis
View More »

Search the Medical Dictionary for Health Definitions & Medical Abbreviations

Updated & New
News & Features

Identify Your Drugs: Use the RxList Pill Identifier Tool

Add RxList Search to Your Website

Google Subscribed Links

Interactive Slideshows on RxList

WebMD Resources

Photos: Allergy Products That W
Natural Relief For Sinus Problen
Slideshow: 10 Tips for Defeatin

Health Extras

Drug User Reviews Now on RxLis
The Secret to Losing Weight from
Healthy Recipes for Health & Livir

Herbal First Aid
Herbal medicine is ancient years have many people st its all natural healing power
Videos »

Featured Centers from WebM

- 18 Tips to Boost Your Mood & Fight
- Photos: Natural Relief for Colds and
- Slideshow: 15 Allergy Products That
- Quiz: Fastest Ways to Lower Choles
- 8 Risk Factors for Diabetes Nerve P
- 9 Painful Symptoms of Depression

& RxList

Popular Searches

- Altace Capsules
- Caduet
- Darvocet-N
- Fioricet
- Lasix
- Mirapex
- Pravachol
- Ritalin
- Ultracet
- Zithromax

persist after onset of complete paralysis (see **WARNINGS**).

Succinylcholine may cause slight increases in intracranial pressure immediately after its injection and during the fasciculation phase (see **PRECAUTIONS**).

As with other neuromuscular blocking agents, the potential for releasing histamine is present following succinylcholine administration. Signs and symptoms of histamine-mediated release such as flushing, hypotension, and bronchoconstriction are, however, uncommon in normal clinical usage.

Succinylcholine has no effect on consciousness, pain threshold, or cerebration. It should be used only with adequate anesthesia (see **WARNINGS**).

Last updated on RxList: 6/3/2008

« previous 1 2 3 4 5 [6] 7 8 next »

Report Problems to the Food and Drug Administration

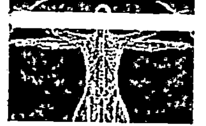
You are encouraged to report negative side effects of prescription drugs to the FDA. Visit the FDA MedWatch website or call 1-800-FDA-1088.

Bookmark this page: SHARE

Privacy Policy

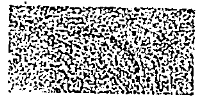
Women's Health
Find out what women really need.

Enter email address SUBMIT



Fibromyalgia

Is Your Pain Due to Fibromyalgia?

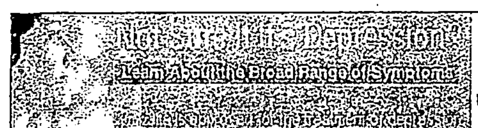


Health Solutions From Our Sponsors

Anxiety Symptom Control
Atherosclerosis?
BPH Treatment
Depression Med for You?
Fibromyalgia Center
Good & Bad Fats
High Blood Pressure?
High Cholesterol?
Learn About Fibro
Men's Urinary Health
Smarter Eating
Treating Depression
Triglyceride Risks
Type 2 Diabetes?
When Pain Is Fibro Pain

RxList Home | Drugs & Medications A-Z List | Picture Slideshows | Pill Identification Tool | Diseases & Conditions | Drug Medical Dictionary
About RxList | Professional Drug Submission Form | Consumer Contact RxList | Terms & Conditions | Privacy Policy | Sponsor Policy | Site Map
WebMD® | MedScape® | eMedicineHealth® | MedicineNet®

Copyright © 2009 by RxList Inc.
RxList does not provide medical advice, diagnosis or treatment. See additional information.



Cymbalta Important Safety Information
Safety Information and Boxed Warning
Prescribing Information
Medication Guide
Cymbalta (duloxetine HCl) is approved for the treatment of depression and generalized anxiety disorder, and for the management of diabetic peripheral neuropathic pain and

Drugs & Medications - Ativan Inj

The display and use of drug information on this site is subject to express terms of use. By continuing to view the drug information, you agree to abide by such terms of use.

Ativan Inj

Important Note: The following information is intended to supplement, not substitute for, the expertise and judgment of your physician, pharmacist or other healthcare professional. It should not be construed to indicate that use of the drug is safe, appropriate, or effective for you. Consult your healthcare professional before using this drug.

LORAZEPAM - INJECTION

PRONUNCIATION: (lor-AYE-zeh-pam)
BRAND NAME(S): Ativan

Review this Drug
16 User Reviews
View Images

SIDE EFFECTS

ATIVAN INJ SIDE EFFECTS

Drowsiness, dizziness, or unsteadiness may occur. If this medication is injected into a muscle, pain/burning/redness at the injection site may occur. If any of these effects persist or worsen, tell your doctor or pharmacist promptly.

Remember that your doctor has prescribed this medication because he or she has judged that the benefit to you is greater than the risk of side effects. Many people using this medication do not have serious side effects.

Tell your doctor immediately if any of these unlikely but serious side effects occur: slow/shallow breathing, loss of consciousness, pain/swelling at injection site (if this drug is injected into a vein), seizures, blurred vision, mental/mood changes (e.g., hallucinations, agitation, confusion).

Tell your doctor immediately if any of these rare but very serious side effects occur: change in the amount of urine, shortness of breath, fast breathing, muscle weakness.

A very serious allergic reaction to this drug is rare. However, seek immediate medical attention if you notice any symptoms of a serious allergic reaction, including: rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing.

This is not a complete list of possible side effects. If you notice other effects not listed above, contact your doctor or pharmacist.

Call your doctor for medical advice about side effects. In the US, you may report side effects to the Food and Drug Administration (FDA) at 1-800-FDA-1088.

In Canada, you may report side effects to Health Canada at 1-866-234-2345.

Does Ativan Inj have any side effects?

See 16 Reviews for this Drug. - OR -

Related to Ativan Inj
Anxiety/Panic Center
Depression Symptoms Quiz
Ending Negative Thoughts
Anxiety Can Signal Depression
Test Your Depression IQ
Anxiety Support Group

FIND A DRUG:
by name or medical condition or shape/color (Pill Identifier)

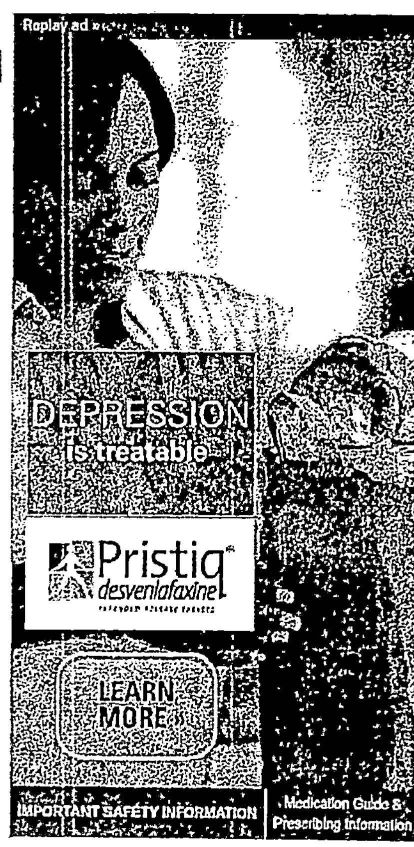
Drug Name
(for example aspirin)

Medical Condition
(for example: diabetes)

Pill Identifier

related links
Share with other caring WebMD members.
Read the top drug news of the day.
Get more health news.

Get the latest safety information from the FDA in partnership with WebMD



Most Popular Stories

1. Masturbation: 5 Things You Didn't Know
2. 6 Daily Habits Making You Sick
3. Flatten Your Abs: 9 Tips
4. Swine Flu: What Are Symptoms of Swine Flu?
5. 6 Foods to Boost Your Mood
6. Secret Summer Diet Foods
7. Foods That Fight Allergies
8. Insulin Changes Occur Years Before Diabetes

[illegible]

CONDITIONS OF USE: [illegible]

Report Problems to the Food and Drug Administration

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit the FDA MedWatch website or call 1-800-FDA-1088.

10. 15 Allergy Products That Work

Women's Health Newsletter
Find out what women really need.

Enter Email Address SUBMIT

Get drug and supplement information on the go with your **iPhone**.

IMPORTANT: About This Section and Other User-Generated Content on WebMD

The opinions expressed in WebMD User-generated content areas like reviews, ratings, blogs, or message boards are solely those of the User, who may or may not have medical or scientific training. These opinions do not represent the opinions of WebMD. User-generated content areas are not reviewed by a WebMD physician or any member of the WebMD editorial staff for accuracy, balance, objectivity, or any other purpose except for compliance with our Terms and Conditions. Some of these opinions may contain information about uses of drug products that have not been approved by the U.S. Food and Drug Administration. WebMD does not endorse any specific product, service, or treatment.

Do not consider WebMD User-generated content as medical advice. Never delay or disregard seeking professional medical advice from your doctor or other qualified healthcare provider because of something you have read on WebMD. You should always speak with your doctor before you start, stop, or change any prescribed part of your care plan or treatment. WebMD understands that reading individual, real-life experiences can be a helpful health information resource but it is never a substitute for professional medical advice, diagnosis, or treatment from a qualified health care provider.

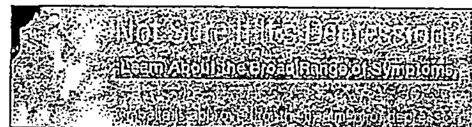
Health Solutions From Our Sponsors

Anxiety Symptom Control | Depression Med for You? | High Blood Pressure? | Men's Urinary Health | Triglyceride Risks
Atherosclerosis? | Fibromyalgia Center | High Cholesterol? | Smarter Eating | Type 2 Diabetes?
BPH Treatment | Good & Bad Fats | Learn About Fibro | Treating Depression | When Pain Is Fibro Pain

In-depth coverage: Stopping Allergies | Depression Symptoms | Cough Medicine Abuse | Vitamins & Supplements Center | Tune Into RAtv | Live Better With Bipolar TV

About WebMD | Terms of Use | Privacy Policy | Sponsor Policy | Site Map | Link to Us | Careers | Contact Us
Advertise With Us | HLTH Corporation | WebMD Corporate | eMedicine® | RxList® | Medscape® | MedicineNet®
Medical Dictionary | First Aid | WebMD the Magazine | WebMD Personal Health Record | WebMD Mobile | Newsletters

©2005-2009 WebMD, LLC. All rights reserved.
WebMD does not provide medical advice, diagnosis or treatment. See additional information

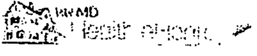


Cymbalta

Safety Information and Boxed Warning Prescribing Information Medication Guide

Important Safety Information

Cymbalta® (duloxetine HCl) is approved for the treatment of depression and generalized anxiety disorder, and for the management of diabetic peripheral neuropathic pain and



Drugs & Medications - Ativan Inj

The display and use of drug information on this site is subject to express terms of use. By continuing to view the drug information, you agree to abide by such terms of use.

Ativan Inj

Important Note: The following information is intended to supplement, not substitute for, the expertise and judgment of your physician, pharmacist or other healthcare professional. It should not be construed to indicate that use of the drug is safe, appropriate, or effective for you. Consult your healthcare professional before using this drug.

LORAZEPAM - INJECTION

PRONUNCIATION: (lor-AYE-zeh-pam)
BRAND NAME(S): Ativan

Review this Drug
16 User Reviews
View Images

PRECAUTIONS

ATIVAN INJ PRECAUTIONS

Before using lorazepam, tell your doctor or pharmacist if you are allergic to it; or to other benzodiazepines (e.g., diazepam), or to polyethylene glycol, propylene glycol, or benzyl alcohol; or if you have any other allergies.

This medication should not be used if you have certain medical conditions. Before using this medicine, consult your doctor or pharmacist if you have: glaucoma (narrow-angle), breathing trouble during sleep (sleep apnea), severe breathing problems (except in patients who are breathing with help from a machine).

Before using this medication, tell your doctor your medical history, especially of: glaucoma (open-angle), kidney disease, liver disease, personal or family history of regular use/abuse of drugs/alcohol, breathing problems (e.g., asthma, chronic obstructive pulmonary disease-COPD).

Before having surgery, tell your doctor or dentist that you are using this medication.

This drug may make you dizzy or drowsy. For at least 8 hours after receiving this drug, you should not get out of bed without help. Do not drive, use machinery, or do any activity that requires alertness until the effects of the medication wear off (at least 24 hours). Avoid alcoholic beverages.

Caution is advised when using this drug in the elderly because they may be more sensitive to the effects of the drug, especially drowsiness.

This drug may have an opposite effect on children, causing restlessness, shaking (tremors), or mental/mood changes (e.g., agitation, hallucinations).

This product contains a preservative (benzyl alcohol) that can infrequently cause serious (sometimes fatal) problems if given in large amounts (more than 100 milligrams per kilogram daily) to an infant during the first months of life. The risk is greater with low-birth-weight infants. Symptoms include sudden gasping, low blood pressure, very slow heartbeat. If you notice any of these symptoms in your newborn, report them to the doctor immediately. If possible, a preservative-free product should be used when treating newborns.

This medication is not recommended for use during pregnancy. Consult your doctor for more details.

This drug passes into breast milk and could have undesirable effects on a nursing infant. Therefore, breast-feeding is not recommended while using this drug. Consult your doctor before breast-feeding.

What should I know before taking Ativan Inj?

See 16 Reviews for this Drug. - OR -

Related to Ativan Inj
Anxiety/Panic Center
Depression Symptoms Quiz
Ending Negative Thoughts
Anxiety Can Signal Depression
Test Your Depression IQ
Anxiety Support Group

related links

Share with other caring WebMD members.
Read the top drug news of the day.
Get more health news.

Get the latest safety information from the FDA in partnership with WebMD

Replay ad
DEPRESSION is treatable.
Pristiq desvenlafaxine
LEARN MORE
IMPORTANT SAFETY INFORMATION
Medication Guide & Prescribing Information

Most Popular Stories

1. Masturbation: 5 Things You Didn't Know
2. 6 Daily Habits Making You Sick
3. Flatten Your Abs: 9 Tips
4. Swine Flu: What Are Symptoms of Swine Flu?
5. 6 Foods to Boost Your Mood
6. Secret Summer Diet Foods
7. Foods That Fight Allergies
8. Insulin Changes Occur Years Before Diabetes

Drug Name
(for example: aspirin)

Medical Condition
(for example: diabetes)

Pill Identifier

10. 15 Allergy Products That Work

Women's Health Newsletter
Find out what women really need.

Enter Email Address

Learn about User Reviews and read IMPORTANT information about user generated content

Get drug and supplement information on the go with your **iPhone**.

Selected from data included with [illegible] by First DataBank, Inc. This copyrighted material has been downloaded [illegible] provider and is not for distribution, except as may be authorized by the applica[illegible]

CONDITIONS OF USE: The [illegible] database is intended to supplement [illegible] The information [illegible] side effects [illegible]

Report Problems to the Food and Drug Administration

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit the FDA MedWatch website or call 1-800-FDA-1088.

IMPORTANT: About This Section and Other User-Generated Content on WebMD

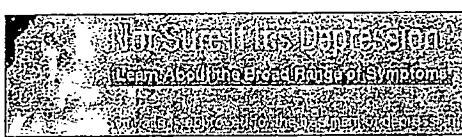
The opinions expressed in WebMD User-generated content areas like reviews, ratings, blogs, or message boards are solely those of the User, who may or may not have medical or scientific training. These opinions do not represent the opinions of WebMD. User-generated content areas are not reviewed by a WebMD physician or any member of the WebMD editorial staff for accuracy, balance, objectivity, or any other purpose except for compliance with our Terms and Conditions. Some of these opinions may contain information about uses of drug products that have not been approved by the U.S. Food and Drug Administration. WebMD does not endorse any specific product, service, or treatment.

Do not consider WebMD User-generated content as medical advice. Never delay or disregard seeking professional medical advice from your doctor or other qualified healthcare provider because of something you have read on WebMD. You should always speak with your doctor before you start, stop, or change any prescribed part of your care plan or treatment. WebMD understands that reading individual, real-life experiences can be a helpful health information resource but it is never a substitute for professional medical advice, diagnosis, or treatment from a qualified health care provider.

Health Solutions From Our Sponsors

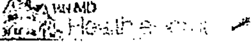
Anxiety Symptom Control
Atherosclerosis?
BPH Treatment
Depression Med for You?
Fibromyalgia Center
Good & Bad Fats
High Blood Pressure?
High Cholesterol?
Learn About Fibro
Men's Urinary Health
Smarter Eating
Treating Depression
Triglyceride Risks
Type 2 Diabetes?
When Pain Is Fibro Pain

©2005-2009 WebMD, LLC. All rights reserved.
WebMD does not provide medical advice, diagnosis or treatment. See additional information



Cymbalta
Safety Information and Boxed Warning
Prescribing Information
Medication Guide
Important Safety Information
Cymbalta® (duloxetine HCl) is approved for the treatment of depression and generalized anxiety disorder, and for the management of diabetic peripheral neuropathic pain and

June 12, 2009



Drugs & Treatments
Drugs & Medications A-Z
Pill Identifier

Common Drugs
Atenolol
Ativan
Cymbalta
Effexor XR
Hydrocodone
Lexapro
Lipitor
Lisinopril
Lyrica
Mobic
Naproxen
Neurontin
Norvasc
Oxycodone
Paxil
Prednisone
Percocet
Prozac
Seroquel
TOPAMAX
Tramadol
Vicodin
Wellbutrin
Xanax
Zoloft

Drugs & Medications - Ativan Inj

The display and use of drug information on this site is subject to express terms of use. By continuing to view the drug information, you agree to abide by such terms of use.

Ativan Inj

Important Note: The following information is intended to supplement, not substitute for, the expertise and judgment of your physician, pharmacist or other healthcare professional. It should not be construed to indicate that use of the drug is safe, appropriate, or effective for you. Consult your healthcare professional before using this drug.

LORAZEPAM - INJECTION

PRONUNCIATION: (lor-AYE-zeh-pam)

BRAND NAME(S): Ativan

Review this Drug
16 User Reviews
View Images

INTERACTIONS

ATIVAN INJ INTERACTIONS

Your doctor or pharmacist may already be aware of any possible drug interactions and may be monitoring you for them. Do not start, stop, or change the dosage of any medicine before checking with your doctor or pharmacist first.

This drug should not be used with the following medication because very serious interactions may occur: sodium oxybate.

If you are currently using the medication listed above, tell your doctor or pharmacist before starting lorazepam.

Before using this medication, tell your doctor or pharmacist of all prescription and nonprescription/herbal products you may use, especially of: birth control pills, clozapine, haloperidol, kava, probenecid, scopolamine, valproic acid.

Tell your doctor or pharmacist if you also take drugs that cause drowsiness such as: certain antihistamines (e.g., diphenhydramine), anti-seizure drugs (e.g., carbamazepine, phenobarbital), medicine for sleep or anxiety (e.g., alprazolam, diazepam, zolpidem), muscle relaxants, narcotic pain relievers (e.g., codeine), psychiatric medicines (e.g., chlorpromazine, risperidone, amitriptyline, trazodone, loxapine).

Check the labels on all your medicines (e.g., cough-and-cold products) because they may contain ingredients that cause drowsiness. Ask your pharmacist about using those products safely.

This document does not contain all possible interactions. Therefore, before using this product, tell your doctor or pharmacist of all the products you use. Keep a list of all your medications with you, and share the list with your doctor and pharmacist.

Does Ativan Inj interact with other medications?

See 16 Reviews for this Drug. - OR -

Related to Ativan Inj
Anxiety/Panic Center
Depression Symptoms Quiz
Ending Negative Thoughts
Anxiety Can Signal Depression
Test Your Depression IQ
Anxiety Support Group

FIND A DRUG:
by name or medical condition or shape/color (Pill Identifier)

Drug Name
(for example: aspirin)

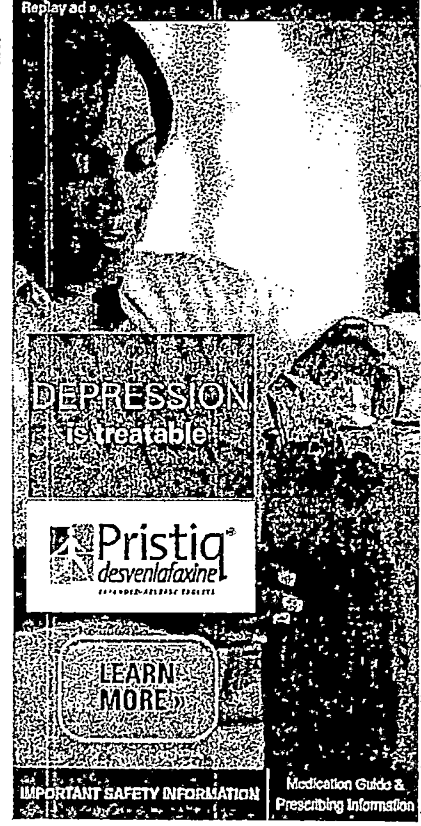
Medical Condition
(for example: diabetes)

Pill Identifier

related links

Share with other caring WebMD members.
Read the top drug news of the day.
Get more health news.

Get the latest safety information from the FDA in partnership with WebMD



Most Popular Stories

1. Masturbation: 5 Things You Didn't Know
2. 6 Daily Habits Making You Sick
3. Flatten Your Abs: 9 Tips
4. Swine Flu: What Are Symptoms of Swine Flu?
5. 6 Foods to Boost Your Mood
6. Secret Summer Diet Foods
7. Foods That Fight Allergies
8. Insulin Changes Occur Years Before Diabetes

[illegible] has not been [illegible] [illegible] authorized by the applicable [illegible]

CONDITIONS OF USE: The information in this database is intended to supplement, not substitute for, the expertise and judgment of healthcare professionals. The information is not intended to cover all possible uses, directions, precautions, drug interactions or adverse effects, nor should it be construed to indicate that use of a particular drug is safe, appropriate or effective for you or anyone else. A healthcare professional should be consulted before taking any drug, changing any diet or commencing or discontinuing any course of treatment.

Report Problems to the Food and Drug Administration

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit the FDA MedWatch website or call 1-800-FDA-1088.

10. 15 Allergy Products That Work

Women's Health Newsletter
Find out what women really need.

Enter Email Address

Get drug and supplement information on the go with your **iPhone.**

IMPORTANT: About This Section and Other User-Generated Content on WebMD

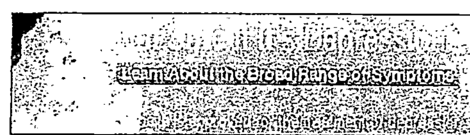
The opinions expressed in WebMD User-generated content areas like reviews, ratings, blogs, or message boards are solely those of the User, who may or may not have medical or scientific training. These opinions do not represent the opinions of WebMD. User-generated content areas are not reviewed by a WebMD physician or any member of the WebMD editorial staff for accuracy, balance, objectivity, or any other purpose except for compliance with our Terms and Conditions. Some of these opinions may contain information about uses of drug products that have not been approved by the U.S. Food and Drug Administration. WebMD does not endorse any specific product, service, or treatment.

Do not consider WebMD User-generated content as medical advice. Never delay or disregard seeking professional medical advice from your doctor or other qualified healthcare provider because of something you have read on WebMD. You should always speak with your doctor before you start, stop, or change any prescribed part of your care plan or treatment. WebMD understands that reading individual, real-life experiences can be a helpful health information resource but it is never a substitute for professional medical advice, diagnosis, or treatment from a qualified health care provider

Health Solutions From Our Sponsors

Anxiety Symptom Control
Atherosclerosis?
BPH Treatment
Depression Med for You?
Fibromyalgia Center
Good & Bad Fats
High Blood Pressure?
High Cholesterol?
Learn About Fibro
Men's Urinary Health
Smarter Eating
Treating Depression
Triglyceride Risks
Type 2 Diabetes?
When Pain Is Fibro Pain

©2005-2009 WebMD, LLC. All rights reserved.
WebMD does not provide medical advice, diagnosis or treatment. See additional information


Important Safety Information
Safety Information and Boxed Warning
Prescribing Information
Medication Guide
Cymbalta (duloxetine HCl) is approved for the treatment of depression and generalized anxiety disorder, and for the management of diabetic peripheral neuropathic pain and

June 12, 2009

Other search tools · Symptoms | Doctors | Hospitals

Log In | Register

WebMD home · Drugs & Medications A-Z

Drugs & Treatments
Drugs & Medications A-Z
Pill Identifier

Common Drugs
Atenolol
Ativan
Cymbalta
Effexor XR
Hydrocodone
Lexapro
Lipitor
Lisinopril
Lyrica
Mobic
Naproxen
Neurontin
Norvasc
Oxycodone
Paxil
Prednisone
Percocet
Prozac
Seroquel
TOPAMAX
Tramadol
Vicodin
Wellbutrin
Xanax
Zoloft

Drugs & Medications - Ativan Inj

The display and use of drug information on this site is subject to express terms of use. By continuing to view the drug information, you agree to abide by such terms of use.

Ativan Inj

Important Note: The following information is intended to supplement, not substitute for, the expertise and judgment of your physician, pharmacist or other healthcare professional. It should not be construed to indicate that use of the drug is safe, appropriate, or effective for you. Consult your healthcare professional before using this drug.

LORAZEPAM - INJECTION

PRONUNCIATION: (lor-AYE-zeh-pam)
BRAND NAME(S): Ativan

Review this Drug
16 User Reviews
View Images

OVERDOSE

ATIVAN INJ OVERDOSE

If overdose is suspected, contact your local poison control center or emergency room immediately. US residents can call the US National Poison Hotline at 1-800-222-1222. Canada residents can call a provincial poison control center. Symptoms of overdose may include: extreme drowsiness/dizziness, confusion, extreme tiredness, unsteadiness, loss of consciousness.

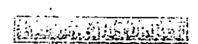
NOTES:
Do not share this medication with others. It is against the law.

MISSED DOSE:
If you miss a dose, use it as soon as you remember. If it is near the time of the next dose, skip the missed dose and resume your usual dosing schedule. Do not double the dose to catch up.

STORAGE:
Refrigerate this medication. Do not freeze. Protect from light. Keep all medicines away from children and pets.

Do not flush medications down the toilet or pour them into a drain unless instructed to do so. Properly discard this product when it is expired or no longer needed. Consult your pharmacist or local waste disposal company for more details about how to safely discard your product.

Information last revised October 2008 Copyright(c) 2008 First DataBank, Inc.

See 16 Reviews for this Drug. - OR - 

Related to Ativan Inj
Anxiety/Panic Center
Depression Symptoms Quiz
Ending Negative Thoughts
Anxiety Can Signal Depression
Test Your Depression IQ
Anxiety Support Group

FIND A DRUG:
by name or medical condition or shape/color (Pill Identifier)

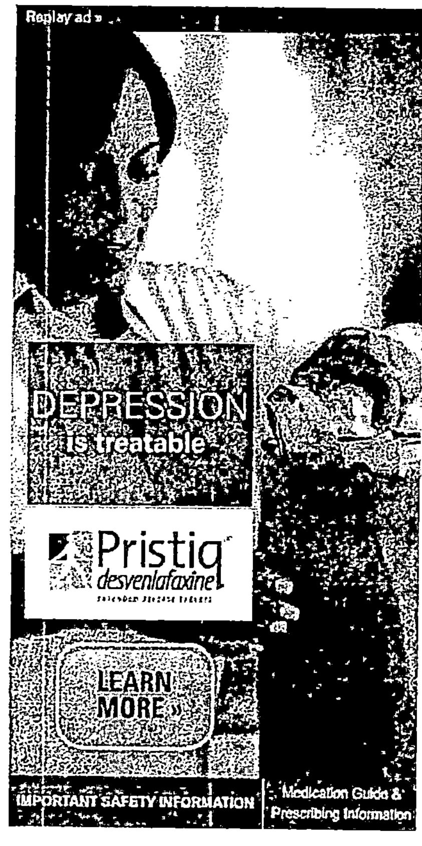
Drug Name (for example: aspirin)
Medical Condition (for example: diabetes)
Pill Identifier

Learn about User Reviews and read IMPORTANT information about user generated content

related links

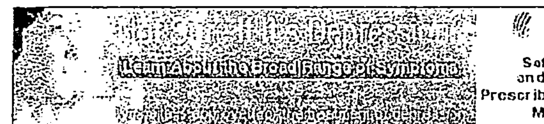
Share with other caring WebMD members.
Read the top drug news of the day.
Get more health news.

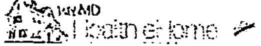
Get the latest safety information from the FDA in partnership with WebMD



Most Popular Stories

1. Masturbation: 5 Things You Didn't Know
2. 6 Daily Habits Making You Sick
3. Flatten Your Abs: 9 Tips
4. Swine Flu: What Are Symptoms of Swine Flu?
5. 6 Foods to Boost Your Mood
6. Secret Summer Diet Foods
7. Foods That Fight Allergies
8. Insulin Changes Occur Years Before Diabetes


Cymbalta
Important Safety Information
Safety Information and Boxed Warning
Prescribing Information
Medication Guide
Cymbalta (duloxetine HCl) is approved for the treatment of depression and generalized anxiety disorder, and for the management of diabetic peripheral neuropathic pain and



Drugs & Medications - Ativan Inj

The display and use of drug information on this site is subject to express terms of use. By continuing to view the drug information, you agree to abide by such terms of use.

Ativan Inj

Important Note: The following information is intended to supplement, not substitute for, the expertise and judgment of your physician, pharmacist or other healthcare professional. It should not be construed to indicate that use of the drug is safe, appropriate, or effective for you. Consult your healthcare professional before using this drug.

LORAZEPAM - INJECTION

PRONUNCIATION: (lor-AYE-zeh-pam)
BRAND NAME(S): Ativan

Review this Drug
16 User Reviews
View Images

OVERDOSE

ATIVAN INJ OVERDOSE

If overdose is suspected, contact your local poison control center or emergency room immediately. US residents can call the US National Poison Hotline at 1-800-222-1222. Canada residents can call a provincial poison control center. Symptoms of overdose may include: extreme drowsiness/dizziness, confusion, extreme tiredness, unsteadiness, loss of consciousness.

NOTES:
Do not share this medication with others. It is against the law.

MISSED DOSE:
If you miss a dose, use it as soon as you remember. If it is near the time of the next dose, skip the missed dose and resume your usual dosing schedule. Do not double the dose to catch up.

STORAGE:
Refrigerate this medication. Do not freeze. Protect from light. Keep all medicines away from children and pets.

Do not flush medications down the toilet or pour them into a drain unless instructed to do so. Properly discard this product when it is expired or no longer needed. Consult your pharmacist or local waste disposal company for more details about how to safely discard your product.

Information last revised October 2008 Copyright(c) 2008 First DataBank, Inc.

See 16 Reviews for this Drug. - OR -

Related to Ativan Inj
Anxiety/Panic Center
Depression Symptoms Quiz
Ending Negative Thoughts
Anxiety Can Signal Depression
Test Your Depression IQ
Anxiety Support Group

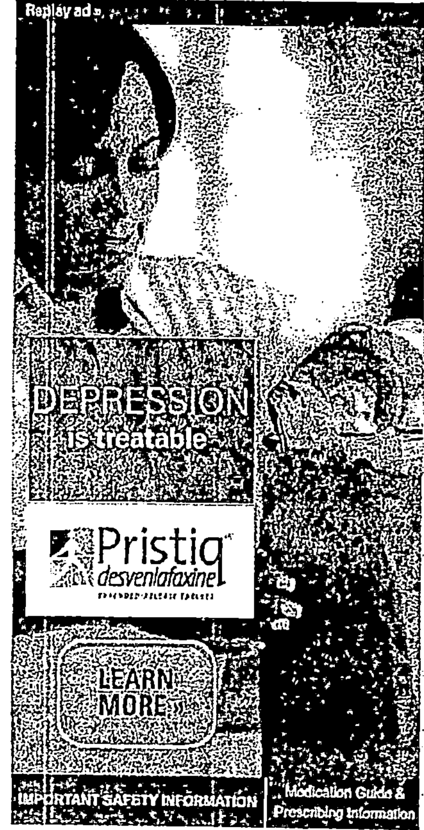
FIND A DRUG:
by name or medical condition or shape/color (Pill Identifier)

Drug Name (for example: aspirin)
Medical Condition (for example: diabetes)
Pill Identifier

Learn about User Reviews and read IMPORTANT information about user generated content

related links
Share with other caring WebMD members.
Read the top drug news of the day.
Get more health news.

Get the latest safety information from the FDA in partnership with WebMD



Most Popular Stories
1. Masturbation: 5 Things You Didn't Know
2. 6 Daily Habits Making You Sick
3. Flatten Your Abs: 9 Tips
4. Swine Flu: What Are Symptoms of Swine Flu?
5. 6 Foods to Boost Your Mood
6. Secret Summer Diet Foods
7. Foods That Fight Allergies
8. Insulin Changes Occur Years Before Diabetes

10. 15 Allergy Products That Work

Women's Health Newsletter
Find out what women really need.

Enter Email Address

Get drug and supplement information on the go with your iPhone.

Report Problems to the Food and Drug Administration

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit the FDA MedWatch website or call 1-800-FDA-1088.

IMPORTANT: About This Section and Other User-Generated Content on WebMD

The opinions expressed in WebMD User-generated content areas like reviews, ratings, blogs, or message boards are solely those of the User, who may or may not have medical or scientific training. These opinions do not represent the opinions of WebMD. User-generated content areas are not reviewed by a WebMD physician or any member of the WebMD editorial staff for accuracy, balance, objectivity, or any other purpose except for compliance with our Terms and Conditions. Some of these opinions may contain information about uses of drug products that have not been approved by the U.S. Food and Drug Administration. WebMD does not endorse any specific product, service, or treatment.

Do not consider WebMD User-generated content as medical advice. Never delay or disregard seeking professional medical advice from your doctor or other qualified healthcare provider because of something you have read on WebMD. You should always speak with your doctor before you start, stop, or change any prescribed part of your care plan or treatment. WebMD understands that reading individual, real-life experiences can be a helpful health information resource but it is never a substitute for professional medical advice, diagnosis, or treatment from a qualified health care provider.

Health Solutions From Our Sponsors

Anxiety Symptom Control | Depression Med for You? | High Blood Pressure? | Men's Urinary Health | Triglyceride Risks
Atherosclerosis? | Fibromyalgia Center | High Cholesterol? | Smarter Eating | Type 2 Diabetes?
BPH Treatment | Good & Bad Fats | Learn About Fibro | Treating Depression | When Pain Is Fibro Pain

©2005-2009 WebMD, LLC. All rights reserved.
WebMD does not provide medical advice, diagnosis or treatment. See additional information

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF RICHLAND)

Phillip Durrett,) IN THE FIFTH CIRCUIT

PLAINTIFF,)

VS) NOTICE OF MOTION AND MOTION FOR RECONSIDERATION

Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,) 09-CP-40-5568

DEFENDANT.)

TO THE DEFENDANTS AND THEIR ATTORNEY, ROBERT GERALD CHAMBERS, JR.:

YOU WILL PLEASE TAKE NOTICE that the undersigned as attorney for the Plaintiff will move before The Honorable L. Casey Manning, Judge, Court of Common Pleas for the Fifth Judicial Circuit ten (10) days from the date hereof or as soon thereafter as counsel may be heard, for an Order of the Court altering or amending or modifying his Order of Dismissal, dated May 25, 2011, filed May 25, 2010, and received by the undersigned on May 27, 2011.

The Plaintiff, Phillip Durett, will move to vacate, alter, amend or modify the Order of Dismissal or take testimony, if necessary, on the issues of whether the subject matter of this action lies within the ambit of the common knowledge and experience of the jury or whether an expert witness be required under S.C. Code Ann. §15-36-100 (C)(2).

The motion is hereby made pursuant to Rule 59 of the SCRCP.

Melvin D. Bannister
PO Box 6833
Columbia, SC 29206-6833
(803) 782-8688, (803) 782-8677-fax
Attorney for the Plaintiff

June 3, 2011

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
Phillip Durrett,	)	IN THE FIFTH CIRCUIT
PLAINTIFF,	)	
VS	)	
Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,	)	COMPLAINT
DEFENDANT.	)	

2013 FEB 28 PM 4:15
JEANETTE W. McBRIDE
C.C.P. & G.S.
FILED

The Plaintiff would show the following:

1. This is a medical malpractice action, which is filed pursuant to the South Carolina Code of Laws, Section 15-79-125.
2. The Plaintiff is a resident of Lexington County, South Carolina; the Defendant Palmetto Health Alliance (hereinafter referred to as Richland) is a corporation and is doing business in Richland County, South Carolina; on information and belief, the Defendant, W. Ross, M.D., is a resident of Richland County, South Carolina.
3. On August 9, 2006, the Plaintiff was involved in an automobile accident.
4. The Plaintiff received physical injuries as a result of the said automobile accident.
5. The Plaintiff was transported to the hospital, which is owned and operated by the Defendant Richland by Emergency Medical Services personnel.
6. Upon the Plaintiff's arrival at the hospital operated by the Defendant Richland, the Plaintiff informed the medical personnel and agents of the Defendant Richland that he was allergic to anesthetic and sedative drugs and that the

personnel were not to provide, administer, and/or treat the Plaintiff with any said drugs.

7. The Plaintiff further stated to the agents of Defendant Richland and to Defendant Ross that if any said drugs were to be administered that the Plaintiff would go to another hospital.
8. The Defendants disregarded the Plaintiff's specific instructions and administered certain anesthetic and sedative drugs to the Plaintiff.
9. The Defendants and their agents, including other medical personnel, failed to monitor the Plaintiff after the administration of the said drugs and administered more of the said drugs to the Plaintiff.
10. The Defendants administered more of the drugs than is recommended by the pharmaceutical manufacturer.
11. The Defendants "over dosed" the Plaintiff.
12. The Defendants knew, or should have known, the administration of the said drugs in the amounts administered to the Plaintiff would cause injuries and damages to the Plaintiff.
13. As a result of the administration of the said drugs, the Plaintiff suffered cardiac and respiratory arrest.
14. As a result of the administration of the said drugs, the Plaintiff went into a coma and/or catatonic like state for approximately 9 days.
15. The Plaintiff had to receive additional medical treatment and expense as a result to the actions of the Defendants.

16. That the Defendants were negligent, grossly negligent, willful, wanton, and careless, at the time and place above-mentioned in the following particulars:

a. In disregarding the specific instructions of the Plaintiff concerning the Plaintiff's medical treatment, including, specifically, the administration of certain drugs;

b. In the administration of certain drugs;

c. In administering excessive amounts of certain drugs to the Plaintiff, causing an "over dose" and causing injuries and damages to the Plaintiff;

d. In failing to monitor the Plaintiff before administering certain drugs;

e. In failing to comply with the statutory laws of the State of South Carolina;

f. In failing to use the degree of care and caution that a reasonably prudent person would have used under the circumstances then and there prevailing;

All of which were the direct and proximate cause of the injuries and damages suffered by the Plaintiff herein, said acts being in violation of the Statute laws of the State of South Carolina.

13. The Plaintiff is informed and believes that he is entitled to judgment against the Defendants in a reasonable sum as actual damages, and for punitive damages in an appropriate amount.

WHEREFORE, Plaintiff prays for a judgment against the Defendants in a reasonable sum as actual damages, together with punitive damages in an appropriate amount, for the costs of this action, and for such other and further relief as the Court may deem just and proper.

Melvin D. Bannister, SC Bar 505
5115 Forest Dr., Suite G
Post Office 6833
sctriallawyer@bellsouth.net
Columbia, South Carolina 29260
(803) 782-8688
Attorney for the Plaintiff

28th day of February, 2013.

JURY TRIAL DEMANDED

STATE OF SOUTH CAROLINA	)	IN THE COMMON PLEAS COURT
COUNTY OF RICHLAND	)	CASE NO.: 2013-CP-40-1259
PHILLIP DURRETT, Plaintiff,	)	
vs.	)	**DEFENDANTS' ANSWER TO PLAINTIFF'S COMPLAINT (Jury Trial Demanded)**
PALMETTO HEALTH ALLIANCE d/b/a PALMETTO RICHLAND MEMORIAL, and W. ROSS, M.D., Defendants.	)	

TO: MELVIN D. BANNISTER, ESQUIRE, ATTORNEY FOR PLAINTIFF:

Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial and Defendant W. Ross, M.D., by and through its undersigned attorneys, answers the Complaint of the Plaintiff as follows:

1. These defendants deny each and every allegation, which is not hereafter specifically admitted.

2. These defendants admit the allegations contained in paragraph 1 of the plaintiff's complaint.

3. These defendants lack knowledge or information sufficient to form a belief as to the allegations of paragraph 2 that the plaintiff was a resident of Lexington County, South Carolina. These defendants admit only so much of the allegations contained in paragraph 2 of the plaintiff's complaint as alleges that Palmetto Health Alliance d/b/a Palmetto Richland Memorial, at all times referenced in this complaint, was a charitable organization as defined in 33-56-20 of the Solicitation of Charitable Funds Act, S.C. Code Ann. Section 33-56-10 et seq. (Supp. 1999) and is licensed and doing business in the County of Richland, State of South

Carolina. These defendants further plead any and all immunities and limitations of liability available under the Solicitation of Charitable Funds Act as potential defenses. These defendants lack information regarding whether Defendant W. Ross, M.D. is a resident of Richland County in South Carolina.

4. Upon information and belief, these defendants admit the allegations contained in paragraphs 3 and 4 of the plaintiff's complaint.

5. In response to Paragraph 5, these defendants crave reference to the medical records.

6. These defendants deny the allegations contained in paragraphs 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 and 16 of the plaintiff's complaint.

7. These defendants deny the allegations contained in paragraph 17 (erroneously mis-numbered as 13) of the plaintiff's complaint.

FOR A FIRST DEFENSE

8. FURTHER ANSWERING THE COMPLAINT AND AS A FIRST DEFENSE THERETO, these defendants alleges any injuries or damages sustained by the Plaintiff were due to and caused by the negligence, gross negligence, carelessness, recklessness, willfulness and wantonness ("negligence") of the Plaintiff, combining, concurring and contributing with the negligence of these defendants, if any, without which contributory negligence, the Plaintiff's alleged injuries and damages would not have been incurred or sustained. Should the negligence of the Plaintiff be determined to be greater than that of these defendants if any, the Plaintiff is entitled to no recovery. If the negligence of the Plaintiff be determined to be not greater than that of these defendants, if any, the Plaintiff's recovery is to be reduced by the percentage of Plaintiff's fault.

FOR A SECOND DEFENSE

9. FURTHER ANSWERING THE COMPLAINT AND AS A SECOND DEFENSE THERETO, an award of punitive damages is prayed for in the Complaint. These defendants contend there is no evidence sufficient to create a jury issue on punitive damages as it also contends that any award of punitive damages against it in this case would be unconstitutional, and that the statutes allegedly authorizing punitive damages are unconstitutional on their face and as applied in this case as it would violate the equal protection, due process clause and excessive fines of the United States Constitution (U.S. Const. Amends. V, VIII, and XIV) and Article I, Section 3 of the Constitution of the State of South Carolina, for the following reasons, among others:

a. The statutes, and the court decisions interpreting the statutes, fail to notify individuals of the nature of the offense for which they may be liable for punitive damages and they fail to limit the award of punitive damages to the degree of reprehensibility of the defendant's misconduct; the disparity between the harm (or potential harm) suffered by the plaintiff and the punitive damages award; and the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases.

b. The statutes, and the court decisions interpreting the statutes, fail to inform judges and juries of the nature of the offenses for which punitive damages can be awarded.

c. The statutes, and the court decisions interpreting the statutes, fail to provide any constitutional standard or means of calculating the amount of punitive damages to be awarded.

d. The statutes, and the court decisions interpreting the statutes, allow persons to repeatedly be put in jeopardy of paying for the same offense; *See State Farm Mutual*

TPG 000115

Automobile Insurance Co. v. Campbell, et al., 123 S. Ct. 1513, 2003 U.S. Lexis 2713, 1523 (2003) ("Punishment on these bases creates the possibility of multiple punitive damages awards for the same conduct.").

e. To the extent the award of punitive damages are criminal or quasi-criminal in nature, they are not awarded upon proof beyond a reasonable doubt, contrary to due process of law; *State Farm Mutual Automobile Insurance Co. v. Campbell, et al.*, 123 U.S. at 1526 ("Great care must be taken to avoid use of the civil process to assess criminal penalties that can be imposed only after the heightened protections of a criminal trial have been observed, including, of course, its higher standards of proof.").

f. The statutes, and the court decisions interpreting the statutes, permit the award of excessive punitive damages without relationship to the public safety, health or welfare said to be served by punitive damages. *State Farm Mutual Automobile Insurance Co. v. Campbell, et al.*, 2003 U.S. LEXIS 2713, 123 U.S. 1513 at 1519, 1520 ("The Due Process Clause of the Fourteenth Amendment prohibits the imposition of grossly excessive or arbitrary punishments on a tortfeasor.").

g. To the extent the trier of fact is permitted to consider the defendant's net worth, wealth or financial condition in awarding punitive damages or in calculating such an award, punitive damages awards violates the due process and equal protection clauses of the United States and South Carolina Constitutions. *State Farm Mut. Auto. Ins. Co. v. Inez Preece Campbell*, 2003 U.S. LEXIS 2713, 123 S. Ct. 1513, at 1525 (2003) ("The wealth of a defendant cannot justify an otherwise unconstitutional punitive damages award."); *State Farm Mut. Auto. Ins. Co. v. Inez Preece Campbell*, 123 S. Ct. at 1520, quoting *Honda Motor Co. v. Oberg*, 512 US 415 at 432 (1994) ("We have admonished that 'punitive damages pose an acute danger of

arbitrary deprivation of property. Jury instructions typically leave the jury with wide discretion in choosing amounts, and the presentation of evidence of a defendant's net worth creates the potential that juries will use their verdicts to express biases against big businesses, particularly those without strong local presences.'").

h. The statutes, and the court decisions interpreting the statutes, fail to place a limit on the amount of punitive damages to be awarded.

i. The statutes, and the court decisions interpreting the statutes, fail to provide adequate post-verdict processes and standards for review by the trial court and also fail to provide adequate appellate review procedures so as to adequately protect due process rights; *Cooper Industries, Inc. v. Leatherman Tool Group, Inc.*, 121 S. Ct. 1678 (2001).

j. The statutes, and the court decisions interpreting the statutes, permit the award of punitive damages without reasonable relationship to the civil or criminal penalties that could be imposed for comparable misconduct in other cases.

k. The statutes, and the court decisions interpreting the statutes, fail to limit the award of punitive damages to criminal or intentional behavior.

l. The statutes, and the court decisions interpreting the statutes, fail to limit the award of punitive damages to what is reasonably required to vindicate this State's legitimate interests in punishment and deterrence for conduct having an impact on the citizens of South Carolina; *See State Farm Mutual Automobile Insurance Co. v. Campbell, et al.*, 123 S. Ct. 1513, 2003 U.S. Lexis 2713, 1522 (2003) (holding that as a general rule, a state does not have a legitimate concern in imposing punitive damages to punish a defendant for unlawful acts committed outside of the State's jurisdiction); *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 572 (1996) (stating "a State may not impose economic sanctions on violators of its laws

with the intent of changing the tortfeasors' . . . conduct in other States"); *White v. Ford Motor Company, et al.*, 312 F.3d 998, 1020 (9th Cir. 2002) (holding that extraterritorial conduct is admissible for its bearing on degree of reprehensibility, but that the jury must be limited to punitive damages reasonably required to vindicate that state's legitimate interests in punishment and deterrence, if any, and are prohibited from imposing punitive damages to protect people or punish harm outside of the state); *Geressy v. Digital Equip. Corp.*, 950 F.Supp. 519, 521-22 (E.D. N.Y. 1997) (noting that punitive damages are limited by "principle of our federal system that state legislation, state policy, and judicial development of state law can only be directed at activity within the state.").

m. The statutes, and the court decisions interpreting the statutes, fail to ensure the award of punitive damages is both reasonable and proportional to the amount of harm to the plaintiff and to the general damages recovered. *See State Farm Mutual Automobile Insurance Co. v. Campbell, et al.*, 123 S. Ct. 1513, 2003 U.S. Lexis 2713, 32 (2003) (stating that few awards exceeding a single-digit ratio between punitive and compensatory damages will satisfy due process).

FOR A THIRD DEFENSE

10. FURTHER ANSWERING THE COMPLAINT AND AS A THIRD DEFENSE THERETO, these defendants submit it may be entitled to a set off or credit for any amount paid to Plaintiff by any third party as compensation for the injuries and damages for which Plaintiff seeks recovery.

FOR A FOURTH DEFENSE

11. FURTHER ANSWERING THE COMPLAINT AND AS A FOURTH DEFENSE THERETO, these defendants submit the injuries and damages for which Plaintiff seeks recovery

TPG 000118

were due to and proximately caused by the intervening negligence, recklessness, willfulness, wantonness, and fault of a party or parties other than these defendants. Such intervening negligence, recklessness, willfulness, wantonness, and fault were the sole cause of the injuries and damages for which Plaintiff seeks recovery and, therefore, Plaintiff may not recover against these defendants.

FOR A FIFTH DEFENSE

12. FURTHER ANSWERING THE COMPLAINT AND AS A FIFTH DEFENSE THERETO, these defendants allege the injuries and damages for which Plaintiff seeks recovery were due to and proximately caused by the sole negligence, recklessness, willfulness, wantonness, and fault of third parties for whom these defendants are not liable. Therefore, the acts or fault of third parties are the real, efficient and proximate cause of the injuries for which Plaintiff seeks recovery, and, therefore, Plaintiff cannot recover against these defendants.

FOR AN SIXTH DEFENSE

13. FURTHER ANSWERING THE COMPLAINT AND AS A SIXTH DEFENSE, these defendants would show that Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial is a charitable organization as defined by Chapter 56 of Title 33 of the South Carolina Code of Laws (1976, as amended) and pursuant to this statutory scheme, recovery against these defendants for any tortuous act or omission is specifically limited to actual damages in a specified amount. Further, these defendants plead the statutory scheme as a bar and/or limitation to recovery by Plaintiff in this action.

FOR A SEVENTH DEFENSE

14. FURTHER ANSWERING THE COMPLAINT AND AS A SEVENTH DEFENSE, these defendants allege Plaintiff has failed to comply with the expert affidavit

requirements of §15-36-100, contained within the South Carolina Frivolous Civil Proceedings Sanctions Act.

FOR AN EIGHTH DEFENSE

15. FURTHER ANSWERING THE COMPLAINT AND AS AN EIGHTH DEFENSE, these defendants allege that this action is barred by the statute of limitations and requests that the matter be dismissed for failure to comply with the statute of limitations.

FOR A NINTH DEFENSE

16. FURTHER ANSWERING THE COMPLAINT AND AS A NINTH DEFENSE, these defendants plead the applicable provisions of the South Carolina Non-Economic Damage Awards Act of 2005 (§15-32-200, et seq.) and §15-38-15, as such provisions may be applicable in this case.

FOR A TENTH DEFENSE

17. FURTHER ANSWERING THE COMPLAINT AND AS A TENTH DEFENSE, these defendants would show that the care and treatment of Plaintiff was within the standard of care required of medical facilities and providers in the field, for which reason these defendants are not liable to Plaintiff in any sum whatsoever.

FOR AN ELEVENTH DEFENSE

18. FURTHER ANSWERING THE COMPLAINT AND AS AN ELEVENTH DEFENSE THERETO, these defendants allege the Complaint fails in whole or in part to state facts sufficient to constitute a cause of action and, therefore, this action should be dismissed pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully answered Plaintiff's Complaint, these defendants pray that the same be dismissed with costs and for such other and further relief as this Court may deem to be just and proper.

TURNER, PADGET, GRAHAM & LANEY, P.A.

Virginia W. Williams

signing for R. Gerald Chambers, Jr.
1901 Main Street, 17th Floor (29201)
Post Office Box 1473
Columbia, SC 29202
Telephone: (803) 227-4201
Facsimile: (803) 799-3957
Attorneys for Defendants

Columbia, South Carolina
June 21, 2013

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
Phillip Durrett,	)	IN THE FIFTH CIRCUIT
PLAINTIFF,	)	
VS	)	
Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,	)	AFFIDAVIT
DEFENDANT.	)	

The undersigned, who being duly sworn, deposes and says::

1. The Plaintiff is a resident of Lexington County, South Carolina; the Defendant Palmetto Health Alliance (hereinafter referred to as Richland) is a corporation and is doing business in Richland County, South Carolina; on information and belief, the Defendant, W. Ross, M.D., is a resident of Richland County, South Carolina.
2. On August 9, 2006, the Plaintiff was involved in an automobile accident.
3. The Plaintiff received physical injuries as a result of the said automobile accident.
4. The Plaintiff was transported to the Defendant Richland's hospital by Richland Emergency Medical Services personnel.
5. Plaintiff informed Richland Emergency Medical Services personnel not to sedate him; said personnel followed Plaintiff's instructions.
6. Upon the Plaintiff's arrival at the hospital operated by the Defendant Richland, the Plaintiff informed the medical personnel and agents of the Defendant Richland that he was allergic to anesthetic and sedative drugs and that the

personnel were not to provide, administer, and/or treat the Plaintiff with any said drugs.

7. The Plaintiff further stated to the agents of Defendant Richland and to Defendant Ross that if any said drugs were to be administered that the Plaintiff would go to another hospital.
8. The Defendants disregarded the Plaintiff's specific instructions, physically restrained him, and administered certain anesthetic and sedative drugs to the Plaintiff.
9. The Defendants and their agents, including other medical personnel, failed to monitor the Plaintiff after the administration of the said drugs and administered more of the said drugs to the Plaintiff.
10. As a result of the administration of the said drugs, the Plaintiff suffered cardiac and respiratory arrest.
11. As a result of the administration of the said drugs, the Plaintiff went into a coma and/or catatonic like state for approximately 9 days.
12. The Plaintiff had to receive additional medical treatment and expense as a result to the actions of the Defendants.
13. That the Defendants were negligent, grossly negligent, willful, wanton, and careless, at the time and place above-mentioned in the following particulars:
    a. In disregarding the specific instructions of the Plaintiff concerning the Plaintiff's medical treatment, including, specifically, the administration of certain drugs;
    b. In the administration of certain drugs;

c. In failing to monitor the Plaintiff before administering certain drugs;

d. In failing to comply with the statutory laws of the State of South Carolina;

e. In failing to use the degree of care and caution that a reasonably prudent person would have used under the circumstances then and there prevailing;

Phillip Durrett

Sworn to before me this 18

Day of Feb, 2010

Notary Public for South Carolina

My commission expires: 12/28/15

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

IN THE COMMON PLEAS COURT

CASE NO.: 2013-CP-40-125

PHILLIP DURRETT,)
)
Plaintiff,)
)
vs.)
)
PALMETTO HEALTH ALLIANCE d/b/a)
PALMETTO RICHLAND MEMORIAL,)
and W. ROSS, M.D.,)
)
Defendants.)
)

STIPULATION OF DISMISSAL WITH PREJUDICE AS TO W. ROSS, M.D.

2014 APR -9 AM 10:18
JEANETTE W. McBRIDE
C.C.P. & G.S.
RICHLAND COUNTY
FILED

It is hereby stipulated by and between counsel for all parties to this action that this case be and hereby is dismissed, discontinued, and forever ended with prejudice pursuant to Rule 41(a)(1) of the South Carolina Rules of Civil Procedure as to Defendant W. Ross, M.D.

WE CONSENT:

MELVIN D. BANNISTER LAW FIRM

Melvin D. Bannister, Esquire
Post Office Box 6833
Columbia, SC 29260

Attorneys for Plaintiff

WE CONSENT:

TURNER PADGET GRAHAM & LANEY, PA

R. Gerald Chambers, Jr., Esquire
P.O. Box 1473
Columbia, SC 29202

Attorneys for Defendant

000125

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF RICHLAND	)	Civil Action No.: 2013-CP-40-01259

Phillip Durrett,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	**AMENDED NOTICE OF MOTION AND AMENDED MOTION FOR SUMMARY JUDGMENT**
	)	
Palmetto Health Alliance d/b/a Palmetto Richland Memorial and W. Ross, M.D.,	)	
	)	
Defendants.	)	
	)	

YOU WILL PLEASE TAKE NOTICE that ten (10) days after service of this Notice upon you, or as soon thereafter as counsel may be heard, counsel for Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial ("Richland Memorial")[1] will move this Court for an Order granting summary judgment on each and every allegation, cause of action, and/or prayer for damages or other relief contained in Plaintiff's Complaint pursuant to Rule 56 of the South Carolina Rules of Civil Procedure. Richland Memorial so moves on the following grounds:

1. Plaintiff filed, pursuant to S.C. Code Ann. § 15-79-125, a Notice of Intent to File Suit with this Court on or about August 5, 2009. In that Notice of Intent, Plaintiff alleges he sustained injury and damages during the course of emergency medical treatment he received at Richland Memorial following an automobile accident that occurred August 9, 2006.

2. Plaintiff's Notice of Intent did not include the affidavit of an expert witness as required by S.C. Code Ann. § 15-79-125(A). Instead, Plaintiff submitted the Affidavit of Melvin

[1] Subsequent to the filing of Defendants' Notice of Motion and Motion for Summary Judgment on February 28, 2014, Plaintiff filed a Stipulation of Dismissal With Prejudice as to Defendant W. Ross, M.D. This Stipulation of Dismissal, filed with the Court April 9, 2014, leaves Richland Memorial as the sole defendant in this action.

Bannister, his attorney, as Exhibit B to the Notice of Intent to File Suit and contends that the expert affidavit requirement is excused by operation of S.C. Code Ann. § 15-36-100(C)(2). In his Affidavit, attorney Bannister states Plaintiff's Notice of Intent and supporting materials were filed "within ten (10) days of the expiration of the statute of limitations." (Bannister Aff., ¶ 2). Further, the Bannister Affidavit states "Plaintiff will file an expert's affidavit to supplement the filing of a Complaint in this matter within forty five (45) days of the filing of such a pleading and a determination by the Court of Common Pleas that such affidavit is required." (*Id.*, ¶ 3) To date, Plaintiff has yet to file an expert affidavit.

3. Defendants filed a motion to dismiss Plaintiff's Notice of Intent on or about September 22, 2009, pursuant to S.C. Code Ann. §§ 15-79-125 and 15-36-100, as well as Rules 12(b)(1) and 12(b)(6), SCRCP. Defendants based their motion upon: (a) Plaintiff's failure to follow the statutory conditions precedent to the filing of a medical malpractice action as set forth in § 15-79-125; and (b) Plaintiff's failure to provide an expert within 45 days of the filing of a Complaint as provided in § 15-36-100(C). Defendants supported their motion with the Affidavit of William Ross, M.D., who opines to a reasonable degree of medical certainty that Defendants did not deviate from the applicable standard of care and that "utilization of these medications is not within the common knowledge of the ordinary lay person and expert testimony is required." (Ross Aff., ¶ 3-4)

4. The Court of Common Pleas for Richland County filed its order dismissing Plaintiff's Notice of Intent to File Suit on May 25, 2011. In its order, the court concluded this case involves complex interactions with drugs allegedly resulting in cardiac arrest and other medical complications. Further, the court concluded Plaintiff ran afoul of S.C. Code Ann. §§ 15-36-100(C)(1) and 15-79-125(A) because he did not file a timely expert affidavit supporting his

allegations of medical malpractice.

5. Plaintiff moved for reconsideration, and, via Form 4 Order filed April 3, 2012, the court ruled the "[m]otion to reconsider granted. Formal order to follow." In an order filed nearly 18 months later – January 8, 2014 – the court noted that "after consideration," the earlier order of dismissal should be vacated without any further discussion or analysis of the substantive issues presented.

6. Plaintiff filed his Summons and Complaint in the Court of Common Pleas for Richland County on February 28, 2013. In his Complaint, Plaintiff re-asserts the allegations set forth in his original Notice of Intent to File Suit and supporting documents.

7. Defendants filed their Answer on or about June 24, 2013, in which they asserted a general denial and numerous substantive defenses, including expiration of the statute of limitations, comparative fault, and Plaintiff's failure to file the required expert affidavit. (*See* Defendants' Answer, ¶¶ 1, 6, 14, 15)

8. In essence, Plaintiff alleges Defendants were negligent in disregarding his instructions and administering "certain anesthetic and sedative drugs" to him in the emergency room. (Plaintiff's Compl., ¶¶ 6-8) As a result, Plaintiff alleges he suffered cardiac arrest, respiratory arrest, and that he went into a coma or catatonic state for nine days. (*Id.*, ¶ 14) By definition, the interplay between the administration of certain medications and any resulting physical condition is a complex medical question well beyond the common knowledge of a lay juror. As such, Plaintiff was required to file a supporting expert affidavit. This he has yet to do.

9. In light of Plaintiff's failure to abide by statutes requiring him to file an expert affidavit, as well as the expiration of the statute of limitations in August of 2009, Defendant Richland Memorial is entitled to an Order from this Court granting it summary judgment on each

and every allegation asserted against it in Plaintiff's Complaint, and it so moves.

This motion is based on the pleadings, discovery responses, depositions, and the substantive and procedural law of the State of South Carolina as set forth more fully in Richland Memorial's supporting memorandum filed contemporaneously herewith.

TURNER, PADGET, GRAHAM & LANEY, P.A.

July 17, 2014 By: ______________________

R. Gerald Chambers, Jr.
Carmelo B. Sammataro
Post Office Box 1473
Columbia, SC 29202
Phone: (803) 254-2200
Fax: (803) 799-3957

ATTORNEYS FOR DEFENDANT PALMETTO HEALTH ALLIANCE D/B/A PALMETTO RICHLAND MEMORIAL

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS

Civil Action No.: 2013-CP-40-01259

Phillip Durrett,

Plaintiff,

vs.

Palmetto Health Alliance d/b/a Palmetto Richland Memorial and W. Ross, M.D.,

Defendants.

MEMORANDUM OF PALMETTO HEALTH ALLIANCE d/b/a PALMETTO RICHLAND MEMORIAL IN SUPPORT OF ITS AMENDED MOTION FOR SUMMARY JUDGMENT

Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial ("Richland Memorial") submits this memorandum in support of its amended motion for summary judgment filed contemporaneously herewith.

FACTUAL BACKGROUND

Plaintiff Phillip Durrett ("Durrett") sustained physical injury in a multi-vehicle collision that occurred August 7, 2006. Specifically, Durrett, who was cited for driving too fast for conditions, failed to observe the flashing lights of an ambulance parked in the eastbound median of Interstate 20 to assist another motorist, struck the ambulance in the rear, and became entrapped in his own vehicle for approximately 15-20 minutes. (August 7, 2006 South Carolina Traffic Collision Report Form, attached as Exhibit 1) Durrett sustained "incapacitating injuries", was extricated from his vehicle, and then transported from the scene by paramedics with Richland County EMS. (*Id.*; DHEC Patient Care Form, attached as Exhibit 2) According to the DHEC Patient Care Form completed by Richland County EMS personnel, Durrett was agitated but remained stable during transport to Richland Memorial. (DHEC Patient Care Form, Exhibit 2) No medications other than saline were administered.

According to Richland Memorial Emergency Department documentation, Durrett was "awake, alert, and oriented . . . upon arrival" in the ER, displayed a "very aggressive, violent nature", and "was on a back board and C-collar, complaining of left leg pain." (August 9, 2006 record (PRMH 0497-98), attached as Exhibit 3) He denied tobacco, alcohol, or illicit drug use[1] and indicated to hospital personnel that he is allergic to Morphine. (*Id.*) During examination, Durrett "was verbal, cussing, noncompliant, and very uncooperative." (*Id.*) For his protection, and to facilitate his medical examination, Durrett was sedated, intubated, examined, and prepped for further radiologic studies to confirm initial impressions of left leg fracture and abdominal injuries. (*Id.*) During his course of treatment in the Emergency Department, Durrett was started on propofol, became hypotensive, and underwent two precordial thumps[2] prior to returning to sinus tachycardia. (August 10, 2006 Consult (PRMH 0501), attached as Exhibit 4) Durrett remained at Richland Memorial until his discharge on August 23, 2006. (August 21, 2006 Progress Note and Discharge Summary (PRMH 00513-515), attached as Exhibit 5)

In his Notice of Intent filed August 5, 2009, Durrett alleged Defendant Richland Memorial and others were negligent in disregarding his instructions and administering "certain (unspecified) anesthetic and sedative drugs" to him in the emergency room, which caused him to go into cardiac arrest. (Notice of Intent, ¶¶ 7-12) These allegations are repeated essentially *verbatim* in Durrett's Complaint filed February 28, 2013. (Plantiff's Compl., ¶¶ 6-8) Defendants filed their Answer on or about June 24, 2013, in which they asserted a general denial and numerous substantive defenses, including expiration of the statute of limitations,

[1] Durrett's urine drug screen was positive for amphetamines. (August 11, 2006 Consult Note (PRMH 0502), attached as Exhibit 6)

[2] "In a precordial thump, a provider strikes with a single blow of the fist to the middle of a persons [sic] sternum. The intent is to interrupt a potentially life-threatening rhythm." http://en.wikipedia.org/wiki/Precordial_thump (last accessed July 16, 2014).

comparative fault, and Durrett's failure to file the required expert affidavit. (Defs.' Answer, ¶¶ 1, 6, 14, and 15)

SUMMARY JUDGMENT STANDARD

South Carolina jurisprudence makes clear that in medical malpractice actions such as this, summary judgment "is appropriate when there is no genuine issue of material fact such that the moving party must prevail as a matter of law." *David v. McLeod Regional Medical Center*, 367 S.C. 242, 626 S.E.2d 1 (2006) (citing SCRCP 56(c)). In order to establish a genuine issue of material fact, Plaintiff must adduce evidence demonstrating "(1) the generally recognized and accepted practices and procedures that would be followed by average, competent practicioners in the defendants' field of medicine under the same or similar circumstances, and (2) that the defendants departed from the recognized and generally accepted standards." *Id.*, 367 at 248-247, 626 S.E.2d at 4 (citing *Pederson v. Gould*, 288 S.C. 141, 143-144, 341 S.E.2d 633, 634 (1986) (additional citation omitted)). Further, Plaintiff must establish that the breach of the applicable standard of care proximately caused his injuries and damages. *Id.* (citing *Green v. Lilliewood*, 272 S.C 186, 193, 249 S.E.2d 910, 913 (1978)).

Plaintiff also must "provide expert testimony to establish both the required standard of care and that defendants' failure to conform to that standard, unless the subject matter lies within the ambit of common knowledge so that no special learning is required to evaluate the conduct of the defendants." *Id.*, 367 S.C. at 248, 626 S.E.2d at 4 (citing *Pederson*, 288 S.C. at 143, 341 S.E.2d at 634). In recognition of these requirements, the South Carolina General Assembly has seen fit to impose the requirement that plaintiffs in medical malpractice actions must, prior to the filing of a summons and complaint, file a "Notice of Intent to File Suit and an affidavit of an

expert witness, subject to the requirements established in Section 15-36-100. . . ." S.C. Code Ann. § 15-79-125(A); *see also* S.C. Code Ann. § 15-36-100.

ARGUMENT

I. PLAINTIFF'S NOTICE OF DISMISSAL AND COMPLAINT ARE SUBJECT TO SUMMARY DISMISSAL GIVEN HIS FAILURE TO FILE THE TIMELY AFFIDAVIT OF AN EXPERT WITNESS AS REQUIRED BY APPLICABLE STATUTORY PROVISIONS.

The legal issue in this case is simple. Durrett's case is subject to dismissal because he did not simultaneously file the affidavit of an expert witness in support of his Notice of Intent to File Suit, which is an absolute prerequisite to the filing or initiating of a civil action alleging injury as a result of medical malpractice. *See* S.C. Code Ann. 15-79-125(A) ("Prior to filing or initiating a civil action alleging injury or death as a result of medical malpractice, the plaintiff shall contemporaneously file a Notice of Intent to File Suit and an affidavit of an expert witness. . . ."). Instead, he relied upon the affidavit of his attorney, which expressly relied upon inapplicable provisions of S.C. Code Ann. 15-36-100(C)(2) in an attempt to excuse his failure to comply with the mandatory pre-suit affidavit requirement. As such, Durrett's Notice of Intent to File Suit was procedurally defective, the subsequent filing of his Complaint was a nullity, and his claims are barred by the statute of limitations. Even assuming, without conceding, that Durrett's claims are procedurally viable, he has adduced no competent evidence establishing a genuine issue for trial. As such, summary judgment is appropriate.

A. Procedural Background

Durrett filed his Notice of Intent to File Suit pursuant to S.C. Code Ann. § 15-79-125 on or after August 5, 2009. In that Notice of Intent, Durrett alleged he sustained injuries and damages during his course of medical treatment at Richland Memorial following his August 9, 2006 automobile accident. Of particular relevance here, Durrett alleges that the administration

of certain medications by Richland Memorial personnel cause him to go into cardiac arrest, thereby causing him to sustain injuries and damages.

Durrett's Notice of Intent did not include the affidavit of an expert witness as required pursuant to S.C. Code Ann. § 15-79-125(A). Instead, Durrett submitted the Affidavit of his attorney, Melvin Bannister ("Bannister"), and contended that he was not required to submit an affidavit in light of the provisions of S.C. Code Ann. § 15-36-100(C)(2) (excusing the contemporaneous filing of an affidavit with the complaint "to support a pleaded specification of negligence involving subject matter that lies within the ambit of common knowledge and experience, so that no special learning is needed to evaluate the conduct of the defendant."). In his Affidavit, Bannister acknowledged Durrett's notice was filed within ten days of expiration of the statute of limitations and pledged to "file an expert's affidavit to supplement the filing of a Complaint in this matter within forty five (45) days of the filing of such a pleading and a determination by the Court of Common Pleas that such an affidavit is required." (Bannister Aff., attached as Exhibit 7, p. 2, ¶ 3) Durrett never filed the affidavit required by §15-79-125(A) (Notice of Intent to File Suit) or the affidavit contemplated by § 15-36-100 (complaint alleging professional negligence).

Defendants filed a motion to dismiss Durrett's Notice of Intent pursuant to S.C. Code Ann. §§ 15-79-125 and 15-36-100, as well as Rules 12(b)(1) and 12(b)(6), SCRCP, on or after September 22, 2009. Defendants' motion was based upon: (a) Durrett's failure to follow the statutory conditions precedent to the filing of a medical malpractice action as set forth in § 15-79-125; and (b) Durrett's failure to provide an expert affidavit within 45 days of the filing of a complaint as provided for in § 15-36-100(C). Defendants supported their motion with the Affidavit of William Ross, M.D., who opined to a reasonable degree of medical certainty, and

without contradiction, that Defendants did not deviate from the applicable standard of care and that administration of the types of drugs at issue in Durrett's Complaint "is not within the common knowledge of the ordinary lay person and expert testimony is required." (Affidavit of W. Ross, M.D., attached as Exhibit 8, ¶¶ 3-4)

The Court of Common Pleas for Richland County filed its order dismissing Durrett's Notice of Intent to File Suit on May 25, 2011. In its order, the court rightly concluded this case involves complex interactions with drugs allegedly resulting in cardiac arrest and other medical complications. (May 25, 2011 Order, attached as Exhibit 9, pp. 3-4) Further, the court concluded Durrett ran afoul of S.C. Code Ann. §§ 15-36-100(C)(1) and 15-79-125(A) because he did not file a timely expert affidavit in support of medical malpractice allegations. (*Id.*, pp. 4-5) Durrett moved for reconsideration, and, via Form 4 Order filed April 3, 2012, the court ruled the "[m]otion to reconsider granted. Formal order to follow." (April 3, 2012 Form 4 Order, attached as Exhibit 10) In an order filed nearly 18 months later – on January 8, 2014 – the court noted that "after consideration," the earlier order should be vacated but provided no additional discussion or analysis of the substantive issues presented. (January 8, 2014 Order, attached as Exhibit 11, p. 2) Further, the court determined, pursuant to § 15-36-100(C)(2)[3], that no affidavit was required because Durrett's claims fell within the ambit of common knowledge and ordered the parties to engage in mediation. (*Id.*, pp. 1-2)

[3] This determination amounts to an error of law because, as explained in greater detail below, § 15-36-100(C)(2) has no application in the pre-suit, Notice of Intent to File Suit, stage of these proceedings.

Durrett filed his Summons and Complaint on or after February 28, 2013, in which he largely re-asserted the allegations set forth in the Notice of Intent. Defendants answered with a general denial and asserted numerous substantive defenses, including expiration of the statute of limitations, comparative fault, and Durrett's failure to file the required expert affidavit.

B. Legal Analysis

Section 15-79-125(A) addresses the notice of intent as a prerequisite to filing an action for medical malpractice and requires the plaintiff to file, contemporaneously with his notice of intent, "an affidavit of an expert witness, subject to the affidavit requirements[4] established in Section 15-36-100 . . . ." Turning to Section 15-36-100, that provision sets forth certain requirements for complaints alleging professional negligence and the requirement that such complaints be supported by the contemporaneously filed affidavit of an expert witness. Specifically, Section 15-36-100(B) makes clear that "in an action for damages alleging professional negligence against . . . any licensed health care facility . . . the plaintiff must file as part of the complaint an affidavit of an expert witness which must specify at least one negligent act or omission claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit." Subsection (C)(1) affords plaintiffs an additional 45 days to file the required affidavit where "the period of limitation will expire, or there is a good faith basis to believe it will expire on a claim stated in the complaint, within ten days of the date of filing and, because of the time constraints, the plaintiff alleges that an affidavit of an expert could not be prepared." Subsection (C)(2) excuses the contemporaneous affidavit requirement where the alleged negligent act or omission involves subject matter that lies with the ambit of common knowledge and experience. Finally, Subsection (D) makes clear

[4] These requirements are set forth in § 15-36-100(A)(1)-(3) and address issues such as, but not necessarily limited to, licensure and other relevant credentials and experience.

that "[t]his section does not extend an applicable period of limitation . . . ." absent an exception that does not apply in this case.

In this case Durrett has failed to file an affidavit of any expert as required pursuant to the statutory provisions addressed in the preceding paragraph. As such, his Notice of Intent to File Suite is subject to summary dismissal, his Complaint is a nullity, and the statute of limitations bars him from seeking recovery against Richland Memorial. The South Carolina Court of Appeals addressed this precise issue in *Ranucci v. Crain*, 397 S.C. 168, 723 S.E.2d 242 (Ct. App. 2012), *reh'g denied* (March 15, 2012). In that case, plaintiff filed a medical malpractice action three years after suffering a collapsed lung following a medical procedure and identified certain physicians she intended to offer as expert witnesses at trial. *Id.*, 397 S.C. at 169-170, 723 S.E.2d at 242-243. In her notice of intent, plaintiff asserted that "time constraints" prevented compliance with the contemporaneous filing requirement and that she would either file an affidavit within 45 days or her allegations would be "within the ambit of common knowledge and experience," thereby obviating the need for an expert affidavit. *Id.*, 397 S.C. at 170, 723 S.E.2d at 243. Defendant moved to dismiss based upon plaintiff's failure to comply with the contemporaneous filing requirement and on the ground that the statute of limitations barred the claim. *Id.* Thereafter, Plaintiff filed the affidavit of her expert, and defendant supplemented his motion to dismiss to point out plaintiff's failure to explain the "time constraints" that prevented her from complying with the applicable statute. *Id.* The circuit court agreed that dismissal was appropriate given plaintiff's untimely expert affidavit, but it rejected defendant's statute of limitations argument. *Id.*, 397 S.C. at 171, 723 S.E.2d at 243.

The court of appeals affirmed dismissal. Addressing the interplay between § 15-79-125 and §15-36-100, the court explained "[e]ach statute governs a distinct time period during the litigation process, and those time periods are consecutive." *Ranucci*, 397 S.C. at 176, 723 S.E.2d at 246. Further, "section 15-79-125(A) invokes only the provisions of section 15-36-100 governing the preparation and content of the affidavit. . . . [and] the legislature clearly intended the two statutes to operate independently of one another and in distinct time frames, with the specific exception that they share the criteria for preparing affidavits of expert witnesses." *Id.*, 397 S.C. at 176-177, 723 S.E.2d at 246-247. Given the clear language of § 15-79-125, the court affirmed dismissal, noting that the contemporaneous affidavit requirements applicable to the notice of intent stage "do not permit a potential plaintiff to file her expert witness's affidavit after she files her Notice of Intent to File Suit." *Id.*, 397 S.C. at 178, 723 S.E.2d at 247[5].

Inasmuch as Durrett failed to comply with the clear requirements of S.C. Code § 15-79-125(A) by filing the required affidavit contemporaneously with his Notice of Intent, the notice is procedurally defective and should be dismissed. The Bannister Affidavit, which relied upon a statute with no import at the notice stage of these proceedings, does nothing to change this result, and the subsequent filing of Durrett's Summons and Complaint should be deemed a nullity. The court did not have the benefit of the guidance provided by the court of appeals in *Ranucci* when it ruled to the contrary, and that error should be corrected without further delay. Thus, given the procedural defects in Durrett's Notice of Intent to File Suit, combined with the passage of time,

[5] The majority in *Ranucci* did not reach the issue of whether the statute of limitations also dictated dismissal of plaintiff's medical malpractice action. In his concurring opinion, however, Chief Judge Few noted that the court's interpretation of these statutory provisions "requires the conclusion that the statute of limitations has expired on any civil action [plaintiff] might have brought for malpractice." *Id.*, 397 S.C. at 179, 723 S.E.2d at 248.

this Court should dismiss Durrett's Notice of Intent to File Suit, strike his improperly filed Complaint, and dismiss this matter with prejudice as barred by the statute of limitations.

II. DEFENDANT IS ENTITLED TO SUMMARY JUDGMENT ON THE ADDITIONAL BASIS THAT PLAINTIFF HAS FAILED TO ADDUCE ANY COMPETENT EVIDENCE DEMONSTRATING A GENUINE ISSUE OF MATERIAL FACT FOR TRIAL.

In addition to Durrett's failure to file the affidavit of an expert witness as required by S.C. Code Ann. § 15-79-125(A), Richland Memorial is entitled to summary judgment given Durrett's failure to adduce any competent evidence, expert or otherwise, demonstrating an issue of fact for trial. Specifically, Durrett has not come forward with any evidence to support the allegations in his Complaint that agents of Richland Memorial disregarded his instructions, administered "anesthetic and sedative drugs" to which he claimed to be allergic, and that the administration of these unspecified "anesthetic and sedative drugs" caused him to sustain injuries and damages. (Plaintiff's Compl., ¶¶ 6, 8, 12-15) To the contrary, the only medical evidence of causation in this case demonstrates that Durrett's alleged injuries and damages stem from the interaction of medically necessary medications with the illegal methamphetamine that was present in Durrett's body at the time of his underlying automobile accident. As such, Richland Memorial is entitled to summary adjudication in its favor on all claims asserted against it in this action.

Pursuant to South Carolina law, "medical malpractice actions require a greater showing than generic allegations and conjecture." *David v. McLeod Regional Medical* Center, 367 S.C. 242, 249, 626 S.E.2d 1, 4 (2006). Indeed, as the South Carolina Supreme Court has observed, "if the patient receives allegedly negligent professional medical care, then expert testimony as to the standard of that type of care is necessary, and the action sounds in medical malpractice." *Dawkins v. Union Hospital District*, ___ S.C. ___, 758 S.E.2d 501 (2014), *reh'g denied* (June 11, 2014) (internal citations omitted). In the uncontroverted opinion of one of Durrett's treating

physicians, "[t]he subject matter of this lawsuit involves the use and administration of various anesthetic and/or sedative medications as well as contraindications for various anesthetic and/or sedative medications . . . . [, and] that the utilization of these medications is not within the common knowledge of the ordinary lay person and expert testimony is required." (Affidavit of W. Ross, M.D., attached as Exhibit 8, at ¶ 4) Here, Durrett relies solely upon "generic allegations and conjecture" in support of his claims and has not produced evidence or testimony from any expert who will testify to a reasonable degree of medical certainty on his behalf.

According to Durrett's own testimony, he was anesthetized and therefore unable to provide any medical history to hospital personnel upon his admission at Richland Memorial. (March 12, 2014 deposition of Phillip Scott Durrett, relevant portions of which are attached as Exhibit 12, p. 44, lines 14-20; p. 45, lines 19-20) He further testified that from the time he presented in the emergency room, it "[m]ight have been a minute" that he remained conscious and that he does not remember anything else until waking up days later. (*Id.*, p. 47, lines 5-21) Along these lines, Durrett could not identify by name any medical provider associated with Richland Memorial, including the physician he named as a defendant in this lawsuit and later dismissed with prejudice. (*Id.*, p. 50, lines 8-23; p. 54, lines 19-24) Similarly, he did not have any knowledge of what medications he actually received while a patient at Richland Memorial or what made him vomit following his sedation in the emergency room. (*Id.*, p. 50, lines 6-24) At the same time, he testified he did not tell EMS or Richland Memorial about any allergies to anesthetic or sedative medications. (*Id.*, p. 65, lines 18-25)

Durrett simply had no memory of what treatment he received or anything specific he discussed with his doctors regarding his treatment. (Durrett Dep., Ex. 12, p. 53, lines 4-15) Durrett also candidly admitted he did not recall giving ***any*** medical history to anyone at the

hospital, including his alleged allergy to anesthetic and/or sedative medications. (*Id.*, p. 60, lines 9-15) Further, when questioned about which medications he received, Durrett himself acknowledged the medically complex nature of drug interaction when he testified "I have no idea. My getting sick from that stuff like that is kind of hard to research." (*Id.*, p. 65, lines 12-15) Nevertheless, Durrett has failed to identify any expert who will opine that his injuries and damages stem from Richland Memorial's administration of medications to which he now claims to be allergic.

The only medical expert who has offered a causation opinion in this case is Richland Memorial's retained expert witness, Dr. Robert Clodfelter ("Dr. Clodfelter"). Dr. Clodfelter is board certified in emergency medicine and serves as the Medical Director of the Emergency Department of the Hilton Head Hospital. (June 11, 2014 deposition of Robert Clodfelter, M.D., relevant portions of which are attached as Exhibit 13, p. 5, lines 5-12) In his review of the relevant medical records, Dr. Clodfelter noted Durrett arrived at Richland Memorial in an uncooperative and combative state and, therefore, was given a paralytic agent and a sedative in order to facilitate a "very rapid trauma assessment." (*Id.*, p. 6, lines 12-23)

Dr. Clodfelter also noted that medical records indicate Durrett admitted ingesting methamphetamine the day before the accident, that Durrett's urine drug screen yielded a positive result for that substance, and that Durrett is allergic to morphine and codeine[6]. (*Id.*, p. 19, lines 1-8) Further, the methamphetamines were still present in Durrett's system because that drug metabolizes quickly and would not have been detectible in a urine screen twenty-four hours after it had been ingested. (*Id.*, p. 23, line 16 – p. 24, line 1) In Dr. Clodfelter's opinion, the methamphetamine in Durrett's system could interact adversely with everything and anything

[6] Neither morphine nor codeine were administered during Durrett's course of treatment at Richland Memorial.

given to the patient, resulting in symptoms including altered mental status, cardiac dysrhythmia, and tachycardia. (*Id.,* p. 22, line 25 – p. 23, line 9)

Turning to the paralytic agents hospital staff actually administered (Norcuron and Anectine), Dr. Clodfelter testified these medications are not indicated to have caused Durrett's cardiac issues. (Clodfelter Dep., Ex. 13, p. 26, line 24 – p. 27, line 4) Instead, Dr. Clodfelter agreed with Durrett's treating cardiologist that Durrett's cardiac issues likely resulted from a combination of the methamphetamines in his system, the administration of propofol, and a sharp drop in blood pressure. (*Id.,* p. 27, lines 5-10; August 11, 2006 consult record) Specifically, Dr. Clodfelter opined that Durrett's "cardiac problems were related to dysrhythmia, which means an abnormal cardiac rhythm due to hypotension and the effects of amphetamines." (*Id.,* p. 27, line 25 – p. 28, line 2)

The dearth of evidence substantiating Durrett's allegations of medical malpractice plainly demonstrate the absence of any genuine material issue of fact for trial. Given Durrett's reliance on supposition and conjecture, and his failure to come forward with competent expert testimony in support of his claims, Defendant Richland Memorial is entitled to an order granting it summary judgment on each and every allegation asserted against it in this lawsuit.

CONCLUSION

For the reasons stated herein, Defendant Richland Memorial respectfully submits that it is entitled to an Order granting it summary judgment and dismissing Plaintiff's claims against it in their entirety and with prejudice.

(Signature page to follow.)

TURNER, PADGET, GRAHAM & LANEY, P.A.

July 17, 2014

By: [signature]

R. Gerald Chambers, Jr.
Carmelo B. Sammataro
Post Office Box 1473
Columbia, SC 29202
Phone: (803) 254-2200
Fax: (803) 799-3957

ATTORNEYS FOR DEFENDANT
PALMETTO HEALTH ALLIANCE D/B/A
PALMETTO RICHLAND MEMORIAL

CERTIFICATE OF SERVICE

I hereby certify that this 17th day of July 2014 a copy of the **MEMORANDUM OF PALMETTO HEALTH ALLIANCE d/b/a PALMETTO RICHLAND MEMORIAL IN SUPPORT OF ITS AMENDED MOTION FOR SUMMARY JUDGMENT** has been served upon other counsel of record, by hand delivery, to the following:

Melvin D. Bannister, Esquire
5115 Forest Drive
Columbia, SC 29206

ATTORNEYS FOR PLAINTIFF

RICHLAND COUNTY
FILED
2014 JUL 17 AM 10: 11
JEANNETTE W. MCBRIDE
C.C.P. & G.S.

EXHIBIT 1

ORIGINAL

D.P.S. USE ONLY 00097838

Page # 1 Of 2

SOUTH CAROLINA TRAFFIC COLLISION REPORT FORM
TR-310 (Rev. 01/2001)

Of Units: 4 | Amended - Attach Copy of Original Report / Corrected | Notified: 1348 | Arrived: 1400

Date: 07 06 | Time: 1343 | County: 40 | (1) Interstate | Collision Location (Rt. # / Name): 20 68 MM | (0) Main | Miles: 3.96 | Dir: N | Near City or Town of: Columbia

Lane # / Dir.: 1 Of 6 E | Distance Offset: .01 Miles | Direction: W | (3) SC Primary | From: Base Intersection (Rt. # / Name): 215 / MONTICELLO Rd | (0) Main | Latitude: 34° 03' 4350"

R.R. Id.: N/A | (2) US Primary | Toward: Second Intersection (Rt. # / Name): 176 / BROAD RIVER RD | (0) Main | Longitude: 81° 02' 5750"

V-837615 Driver/Pedestrian's Full Name: DUKRETT - PHILIP SCOTT
Unit # 1 | Sex: M | Race: W | Street:
Birth Date: | City, State, & Zip: Columbia SC 29206
State: SC | Driver's License #: 4458140 | Insurance Company: AllSTATE
Year: 1996 | Body: 4S | Vehicle Make: OLDS | VIN #: 1G3HN52K1T4835747
State: SC | Year: 2006 | License Plate #: 715 PBA | Owner's D.L. #:
Home Telephone: | Owner's Full Name: DURRETT - PHILIP SCOTT
Bus. Telephone: N/A | Street: 6848 BATCHELFORD RD
Contributed To Collision: (Yes) | City, State, & Zip: Columbia SC 29206
Estimated Speed: 65 | Speed Limit: 60 | C.D.L. Req: No | T/B S Req: No | Summons #: C696404 | Code: 21 | Summons #: N/A | Towed By: Capital City

V-837616 Driver/Pedestrian's Full Name: COLLINS - KEVIN SCOTT
Unit # 2 | Sex: M | Race: W | Street: 236 KYZER RD
Birth Date: | City, State & Zip:
State: SC | Driver's License #: | Insurance Company: EMPIRE FIRE & MARINE
Year: 1999 | Body: VN | Vehicle Make: Ford | VIN #: 1FDSS34FXXHB74575
State: SC | Year: 2007 | License Plate #: P109447 | Owner's D.L. #: N/A
Home Telephone: | Owner's Full Name: Mobile CARE HEALTH SER LLC
Bus. Telephone: N/A | Street: 2926 LEAPHART RD
Contributed To Collision: (No) | City, State, & Zip: West Columbia SC 29169
Estimated Speed: 0 | Speed Limit: 60 | C.D.L. Req: No | T/B S Req: No | Alc/Drg info: No | Summons #: N/A | Summons #: N/A | Towed By:

V-837617 Driver/Pedestrian's Full Name: MCKINNEY - REBECCA
Unit # 3 | Sex: F | Race: W | Street:
Birth Date: | City, State, & Zip: PEACHLAND NC 28133
State: NC | Driver's License #: | Insurance Company: VIKING INS
Year: 2002 | Body: 4D | Vehicle Make: DODG | VIN #: 2B3HD46222H191697
State: NC | Year: 2007 | License Plate #: VTB 7923 | Owner's D.L. #: 20003152
Home Telephone: | Owner's Full Name: MCKINNEY - REBECCA
Bus. Telephone: | Street:
Contributed To Collision: (No) | City, State, & Zip: PEACHLAND NC 28133
Estimated Speed: 0 | Speed Limit: 60 | C.D.L. Req: No | T/B S Req: No | Alc/Drg info: No | Summons #: N/A | Summons #: N/A | Towed By: HAPPY DAVIS

Dir. of Travel: Unit 1. E | Unit 2: E | Unit 3: E

Unit 1 Dam.	Unit 2 Dam.	Unit 3 Dam.	Prop. Dam. 1	Prop. Dam. 2
$ 5000.00	$ 1000.00	$ 1500.00	$ N/A	$ N/A

Property Owner/Witness: CATOE - JASON | Property Owner/Witness: N/A
Address: | Address:
State: SC | Zip: 29020 | Phone: | State: | Zip: | Phone:

MEDIAN

Photo: (Y) N | Describe What Happened (Refer to Units by Number):
UNITS # 1, 2, 3, + 4 WERE TRAVELING EAST ON I-20. THE DRIVER OF UNIT #3 WAS HAVING A SEIZURE. UNIT #2 WHICH WAS A MOBILE CARE AMBULANCE, STOPPED TO HELP THE DRIVER OF UNIT #3. THE DRIVER OF UNIT #1, WHO WAS DRIVING TOO FAST FOR CONDITIONS FAILED TO NOTICE UNIT #2'S EMERGENCY LIGHTS. UNIT #1 STRUCK UNIT #2 IN THE REAR CAUSING UNIT #2 TO STRIKE UNIT #3. UNIT #1 THEN WENT ACROSS ALL THREE LANES, COMING TO REST IN LANE 3. UNIT #1 WAS THEN STRUCK BY UNIT #4.

NOTICE: THIS REPORT IS FOR STATISTICAL REPORTING PURPOSES ONLY AND IS A REFLECTION OF THE OFFICER'S BEST KNOWLEDGE, OPINION AND BELIEF CONCERNING THE COLLISION BUT NO WARRANTY IS MADE AS TO THE FACTUAL ACCURACY THEREOF.

Investigating Officer's Name: CARLSON - WL | Rank: TFC | Badge #: 322 | Code: HP0100 | Date: 09-09-2006 | Reviewer's Name: [illegible] | Rank: [illegible] | Internal Agency Code: 133914

Unit	Date of Birth	Sex	Race	INJ	Seat	R/SD	A.B.D.	Eject	L/I	Tran	Name	Street Address	Zip Code
1			W	3	01	13	13	1	2	1	DRIVER UNIT #1		
2	7	F	W	0	03	13	13	1	1	2			
		M	W	0	20	88	93	7	4	2			
3		F	W	2	01	13	93	1	1	1	DRIVER UNIT #3		
4		M	W	0	01	13	43	1	1	2			
4		F	W	0	03	13	93	1	1	2			

Race A - Asian/Pacific Islander; B - African American; I - Alaskan Native or American Indian; W - Caucasian; H - Hispanic; O - Other; U - Unk

a) Injury Status 0- Not Injured; 1- Possible; 2- Non-incapacitating; 3- Incapacitating; 4- Fatal
b) Motorcycle Only Head Injury: 1-Yes 2-No

Seating Loc. 01 02 03 / 04 05 06 / 07 08 09; 20- Pedestrian; 30- Trailing Unit; 40- Bus or Van (4th row or Higher); 50- Other Enclosed Area (nontrailing); 51- Other Unenclosed Area (nontrailing); 60- Sleeper of Cab; 70- Riding on Unit Exterior; 80- Lap; 99- Unk /NA

Restraint/Safety Device 00- None Used; 11- Shoulder Belt Only; 12- Lap Belt Only; 13- Shoulder & Lap Belt; 21- Child Safety Seat; 88- Other; 99- Unk
Pedestrian, Motor/Pedalcycle Only: 31- Helmet; 41- Protective Pads; 51- Reflective Clothing; 61- Lighting

Air Bag Deployment / Switch
a) 1-Deployed Front; 2-Deployed Side; 3-Deployed Both; 4-Not Deployed; 7-Not Applicable; 9-Deployment Unk.
b) 1- Switch in On Position; 2- Switch in Off Position; 3- No Switch; 9- Unknown

Ejection 1- Not Ejected; 2- Part. Ejected; 3- Tot. Ejected; 7- Not App.; 9- Unk

Location After Impact 1- Not Trapped; 2- Extricated (Mechanical Means); 3- Freed (non-mech.); 4- Not Applicable; 9- Unknown

a) Transported to Medical Facility 1- Yes; 2- No; 3- Unknown
b) By 1- EMS; 2- Police; 8- Other; 9- Unk

Mail Orig. to SCDPS, Office of Financial Responsibility, PO Box 1498, Blythewood, SC 29016

Sequence of Events

Non-Collision 01- Cargo/Equip Loss or Shift; 02- Cross Median/Center Line; 03- Downhill Runaway; 04- Equipment Failure; 05- Fire/Explosion; 06- Immersion; 07- Jackknife; 08- Overturn/Rollover; 09- Ran off Road Left; 10- Ran off Road Right; 11- Separation of Units; 12- Spill (Two-Wheeled Veh); 18- Other Non-collision; 19- Unk Non-collision

Collision Not Fixed 20- Animal (Deer Only); 21- Animal (All Other); 22- Motor Veh (In Transport); 23- Motor Veh (Stopped); 24- Motor Veh (Other Roadway); 25- Pedalcycle; 26- Motor Veh (Parked); 27- Pedestrian; 28- Railway Veh; 29- Work Zone Maint. Equip.; 38- Other Movable Object; 39- Unk. Movable Object

Collision Fixed Object 40- Bridge Overhead Structure; 41- Bridge Parapet End; 42- Bridge Pier or Abutment; 43- Bridge Rail; 44- Culvert; 45- Curb; 46- Ditch; 47- Embankment; 48- Equipment; 49- Fence; 50- Guardrail End; 51- Guardrail Face; 52- Highway Traffic Sign Post; 53- Impact Attenuator/Crash Cushion; 54- Light/Luminaire Support; 55- Mail Box; 56- Median Barrier; 57- Overhead Sign Support; 58- Other (Post, Pole, Support, Etc.); 59- Other (Wall, Building, Tunnel, Etc.); 60- Tree; 61- Utility Pole; 62- Work Zone Maint. Equipment; 64- Other; 69- Unk

Event 1	Event 2	Event 3	Event 4	Most Harmful	1st Harmful
25				25	22
22				22	
22				22	

Manner of Collision (Struck Veh) 00- Not Coll. W/ Motor Veh; 10- Rear End; 20- Head On; 30- Rear-to-Rear; 41- Angle; 42- Angle; 43- Angle; 50- Sideswipe Same Dir; 60- Sideswipe Opposite Dir; 70- Backed Into; 99- Unknown
1st Harmful Collision: 00

1st / Most Deformed Area 21- Pedestrian; 81- None; 92- Rollover; 93- Total; 94- Under Carriage; 98- Other; 99- Unk
1st Deformed: 12 | 6 | 7 — Most Deformed: 11 | 6 | 7

Vehicle Type: 01- Automobile; 12- Pickup Truck; 13- Truck Tractor; 14- Other Truck; 15- Full Size Van; 16- Mini Van; 17- Sport Utility; 25- Motorcycle; 26- Other Motorbike; 27- Pedalcycle; 38- Animal Drawn Veh; 39- Animal (Ridden); 41- Pedestrian; 51- Train; 61- School Bus; 62- Passenger Bus; 98- Other; 99- Unk (Hit and Run Only)
Entries: 01, 15, 01, X

Alcohol / Drug Test Given 1- Given - Known Results; 2- Given - Unusable; 3- Given - Pending; 4- None; 5- Refused

Test Type 1- Breath (Alc Only); 2- Blood; 3- Urine; 4- Serum; 8- Other

Drug Results 1- Amphetamines; 2- Cocaine; 3- Marijuana; 4- Opiates; 5- PCP; 8- Other

Alc Test Results A1- A2- A3-

Special Use Only 1 2 3 4 5 6 7

Underride/Override 1- Under- Compartment Intrusion; 2- Under- No Intrusion; 3- Under- Unknown; 4- Over- MV in Transport; 5- Over- Other Vehicle; 6- None; 9- Unk
Entries: 6, 6, 6

Extent of Deformity 0- None/Minor; 2- Functional Damage; 3- Disabling Damage; 4- Severe/Totaled; 5- Not Applicable; 9- Unk
Entries: 3, 3, 3

Vehicle Use Code 01- Personal; 02- Driver Training; 03- Construction/Maint.; 04- Ambulance; 05- Military; 06- Transport Passengers; 07- Transport Property; 08- Farm Use; 09- Wrecker or Tow; 10- Police; 11- Government; 12- Fire Fighting; 13- Logging; 18- Other; 41- Pedestrian
Entries: 01, 04, 01

Vehicle Attachment 1- None; 2- Mobile Home; 3- Semi-Trailer; 4- Utility Trailer; 5- Farm Trailer; 6- Trailer w/Boat; 7- Camper Trailer; 8- Towed Motor Vehicle; 9- Petroleum Tanker; A- Lowboy Trailer; B- Autocarrier Trailer; C- Other Tanker; D- Flat Bed; E- Twin Trailers; F- Other
Entries: 1, 1, 1

Trafficway 1- Two-way, Not Divided; 2- Two-way, Divided, Unprotected Median; 3- Two-way, Divided, Barrier; 4- One-Way; 8- Other — 3

1st Harmful Event Loc 1- Gore; 2- Island; 3- Median; 4- Roadside; 5- Roadway; 6- Shoulder; 7- Sidewalk; 8- Outside Trafficway; 9- Unk — B' X-walk 1-Y 2-N 9-U — 5, 2

Action Prior to Impact (Vehicle) 01- Backing; 02- Changing Lanes; 03- Entering Traffic Lane; 04- Leaving Traffic Lane; 05- Making U-turn; 06- Movements Essentially Straight Ahead; 07- Overtaking/Passing; 08- Parked; 09- Slowing or Stopped in Traffic; 10- Turning Left; 11- Turning Right; 88- Other; 99- Unk.
(Non-motorist) 21- Approaching/Leaving Vehicle; 22- Entering/Crossing Location; 23- Playing/Working on Vehicle; 24- Pushing Vehicle; 25- Standing; 26- Walking, Playing, Cycling; 27- Working
Entries: 06, 08, 06, X

Road Character 1- Straight - Level; 2- Straight - On Grade; 3- Straight - Hillcrest; 4- Curve - Level; 5- Curve - On Grade; 6- Curve - Hillcrest — 1

Road Surface Condition 1- Dry; 2- Wet; 3- Snow; 4- Slush; 5- Ice; 6- Contaminate; 7- Water (Standing, etc.); 8- Other; 9- Unk — 1

Traffic Control Type 01- Stop and Go Light; 02- Flashing Traffic Signal; 11- RR (X-bucks, Lights & Gates); 12- RR (X-bucks & Lights); 13- RR (X-bucks Only); 21- Officer or Flagman; 22- Oncoming Emergency Vehicle; 31- Pavement Markings (only); 41- Stop Sign; 42- School Zone Sign; 43- Yield Sign; 44- Work Zone; 45- Other Warning Signs; 51- Flashing Beacon; 98- None; 99- Unk. — 31

Weather Condition 1- Clear (no adverse conditions); 2- Rain; 3- Cloudy; 4- Sleet, Hail; 5- Snow; 6- Fog, Smog, Smoke; 7- Blowing Sand, Oil, Dirt or Snow; 8- Severe Crosswinds; 9- Unk — 1

Light Condition 1- Daylight; 2- Dawn; 3- Dusk; 4- Dark (Lighting Unspecified); 5- Dark (Street Lamp Lit); 6- Dark (Street Lamp Not Lit); 7- Dark (No lights) — 1

School Bus Involved: 1- Yes, Directly; 2- Yes, Indirectly; 3- No; 9- Unk. — 3

Work Zone: 1- Yes 2- No — 2
Work Zone Location 1- Before 1st Sign; 2- Advanced Warning Area; 3- Transition Area; 4- Activity Area; 5- Termination Area
Work Zone Type 1- Shoulder/Median Work; 2- Lane Shift/Crossover; 3- Intermittent/Moving Work; 4- Lane Closure; 8- Other; 9- Unk
Workers Present: 1- Yes 2- No

Junction Type 01- Crossover; 02- Driveway; 03- Five/More Points; 04- Four-way Intersection; 05- Railway Grade Crossing; 07- Shared Use Paths or Trail; 08- T-Intersection; 09- Traffic Circle; 12- Y-Intersection; 13- Nonjunction; 99- Unk — 13

Contributing Factors

Primary: 03

Driver 01- Disregarded Signs, Signals, Etc.; 02- Distracted/Inattention; 03- Driving Too Fast for Conditions; 04- Exceeded Authorized Speed Limit; 05- Failed to Yield Right of Way; 06- Ran off Road; 07- Fatigued/Asleep; 08- Followed Too Closely; 09- Made an Improper Turn; 10- Medical Related; 12- Aggressive Operation of Vehicle; 13- Over-correcting/Over-steering; 14- Swerving to Avoiding Object; 15- Wrong Side or Wrong Way; 16- Under the Influence; 17- Vision Obscured (Within Unit); 18- Improper Lane Usage/Change; 19- Cell Phone; 28- Other Improper Action; 29- Unk

Roadway 30- Debris; 31- Non-highway Work; 32- Obstruction in Roadway; 33- Road Surface Condition (i.e., Wet); 34- Rut, Holes, Bumps; 35- Shoulders (None, Low, Soft, High); 36- Traffic Control Device (i.e., Missing); 37- Work Zone (Constr./Maint./Utility); 38- Worn, Travel-Polished Surface; 48- Other; 49- Unk

Non-Motorist 50- Inattentive; 51- Lying &/or Illegally in Roadway; 52- Failure to Yield R of W; 53- Not Visible (Dark Clothing); 54- Disregard Signs, Signals, Etc; 55- Improper Crossing; 56- Darting; 57- Wrong Side of Road; 58- Other; 59- Unk; 65- Under the Influence; 07- Other Person Under Influence

Environmental 60- Animal in Road; 61- Glare; 62- Obstruction; 63- Weather Cond.; 68- Other; 69- Unk

Vehicle Defect 70- Brakes; 71- Steering; 72- Power Plant; 73- Tires/Wheel; 74- Lights; 75- Signals; 76- Windows/Shield; 77- Restraint System; 78- Truck Coupling; 79- Cargo; 80- Fuel System; 88- Other; 89- Unk

Others:

000147

ORIGINAL

SOUTH CAROLINA TRAFFIC COLLISION REPORT FORM TR-310 (Rev 01/2001)

D.P.S. USE ONLY	Page #	# Of Units	Amended - Attach Copy of Original Report / Corrected	Notified	Arrived
060977828	2 Of 2	4		1345	1400

Date	Time	County	Route Type	Collision Location (Rt. # / Name)	Main/Alt	Miles	Dir	Near City or Town of
[illegible] 06	1343	40	(1) Interstate 4- Secondary 2- US Primary 5- County 3- SC Primary	On 20	(0) Main 6-Connection 2-Alternate 7-Business 5-Spur	3.96	(N) E S W	Columbia

Lane # / Dir.	Distance Offset	Direction	Route Type	Base Intersection (Rt. # / Name)	Main/Alt	ASRU code	MP/Grid
# 1 Of 6 N (E) S W	.01 Miles Feet	N E S (W)	1- Interstate 4- Secondary 2- US Primary 5- County (3) SC Primary 6- Other	From 215 / MONTICELLO RD	(0) Main 6-Connection 2-Alternate 7-Business 5-Spur 9-Other	Latitude	34° 03' 4250"

R.R. Id.	From (Ramp Only)	To	Route Type	Second Intersection (Rt. # / Name)	Main/Alt	Longitude
N/A	N E S W 1 - Entrance 2 - Exit	N E S W	1- Interstate 4- Secondary (2) US Primary 5- County 3- SC Primary 6- Other	Toward 176 / BROAD RIVER RD	(0) Main 6-Connection 2-Alternate 7-Business 5-Spur 9-Other	81° 02' 5750"

V-837618

Field	Value
Driver/Pedestrian's Full Name	EVERETT- COREY VAUGHN
Unit #	4
Sex	M
Race	W
Street	[illegible]
Birth Date	
City, State, & Zip	SEYMOUR TN 37865
State	TN
Driver's License #	080599081
Insurance Company	SAFE AUTO
Year	2003
Body	4D
Vehicle Make	NISS
VIN #	1N1DA31A13T411551
State	TN
Year	2007
License Plate #	683 BFY
Owner's D.L. #	
Home Telephone	
Owner's Full Name	EVERETT - COREY VAUGHN
Bus. Telephone	N/A
Street	
Contributed To Collision	Yes (No)
City, State, & Zip	SEYMOUR TN 37865
Estimated Speed	60
Speed Limit	60
C.D.L. Req:	Yes (No)
T/B S Req	Yes (No)
Alc/Drg info (see back):	Yes (No)
Summons #	N/A
Code	
Summons #	N/A
Code	
Towed By	N/A

V-837619

Field	Value
Driver/Pedestrian's Full Name	
Unit #	N/A
Sex	
Race	
Street	
Birth Date	
City, State, & Zip	
State	
Driver's License #	
Insurance Company	
Year	
Body	
Vehicle Make	
VIN #	
State	
Year	
License Plate #	
Owner's D.L. #	
Home Telephone	( )
Owner's Full Name	
Bus. Telephone	( )
Street	
Contributed To Collision	Yes No
City, State, & Zip	
Estimated Speed	
Speed Limit	
C.D.L. Req:	Yes No
T/B S Req.	Yes No
Alc/Drg info (see back).	Yes No
Summons #	
Code	
Summons #	
Code	
Towed By	

V-837620

Field	Value
Driver/Pedestrian's Full Name	
Unit #	
Sex	
Race	
Street	
Birth Date	
City, State, & Zip	
State	
Driver's License #	
Insurance Company	
Year	
Body	
Vehicle Make	
VIN #	
State	
Year	
License Plate #	
Owner's D.L. #	
Home Telephone	( )
Owner's Full Name	
Bus. Telephone	( )
Street	
Contributed To Collision	Yes No
City, State, & Zip	
Estimated Speed	
Speed Limit	
C.D.L. Req:	Yes No
T/B S Req:	Yes No
Alc/Drg info (see back)	Yes No
Summons #	
Code	
Summons #	
Code	
Towed By	

Dir. of Travel: Unit 4: N S (E) W | Unit 2: N S E W | Unit 3: N S E W

North

Unit 4 Dam.	Unit 2 Dam.	Unit 3 Dam.	Prop. Dam. 1	Prop. Dam. 2
$ 500.00	$ N/A	$ N/A	$ N/A	$ N/A

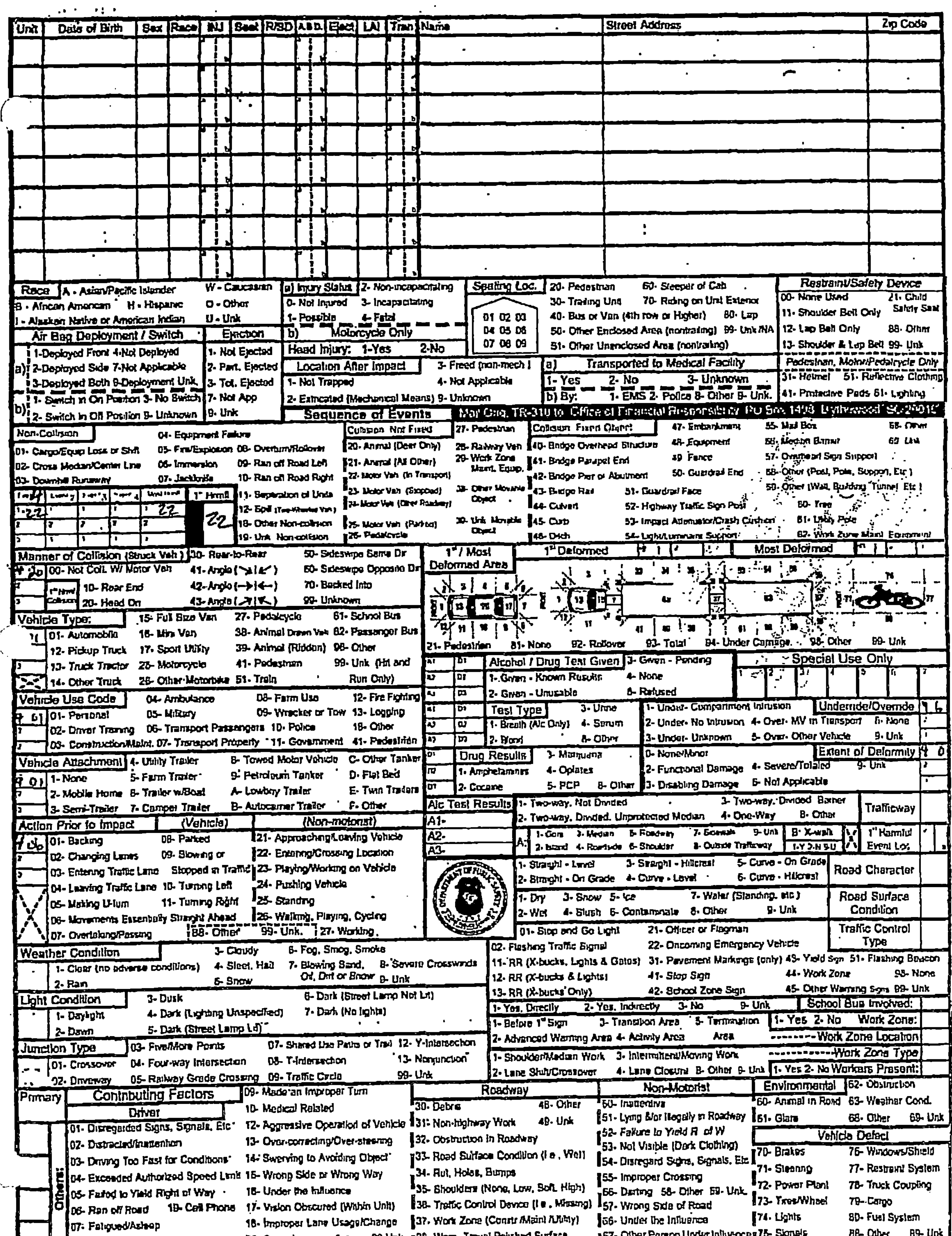
Property Owner/Witness	Property Owner/Witness
Address	Address
State / Zip / Phone	State / Zip / Phone

Photo: Y N

Describe What Happened (Refer to Units by Number)

NOTICE - THIS FORM IS FOR STATISTICAL REPORTING PURPOSES ONLY AND IS A REFLECTION OF THE OFFICER'S BEST KNOWLEDGE, OPINIONS AND BELIEF COVERING THE COLLISION BUT NO WARRANT IS MADE AS TO THE FACTUAL ACCURACY THEREOF.

Investigating Officer's Name	Rank	Badge #	Code	Date	Reviewer's Name	Rank	Internal Agency Code
CARLSON - WL	TPO	302	HP0100	01-09-2006	HERRING - CL	CPL	



Unit	Date of Birth	Sex	Race	INJ	Seat	R/SD	A.B.D.	Eject	LAI	Tran	Name	Street Address	Zip Code

Race A - Asian/Pacific Islander; W - Caucasian; B - African American; H - Hispanic; O - Other; I - Alaskan Native or American Indian; U - Unk

a) Injury Status 0- Not Injured; 1- Possible; 2- Non-incapacitating; 3- Incapacitating; 4- Fatal; b) Motorcycle Only; Head Injury: 1-Yes 2-No

Seating Loc. 01 02 03 / 04 05 06 / 07 08 09; 20- Pedestrian; 30- Trailing Unit; 40- Bus or Van (4th row or Higher); 50- Other Enclosed Area (nontrailing); 51- Other Unenclosed Area (nontrailing); 60- Sleeper of Cab; 70- Riding on Unit Exterior; 80- Lap; 99- Unk/NA

Restraint/Safety Device 00- None Used; 11- Shoulder Belt Only; 12- Lap Belt Only; 13- Shoulder & Lap Belt; 21- Child Safety Seat; 88- Other; 99- Unk; Pedestrian, Motor/Pedalcycle Only: 31- Helmet; 41- Protective Pads; 51- Reflective Clothing; 61- Lighting

Air Bag Deployment / Switch a) 1-Deployed Front; 2-Deployed Side; 3-Deployed Both; 4-Not Deployed; 7-Not Applicable; 9-Deployment Unk. b) 1- Switch in On Position; 2- Switch in Off Position; 3- No Switch; 9- Unknown

Ejection 1- Not Ejected; 2- Part. Ejected; 3- Tot. Ejected; 7- Not App; 9- Unk

Location After Impact 1- Not Trapped; 2- Extricated (Mechanical Means); 3- Freed (non-mech.); 4- Not Applicable; 9- Unknown

a) Transported to Medical Facility 1- Yes 2- No 3- Unknown; b) By: 1- EMS 2- Police 8- Other 9- Unk.

Sequence of Events — Mail Orig. TR-310 to: Office of Financial Responsibility, PO Box 1498, Blythewood, SC 29016

Non-Collision 01- Cargo/Equip Loss or Shift; 02- Cross Median/Center Line; 03- Downhill Runaway; 04- Equipment Failure; 05- Fire/Explosion; 06- Immersion; 07- Jackknife; 08- Overturn/Rollover; 09- Ran off Road Left; 10- Ran off Road Right; 11- Separation of Units; 12- Spill (Two-Wheeled Veh); 18- Other Non-collision; 19- Unk. Non-collision

Unit	Event 1	Event 2	Event 3	Most Harmful	1st Hrmfl
1	22			22	22
2					
3					

Collision Not Fixed 20- Animal (Deer Only); 21- Animal (All Other); 22- Motor Veh (In Transport); 23- Motor Veh (Stopped); 24- Motor Veh (Other Roadway); 25- Motor Veh (Parked); 26- Pedalcycle; 27- Pedestrian; 28- Railway Veh; 29- Work Zone Maint. Equip.; 38- Other Movable Object; 39- Unk. Movable Object

Collision Fixed Object 40- Bridge Overhead Structure; 41- Bridge Parapet End; 42- Bridge Pier or Abutment; 43- Bridge Rail; 44- Culvert; 45- Curb; 46- Ditch; 47- Embankment; 48- Equipment; 49- Fence; 50- Guardrail End; 51- Guardrail Face; 52- Highway Traffic Sign Post; 53- Impact Attenuator/Crash Cushion; 54- Light/Luminaire Support; 55- Mail Box; 56- Median Barrier; 57- Overhead Sign Support; 58- Other (Post, Pole, Support, Etc.); 59- Other (Wall, Building, Tunnel, Etc.); 60- Tree; 61- Utility Pole; 62- Work Zone Maint. Equipment; 68- Other; 69- Unk

Manner of Collision (Struck Veh) 00- Not Coll. W/ Motor Veh; 10- Rear End; 20- Head On; 30- Rear-to-Rear; 41- Angle; 42- Angle; 43- Angle; 50- Sideswipe Same Dir; 60- Sideswipe Opposite Dir; 70- Backed Into; 99- Unknown

1st / Most Deformed Area — 1st Deformed; Most Deformed; 21- Pedestrian; 81- None; 92- Rollover; 93- Total; 94- Under Carriage; 98- Other; 99- Unk

Vehicle Type 01- Automobile; 12- Pickup Truck; 13- Truck Tractor; 14- Other Truck; 15- Full Size Van; 16- Mini Van; 17- Sport Utility; 25- Motorcycle; 26- Other Motorbike; 27- Pedalcycle; 38- Animal Drawn Veh; 39- Animal (Ridden); 41- Pedestrian; 51- Train; 61- School Bus; 62- Passenger Bus; 98- Other; 99- Unk (Hit and Run Only)

Alcohol / Drug Test Given 1- Given - Known Results; 2- Given - Unusable; 3- Given - Pending; 4- None; 5- Refused

Test Type 1- Breath (Alc Only); 2- Blood; 3- Urine; 4- Serum; 8- Other

Drug Results 1- Amphetamines; 2- Cocaine; 3- Marijuana; 4- Opiates; 5- PCP; 8- Other

Alc Test Results A1- A2- A3-

Special Use Only

Underride/Override 1- Under- Compartment Intrusion; 2- Under- No Intrusion; 3- Under- Unknown; 4- Over- MV in Transport; 5- Over- Other Vehicle; 8- None; 9- Unk

Extent of Deformity 0- None/Minor; 2- Functional Damage; 3- Disabling Damage; 4- Severe/Totaled; 6- Not Applicable; 9- Unk

Vehicle Use Code 01- Personal; 02- Driver Training; 03- Construction/Maint.; 04- Ambulance; 05- Military; 06- Transport Passengers; 07- Transport Property; 08- Farm Use; 09- Wrecker or Tow; 10- Police; 11- Government; 12- Fire Fighting; 13- Logging; 18- Other; 41- Pedestrian

Vehicle Attachment 1- None; 2- Mobile Home; 3- Semi-Trailer; 4- Utility Trailer; 5- Farm Trailer; 6- Trailer w/Boat; 7- Camper Trailer; 8- Towed Motor Vehicle; 9- Petroleum Tanker; A- Lowboy Trailer; B- Autocarrier Trailer; C- Other Tanker; D- Flat Bed; E- Twin Trailers; F- Other

Trafficway 1- Two-way, Not Divided; 2- Two-way, Divided, Unprotected Median; 3- Two-way, Divided, Barrier; 4- One-Way; 8- Other

1st Harmful Event Loc. 1- Gore; 2- Island; 3- Median; 4- Roadside; 5- Roadway; 6- Shoulder; 7- Sidewalk; 8- Outside Trafficway; 9- Unk; B- X-walk (1-Y 2-N 9-U)

Road Character 1- Straight - Level; 2- Straight - On Grade; 3- Straight - Hillcrest; 4- Curve - Level; 5- Curve - On Grade; 6- Curve - Hillcrest

Road Surface Condition 1- Dry; 2- Wet; 3- Snow; 4- Slush; 5- Ice; 6- Contaminate; 7- Water (Standing, etc.); 8- Other; 9- Unk

Action Prior to Impact (Vehicle) 01- Backing; 02- Changing Lanes; 03- Entering Traffic Lane; 04- Leaving Traffic Lane; 05- Making U-Turn; 06- Movements Essentially Straight Ahead; 07- Overtaking/Passing; 08- Parked; 09- Slowing or Stopped in Traffic; 10- Turning Left; 11- Turning Right; 88- Other; 99- Unk.
(Non-motorist) 21- Approaching/Leaving Vehicle; 22- Entering/Crossing Location; 23- Playing/Working on Vehicle; 24- Pushing Vehicle; 25- Standing; 26- Walking, Playing, Cycling; 27- Working

Traffic Control Type 01- Stop and Go Light; 02- Flashing Traffic Signal; 11- RR (X-bucks, Lights & Gates); 12- RR (X-bucks & Lights); 13- RR (X-bucks Only); 21- Officer or Flagman; 22- Oncoming Emergency Vehicle; 31- Pavement Markings (only); 41- Stop Sign; 42- School Zone Sign; 43- Yield Sign; 44- Work Zone; 45- Other Warning Signs; 51- Flashing Beacon; 98- None; 99- Unk

Weather Condition 1- Clear (no adverse conditions); 2- Rain; 3- Cloudy; 4- Sleet, Hail; 5- Snow; 6- Fog, Smog, Smoke; 7- Blowing Sand, Oil, Dirt or Snow; 8- Severe Crosswinds; 9- Unk

Light Condition 1- Daylight; 2- Dawn; 3- Dusk; 4- Dark (Lighting Unspecified); 5- Dark (Street Lamp Lit); 6- Dark (Street Lamp Not Lit); 7- Dark (No lights)

School Bus Involved: 1- Yes, Directly; 2- Yes, Indirectly; 3- No; 9- Unk

Work Zone: 1- Yes 2- No; **Work Zone Location** 1- Before 1st Sign; 2- Advanced Warning Area; 3- Transition Area; 4- Activity Area; 5- Termination Area; **Work Zone Type** 1- Shoulder/Median Work; 2- Lane Shift/Crossover; 3- Intermittent/Moving Work; 4- Lane Closure; 8- Other; 9- Unk; **Workers Present:** 1- Yes 2- No

Junction Type 01- Crossover; 02- Driveway; 03- Five/More Points; 04- Four-way Intersection; 05- Railway Grade Crossing; 07- Shared Use Path or Trail; 08- T-Intersection; 09- Traffic Circle; 12- Y-Intersection; 13- Nonjunction; 99- Unk

Contributing Factors (Primary / Others)

Driver 01- Disregarded Signs, Signals, Etc; 02- Distracted/Inattention; 03- Driving Too Fast for Conditions; 04- Exceeded Authorized Speed Limit; 05- Failed to Yield Right of Way; 06- Ran off Road; 07- Fatigued/Asleep; 08- Followed Too Closely; 09- Made an Improper Turn; 10- Medical Related; 12- Aggressive Operation of Vehicle; 13- Over-correcting/Over-steering; 14- Swerving to Avoiding Object; 15- Wrong Side or Wrong Way; 16- Under the Influence; 17- Vision Obscured (Within Unit); 18- Improper Lane Usage/Change; 19- Cell Phone; 28- Other Improper Action; 29- Unk.

Roadway 30- Debris; 31- Non-highway Work; 32- Obstruction in Roadway; 33- Road Surface Condition (i.e., Wet); 34- Rut, Holes, Bumps; 35- Shoulders (None, Low, Soft, High); 36- Traffic Control Device (i.e., Missing); 37- Work Zone (Constr./Maint./Utility); 38- Worn, Travel-Polished Surface; 48- Other; 49- Unk

Non-Motorist 50- Inattentive; 51- Lying &/or Illegally in Roadway; 52- Failure to Yield R. of W.; 53- Not Visible (Dark Clothing); 54- Disregard Signs, Signals, Etc; 55- Improper Crossing; 56- Darting; 57- Wrong Side of Road; 58- Other; 59- Unk.; 56- Under the Influence; 57- Other Person Under Influence

Environmental 60- Animal in Road; 61- Glare; 62- Obstruction; 63- Weather Cond.; 68- Other; 69- Unk

Vehicle Defect 70- Brakes; 71- Steering; 72- Power Plant; 73- Tires/Wheel; 74- Lights; 75- Signals; 76- Windows/Shield; 77- Restraint System; 78- Truck Coupling; 79- Cargo; 80- Fuel System; 88- Other; 89- Unk

EXHIBIT 2

243

DHEC PATIENT CARE FORM

Q.A. NO. 36FK

TRIP NO. 634878

PATIENT IDENTIFICATION (Please Print)

LAST NAME (10-29): Durrett FIRST NAME (30-45): Scott P MI (46): Mr

STREET (47-71):

CITY (72-87): Cola STATE (88-89): SC ZIP CODE (90-94): 29206

(95-103)

SEX (104)
1 ☒ Male
2 ☐ Female
3 ☐ Undetermined

RACE (105)
1 ☒ White
2 ☐ Black
3 ☐ Am. Indian
4 ☐ Hispanic
5 ☐ Asian
6 ☐ Other

AGE (106-109)
047

CHECK ONE
1 ☒ YRS.
2 ☐ MOS.
3 ☐ DAYS

DISPOSITION (110-111)
01 ☐ TREAT/NO TRANS.
02 ☐ DOA AT SCENE
03 ☒ HOSPITAL ER
04 ☐ HOSP. DIR. ADMIT.
06 ☐ PATIENT'S HOME
07 ☐ NURSING HOME
08 ☐ DR.'S OFFICE
09 ☐ OUTPATIENT
10 ☐ PT. REFUSED TREAT.
13 ☐ EMS TRANSFER

TYPE OF INCIDENT

TRAUMA (112)
1 ☒ MVA
2 ☐ MC
3 ☐ BIKES
4 ☐ PED
5 ☐ ASSAULT
6 ☐ FALL
7 ☐ FIRE
8 ☐ INTERFAC
9 ☐ OTHER

MEDICAL (113)
1 ☐ ENVIRON
2 ☐ BEHAV
3 ☐ OB/GYN
4 ☐ RESP
5 ☐ CARDIAC
6 ☐ INTERFAC
7 ☐ OTHER

CALL TYPE

TO SCENE (114)
1 ☒ EMERGENT
2 ☐ NONEMERGENT
CODE 03

PATIENT STATUS

ON SCENE (115)
1 ☒ URGENT
2 ☐ NON URGENT

FROM SCENE (116)
1 ☐ URGENT
2 ☒ NON URGENT
CODE 01

INCIDENT LOCATION

ST. OR HWY. NAME OR NO.: I-20 @ 68

CITY: Cola SC

County (117-118): 40 Zip Code (119-123): 29203

SAFETY EQP (124)
1 ☒ Seatbelts
2 ☐ Helmets
3 ☐ Airbags
4 ☐ Child Seat
5 ☐ None
6 ☐ Unkn.

SITE OF INCIDENT (125)
1 ☒ ROADWAY
2 ☐ RESIDENCE
3 ☐ INDUSTRIAL
4 ☐ RECREATIONAL
5 ☐ AGRICULTURAL
6 ☐ OTHER

PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (126-137)
003 ☐ Seizure
004 ☐ Diabetic
011 ☐ Abrasion/Contusions
013 ☐ Laceration
023 ☒ Fracture
024 ☐ Multitrauma/Shock
030 ☐ Head Injury
032 ☐ Spinal Injury
034 ☐ Stroke
051 ☐ G.I. Problems
074 ☐ Respiratory Distress
080 ☐ Coronary Problems
083 ☐ Cardiac Arrest

Other: 177 Other: 223

PRIMARY IMPRESSION (138-140)
023

TREATMENT PROCEDURES (141-174)
01 ☐ Dressing Applied
02 ☒ Limb Splinted
03 ☒ Spine Immobilized
04 ☒ Neck Immobilized
05 ☐ OB Assistance
06 ☐ Oral Airway Used
07 ☒ Oxygen Given
08 ☐ Suction Used
09 ☐ Antishock Trousers
10 ☐ Airway Maintained
11 ☐ Antishock Treatment
12 ☐ Artificial Resp.
13 ☐ Cardiac Massage
14 ☐ Bleeding Controlled
15 ☐ Cold Application
16 ☐ Patient Restrained
17 ☒ Other (Use Comments)
18 ☐ Ventilator

HCFA CODES (175-180)

ADVANCED PROCEDURES (190-223)
[illegible]

DRUGS USED (226-241)

DRUG	DOSE	TIME	DRUG	DOSE	TIME

SITE OF TRAUMA (181-189)
1 ☐ Head
2 ☐ Face
3 ☐ Neck
4 ☐ Chest
5 ☐ Abdomen
6 ☐ Hip/Pelvis
7 ☐ Upper Extr.
8 ☐ Lower Extr.
lock

REVISED TRAUMA SCORE
GCS: (242) EYES ____ (243) VERBAL ____ (244) MOTOR ____ (245-246) GLASGOW ____

(247-249) SBP ____ (250-252) RR ____

RTS (254-255)

(253) ANATOMICAL INJ. 1 ☐ YES 2 ☐ NO

VITAL SIGNS

BP	PULSE RATE	PULSE	RESP. RATE	RESPIRATIONS	PUPIL	LEVEL OF CONSC.	TIME
1?/P	78	☒ REG.	30	☒ REG.	E	A	1416
110/P	80	☒ REG.	30	☒ REG.	E	A	1420
/		REG. / IRREG.		REG. / IRREG.			
/		REG. / IRREG.		REG. / IRREG.			
/		REG. / IRREG.		REG. / IRREG.			

EXPOSURE TO PT's BODY FLUIDS? (256) 1. ☐ YES 2. ☒ NO

1st Responder (257) 1. ☒ YES Name: 278 2. ☐ NO

COMMENTS INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI

PT CC of (L) Leg pain, PT a/so presented c̄ Bandaged (L) forearm. PT restrained driver of vehicle c̄ heavy front end damage. PT entrapped by steering wheel and dashboard. PT refused O2 and C-collar. PT freed from vehicle. PT→LSB. C-collar applied. PMS intact x4. PT→243. VS taken. LP [?] ST @ 78-88 Ø Ectopy. NRB @ 15 LPM. PT is A&Ox3, skin W/D color good strong radial pulse. BS clear x4. Abd soft & non-tender. Pelvis stable. IV of LS via 18 in (R) hand. ER contacted. PT→Trauma #1 Report to ER staff. PT gave large amount of cash to [?] companion. PT gave unknown object also to ER.

Patient Care Form Left In (258): 1. ☒ ED 2. ☐ ICU 3. ☐ OTHER ☐ See Page 2

TIME RECORD

RUN DATE (259-266): MONTH 06 DAY 09 YEAR 06

Call Received: (267-270)	1348
Call Dispatched: (271-274)	1348
Departed Base: (275-278)	1349
Arrive Scene: (279-282)	1358
Departed Scene: (283-286)	[illegible]
Arrive Destination: (287-290)	1423

CAUSE OF DELAY: ____

DHEC PERMIT NO (291-295)
[illegible]

RECEIVING AGENCY (296-299)
2015

SENDING AGENCY (300-303)

PROVIDER TIME (OPTIONAL)

ATTENDANT'S SIGNATURE & CERTIFICATION NO.

PRIMARY PATIENT ATTENDANT (304-308): [signature] 84133

2ND ATTENDANT/DRIVER (309-313): Stephen Zoel 29601

3RD ATTENDANT/DRIVER (314-318):

RECEIVING NURSE OR PHYSICIAN: Carly Brandenburg, RN

DHEC 2050 REV. (01/2004)

EMS PROVIDER COPY

REPORT NO. (1-9) 250413

EXHIBIT 3

Client Name: Palmetto Health Richland

Client Address: 5 Richland Medical Park

Columbia, SC 29203

Admitting Physician: Bynoe MD, Raymond P
Attending Physician: Bynoe MD, Raymond P

Patient Name: DURRETT, PHILLIP

Patient Address: :

COLUMBIA, SOUTH CAROLINA 29206

Age: 47 years
Date of Birth: ·

MRN: R013106409
FIN: R0622101597
Financial Class: MIAP

Admit Date: 8/9/2006
Admit Time: 6:00:00 PM
Discharge Date: 8/23/2006
Discharge Time: 8:45:00 PM

Emergency Department Documentation

Performing Physician:	Performed Date/Time:	Authenticated By:	Authenticated Date/Time:
Moslander MD, Terry V	8/10/2006 9:01:00 AM	Fuerst MD, Ronnie S	8/12/2006 2:57:30 PM

Emergency Dept
DATE OF VISITATION: 08/09/2006

ACCOUNT NUMBER: 0622101597

ATTENDING: Attending present was Dr. Ron Fuerst, present and available at all times.

MODE OF ARRIVAL: EMS.

CHIEF COMPLAINT: Motor vehicle crash.

HISTORY OF PRESENT ILLNESS: This is a 47-year-old Caucasian male, with no prior medical history, involved in a motor vehicle crash with a motor vehicle. Was reported by EMS that the patient was entrapped for approximately 15 minutes and had to be extricated from the car. Said there was severe right-sided damage with the right side of the fender and engine compartment pushed back into the car. Patient was awake, alert and oriented x3 upon arrival. He is very aggressive, violent nature. His GCS was 15, verbal 5, motor 6. Upon arrival, he was on back board and C-collar, complaining of left leg pain.

ADDENDUM: Patient said he was wearing a seat belt and air bags were deployed.

REVIEW OF SYSTEMS: Negative for fevers, chills, sweats, nausea, vomiting, headache, blurry vision, chest pain, abdominal pain, loss of consciousness.

FAMILY HISTORY: No significant medical injuries of primary family members.

SOCIAL HISTORY: He denies tobacco, alcohol, or illicit drug use.

PAST MEDICAL HISTORY: Patient says he has had several surgeries in the past for previous accidents.

MEDICATIONS: None.

ALLERGIES: He is allergic to MORPHINE. States that during a surgery they gave him morphine and they had to bring ATLS protocols into action to bring him back.

PHYSICAL EXAMINATION:
VITAL SIGNS: Pulse 88, respiration 20, blood pressure is 139/107, pulse ox is 96% on room air.
GENERAL APPEARANCE: Well-developed, well-nourished, overweight Caucasian male. GCS of 15, eyes 4, verbal 5, motor 6.
HEENT: Normocephalic, atraumatic. Pupils equal, round and reactive to light.
Extraocular movements intact. Nares are patent. Oropharynx was deemed clear. His mid face was stable. He had no tenderness over his mandible. He had no tympanum bilaterally.
NECK: In C-collar. He had no midline tenderness. Trachea was in midline.
LUNGS: Respirations clear to auscultation bilaterally. No wheezes, rales, or rhonchi. Equal breath sounds.
CARDIOVASCULAR: Regular rate and rhythm, no murmurs, rubs or gallops are appreciated.

Emergency Department Documentation

Performing Physician:	Performed Date/Time:	Authenticated By:	Authenticated Date/Time:
Moslander MD, Terry V	8/10/2006 9:01:00 AM	Fuerst MD, Ronnie S	8/12/2006 2:57:30 PM

ABDOMEN: Soft, nondistended, nontender, had positive bowel sounds.
MUSCULOSKELETAL: Patient had full range of motion of his upper extremities bilaterally. He had no tenderness to palpation over his wrists, elbows, or shoulders. No tenderness over his vertebral column. The patient did have tenderness over his left knee and thigh, appeared to be a small deformity just on the proximal tibia with some discoloration and bruising. He had good distal pulses bilaterally.
SKIN: Patient had abrasion to the left hand. He had a 4-cm laceration to the left forearm and an 8-cm laceration to the left forearm with significant bleeding.
NEUROLOGICAL: Cranial nerves 2-12 are grossly intact. No focal deficits were appreciated. He had strength in the upper and lower extremities bilaterally, sensation bilaterally.

MEDICAL DECISION MAKING: After reviewing history of present illness and physical examination, patient was dispatched out as an 811, and 811 labs, CT of the head, C-spine, and chest, abdomen and pelvis were ordered for the patient as well as x-rays of the left hip and thigh, knee, and tib-fib as well as x-rays for the left forearm.

LABORATORY: His labs and x-rays are pending at this time.

EMERGENCY DEPARTMENT COURSE: Patient was brought back to the emergency department where he was promptly evaluated and given a thorough examination. During the whole examination, patient was verbal, cussing, noncompliant, and very uncooperative. Trauma came down to evaluate the patient. Patient was not cooperating. It was determined at that time that the patient would need to be intubated for protection and his own care. Intubation was then done using 10 of Norcuron, 5 Versed, and 150 succinylcholine x2. Patient was initially bagged up to 100% preoxygenated. He was given the RSI medications and using a Miller blade while head was held in C-spine precautions, cords were attempted to be visualized. Patient's initial intubation was difficult. Patient had to be re-oxygenated and re-bagged while cricoid pressure was applied. Second attempt was then attempted at this time. A 7.5 ET tube was passed to approximately 26 cm. There was good color change, good breath sounds. Chest x-ray was then ordered to validate placement of the ET tube. Patient at that time was waiting to go to his radiologic studies. Patient did have a FAST examination while he was here in the emergency department, which was negative.

CLINICAL IMPRESSION:
1. Questionable left leg fracture secondary to motor vehicle crash.
2. Questionable abdominal injury secondary to motor vehicle crash.
3. Lacerations to left forearm secondary to motor vehicle crash.
4. Intubated, ventilated.

DISPOSITION: Patient will be admitted to trauma service.
Reviewed and agree with above note

Dictated by: Terry Moslander, MD

TM:hs
D: 08/09/2006 3:15 P T: 08/10/2006 9:01 A
Job #: 000347471 T Job #: 918237 Doc #: 886993

EXHIBIT 4

CONSULTS

Performing Physician:	Performed Date/Time:	Authenticated By:	Authenticated Date/Time:
Gowder MD, Daniel W	8/11/2006 3:15:00 PM	Hendricks MD, C W	8/14/2006 2:35:11 PM

Consultation Report
DATE OF CONSULTATION: 08/10/2006

CONSULTING ASSISTANT: Dr. Raymond Bynoe from the trauma surgery service.

REASON FOR CONSULTATION: Ventricular tachycardia and transesophageal echocardiogram.

HISTORY OF PRESENT ILLNESS: This is a 47-year-old white male who is in the CCU now. He came into the hospital yesterday via the ER after he was involved in an MVC. No loss of consciousness. He was entrapped for approximately 15-20 minutes. He was intubated in the emergency room secondary to his altered mental status. He is now sedated and paralyzed, unable to tell me any of his other history. Per the notes and staff here at the hospital last night, after being admitted to the hospital, he had an episode after he was started on propofol of hypotension. He began having many PVCs, went into possibly a junctional, and then a ventricular tachycardia with this hypotension. He did have a precordial thump x2, and then subsequently came back into sinus tachycardia. He did not have to be defibrillated. It was thought potentially the patient was having an MI. After the propofol was stopped, the patient was placed on Levophed overnight and is now off Levophed and normotensive. Patient has no history of any coronary problems. The rest of his history is per the chart.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: He has had multiple extremity fracture surgeries in the past.

REVIEW OF SYSTEMS: Unable to be obtained secondary to patient was intubated. The rest of the review of systems negative.
FAMILY HISTORY: Unknown.

SOCIAL HISTORY: He was asked about drug use prior to intubation and he denied any alcohol, tobacco, or illicit drug use.

ALLERGIES: MORPHINE and CODEINE.

MEDICATIONS: None, prior to hospital. The patient is now on medications including Ativan drip, Norcuron drip, fentanyl drip. He is also on Carafate, Lovenox, Mycostatin, Colace, Dulcolax, and Lopressor.

PHYSICAL EXAMINATION:
VITAL SIGNS: Heart rate 121, blood pressure 117/70, pulse ox 99% on an

EXHIBIT 5

Documents

Performing Physician:	Performed Date/Time:	Authenticated By	Authenticated Date/Time:
Barefoot PA, Gregory E	8/21/2006 5:18:00 PM	Bynoe MD, Raymond P	8/27/2006 12:55:29 PM

Progress Notes

ADMISSION DIAGNOSES:
1. Status post motor vehicle collision.
2. Combativeness with possible aspiration.
3. Left lower extremity deformity.
4. Possible intrathoracic injury.
5. Possible intraabdominal injury.
6. Possible spinal injury.

TRANSFER DIAGNOSES:
1. Status post motor vehicle collision.
2. Concussion.
3. Ventricular tachycardia, resolved.
4. Aspiration pneumonitis/methicillin susceptible staphylococcus aureus.
5. Left forearm laceration.
6. Left tibial plateau fracture.
7. Positive amphetamines on urine drug screen.
8. Respiratory failure.

ATTENDINGS:
1. Dr. Raymond Bynoe.
2. Dr. James Morrison.
3. Dr. Stephen Fann.

CONSULTANTS:
1. Columbia Heart Center.
2. USC Psychiatry, Dr. Brandenburg and Dr. Mozingo.
3. Premier Orthopedics, Dr. James Carr.

PROCEDURES:
1. On August 10, 2006, fiberoptic bronchoscopy.
2. On August 11, 2006, fiberoptic bronchoscopy.
3. On August 16, 2006, fiberoptic bronchoscopy.
4. On August 16, 2006, open tracheostomy.
5. On August 17, 2006, open reduction, internal fixation of left tibia plateau fracture.

HOSPITAL COURSE: The patient is a 47-year-old Caucasian male who on August 9, 2006, was involved in a MVC, positive loss of consciousness with entrapment. He was extricated and brought into Palmetto Richland Emergency Department. Glasgow coma scale was 15 prior to arrival. Upon evaluation in accordance with ATLS guidelines by the trauma services team, it was noted that the patient became cooperative and combative. An RSI was underway and there was some suspicion whether or not the patient aspirated secondary to the RSI. Also on exam, the patient was noted to have a left lower extremity deformity as well as a left upper extremity forearm laceration. Otherwise, the exam was essentially unremarkable. The patient was further examined with CAT scans of the head, chest, abdomen, pelvis, and C-spine. The patient was then admitted to the surgical trauma service for additional evaluation and management. Upon evaluation of the films, it was noted that the patient did have what was felt to be aspiration pneumonitis and on the date of admission, the patient went into ventricular tachycardia. A work up did not reveal any

Performing Physician:	Performed Date/Time:	Authenticated By	Authenticated Date/Time:
Barefoot PA, Gregory E	8/21/2006 5:18:00 PM	Bynoe MD, Raymond P	8/27/2006 12:55:29 PM

true MI. Columbia Heart Center evaluated the patient and ordered a TEE to rule out blunt cardiac injury. He did not have blunt cardiac injury on their examination. They continued to follow loosely for a period of time and they have since signed off. Also, the patient was noted to have a tibial plateau fracture. Dr. James Carr was consulted concerning this. Ultimately, the patient underwent an ORIF of the left tibia and the patient is weightbearing as tolerated in the knee immobilizer which physical therapy has worked with the patient concerning this. The patient did develop some respiratory failure early on and ultimately had a tracheostomy tube placed on August 16, 2006, and he was de-cannulated on August 21, 2006. He developed a febrile episode which was worked up and his pneumonitis actually turned into pneumonia with staphylococcus aureus and he received antibiotics for this and these antibiotics are to go off on August 22. He is currently on cefepime, tobramycin, and Flagyl. The patient was noted to have amphetamines on urine drug screen and he actually had "crystal meth" the night of the incident and psychiatry saw the patient in consultation and felt that he would be suitable for LRADAC upon followup. Otherwise, the patient is doing well. He was de-cannulated today. His NG was removed, and he was placed on a full liquid diet and he was felt to be suitable for transfer to 7 East. Condition at transfer is stable. Disposition is 7 East.

Transfer medications include the following:

1. Normal saline at KVO.
2. Lovenox 40 mg subcu q.12h.
3. Colace 100 mg p.o. 2 times daily.
4. Zofran 4 mg IV q.6h. p.r.n. nausea and vomiting.
5. Dulcolax 1 p.r. q.48h.
6. Lopressor 50 mg p.o. b.i.d.
7. Tobramycin 300 mg IV q.24h. with a stop date of 8/22.
8. Cefepime 1 g IV q.12h. with a stop date of 8/22.
9. Flagyl 800 mg IV q.6h. with a stop date of 8/22.
10. Lortab 5/325 one to two by mouth every 6 hours as needed for pain.

This dictation is an addendum to the transfer summary dated 8/21/06 by Gregory Barefoot, PA.

ADDENDUM TO 000360241, document number 892627.

HOSPITAL COURSE: All other details concerning the patient's hospital course were included up until the 21st of August. At this time, he was transferred to 7 East. On August 21, the patient visited by psychiatry, who referred him to LRADAC for amphetamine abuse. The patient was evaluated by speech pathology, speech therapy, and was placed on a full liquid diet, which was upgraded prior to his discharge. He did well over the next 2 days. No acute event occurred. He completed the courses of his antibiotics, including tobramycin, cefepime, and Flagyl for his aspiration pneumonitis. On August 22, 2006, his left tibial plateau fracture having been repaired, was revisited by orthopedics. He was told to be weightbearing as tolerated with his knee immobilizer. The patient progressed well with physical therapy and occupational therapy and was felt to be safe and adequate for discharge on August 23, 2006.

Discharge condition good.

DISPOSITION: Discharge to home with family.

MEDICATIONS:
1. Colace 100 mg 1 p.o. b.i.d. while taking Lortab.

Documents

Performing Physician:	Performed Date/Time:	Authenticated By	Authenticated Date/Time:
Barefoot PA, Gregory E	8/21/2006 5:18:00 PM	Bynoe MD, Raymond P	8/27/2006 12:55:29 PM

2. Lortab 5/500 mg 1 to 2 p.o. q.6h. p.r.n. pain.

DISCHARGE INSTRUCTIONS: The patient was instructed to follow up with LRADAC as an outpatient for his amphetamine addiction/abuse. He was also instructed to follow up with Dr. Carr at 3 Med Park on September 13 at 1 p.m. He was given the number, 434-6908 as a contact. He is also instructed to follow up with the trauma clinic at 1801 Sunset in approximately 10 to 14 days. The number given was 434-4100. His return to work was to be determined in followup. He was instructed to bear weight as tolerated with his knee immobilized in place. He was also provided a rolling walker. His diet was mechanical, soft, with thin liquids. Upon discharge, he was instructed to contact the MD if he had any increased pain, swelling, fever over 101 degrees, and to contact the trauma resident on call if he had any problems or questions.

Dictated by: Gregory Barefoot, PA

GB:hsEDITED 08/24/2006
08/21/2006 4:51 P T: 08/21/2006 5:18 P
D #: 000360241/362911 T Job #: 276882/332608
Doc #: 892627
cc: Gregory Barefoot, PA
Raymond P Bynoe, MD

Electronically Signed & Verified on 08/27/2006 12:55
by Raymond P Bynoe MD

Allergies

Substance: codeine	
Update Dt Tm Updated By	
8/9/2006 11:58:03 PM Young RN, Leah N	Reaction Status: Active; Type: Allergy; Category: Drug Allergy;

Substance: morphine	
Update Dt Tm Updated By	
8/9/2006 7:11:51 PM Leaphart RPh, Ashley R	Reaction Status: Active; Type: Allergy; Category: Drug Allergy;

EXHIBIT 6

Consults

Performing Physician:	Performed Date/Time:	Authenticated By:	Authenticated Date/Time:
Gowder MD, Daniel W	8/11/2006 3:15:00 PM	Hendricks MD, C W	8/14/2006 2:35:11 PM

APRV vent setting, 14 respirations. He is slightly febrile with a temperature of 37.9 Celsius.
GENERAL: He is sedated and paralyzed.
ENT: He has no evidence of any facial trauma overtly.
CARDIOVASCULAR: Tachy with no murmur.
RESPIRATORY: He has bilateral rhonchi.
GI: Nondistended, soft.
MUSCULOSKELETAL: There is no swelling. During the exam, he is paralyzed.
SKIN: There is no rash. Multiple tattoos.

LABORATORY DATA: INR is 1.0. CBC shows a hemoglobin of 15.0. BMP significant for a slightly elevated potassium of 5.6 which could potentially be related to a crush injury since the patient was entrapped. He is hypocalcemic slightly at 7.7. He has an anion gap of 5. Cardiac enzymes are negative x3 sets. Phosphorus 2.9. Magnesium is slightly low * 1.4. Chest x-ray shows bilateral air-space opacities. EKGs: Prior to .s episode last night, he had an EKG that showed sinus tach with no significant abnormalities. The rhythm strips do demonstrate multiple PVCs as well as episodes of junctional rhythm as well as potentially some v-tach, although this could represent some sort of tachycardia with some aberrant conductions that potentially was not v-tach at all. It is difficult to say at that point. He did receive 2 precordial thumps last night which apparently led him going back into sinus tach. He never had to be defibrillated. He was taken off the propofol after this and the propofol potentially was a potentiator of this. His 12-lead after this episode did show a sinus tach with a right bundle branch block, some slight ST elevations in V1 and V2 with some slight ST depressions in V3 through V6 with some depressions in II, III, and aVF, which could potentially represent some ischemia the patient had. Overnight, though, his EKG has normalized, and his enzymes were negative overnight.

ASSESSMENT AND PLAN:
1. Episodes of ventricular tachycardia/junctional/premature ventricular contractions with hypotension. He did have 3 sets of negative cardiac enzymes. His EKG is now normal, shows normal sinus rhythm. He does not have any other real risk factors for coronary artery disease. His urine drug screen was positive for amphetamines, and he did have this episode after receiving a bolus of propofol which potentially could have made him go hypotensive and, thus, have some decreased perfusion to his heart causing him to have this arrhythmia. A TTE was attempted but unable to be performed due to poor windows. We have been asked to do a TEE which we will plan to do. At this point, I would not see any reason to start an antiarrhythmic such as amiodarone. Since the patient has had no more arrhythmia, it seems to be logical that this was probably

EXHIBIT 7

EXHIBIT B

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
Phillip Durrett,	)	IN THE FIFTH CIRCUIT
PLAINTIFF,	)	
VS	)	AFFIDAVIT
Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,	)	
DEFENDANT.	)	

RICHLAND COUNTY
FILED
2009 AUG -5 PM 4:43
JEANETTE W. McBRIDE
C.C.P. & G.S.

PERSONALLY APPEARED BEFORE ME, THE UNDERSIGNED, BEING DULY SWORN, SAYS AS FOLLOWS:

1. I represent the Plaintiff Phillip Durrett.

2. The Plaintiff is filing the Notice of Intent, a short plain statement of facts, and Answers to the Standard Interrogatories within ten (10) days of the expiration of the statute of limitations for the injury to Phillip Durrett.

3. Because of time constraints the Plaintiff could not prepare an affidavit of an expert in this case. Further, an affidavit of an expert is not required under the South Carolina Code of Laws § 15-36-100 (C) (2). The Plaintiff will file an expert's affidavit to supplement the filing of a Complaint in this matter within forty five (45) days of the filing of such pleading and a determination by the Court of Common Pleas that such affidavit is required.

Melvin D. Bannister, Esquire

Sworn to before me on
this 4 day of August 2009.

Notary Public for South Carolina
My Commission expires: 7-16-2011

EXHIBIT 8

STATE OF SOUTH CAROLINA)
) IN THE COMMON PLEAS COURT
COUNTY OF RICHLAND) CASE NO.: 09-CP-40-5568

PHILLIP DURRETT,)
Plaintiff,)
vs.)
PALMETTO HEALTH ALLIANCE d/b/a)
PALMETTO RICHLAND MEMORIAL,)
and W. ROSS, M.D.,)
Defendants.)

AFFIDAVIT OF W. ROSS, M.D.

RICHLAND COUNTY FILED
2010 FEB 26 AM 11:06
JEANETTE W. McBRIDE C.C.P. & G.S.

PERSONALLY APPEARED before me William Ross, M.D., who, first being duly sworn, deposes and states as follows:

1. I am a physician licensed to practice medicine in the State of South Carolina.

2. I am a Defendant in the above-captioned matter and have reviewed all of the pertinent medical records from Palmetto Richland Memorial.

3. It is my opinion, to a reasonable degree of medical certainty, that there has been no deviation from the standard of care in this case by any of the Defendants.

4. The subject matter of this lawsuit involves the use and administration of various anesthetic and/or sedative medications as well as contraindications for various anesthetic and/or sedative medications. It is my opinion that the utilization of these medications is not within the common knowledge of the ordinary lay person and expert testimony is required.

[signature] MD
William Ross, MD

SWORN TO before me this 24th
day of February, 2010
[signature]
Notary Public for South Carolina
My Commission Expires: 5/23/2016

EXHIBIT 9

Form 4

STATE OF SOUTH CAROLINA **JUDGMENT IN A CIVIL CASE**

COUNTY OF RICHLAND **CASE NO: 2009CP4005568**

IN THE COURT OF COMMON PLEAS

2011 MAY 25 AM 11:56

JEANETTE W. McBRIDE
C.C.P. & G.S.

FILED

Phillip Durrett *vs.* **Palmetto Health Allia**

Plaintiff Defend

CHECK ONE:

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or hear and a decision rendered.

☐ **ACTION DISMISSED (*CHECK REASON*):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other:

☐ **ACTION STRICKEN (*CHECK REASON*):** ☐ Rule 40(j) SCRCP; ☐ Bankruptcy:
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other: ______________________________

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (*CHECK APPLICABLE BOX*):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other
NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order; ☐ Statement of Judgment by the Court:

Dated at Columbia, South Carolina, this _____ day of ______________, 2011.

____
PRESIDING JUDGE

This judgment was entered on the _______ day of ______________, 2011, and a copy mailed first class this 25th day of May, 2011, to attorneys of record or to parties (when appearing pro se) as follows:

Melvin Dean Bannister
ATTORNEY(S) FOR THE PLAINTIFF(S)

Robert Gerald Chambers, Jr.
ATTORNEY(S) FOR THE DEFENDANT(S)

Jeanette W McBride
Clerk of Court

SCRCP APP-24/FORM 4

STATE OF SOUTH CAROLINA	)	IN THE COMMON PLEAS COURT
	)	
COUNTY OF RICHLAND	)	CASE NO.: 09-CP-40-5568
PHILLIP DURRETT,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	
	)	**ORDER OF DISMISSAL**
PALMETTO HEALTH ALLIANCE d/b/a PALMETTO RICHLAND MEMORIAL, and W. ROSS, M.D.,	)	
	)	
Defendants.	)	

FILED
2011 MAY 25 AM 11:56
JEANETTE W. McBRIDE
C.C.P. & G.S.

This matter came before the Court for oral argument on the motion of Defendants Palmetto Health Alliance d/b/a Palmetto Richland Memorial ("Defendant Hospital") and W. Ross M.D. ("Defendant Ross") (collectively "Defendants") to dismiss the Notice of Intent to File Suit and any claims that have been or could be alleged by Plaintiff Phillip Durrett ("Plaintiff") against Defendants. Present on behalf of Plaintiff was Melvin D. Bannister. Present for Defendants was R. Gerald Chambers, Jr. of Turner Padget Graham & Laney, P.A. The motion was argued before The Honorable L. Casey Manning. After considering the written submissions and argument of the parties, the Court hereby grants Defendants' motion and dismisses this matter for the reasons set forth herein.

FACTUAL AND PROCEDURAL BACKGROUND

Plaintiff initiated this medical malpractice action with the filing of his original Notice of Intent to File Suit ("Original Notice") in the Richland County Court of Common Pleas on August 5, 2009. In his Original Notice, Plaintiff alleged he was transferred to Defendant Hospital shortly after sustaining physical injuries in an automobile accident on August 9, 2006. Original Notice ¶¶ 2-3. Upon arrival, Plaintiff informed Defendants that he was allergic to anesthetic and

sedative drugs and asked that such drugs not be administered to him. Original Notice ¶¶ 5-6. Plaintiff then alleges his warnings to Defendants were disregarded, he was administered said drugs, and as a result he suffered cardiac and respiratory arrest followed by a coma or catatonic like state for approximately nine days. Original Notice ¶¶ 7-10. Plaintiffs also had to receive additional medical treatment and incurred greater expense as a result of Defendants' alleged conduct. Original Notice ¶ 11. Based on these allegations Plaintiff claims Defendants were negligent and thus liable for his damages. Original Notice ¶¶ 12-13. In addition to the Original Notice Plaintiff also submitted an affidavit signed by Plaintiff's attorney, Melvin Bannister, stating that Plaintiff's Original Notice was filed within ten days of the expiration of the statute of limitations for Plaintiff's injuries. Bannister Aff. ¶2. He affirms that time constraints prevented the preparation of an expert affidavit and further that an expert affidavit was not required under the South Carolina Code of Laws section 15-36-100(C) (2) and per the factual allegations of the claim. Bannister Aff. ¶3. Bannister agreed to file an expert affidavit to supplement a Complaint within forty five days of its filing and a determination by the Court that an expert affidavit is required. Id.

For all of the reasons stated in greater detail below, Plaintiff failed to follow the filing requirements for this medical malpractice action by not filing an expert affidavit with the Original Notice. Accordingly, Plaintiff's claims against Defendants are dismissed pursuant to 12(b) (1) and 12(b) (6) of the South Carolina Rules of Civil Procedure.

LEGAL STANDARD

A motion to dismiss on the pleadings based on failure to state a claim and lack of subject matter jurisdiction is the proper vehicle for challenging compliance with the filing requirements of a medical malpractice action. S.C. R. Civ. P. 12(b) (1), 12(b) (6); S.C. Code Ann. §15-36-

100(F). "In considering the motion to dismiss a complaint based on a failure to state facts sufficient to constitute a cause of an action, a trial court must base its ruling solely on allegations set forth in the complaint." Doe v. Marion, 373 S.C. 390, 395, 645 S.E.2d 245, 247 (2007). A Rule 12(b) (6) motion must be sustained where the facts alleged and inferences reasonably deducible therefrom would not entitle plaintiff to relief under any theory of recovery. *Id.*

ANALYSIS

South Carolina law requires Plaintiff to file an expert affidavit contemporaneously with his Notice of Intent to File Suit, this medical malpractice action against Defendants. S.C. Code Ann. §15-79-125(A) (referencing section 15-36-100 for specifications of filing the affidavit). Section 15-36-100(C) (2) provides an exception to this rule: "the contemporaneous filing requirement…is not required to support a pleaded specification of negligence involving subject matter that lies within the ambit of common knowledge and experience, so that no special learning is needed to evaluate the conduct of the defendant." S.C. Code Ann. §15-36-100(C) (2).

Plaintiff wrongly relies on *Hickman v. Sexton Clinic, P.A* to argue that an expert affidavit is not needed to support his cause of action. In *Hickman*, an unsupervised hygienist "ram[med] something sharp into the plaintiff's mouth, causing pain, cutting her tongue and necessitating stitches. 295 S.C. 164, 166, 367 S.E.2d 453 (Ct. App. 1988). The court found that this testimony alone, from the non-expert plaintiff, alleged a sufficient causal connection rising above mere speculation or conjecture that a duty was breached. Id. at 168, 367 S.E.2d 453. Plaintiff's case is not so clear. The complaint alleges that "certain anesthetic and sedative drugs" were administered to Plaintiff, causing cardiac arrest, respiratory arrest, and a coma or catatonic state for approximately 9 days. Pl. Compl. ¶¶7, 9, 10. These conditions are not the same as a sharp object cutting a mouth requiring stitches; the complexities of cardiac arrest, respiratory arrest, a

coma or catatonic state, and the makeup, side effects, dosages, and administration of particular drugs certainly require special learning to evaluate Defendants' conduct as a potential cause of Plaintiff's injuries. Ross Aff. ¶4. Even Plaintiff recognizes this complexity by attaching voluminous and wordy materials to his Return to Motion to Dismiss. Plaintiff's alleged facts do not match *Hickman*. Rather, *Hickman* advocates the necessity of an expert affidavit in this case, where causation is not simple and direct.

Plaintiff also wrongly relies on *Stallings v. Ratliff.* In *Stallings* the plaintiff's malpractice theory was that the doctor breached his duty to inform the plaintiff about the potential risks related to the procedure he performed. 292 S.C. 349, 356 S.E.2d 414 (Ct. App. 1987). In reviewing the case after trial, the Court of Appeals found the *expert* testimony presented by the plaintiff was sufficient enough to go to the jury on the standard of care and that there was a breach of that standard. Id. at 352-54, 356 S.E.2d 414. Plaintiff is correct to state that failure to inform of potential risks can be a basis for a malpractice suit. However, Plaintiff is incorrect to suggest that no expert testimony is needed to make that conclusion. *Stallings* clearly states the opposite, making the decision based on the expert testimony provided. Id.

Furthermore, Plaintiff has failed to provide an expert affidavit within the forty-five day grace period in section 15-36-100(C) (1). When an action is filed within ten days of the statute of limitation expiration and the plaintiff alleges an expert affidavit could not be prepared due to time constraints, the court allows the plaintiff an extra forty-five days from the filing to submit the affidavit. S.C. Code Ann. §15-36-100(C) (1). "Upon motion, the trial court, after hearing and for good cause, may extend the time as the court determines justice requires." Id. Plaintiff's Notice of Intent to File Suit and affidavit were filed August 5, 2009. Plaintiff made no motion

before the court to extend the forty-five day grace period. Again, Plaintiff's claim fails and is dismissed

Lastly, even if the Medical Malpractice Reform Act and its provisions under section 15-79-125 do not apply Plaintiff is still required to file an expert affidavit in compliance with the South Carolina Frivolous Civil Proceedings Sanctions Act, section 15-36-100. Section 15-36-100(B) states, "...in an action for damages alleging professional negligence against a professional licensed by or registered with the State of South Carolina and listed in subsection (G) or against any licensed health care facility...the plaintiff must file as part of the complaint an affidavit of an expert witness which must specify at least one negligent act or omission claimed to exist and the factual basis for each claim." S.C. Code Ann. §15-36-100(B). Subsection (C) again provides the forty-five day grace period. Plaintiff has not complied with either of these provisions.

This case involves issues beyond common knowledge and experience, Plaintiff was required to file an expert affidavit with his Notice of Intent to File Suit. Plaintiff failed to do so and further failed to file such affidavit within the forty-five day grace period; he likewise did not move to request from the Court more than forty-five days to file an expert affidavit. Because he did not comply with these provisions under the Medical Malpractice Reform Act or the South Carolina Frivolous Civil Proceedings Sanctions Act, this Court grants Defendant's Motion to Dismiss.

AND IT IS SO ORDERED.

The Honorable L. Casey Manning
Presiding Judge

Columbia, South Carolina
May 25, 2010

000173

EXHIBIT 10

FORM 4

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

JUDGMENT IN A CIVIL CASE

CASE NO. 2009 -CP- 4005568

Durrett, Phillip

PLAINTIFF(S)

Palmetto Health Alliance, et al

DEFENDANT(S)

Submitted by:	Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

RICHLAND COUNTY FILED
2012 APR -3 AM 11:51
JEANETTE W. McBRIDE C.C.P. G.S.

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other ______

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other ______

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other ______

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☑ See attached order (formal order to follow) ☐ Statement of Judgment by the Court: Motion to Reconsider Granted. Formal order to follow.

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.
Additional Information for the Clerk : ______

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

[signature]
Circuit Court Judge

2261
Judge Code

4-2-12
Date

SCANNED

For Clerk of Court Office Use Only

This judgment was entered on the _________ day of _____________, 20___ and a copy mailed first class or placed in the appropriate attorney's box on this 3 day of April, 2018 to attorneys of record or to parties (when appearing pro se) as follows:

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Jeanette W. McBride
CLERK OF COURT

Court Reporter: ______________________________

SCRCP Form 4C (12/2011)

EXHIBIT 11

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

JUDGME IN A CIVIL CASE

CASE NUMBER: 2009CP4005568

Phillip Durrett

PLAINTIFF(S)

Palmetto Health Alliance
Palmetto Richland Memorial
DEFENDANT(S)

Submitted by:	Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

RICHLAND COUNTY FILED 2013 JAN -8 PM 3:06 JEANETTE W. McBRIDE C.C.P., G.S. & F.C.

DISPOSITION TYPE (CHECK ONE)

☐ JURY VERDICT. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ DECISION BY THE COURT. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ ACTION DISMISSED (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other ____

☐ ACTION STRICKEN (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other ____

☐ DISPOSITION OF APPEAL TO THE CIRCUIT COURT (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other ____

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.

Additional Information for the Clerk : ____

INFORMATION FOR THE PUBLIC INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled
		$
		$
		$

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

Circuit Court Judge ____ Judge Code ____ Date ____

For Clerk of Court Office Use Only

This judgment was entered on the ____ day of ____, 20____ and a copy mailed first class or placed in the appropriate attorney's box on this 8 January 2013 to attorneys of record or to parties (when appearing pro se) as follows:

Melvin Dean Bannister

Robert Gerald Chambers Jr.

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Court Reporter ____

Clerk of Court Jeanette W McBride

SCRCP Form 4C (10/2011)

SCANNED

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS

COUNTY OF RICHLAND)

IN THE FIFTH CIRCUIT

Phillip Durrett,

PLAINTIFF,

VS

Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,

DEFENDANT.

ORDER GRANTING PLAINTIFF'S MOTION FOR RECONSIDERATION
09-CP-40-5568

RICHLAND COUNTY
FILED
2014 JAN -8 PM 3:01
JEANETTE W. McBRIDE
C.C.P., G.S.

This matter came before the Court for a hearing on Plaintiff's Motion for Reconsideration on August 25, 2011.

A review of the status of the case is as follows:

The Plaintiff filed a medical malpractice action against the Defendants by filing a Notice of Intent to File Suit, Statement of Case (Complaint) on August 5, 2009. The Defendants filed a Motion to Dismiss on September 22, 2009. A hearing on Defendants' Motion to Dismiss was heard on March 2, 2010. An Order granting the dismissal of the action was filed May 25, 2010. Plaintiff timely filed a Motion for Reconsideration on June 6, 2011.

Based upon the pleadings, affidavits and supporting documents, and argument of counsel, I find the following:

Upon the commencement of the action, the Plaintiff did not file an affidavit of an expert witness, which would support the allegations of medical malpractice. Instead, Plaintiff's counsel filed an affidavit, which indicated an expert's affidavit was not required under the South Carolina Code of Laws, section 15-36-100 (C) (2). This Court originally

granted the Order of Dismissal based upon Plaintiff's failure to file an expert witness affidavit.

After reconsideration, I find that Order of Dismissal (May 25, 2011) should be vacated.

Pursuant to section 15-79-125 of the South Carolina Code of Laws, I further find that the parties shall participate in a mediation conference within 90 days of this Order. In the event the matter cannot be resolved through mediation, the Plaintiff may file the civil action by filing a summons and complaint.

WHEREFORE, IT IS ORDERED that the Order of Dismissal (May 25, 2011) is hereby vacated.

It is further ordered that the parties shall participate in a mediation conference within 90 days of the execution of this Order.

AND IT IS SO ORDERED.

L. Casey Manning, Judge
Court of Common Pleas for the
Fifth Judicial Circuit

Columbia, South Carolina
7 day of Jan, 2013

EXHIBIT 12

1 STATE OF SOUTH CAROLINA)
: IN THE COURT OF COMMON PLEAS
2 COUNTY OF RICHLAND) Case No. 2013-CP-40-1259
3
PHILLIP SCOTT DURRETT,)
4)
Plaintiff,)
5) **DEPOSITION OF:**
-vs-) PHILLIP SCOTT DURRETT
6)
PALMETTO HEALTH ALLIANCE,)
7 D/B/A PALMETTO RICHLAND)
MEMORIAL, AND W. ROSS,)
8 M.D.,)
)
9 Defendants.)
10
11
12 Given before KATHRYN BOSTROM, Court Reporter and
13 Notary Public at the Office of TURNER PADGET GRAHAM AND
14 LANEY, 1901 MAIN STREET, 17TH FLOOR, COLUMBIA, South
15 Carolina, on WEDNESDAY, MARCH 12, 2014, commencing at
16 1:42 p.m.
17
18
19
20
21
22 RAY SWARTZ & ASSOCIATES OF SOUTH CAROLINA
-Professional Court Reporters-
23
Serving the Legal Community Since 1957
24
1-800-822-8711
25

1 A They took me out the ambulance. I was still begging
2 him to undo the strap on my leg, just the strap on my
3 leg. They could have kept everything else on me, but
4 that was -- it was very, very painful. They rolled me
5 in there and I was still asking -- because they rolled
6 me in, walked off. And I was screaming to undo the
7 strap. And that's when I heard the trauma nurse look
8 over and say -- I guess it was the trauma nurse. All
9 I can tell you is it was a woman. She was standing
10 right by where they brought me in. And she said put
11 him under. And that's when I let loose. If I could
12 have got my knife out of my pocket, the straps
13 would've been off me. I'll tell you right now. I
14 asked to be transferred. I begged them to quit. They
15 held me down and they told me that was oxygen they
16 were giving me. And that's the end of my story right
17 there because that's it. Nobody asked me a question.
18 I was waiting. I figured somebody's going to talk to
19 me. That's what I have a problem with the hospital
20 over right there.
21 Q No oneasked you any questions or spoke with you?
22 A Exactly, okay? And I noticed in the forms, it says I
23 had internal injuries or I was complaining. That's a
24 lie. There was no complaining. I had no bruises in
25 my belly, nothing else. I had a cut on my arm and a

1 broken leg. I was very alert. So I don't know where
2 they got all that information, that supposedly I had
3 internal injuries and stuff, yet they never found any
4 or I was complaining of it because if they say I was
5 complaining of it, they're lying. That's just flat
6 out lie.
7 Q So you read somewhere in here where you allegedly were
8 complaining of internal injuries?
9 A That's yours, but you want to see the one I got,
10 because mines this thick?
11 Q Oh, I've got -- I've got --
12 A Okay. All right. The first sheet says that.
13 Q That you were complaining of internal injury?
14 A Or somebody said I had internal injuries, to check me
15 for it or whatever. I had none. I had no blood
16 coming out of my butt as they said. All this stuff, I
17 had none of that. I had a broken leg and a cut on my
18 arm.
19 Q Did you give them any medical history at all?
20 A I just told you, they didn't ask me any questions.
21 Q Did you have an ID card or anything that showed you
22 would be allergic to morphine --
23 A Sir, I had nothing. Nothing. I was waiting on them
24 to talk to me. I had nothing. I don't have a
25 bracelet, don't have anything on me that tells them

1 holding me down, I'm fighting them, and they're
2 telling me to relax, it's only oxygen, okay? And
3 that's the end of it. I have nothing else to say
4 because I don't know anything else.
5 Q So from the time that they rolled you in to the
6 emergency department to the time you don't have any
7 memory of anything else --
8 A Might have been a minute.
9 Q Okay. And then you don't have any memory for about
10 how long? What's the next thing you remember? Let me
11 put it to you that way.
12 A Waking up with a bunch of tubes in my throat and
13 somebody trying to ask me questions. I'll never
14 forget that part because that's why -- I'll just stop
15 that.
16 Q And do you know when this was? Do you have any idea?
17 A Sir, I didn't even know where I was, anything else
18 when I came to.
19 Q Had you had a surgery on your leg yet?
20 A I guess. I presume. Sir, I was in a coma for, I
21 don't know, two weeks.
22 Q Okay. Well, when you came out of the -- of the coma -
23 -
24 A Oh, yes. I thought I had surgery on it because I was
25 bandaged up pretty good. And -- but I had, like I

1 only two comments you recall before you were
2 unconscious, was the nurse saying to put him under and
3 someone telling you to -- saying relax, --
4 A Yes, sir.
5 Q -- it's only oxygen.
6 A That's the only two comments I remember. I was pretty
7 much doing some yelling.
8 Q Do you know who Dr. Ross is?
9 A Huh-uh.
10 Q No?
11 A I know some of them came in and talked to me after I
12 came out of it, but I couldn't tell you who did what.
13 I think the surgeon talked to me. Don't remember. Is
14 Dr. Ross a male or a female?
15 Q Male.
16 A I have no idea. I talked with three or four of them,
17 so.
18 Q But you don't know specifically who he is? You don't
19 know why --
20 A I don't remember.
21 Q You don't know what he did --
22 A No, sir. Couldn't tell you. Why? Did he supposedly
23 have a conversation with me?
24 Q I'm just trying to find out.
25 A I'm just asking. I'm just asking? I don't know.

1 while you could talk to them?
2 A Yes, sir. It was probably the day before or two days
3 before I got out.
4 Q And tell me about that conversation.
5 A I couldn't tell you what it was about, which ones I
6 know came in and they told me what they did to me and
7 stuff like that. And I couldn't tell you what they
8 even said. I'm just telling you up front.
9 Q You don't have any memory?
10 A I know I thanked whoever it was because I mean, hell,
11 I was still alive, so somebody did something. All I
12 know is I wasn't dying when I got brought in there,
13 from what I was told being in the -- my heart stopping
14 and everything else, it sounded like I died while I
15 was there though. So --
16 Q Were you given any explanation why your heart stopped?
17 A Huh-uh. I didn't even know I got paddled until I read
18 it.
19 Q Okay. So it's your understanding you got paddled?
20 A Well, whatever started me again. I'm guessing that's
21 what it was. I asked somebody what that meant and
22 that's what they told me, so.
23 Q Who did you ask?
24 A Nobody that's a doctor, trust me.
25 Q Okay. So you remained unconscious the entire time

1 while you were -- up until the time your leg was had
2 your surgery?
3 A No, sir. I was unconscious through the surgery. From
4 what I understand, they didn't do my leg surgery for
5 days and when I didn't come to for 13 or 14 days,
6 whatever the time frame there was. When you're
7 unconscious, you don't know. I mean, I didn't even
8 know I'd been in a coma. I thought maybe it just
9 happened. I don't know. There's no answer for you
10 there.
11 Q Okay.
12 A I know they weren't concerned about me having a broken
13 leg or they would have taken the damn strap off me.
14 Q And did anyone ever explain to you the reason why you
15 were unconscious for so long?
16 A No, sir. Nobody even explained I had a heart problem
17 in there. See, that kind of baffles me through all
18 this, why I didn't get more explanation.
19 Q And you don't remember the name of any physicians or
20 your nurses that you spoke with; is that right?
21 A Yes, sir. I know I had one guy in there that I'd made
22 a mess in the bed a couple times and I felt sorry for
23 him because he had to clean me up each time, but I
24 don't even know his name. I think I was probably in
25 there a few more days than one or two after I came to,

1 period?
2 A I don't know. Not very often. I mean, not, like,
3 three, four days in a row or anything like that. No.
4 But I can -- you can rest assured, I was going to tell
5 the doctor because that was why I was waiting on him,
6 to talk to him. I know better. With the problems
7 I've had, I don't hide nothing from a doctor. God, I
8 ate a bunch that morning, too.
9 Q So you don't recall giving any medical history at all
10 to anyone?
11 A None. None.
12 Q To EMS or the hospital?
13 A Nobody. I believe it would have been a whole
14 different story if they hadn't have put the strap
15 across my leg. I'll tell you that.
16 Q After you got out of the hospital, did you have to
17 have any of the follow-up medical care as a result of
18 your broken leg or anything else?
19 A I went to a rehab doctor or something over there once,
20 maybe twice. They told me what I needed to do and
21 kind of heal up as quick as I can, so I spent a month
22 in a wheelchair. And I was on a walker even though
23 they wanted me to stay in the wheelchair, so.
24 Q How long were you on the walker?
25 A Good God. That was horrible. Probably three or four

1 me under. It wasn't a male.
2 Q I'll let you talk to your attorney about that after --
3 after we're done.
4 A Okay. Well, I don't think we even know who the female
5 is.
6 MR. CHAMBERS: I'll let you take a quick break.
7 I think I'm almost done. Let me just take a
8 quick break. I've got to go make a quick
9 telephone call, guys, but I'll be right back.
10 (Off the record)
11 BY MR. CHAMBERS:
12 Q It'd be fair to say that you're not sure what
13 medications you were given at Richland, are you?
14 A I have no idea. My getting sick from that stuff like
15 that is kind of hard to research. I mean, --
16 Q Sure.
17 A -- to me it is anyway. I don't know --
18 Q And do you recall telling anyone from the EMS crew or
19 anyone at the hospital that you were allergic to
20 anesthetic drugs?
21 A No, sir. Huh-uh. I know I was conscious enough. I
22 was waiting on somebody to talk to me at the hospital.
23 I was, you know -- and getting that strap off my leg.
24 Q And you never told them of any allergies that you had?
25 A Not that I know of. No, sir. I really don't think

EXHIBIT 13

1 STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
) NINTH JUDICIAL CIRCUIT
2 COUNTY OF CHARLESTON)
3 PHILLIP DURRETT,) CASE NO. 09-CP-40-05563
)
4 Plaintiff,)
)
5 v.) DEPOSITION OF:
) ROBERT CLODFELTER, M.D.
6 PALMETTO HEALTH ALLIANCE,)
d/b/a PALMETTO RICHLAND)
7 MEMORIAL, & W. ROSS, M.D.,)
)
8 Defendants.)
)
9
10
11 Given before Christine Mullinax, Court Reporter and
12 Notary Public, at the library at Hilton Head Hospital,
13 located at 25 Hospital Center Blvd., Hilton Head, South
14 Carolina, 29926, on Wednesday, June 11, 2014,
15 commencing at 12:06 p.m.
16
17
18
19
20
21 RAY SWARTZ & ASSOCIATES OF SOUTH CAROLINA
-Professional Court Reporters-
22 Serving the Legal Community Since 1957
1-800-822-8711
23 Beaufort Camden Charleston Columbia
24 Florence Greenville Greenwood Hilton Head
Lexington Myrtle Beach Newberry Orangeburg
25 Spartanburg Summerville Sumter West Columbia

1 A. I went to medical school at the University of
2 South Florida in Tampa. And following that, went to
3 residency in emergency medicine in Dayton, Ohio, at
4 White State University; completed that program in 1983.
5 I've been practicing emergency medicine
6 full-time ever since; currently the medical director of
7 the emergency department here. I've been in this
8 emergency department for 17 years.
9 Q. All right, sir. Thank you. Board certified?
10 A. That is correct.
11 Q. And that's in emergency medicine?
12 A. In emergency medicine.
13 Q. What have you reviewed as far as documents in
14 reference to this action?
15 A. I have in front of me two binders with medical
16 records of the hospitalization and the EMS run prior to
17 the hospitalization for patient, Phillip Durrett.
18 Q. Should a doctor be aware of the dosages and
19 warnings on medications before ordering them for a
20 patient?
21 A. Yes.
22 Q. What medications was ordered for Mr. Durrett,
23 his entry into the emergency room?
24 A. There were a sequence of medications that were
25 given to the patient because of the need to secure his

1 cooperation and airway. And as a result of that, the
2 trauma team elected to perform rapid sequence
3 intubation, a technique that employs a number of
4 different medications.
5 So, in this case, they gave to Mr. Durrett
6 Ativan and Norcuron to facilitate intubation.
7 Q. How much was given to him over what period of
8 time?
9 A. Of those specific agents, or of everything that
10 was given?
11 Q. Well, at least those two to begin with.
12 A. To start with, the patient was given
13 10 milligrams of Norcuron, a paralytic agent, with
14 2 milligrams of Ativan. He was then put on an Ativan
15 drip later once he was sedated.
16 Q. When was he sedated?
17 A. Soon after his arrival in the emergency
18 department. He arrived in a combative, uncooperative
19 mode, and the team felt that he needed to be sedated
20 and intubated in order to prevent harm to himself or
21 others, and also to facilitate the need for a very
22 rapid trauma assessment, including imaging such as CT
23 scans.
24 Q. What time he did arrive at the hospital?
25 A. On the 9th of August, 2006, it is first noted on

1 A. Well, in terms of medications and substances, he
2 admitted using Methamphetamine that day before getting
3 in the car crash that was found in a toxicology urine
4 drug screen that day --
5 Q. But that --
6 A. He gave the allergy report that he was allergic
7 to morphine and codeine, and that is documented on the
8 chart.
9 Q. Okay. When did he give the history concerning
10 the use of Methamphetamine?
11 A. That was documented later in the evaluation, and
12 I can give you a specific date, if you would like?
13 That was on the 21st of August, 2006, as per a note
14 that was documented on the record at 10:25 a.m.
15 Q. When did he give the history of the allergies to
16 morphine and?
17 A. Morphine and codeine?
18 Q. Codeine, yes?
19 A. That was documented on the initial record in the
20 emergency department on the 9th of August.
21 Q. And who gave that history to medical personnel?
22 A. It's not noted. It could have been the patient
23 or the paramedics.
24 Q. Was there any contact between the paramedics and
25 hospital personnel prior to Mr. Durrett's arrival at

1 earlier in the day of his accident.
2 Q. Was it earlier the day of the accident? Or was
3 it?
4 A. I will quote this, if you don't mind. Quote, *he*
5 *admits to trying some Ice at a party the day of the*
6 *accident*, end quotes.
7 Q. May I see that page just for a second?
8 A. (Witness complied.)
9 Q. Do you know who wrote there as far as actually
10 penned it on paper?
11 A. I can tell you that there's a signature that I
12 can't discern. He didn't print the name under the
13 signatures, so I can't really tell you exactly who
14 signed this. It looks like there may be two signatures
15 here. That might be that, an attending physician. I
16 can't say.
17 Q. And on that note, there is -- and where you
18 quoted --
19 A. Yes.
20 Q. -- is it stricken through, *the day before*?
21 A. Yes, as if omitted.
22 Q. Okay. Would the Methamphetamine have any action
23 or counteraction or relation to the drugs that were
24 given to him in the emergency room?
25 A. Presence of Methamphetamine in the system could

1 potentially interact adversely with everything and
2 anything that is given to the patient during his
3 treatment.
4 Q. What symptoms would Mr. Durrett have had from
5 the use of the Methamphetamine?
6 A. Typically, agitation and combativeness, change
7 in mental status, cardiac dysrhythmias are possible,
8 tachycardia, are some of the more common effects of
9 that class of medications.
10 Q. And so, he would have been suffering these prior
11 to the accident?
12 A. He could, yes.
13 Q. And if he wasn't, does that mean that he would
14 not have had an interaction with the drugs provided to
15 him at the hospital?
16 A. Well, because we have on the chart -- they had
17 on the chart a positive urine drug screen with
18 methodology that with you finding or detecting
19 Methamphetamine, it means it's been in recent use
20 because the metabolism of amphetamines are such that we
21 don't find it in the urine, for example, the day after
22 use or days beyond that.
23 So, it's one of the agents that is not
24 detectable, unlike marijuana which you can detect for
25 days and days after use. Certain agents like cocaine

1 and amphetamines are not in the system a day later.
2 Q. Did the EMS employees relate any history to
3 medical personnel at the hospital as to how the
4 accident happened?
5 A. It is not on their documentation. So, unless
6 you were able to find a copy of the transmission, the
7 actual report that is by telemetry from the paramedics
8 to the ED, I can't comment on the details of what they
9 may have transmitted.
10 Q. And was there anything in the notes about any
11 oral report by the EMS personnel after they arrived at
12 the emergency room?
13 A. Again, all I can comment is on what is
14 documented on the EMS report and the ED chart. So, I
15 don't know the extent of the conversation beyond what
16 is documented.
17 Q. Was there any video of the emergency room
18 treatment performed at the hospital?
19 A. There's no indication in the chart that there
20 was any videotaping of anything.
21 Q. Is that a normal process to video treatment of
22 emergency room patients?
23 A. No, it's not.
24 Q. Do you know if Richland, Palmetto Health
25 Richland has employed the video process in the past?

1 with a specific date.
2 Q. That's okay. We'll, if we need to get back to
3 that. What drug or drugs were used to intentionally
4 keep Mr. Durrett in this state?
5 A. Are you talking about after the initial
6 induction, or later?
7 Q. To keep him in this intentional state, whether
8 you want to call it sedated state or coma?
9 A. Primarily, the agent used was Ativan by
10 continuous drip.
11 Q. And that is also used in the emergency room?
12 A. That is correct.
13 Q. Is that what caused him to be sedated, or was it
14 a combination of all the drugs that was given to him at
15 the emergency room?
16 A. Some of the medications -- two of the
17 medications did not have any sedative effect, yet put
18 him in a state of his muscles being paralyzed to
19 facilitate intubation. That was the succinylcholine
20 and Norcuron. The Ativan was the sedative agent,
21 followed by Propofol and later, analgesics were added
22 such as Dilaudid to help with pain management that
23 would also lead to sedation.
24 Q. The paralyzing agents, those were the Norcuron
25 and the Anectine?

1 A. Correct.
2 Q. Would either of those or a combination of those
3 cause Mr. Durrett's heart problems?
4 A. There's no indication of that.
5 Q. What caused Mr. Durrett's heart problems?
6 A. I think it was the combination of the
7 amphetamines in his system followed by a drop in his
8 blood pressure. That is echoed by a cardiologist who
9 consulted and said the same thing, and I agree with
10 that.
11 Q. Did Mr. Durrett's heart suffer any damage?
12 A. No indication of that per serial cardiac
13 enzymes, transesophageal echocardiogram, and repeat
14 EKGs.
15 Q. Does a heart regenerate?
16 A. That's a difficult question to answer. You can
17 have development of clavicle circulation after
18 infarction, for example, which would mean, yes. But
19 generally speaking, heart muscle lost is heart muscle
20 lost.
21 Q. Did Mr. Durrett have a heart attack while he was
22 in the hospital?
23 A. No indication of that.
24 Q. What was his cardiac problems?
25 A. I believe his cardiac problems were related to

1 dysrhythmia, which means an abnormal cardiac rhythm due
2 to hypotension and the effects of amphetamines.
3 Q. Why was Mr. Durrett kept in the intentional
4 sedation state?
5 A. Because, in part, of the problems that he had
6 with his lungs following aspiration and the result in
7 pneumonitis.
8 Q. Any other drugs provided to Mr. Durrett to help
9 clear up these problems while he was under sedation?
10 A. Yes, he was given antibiotics to help with the
11 pneumonitis that occurred.
12 Q. Approximately how many times have you given your
13 deposition in medical cases?
14 A. I would estimate eight times in total.
15 Q. And have you ever testified on behalf of a
16 plaintiff?
17 A. I have not.
18 Q. Have you ever been retained by plaintiff's
19 attorney or a plaintiff?
20 A. I have never been asked to review or participate
21 in a case from a plaintiff's standpoint.
22 Q. Is this a teaching hospital here?
23 A. No, it is not.
24 Q. And are you an employee of the hospital here?
25 A. No, I am not.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF RICHLAND	)	Civil Action No.: 2013-CP-40-01259

Phillip Durrett,	)	
Plaintiff,	)	
vs.	)	**MOTION TO RECONSIDER**
Palmetto Health Alliance d/b/a Palmetto Richland Memorial and W. Ross, M.D.,	)	
Defendants.	)	

RICHLAND COUNTY FILED
2014 DEC 18 PM 3: 23
JEANNETTE W. McBRIDE C.C.P. & G.S.

Pursuant to Rule 59(e) of the South Carolina Rules of Civil Procedure, Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial ("Palmetto Health") hereby moves the Court to reconsider the denial of Palmetto Health's motion for summary judgment regarding Plaintiff's medical malpractice claims for the following reasons:

1. The Order erroneously concludes that there exists an issue of material fact for trial.

2. The Order erroneously concludes that Palmetto Health's motion was "based mainly on [its] argument that Plaintiff was required . . ." an expert affidavit prior to the filing of Plaintiff's Complaint. In point of fact, Palmetto Health's motion also addressed the dearth of record evidence supporting Plaintiff's medical malpractice claims.

3. The Order erroneously misapplies the holdings in recently decided decisions by the South Carolina Supreme Court to conclude Plaintiff successfully invoked the "common knowledge" exception codified at S.C. Code Ann. § 15-36-100(C)(2) and that Plaintiff was not required to file an expert witness affidavit.

4. The Court erroneously relied upon the self-serving affidavit of Plaintiff to support a finding that Plaintiff informed Palmetto Health staff members of his alleged allergy to anesthetic drugs, particularly no other record evidence supports Plaintiff's contention that such an exchange actually occurred.

5. The Court erroneously relied upon the self-serving affidavit of Plaintiff to conclude that Palmetto Health staff were unaware of or ignored "material/instructions for the provision of certain drugs to the Plaintiff. . . ." Moreover, Plaintiff is not qualified by education, training, or experience to make this unsupported allegation.

6. The Court erroneously relied upon Plaintiff's allegation that Palmetto Health was negligent in providing certain drugs against his instructions, failing to monitor Plaintiff, and in overdosing Plaintiff. These allegations are not supported by record evidence beyond Plaintiff's self-serving allegations, and Plaintiff is not medically qualified to make these allegations.

7. The Court erred, as a matter of law, in concluding that expert testimony is not necessary in this case to aid the trier of fact in understanding the proper administration of anesthetic medications, how those medications are designed to work, and how those medications interacted with the illegal narcotics present in Plaintiff's bloodstream at the time of his admission to the emergency room.

8. The Court erred in refusing to grant summary judgment as to Plaintiff's allegations that Palmetto Health failed to monitor Plaintiff or to inform him of the potential side effects of certain medications where those speculative and conjectural allegations are not supported by any record evidence, effectively applying the more lenient Rule 12 standard rather than the "genuine issue" standard imposed by Rule 56, SCRCP.

9. The Court erred as a matter of law ruling that "[t]he administration of said [anesthetic] drugs caused the Plaintiff to suffer cardiac and respiratory arrest and to induce a coma" where those assertions are not supported by any expert evidence. In fact, the only expert to testify in this matter unequivocally testified that Plaintiff's cardiac and respiratory issues resulted from an interaction between medications administered by Palmetto Health and the undisclosed and illegal narcotics already present in Plaintiff's bloodstream.

10. The Court erred as a matter of law in ruling that an "individual with common knowledge and experience" is aware of the possible side effects of the medications administered in the care and treatment of Plaintiff.

11. The Court erroneously concluded that Plaintiff "has evidence" to support his claims when, in point of fact, the only support for Plaintiff's claims is derived from his own self-serving allegations.

12. The Court erroneously concluded that Plaintiff's Complaint was filed in a timely manner.

13. The Court erroneously concluded that the prior order granting Plaintiff's motion for reconsideration constitutes the "law in this case" where that order was interlocutory and, therefore, not subject to immediate appellate review.

Based upon these submissions, along with all relevant statutory and common law authority, Palmetto Health respectfully moves the Court to reconsider that its Order denying summary judgment on each of Plaintiff's medical malpractice claims against Palmetto Health. Palmetto Health's counsel further certifies that consultation with opposing counsel would serve no useful purpose.

(Signature page to follow.)

TURNER, PADGET, GRAHAM & LANEY, P.A.

December 18, 2014

By: ______________________________

R. Gerald Chambers, Jr.
Carmelo B. Sammataro
Post Office Box 1473
Columbia, SC 29202
Phone: (803) 254-2200
Fax: (803) 799-3957

ATTORNEYS FOR DEFENDANT PALMETTO HEALTH ALLIANCE D/B/A PALMETTO RICHLAND MEMORIAL

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF RICHLAND	)	Civil Action No.: 2013-CP-40-01259
Phillip Durrett,	)	
Plaintiff,	)	
vs.	)	**MEMORANDUM OF PALMETTO HEALTH ALLIANCE d/b/a PALMETTO RICHLAND MEMORIAL IN SUPPORT OF ITS MOTION TO RECONSIDER**
Palmetto Health Alliance d/b/a Palmetto Richland Memorial and W. Ross, M.D.,	)	
Defendants.	)	

RICHLAND COUNTY FILED
2016 JAN 15 11:09
JEANETTE W. McBRIDE C.C.P. & G.S.

Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial ("Richland Memorial") submits this memorandum in support of its motion to reconsider the denial of summary judgment in its favor.

FACTUAL BACKGROUND

Plaintiff Phillip Durrett ("Durrett") sustained physical injury in a multi-vehicle collision that occurred August 7, 2006. Specifically, Durrett, who was cited for driving too fast for conditions, failed to observe the flashing lights of an ambulance parked in the eastbound median of Interstate 20 to assist another motorist, struck the ambulance in the rear, and became entrapped in his own vehicle for approximately 15-20 minutes. (August 7, 2006 South Carolina Traffic Collision Report Form (Ex. 1 to Def.'s Mot. for Summ. J.)) Durrett sustained "incapacitating injuries", was extricated from his vehicle, and transported from the scene by paramedics with Richland County EMS. (*Id.*; DHEC Patient Care Form (Ex. 2 to Def.'s Mot. for Summ. J.)) According to the DHEC Patient Care Form, Durrett was agitated but remained stable during transport to Richland Memorial. (Ex. 2 to Def.'s Mot. for Summ. J.) No medications other than saline were administered.

According to Richland Memorial Emergency Department documentation, Durrett was "awake, alert, and oriented . . . upon arrival" in the ER, displayed a "very aggressive, violent nature", and "was on a back board and C-collar, complaining of left leg pain." (August 9, 2006 record (PRMH 0497-98) (Ex. 3 to Def.'s Mot. for Summ. J.)) He denied tobacco, alcohol, or illicit drug use[1] and indicated to hospital personnel that he is allergic to Morphine. (*Id.*) During examination, Durrett "was verbal, cussing, noncompliant, and very uncooperative." (*Id.*) For his protection, and to facilitate his medical examination, Durrett was sedated, intubated, examined, and prepped for further radiologic studies to confirm initial impressions of left leg fracture and abdominal injuries. (*Id.*) During his course of treatment in the Emergency Department, Durrett was started on propofol, became hypotensive, and underwent two precordial thumps[2] prior to returning to sinus tachycardia. (August 10, 2006 Consult (PRMH 0501) (Ex. 4 to Def.'s Mot. for Summ. J.)) Durrett remained at Richland Memorial until his discharge on August 23, 2006. (August 21, 2006 Progress Note and Discharge Summary (PRMH 00513-515) (Ex. 5 to Def.'s Mot. for Summ. J.))

In his Notice of Intent filed August 5, 2009, Durrett alleged Defendant Richland Memorial and others were negligent in disregarding his instructions and administering "certain (unspecified) anesthetic and sedative drugs" to him in the emergency room, which caused him to go into cardiac arrest. (Notice of Intent, ¶¶ 7-12) These allegations are repeated essentially *verbatim* in Durrett's Complaint filed February 28, 2013. (Plaintiff's Compl., ¶¶ 6-8) Defendants filed their Answer on or about June 24, 2013, in which they asserted a general denial

---

[1] Durrett's urine drug screen was positive for amphetamines. (August 11, 2006 Consult Note (PRMH 0502) (Ex. 6 to Def.'s Mot. for Summ. J.))

[2] "Hypotensive" refers to abnormally low blood pressure. "In a precordial thump, a provider strikes with a single blow of the fist to the middle of a persons [sic] sternum. The intent is to interrupt a potentially life-threatening rhythm." http://en.wikipedia.org/wiki/Precordial_thump (last accessed July 16, 2014).

and numerous substantive defenses, including expiration of the statute of limitations, comparative fault, and Durrett's failure to file the required expert affidavit. (Defs.' Answer, ¶¶ 1, 6, 14, and 15)

LEGAL STANDARD

1. Rule 59(e)

The South Carolina Supreme Court has held that "it is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court 'alter or amend the judgment,' but also a vehicle to seek 'reconsideration' of issues and arguments. . . . Consequently, a party usually is allowed to ask the court to reconsider its decision even if it means rehashing all or part of an argument previously presented." *Elam v. S.C. DOT*, 361 S.C. 9, 22, 602 S.E.2d 772, 778-779 (2004).

2. Summary Judgment

South Carolina jurisprudence makes clear that in medical malpractice actions such as this, summary judgment "is appropriate when there is no genuine issue of material fact such that the moving party must prevail as a matter of law." *David v. McLeod Regional Medical Center*, 367 S.C. 242, 626 S.E.2d 1 (2006) (citing SCRCP 56(c)). In order to establish a genuine issue of material fact, Plaintiff must adduce evidence demonstrating "(1) the generally recognized and accepted practices and procedures that would be followed by average, competent practicioners in the defendants' field of medicine under the same or similar circumstances, and (2) that the defendants departed from the recognized and generally accepted standards." *Id.*, 367 at 248-247, 626 S.E.2d at 4 (citing *Pederson v. Gould*, 288 S.C. 141, 143-144, 341 S.E.2d 633, 634 (1986) (additional citation omitted)). Further, Plaintiff must establish that the breach of the applicable standard of care proximately caused his injuries and damages. *Id.* (citing *Green v. Lilliewood,* 272 S.C. 186, 193, 249 S.E.2d 910, 913 (1978)).

000208

Plaintiff also must "provide expert testimony to establish both the required standard of care and that defendants' failure to conform to that standard, unless the subject matter lies within the ambit of common knowledge so that no special learning is required to evaluate the conduct of the defendants." *Id.*, 367 S.C. at 248, 626 S.E.2d at 4 (citing *Pederson*, 288 S.C. at 143, 341 S.E.2d at 634). In recognition of these requirements, the South Carolina General Assembly has seen fit to impose the requirement that plaintiffs in medical malpractice actions must, prior to the filing of a summons and complaint, file a "Notice of Intent to File Suit and an affidavit of an expert witness, subject to the requirements established in Section 15-36-100. . . ." S.C. Code Ann. § 15-79-125(A); *see also* S.C. Code Ann. § 15-36-100.

ARGUMENT

I. PLAINTIFF'S NOTICE OF DISMISSAL AND COMPLAINT ARE SUBJECT TO SUMMARY DISMISSAL GIVEN HIS FAILURE TO FILE THE TIMELY AFFIDAVIT OF AN EXPERT WITNESS AS REQUIRED BY APPLICABLE STATUTORY PROVISIONS.

The legal issues in this case are simple. Durrett's case is subject to dismissal because he did not file the affidavit of an expert witness in support of his Notice of Intent to File Suit or his Complaint, which is an absolute prerequisite to the filing or initiating of a civil action alleging injury as a result of medical malpractice. *See* S.C. Code Ann. 15-79-125(A) ("Prior to filing or initiating a civil action alleging injury or death as a result of medical malpractice, the plaintiff shall contemporaneously file a Notice of Intent to File Suit and an affidavit of an expert witness. . . ."). Instead, he relied upon the affidavit of his attorney, which expressly relied upon inapplicable provisions of S.C. Code Ann. 15-36-100(C)(2) in an attempt to excuse his failure to comply with the mandatory affidavit requirement. As such, Durrett's Notice of Intent to File Suit was procedurally defective, and his claims are barred by the statute of limitations. Even assuming, without conceding, that Durrett's claims are procedurally viable, he has adduced no

competent evidence establishing a genuine issue for trial. As such, summary judgment is appropriate.

A. Procedural Background

Durrett filed his Notice of Intent to File Suit pursuant to S.C. Code Ann. § 15-79-125 on or after August 5, 2009. In that Notice of Intent, Durrett alleged he sustained injuries and damages during his course of medical treatment at Richland Memorial following his August 9, 2006 automobile accident. Of particular relevance here, Durrett alleges the administration of certain medications by Richland Memorial personnel cause him to go into cardiac arrest, thereby causing him to sustain injuries and damages.

Durrett's Notice of Intent did not include the affidavit of an expert witness as required pursuant to S.C. Code Ann. § 15-79-125(A). Instead, Durrett submitted the Affidavit of his attorney, Melvin Bannister ("Bannister"), and contended that he was not required to submit an affidavit in light of the provisions of S.C. Code Ann. § 15-36-100(C)(2) (excusing the contemporaneous filing of an affidavit with the complaint "to support a pleaded specification of negligence involving subject matter that lies within the ambit of common knowledge and experience, so that no special learning is needed to evaluate the conduct of the defendant."). In his Affidavit, Bannister acknowledged Durrett's notice was filed within ten days of expiration of the statute of limitations and pledged to "file an expert's affidavit to supplement the filing of a Complaint in this matter within forty five (45) days of the filing of such a pleading and a determination by the Court of Common Pleas that such an affidavit is required." (Bannister Aff. (Ex. 7 to Def.'s Mot. for Summ. J.), p. 2, ¶ 3) Durrett never filed the affidavit required by §15-79-125(A) (Notice of Intent to File Suit) or the affidavit contemplated by § 15-36-100 (complaint alleging professional negligence).

Defendants filed a motion to dismiss Durrett's Notice of Intent pursuant to S.C. Code Ann. §§ 15-79-125 and 15-36-100, as well as Rules 12(b)(1) and 12(b)(6), SCRCP, on or after September 22, 2009. Defendants' motion was based upon: (a) Durrett's failure to follow the statutory conditions precedent to the filing of a medical malpractice action as set forth in § 15-79-125; and (b) Durrett's failure to provide an expert affidavit within 45 days of the filing of a complaint as provided for in § 15-36-100(C). Defendants supported their motion with the Affidavit of William Ross, M.D., who opined to a reasonable degree of medical certainty, and without contradiction, that Defendants did not deviate from the applicable standard of care and that administration of the types of drugs at issue in Durrett's Complaint "is not within the common knowledge of the ordinary lay person and expert testimony is required." (Aff. of W. Ross, M.D., (Ex. 8 to Def.'s Mot. for Summ. J.), ¶¶ 3-4)

The Court of Common Pleas for Richland County filed its order dismissing Durrett's Notice of Intent to File Suit on May 25, 2011. In its order, the court rightly concluded this case involves complex interactions with drugs allegedly resulting in cardiac arrest and other medical complications. (May 25, 2011 Order (Ex. 9 to Def.'s Mot. for Summ. J.), pp. 3-4) Further, the court concluded Durrett ran afoul of S.C. Code Ann. §§ 15-36-100(C)(1) and 15-79-125(A) because he did not file a timely expert affidavit in support of medical malpractice allegations. (*Id.*, pp. 4-5) Durrett moved for reconsideration, and, via Form 4 Order filed April 3, 2012, the court ruled the "[m]otion to reconsider granted. Formal order to follow." (April 3, 2012 Form 4 Order (Ex. 10 to Def.'s Mot. for Summ. J.)) In an order filed nearly 18 months later – on January 8, 2014 – the court noted that "after consideration," the earlier order should be vacated but provided no additional discussion or analysis of the substantive issues presented. (January 8, 2014 Order (Ex. 11 to Def.'s Mot. for Summ. J.), p. 2) Further, the court determined, pursuant to

§ 15-36-100(C)(2), that no affidavit was required because Durrett's claims fell within the ambit of common knowledge and ordered the parties to engage in mediation. (*Id.*, pp. 1-2)

Durrett filed his Summons and Complaint on or after February 28, 2013, in which he largely re-asserted the allegations set forth in the Notice of Intent. Defendants answered with a general denial and asserted numerous substantive defenses, including expiration of the statute of limitations, comparative fault, and Durrett's failure to file the required expert affidavit.

B. Legal Analysis

Section 15-79-125(A) addresses the notice of intent as a prerequisite to filing an action for medical malpractice and requires the plaintiff to file, contemporaneously with his notice of intent, "an affidavit of an expert witness, subject to the affidavit requirements[3] established in Section 15-36-100 . . . ." Turning to Section 15-36-100, that provision sets forth certain requirements for complaints alleging professional negligence and the requirement that such complaints be supported by the contemporaneously filed affidavit of an expert witness. Specifically, Section 15-36-100(B) makes clear that "in an action for damages alleging professional negligence against . . . any licensed health care facility . . . the plaintiff must file as part of the complaint an affidavit of an expert witness which must specify at least one negligent act or omission claimed to exist and the factual basis for each claim based on the available evidence at the time of the filing of the affidavit." Subsection (C)(1) affords plaintiffs an additional 45 days to file the required affidavit where "the period of limitation will expire, or there is a good faith basis to believe it will expire on a claim stated in the complaint, within ten days of the date of filing and, because of the time constraints, the plaintiff alleges that an affidavit of an expert could not be prepared." Subsection (C)(2) excuses the contemporaneous

[3] These requirements are set forth in § 15-36-100(A)(1)-(3) and address issues such as, but not necessarily limited to, licensure and other relevant credentials and experience.

affidavit requirement where the alleged negligent act or omission involves subject matter that lies with the ambit of common knowledge and experience. Finally, Subsection (D) makes clear that "[t]his section does not extend an applicable period of limitation . . . ." absent an exception that does not apply in this case.

Durrett failed to file an affidavit of any expert as required pursuant to the statutory provisions addressed in the preceding paragraph. As such, his Notice of Intent to File Suit and Complaint are subject to summary dismissal, and the statute of limitations bars him from seeking recovery against Richland Memorial. To the extent Durrett relies upon *Ranucci v. Crain*, 409 S.C. 493, 763 S.E.2d 189 (2014) or *Grier v. AMISUB of South Carolina, Inc.*, 397 S.C. 532, 725 S.E.2d 693 (2012), to compel a different result, his reliance is misplaced. *Ranucci* addressed the interplay between §§ 15-79-125 and 15-36-100 at the *pre-suit* phase and affirmed the legislative intent that those provisions be read in harmony. *Grier* addressed (and rejected) the contention that the expert affidavit plaintiff's *pre-suit* expert affidavit is required to contain an opinion as to proximate cause. Unlike Durrett, the plaintiffs in both of those cases ultimately proffered the affidavit of an expert witness to bolster their medical malpractice claims.

Inasmuch as Durrett failed to comply with the clear requirements of S.C. Code § 15-79-125(A) by filing the required affidavit contemporaneously with his Notice of Intent or at any point thereafter, Durrett's filings are procedurally defective and should be dismissed. The Bannister Affidavit, does nothing to change this result. Thus, given the procedural defects in Durrett's Notice of Intent to File Suit, combined with the passage of time, this Court should dismiss Durrett's Notice of Intent to File Suit and Complaint, and dismiss this matter with prejudice as barred by the statute of limitations.

II. DEFENDANT IS ENTITLED TO SUMMARY JUDGMENT ON THE ADDITIONAL BASIS THAT PLAINTIFF HAS FAILED TO ADDUCE ANY COMPETENT EVIDENCE DEMONSTRATING A GENUINE ISSUE OF MATERIAL FACT FOR TRIAL.

In addition to Durrett's failure to file the affidavit of an expert witness, Richland Memorial is entitled to summary judgment given Durrett's failure to adduce any competent evidence, expert or otherwise, demonstrating an issue of fact for trial. Specifically, Durrett has not come forward with any evidence to support the allegations in his Complaint that agents of Richland Memorial disregarded his instructions, administered "anesthetic and sedative drugs" to which he claimed to be allergic, and that the administration of these unspecified "anesthetic and sedative drugs" caused him to sustain injuries and damages. (Plaintiff's Compl., ¶¶ 6, 8, 12-15) To the contrary, the only medical evidence of causation in this case demonstrates that Durrett's alleged injuries and damages stem from the interaction of medically necessary medications with the illegal methamphetamine that was present in Durrett's body at the time of his underlying automobile accident. Furthermore, this case clearly falls outside of the common knowledge exception found in § 15-36-100(C)(2) given the complicated nature of drug interaction, both with other drugs and with the human body. As such, Richland Memorial is entitled to summary adjudication in its favor on all claims asserted against it in this action.

Pursuant to South Carolina law, "medical malpractice actions require a greater showing than generic allegations and conjecture." *David v. McLeod Regional Medical* Center, 367 S.C. 242, 249, 626 S.E.2d 1, 4 (2006). Indeed, as the South Carolina Supreme Court has observed, "if the patient receives allegedly negligent professional medical care, then expert testimony as to the standard of that type of care is necessary, and the action sounds in medical malpractice." *Dawkins v. Union Hospital District*, 408 S.C. 171, 758 S.E.2d 501 (2014), *reh'g denied* (June 11, 2014) (internal citations omitted). In the uncontroverted opinion of one of Durrett's treating

physicians, "[t]he subject matter of this lawsuit involves the use and administration of various anesthetic and/or sedative medications as well as contraindications for various anesthetic and/or sedative medications . . . . [, and] that the utilization of these medications is not within the common knowledge of the ordinary lay person and expert testimony is required." (Ross Aff., (Ex. 8 to Def.'s Mot. for Summ. J.) at ¶ 4) Here, Durrett relies solely upon "generic allegations and conjecture" in support of his claims and has not produced evidence or testimony from any expert who will testify to a reasonable degree of medical certainty on his behalf.

According to Durrett's own testimony, he was anesthetized and therefore unable to provide any medical history to hospital personnel upon his admission at Richland Memorial. (March 12, 2014 deposition of Phillip Scott Durrett (Ex. 12 to Def.'s Mot. for Summ. J.), p. 44, lines 14-20; p. 45, lines 19-20) He further testified that from the time he presented in the emergency room, it "[m]ight have been a minute" that he remained conscious and that he does not remember anything else until waking up days later. (*Id.*, p. 47, lines 5-21) Along these lines, Durrett could not identify by name any medical provider associated with Richland Memorial, including the physician he named as a defendant in this lawsuit and later dismissed with prejudice. (*Id.*, p. 50, lines 8-23; p. 54, lines 19-24) Similarly, he did not have any knowledge of what medications he actually received while a patient at Richland Memorial or what made him vomit following his sedation in the emergency room. (*Id.*, p. 50, lines 6-24) At the same time, he testified he did not tell EMS or Richland Memorial about any allergies to anesthetic or sedative medications. (*Id.*, p. 65, lines 18-25)

Durrett simply had no memory of what treatment he received or anything specific he discussed with his doctors regarding his treatment. (Durrett Dep., p. 53, lines 4-15) Durrett also candidly admitted he did not recall giving ***<u>any</u>*** medical history to anyone at the hospital,

including his alleged allergy to anesthetic and/or sedative medications. (*Id.,* p. 60, lines 9-15) Further, when questioned about which medications he received, Durrett himself acknowledged the medically complex nature of drug interaction when he testified "I have no idea. My getting sick from that stuff like that is kind of hard to research." (*Id.,* p. 65, lines 12-15) Nevertheless, Durrett has failed to identify any expert who will opine that his injuries and damages stem from Richland Memorial's administration of medications to which he now claims to be allergic.

The only medical expert who has offered a causation opinion in this case is Richland Memorial's retained expert witness, Dr. Robert Clodfelter ("Dr. Clodfelter"). Dr. Clodfelter is board certified in emergency medicine and serves as the Medical Director of the Emergency Department of the Hilton Head Hospital. (June 11, 2014 deposition of Robert Clodfelter, M.D., (Ex. 13 to Def.'s Mot. for Summ. J.), p. 5, lines 5-12) In his review of the relevant medical records, Dr. Clodfelter noted Durrett arrived at Richland Memorial in an uncooperative and combative state and, therefore, was given a paralytic agent and a sedative in order to facilitate a "very rapid trauma assessment." (*Id.,* p. 6, lines 12-23)

Dr. Clodfelter also noted that medical records indicate Durrett admitted ingesting methamphetamine the day before the accident, that Durrett's urine drug screen yielded a positive result for that substance, and that Durrett is allergic to morphine and codeine[4]. (*Id.,* p. 19, lines 1-8) Further, the methamphetamines were still present in Durrett's system because that drug metabolizes quickly and would not have been detectible in a urine screen twenty-four hours after it had been ingested. (*Id.,* p. 23, line 16 – p. 24, line 1) In Dr. Clodfelter's opinion, the methamphetamine in Durrett's system could interact adversely with everything and anything

[4] Neither morphine nor codeine were administered during Durrett's course of treatment at Richland Memorial.

given to the patient, resulting in symptoms including altered mental status, cardiac dysrhythmia, and tachycardia. (*Id.*, p. 22, line 25 – p. 23, line 9)

Turning to the paralytic agents hospital staff actually administered (Norcuron and Anectine), Dr. Clodfelter testified these medications are not indicated to have caused Durrett's cardiac issues. (Clodfelter Dep., Ex. 13, p. 26, line 24 – p. 27, line 4) Instead, Dr. Clodfelter agreed with Durrett's treating cardiologist that Durrett's cardiac issues likely resulted from a combination of the methamphetamines in his system, the administration of propofol, and a sharp drop in blood pressure. (*Id.*, p. 27, lines 5-10; August 11, 2006 consult record) Specifically, Dr. Clodfelter opined that Durrett's "cardiac problems were related to dysrhythmia, which means an abnormal cardiac rhythm due to hypotension and the effects of amphetamines." (*Id.*, p. 27, line 25 – p. 28, line 2)

The dearth of evidence substantiating Durrett's allegations of medical malpractice plainly demonstrates the absence of any genuine material issue of fact for trial. Given Durrett's reliance on supposition and conjecture, and his failure to come forward with competent expert testimony in support of his claims, Defendant Richland Memorial is entitled to an order granting it summary judgment on each and every allegation asserted against it in this lawsuit. Moreover, Durrett is nothing like the plaintiff in *Brouwer v. Sisters of Charity Providence Hosps.*, 409 S.C. 514, 522, 763 S.E.2d 200, 203-204 (2014) (plaintiff with a known latex allergy noted on pre-procedure paperwork successfully invoked common knowledge exception at the pre-suit phase). In comparison to plaintiffs in *Brouwer* and related cases, complex issues relating to drug interactions and Durrett's concession that he never conveyed *any* medical history, including known allergies, to hospital staff, prevent him from invoking the common knowledge exception.

For all of these reasons, Durrett's Complaint should be dismissed with prejudice and judgment entered for Richland Memorial.

CONCLUSION

For the reasons stated herein, Defendant Richland Memorial respectfully submits that it is entitled to an Order granting its motions for summary judgment and to reconsider, as well as an Order dismissing Plaintiff's claims against it in their entirety and with prejudice.

TURNER, PADGET, GRAHAM & LANEY, P.A.

January 15, 2016

By: ______________________

R. Gerald Chambers, Jr.
Carmelo B. Sammataro
Post Office Box 1473
Columbia, SC 29202
Phone: (803) 254-2200
Fax: (803) 799-3957

ATTORNEYS FOR DEFENDANT PALMETTO HEALTH ALLIANCE D/B/A PALMETTO RICHLAND MEMORIAL

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
Phillip Durrett,	)	IN THE FIFTH CIRCUIT
PLAINTIFF,	)	
VS	)	
Palmetto Health Alliance, d/b/a Palmetto Richland Memorial, and W. Ross, M.D.,	)	RETURN TO MOTION FOR RECONSIDERATION 13-CP-40-1259
DEFENDANT.	)	

In addition to the argument put forth in Plaintiff's Return to Motion for Summary Judgment and the attached Exhibits, the Plaintiff would show that he has testified at a deposition on March 12, 2014. Excerpts are attached in Plaintiff's Exhibit 6.

Plaintiff testified that he has had problems with anesthesia during previous surgeries. He knew he had a problem with it (anesthesia). And he was scared to death, if he ever had to have it (provision of anesthesia) happen again. His surgeon, Dr. Shealy, told the Plaintiff that the Plaintiff had some problem with the anesthesia.

Due to his fear, the Plaintiff had surgery and "made the doctor here do surgery where I was awake the whole time. I wouldn't let him put me under"

The Plaintiff further testified that he would get violently sick and vomit, after receiving anesthesia.

In response to Defendant's counsel's question: "And you just don't know what it is about the anesthesia that caused you to have this vomiting reaction?", the Plaintiff responded: "All I can tell you is I know I'm going to have a reaction of some sort if they

do not know I have a problem with it. I guarantee you that's going to happen and it's already been proven right there."

The EMS did not provide him any medication in the ambulance for his pain; and he did not ask for anything, because "I'd tell them no until I told them what – could tell them what I was allergic to and stuff." Further, he testified: "There's something on there about morphine. I didn't tell him, so I don't know who told him, but it wasn't me."

Upon being in the Emergency Room the Plaintiff was begging to undo the strap on his leg. It was very painful. He was screaming. A female agent of the Defendant said "put him under". The Plaintiff then stated: "I tell you right now. I asked to be transferred. I begged them to quit. They held me down... Nobody asked me a question. I was waiting. I figured somebody's going to talk to me." Counsel then asked: "No one asked you any questions or spoke with you?" Plaintiff answered counsel: "Exactly, okay." Further counsel asked: "Did you have an ID card or anything that showed you would be allergic to morphine –" Plaintiff answered: "Sir, I had nothing. Nothing. I was waiting on them to talk to me. I had nothing... I was conscious. They could have talked to me... If they had taken that damn strap off my leg, I would've quit screaming at them. They wouldn't... What else can a person do other than tell them to stop, ask them to transfer you, something, when you know they're getting ready to do something to you that might not be good" The Plaintiff further testified: "That's what the people holding me down said, relax, it's only oxygen. I knew they were lying. I knew it was a lie because when she said put him under," "I was somebody to at least walk over to me, ask me what was wrong, where I was hurt, something. Nobody ever

did that. All she – I heard her yell put him under and I went into survival mode right them,"

The Plaintiff was asked at deposition if he knew what caused him to vomit? He answered: "I know they (Defendant's agents) said I vomited and that's what went into my lungs and stopped everything." The Plaintiff further presumed "the same thing that caused me to vomit all the other times."

As to the ingestion of recreational drugs, it was over 24 hours before the accident. He had probably 8-10 hours sleep before he left home to come to work. He admitted to using speed. He further stated: "I was waiting to tell the doctor... That's why I said somebody should have talked to me. And I'll tell you right now, that's the only person I would have told that, is the doctor. I know better." He further stated: "with the problems I've had, I don't hide nothing from a doctor. God, I ate a bunch that morning, too."

When questioned: "So you don't recall giving any medical history at all to anyone?", he answered: "None. None." Not to EMS or nobody.

Plaintiff further testified: "I really hope this just makes the people in the emergency room to their job, all of it, because I don't think it would have happened if somebody had taken the time to talk to me."

In answering the question: "When you went into the ER, why did you tell them you wanted to transfer to a different hospital?, he answered: "Because they were trying to hold me down after I – I didn't say that until she yelled put him under. That's when I said that.

Michael Charpia was deposed on March 12, 2014 by Defendant's counsel. Excerpts are attached in Plaintiff's Exhibit 7.

Mr. Charpia testified that the Plaintiff had an allergic reaction to being put under and that the Plaintiff always had a fear of his, being put under.

After arriving at the Defendant's ER, Mr. Charpia was informed by Defendant's agent(s) that the Plaintiff's heart had stopped. Mr. Charpia was beginning to wonder if Plaintiff was alive or dead.

The Plaintiff further told Mr. Charpia that the Plaintiff told the Defendant's agents not to put him under and that he was allergic to it (medications).

In the minutes prior to being taken to the ER, the Plaintiff had a telephone conversation with Mr. Charpia. Mr. Charpia testified that they could understand each other, that the Plaintiff was coherent, and he was able to explain that the accident happened when the Plaintiff ran into an ambulance.

Respectfully submitted.

Melvin D. Bannister
PO Box 6833
Columbia, SC 29260
803-782-8688; 803-782-8677—fax
Attorney for the Plaintiff

January 25, 2016

1 STATE OF SOUTH CAROLINA)
: IN THE COURT OF COMMON PLEAS
2 COUNTY OF RICHLAND) Case No. 2013-CP-40-1259

3

PHILLIP SCOTT DURRETT,)
4)
Plaintiff,)
5) DEPOSITION OF:
-vs-) MICHAEL CHARPIA
6)
PALMETTO HEALTH ALLIANCE,)
7 D/B/A PALMETTO RICHLAND)
MEMORIAL, AND W. ROSS,)
8 M.D.,)
)
9 Defendants.)

10

11

12 Given before KATHRYN BOSTROM, Court Reporter and
Notary Public at the Office of TURNER PADGET GRAHAM AND
13 LANEY, 1901 MAIN STREET, 17TH FLOOR, COLUMBIA, South
Carolina, on WEDNESDAY, MARCH 12, 2014, commencing
14 at 12:55 p.m.

15

16

17

18

---

19 RAY SWARTZ & ASSOCIATES OF SOUTH CAROLINA
-Professional Court Reporters-
20

21 Serving the Legal Community Since 1957

22

23 1-800-822-8711

24

25

APPEARANCES

For the Plaintiff: MELVIN BANNISTER, ESQUIRE
5115 FOREST DRIVE SUITE G-1
POST OFFICE BOX 6833
COLUMBIA, SC 29206

For the Defendant: R. GERALD CHAMBERS, ESQUIRE
TURNER PADGET GRAHAM & LANEY
POST OFFICE BOX 1473
COLUMBIA, SC 29202

INDEX TO EXAMINATIONS:

DIRECT EXAMINATION BY MR. CHAMBERS.................. 4
CROSS EXAMINATION BY MR. BANNISTER................ 30

INDEX TO EXHIBITS:

THERE WERE NO EXHIBITS MARKED DURING THIS DEPOSITION.

WHEREUPON, the deponent was explained his right to read and sign the deposition and WAIVED that right.

MICHAEL CHARPIA, being duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. CHAMBERS:

Q Mr. Charpia, my name is Gerald Chambers. I'm an attorney, obviously, here in Columbia and I represent the hospital and the physician in a case brought by Mr. Durrett. You've been identified as a witness. I just want to learn a little bit about what you may know about this case.

A The morning of the accident, after Scott called the shop, the shop called me. And I left immediately from my house, which I live on this side of Sumerville, Exit 195 on 26. And seven miles up the road is when I called him and he answered the phone and he told me he was in an accident, that his arm was cut, and his leg was broke. And I could hear people -- him telling people just rip the seat back and I can slide out. And there was -- and that's all about I can tell you.

Q Okay. Well, let me back up a little bit. Have you ever give your deposition before, anything like

this?

A No.

Q Okay. Let me just go over a few rules with you. You're doing good so far. This is just a series of questions and answers. I just want you to answer to the best of your ability.

A All right.

Q If you don't know something, just tell me to repeat it or rephrase it.

A Okay.

Q As you know, the court reporter just placed you under oath, just as if you would testify in a trial. And she's taking down everything that we say, so it's important that you give verbal answers and by that, my just saying yes or no instead of uh-huh or huh-uh because I can certainly understand you, but, you know two or three months from now when I go back to read this again, I might not be sure if an huh-uh is really a yes or a no.

A Okay.

Q And also, since the court reporter's taking down, for her benefit, if you would let me finish my question before you answer, and likewise, I'll let you finish your answer before going on to the next question because if we're both talking at the same

6

1 time, she has a hard time taking everything down.
2 She's going to get mad at us. Now, I don't think
3 this is going to take this long, but it's not an
4 endurance contest. If you need to take a break at
5 any time, just tell me you need to take a break.
6 A Okay.
7 Q Hopefully, none of the questions I ask you can be
8 very confusing, but if they are, just tell me that
9 you don't understand and ask me to repeat it or
10 rephrase it; is that okay?
11 A Yes, sir.
12 Q All right. Now, we've gotten your name already.
13 What's your date of birth, Mr. Charpia?
14 A 1/12/1952.
15 Q Where were you born?
16 A Charleston, South Carolina.
17 Q Have you lived in Charle -- or South Carolina most
18 of your life?
19 A All my life.
20 Q Okay. And where do you currently reside?
21 A At 121 Prince Edward Drive, Summerville, South
22 Carolina 29483.
23 Q How long have you been at that address
24 approximately?
25 A Six years.

7

1 Q And do you have any relatives that live in Richland
2 County?
3 A No, sir.
4 Q What's your educational background?
5 A High school and then some Trident Tech.
6 Q When did you graduate from high school?
7 A 1970.
8 Q Where did you go to high school?
9 A North Charleston High School.
10 Q And what classes did you take at Trident Tech, just
11 generally?
12 A Mainly I worked motor repair and took one accounting
13 class.
14 Q Did you obtain any type of a degree from Midlands
15 Tech?
16 A No. No, this was Trident Tech.
17 Q Excuse me, Trident Tech. Where is Trident Tech.?
18 A On Rivers Avenue, Highway 52 in Charleston, South
19 Carolina.
20 Q You ever been in the military?
21 A I was an Air Force Reserves.
22 Q How long were you in the Reserves?
23 A I was in the Reserves six years.
24 Q What did you do in the Air Force?
25 A Flight line mechanic.

8

1 Q What did you work on?
2 A 141s, C141s.
3 Q And were you in the Reserves the entire time?
4 A Yes, sir.
5 Q Where would you do your Reserve duty at?
6 A Charleston. Like I said, went to basic training at
7 Lackland Air force Base. Went in -- I'd say it was
8 June 15th of 1970, went to basic. Come out August
9 25th, I believe it was, of 1970.
10 Q Did you receive an honorable discharge?
11 A Yes, sir. That -- that was in -- that was May 15th
12 of 1976 when I got out.
13 Q How do you know Mr. Durrett?
14 A I've known Scott over 25 years. Just met him
15 messing around motorcycles and he's used to do auto
16 trim and my father used to have a car lot, used car
17 lot.
18 Q And did Mr. Durrett work for you father for a while?
19 A No. No. He was -- had his own business. Just, you
20 know, pin stripes on cars and --
21 Q So how did you two meet? Was it through --
22 A I can't remember.
23 Q -- work or --
24 A I can't really remember, to tell you the truth. But
25 just through work, just casual meeting. I'm not

9

1 sure.
2 Q Did you and Mr. Durrett ever work together I assume?
3 A We worked on some motorcycles together.
4 Q Did you ever work for him directly?
5 A No.
6 Q How are you currently employed?
7 A I run a wrecker service, Charpia Towing. I just
8 started it back up.
9 Q When did you start it back up?
10 A This just started back up probably about six months
11 ago because I was with West Side Wrecker Services
12 for about 15 years and my partner got killed and so
13 we shut it down.
14 Q So you shut it down and you formed Charpia Towing
15 Service?
16 A Yes, sir.
17 Q Okay. So you've been in the towing service for over
18 20 years then?
19 A Yes, sir.
20 Q Okay. So were you and Mr. Durrett ever a member of
21 any social clubs or anything of that nature
22 together?
23 A No. What do you mean social clubs?
24 Q Any type of a club or anything or just
25 acquaintances?

1 A Oh, just acquaintances. I've never belonged to any
2 type of club.
3 Q Okay.
4 A Except for water ski club years ago.
5 Q Okay. So you just met him through your -- both of
6 you have, I guess, a passion for motorcycles?
7 A I'm not sure whether it was that or whether it was
8 through autos to start with, you know, because I,
9 like I said, before this mess with motorcycles, he
10 used to do the auto trim putting, you know, pin
11 stripes and stripes on Camaros, just stuff like
12 that. And being associated with used cars and
13 everything, you know, he's just somebody that you'd
14 call and come pin stripe a car.
15 Q Okay.
16 A And that could have been the way I met him. I'm not
17 real sure, but, you know.
18 Q Okay.
19 A Like I said, just got to know him and know -- I
20 don't know, 25 years.
21 Q How often do you see Mr. Durrett?
22 A Probably once or twice a week.
23 Q And has that been consistent for a good period of
24 time?
25 A Yes, sir.

1 Q Are you married?
2 A No, sir.
3 Q You ever been married?
4 A Yes, sir.
5 Q Divorced?
6 A Yes. Got divorced in 1976.
7 Q Okay. So you started to tell me a little bit about
8 what, I guess, you know about this case, which this
9 occurred back in 2006, in August of 2006. Where
10 were you living at that time?
11 A Living about a mile and a half from where I'm living
12 right now. I lived at -- that was 107 Hill Street.
13 Q But you still lived in Summerville?
14 A Yes, sir. I lived at that residence 16 years.
15 Q And where was Mr. Durrett living at the time of the
16 accident in August of '06? I don't need the
17 address, but just what city was he in if you can
18 remember?
19 A He was living in Columbia.
20 Q And even though you were in Summerville and he was
21 in Columbia, would you still see him about once or
22 twice a week?
23 A Yes.
24 Q And would he typically come to your house? Would
25 you go to his house? How would that work?

1 A It varies because I've got friends that have got a
2 lot of motorcycles and I'll bring them to Scott and
3 --
4 Q To work on?
5 A Yes. I brought one today, actually. And I'll pick
6 it up for this friend of mine, you know, probably
7 the next three or four days and --
8 Q All right. Other than what you may have had in the
9 Air Force, do you have any medical training?
10 A No, sir.
11 Q And prior to this motor vehicle accident that you
12 started telling me about, do you know of any of Mr.
13 Durrett's medical history or anything of that
14 nature?
15 A I know he'd had a couple bike wrecks and it after
16 one of them that, you know, I know that he had an
17 allergic reaction to being put under. And that was
18 always a fear of his, being put under.
19 Q When did that occur; do you remember? Can we go off
20 the record, just one minute?
21 (Off the record)
22 BY MR. CHAMBERS:
23 Q All right. Mr. Charpia, before we got interrupted,
24 you were telling me about an allergic reaction that
25 Mr. Durrett had had and I was asking you if you knew

1 any more detail with -- about this. When did it
2 occur; do you know?
3 A I'd have to say late 90s, somewhere between '95 and
4 '99. I can't -- I'm not sure exactly.
5 Q And when did you first learn of this allergic
6 reaction that he had had?
7 A It was after he was in the hospital that time. And,
8 you know, he'd talk about it. He's talked about on
9 several occasions, you know.
10 Q So did you go see him while he was in the hospital?
11 A Yes, sir.
12 Q Okay. And that's when he told you about this
13 reaction?
14 A No, it was afterwards.
15 Q After he left the hospital?
16 A Yeah. It was -- we've had numerous dinners together
17 and he would just, you know, hang out together.
18 Q Okay. Why was Mr. Durrett in the hospital on this
19 occasion?
20 A Motorcycle wreck.
21 Q Do you remember what hospital he was in?
22 A Trident, I think.
23 Q Trident? He can't answer for you. Tell me the best
24 you know.
25 A I can't remember.

1 Q Was it in -- it was in Charleston though?
2 A Yeah, it was in Charleston. I can't remember. I go
3 to hospitals so much.
4 Q Was the hospital downtown or was it someplace else?
5 A It had to be -- let me think when he was in the
6 hospital. That was downtown. I'm still not sure
7 which hospital it was.
8 Q Okay. And what is your understanding -- I know
9 you're not a doctor, but what's your understanding
10 of what Mr. Durrett had an allergic reaction to?
11 A Just whenever he was put under, he had problems with
12 it.
13 Q Do you know what type of problems that he had?
14 A What I understand is it was like it almost, I guess,
15 body shut down or heart stopped, something, you
16 know. I'm not sure what problems were. He just,
17 you know, he said he couldn't be put under.
18 Q Do you know what particular medication it was that
19 caused this?
20 A No, sir. I don't even know what they put you under
21 with.
22 Q Okay. So I assume he had to have surgery as a
23 result of this motorcycle accident; is that right?
24 A Yeah. I remember -- seemed like he broke both his
25 hands or wrists, both hands on it. I'm not sure

1 what else.
2 Q Okay. And was the problem -- it's your
3 understanding that there was a problem with -- it
4 was a problem with the anesthesia?
5 A Yes, sir, what I understand.
6 Q And your only understanding of this is coming from
7 Mr. Durrett; is that right?
8 A Yes, sir.
9 Q Okay. You never spoke with any physicians or anyone
10 at the hospital about this issue?
11 A No, sir.
12 Q All right. Did Mr. Durrett have any more problems
13 with anesthesia up until the time of the incident at
14 Richland, that you're aware of?
15 A Not that I'm aware of, but like I said, I couldn't
16 tell you. I don't know.
17 Q Okay.
18 A Other than Richland, I knew if he even had problems,
19 you know, back in the '90s, you know.
20 Q Right.
21 A In the motorcycle accident.
22 Q Okay. But that's the only other occasion --
23 A Yeah.
24 Q -- you're aware of?
25 A Yeah, that I was aware of. Yes, sir.

1 Q Okay. Now, walk me back through the morning of the
2 accident when Mr. Durrett called you. You were in -
3 - were you at home in Summerville?
4 A Yes, I was at home.
5 Q Okay.
6 A And apparently, he'd called his shop and the shop
7 called me and told me he was in an accident. And
8 like I said, anytime, you know, I leave immediately
9 and I'd already gotten on the highway and I remember
10 I was right around the Ridgeville exit and I called
11 and he answered the phone. That was about eight
12 miles from my house.
13 Q You were only about eight miles from your house when
14 you -- when --
15 A When I called and he answered the phone.
16 Q Okay. And what did Mr. Durrett tell you?
17 A He told me that he'd had an accident and that his
18 leg was broke and his arm was gashed open. And he
19 was still in the car.
20 Q And were you on your way to the accident?
21 A Well, I was headed up there and I was trying to find
22 out which hospital he was going to. And like I
23 said, I made it to the hospital, what I understand,
24 about 10 minutes after he got to the hospital. Now,
25 I mean, I drive exceptionally fast, you know. I had

1 something in to run, too.
2 Q So you called Mr. Durrett and he answered the phone?
3 A Yes, sir.
4 Q Was he still at the accident site?
5 A Yes, sir. He was still in the car because --
6 because I could hear him telling the whoever was
7 trying to get him out of the car that "just lay the
8 seat back and I can slide out," you know.
9 Q Okay. Do you know if anyone else was with Mr.
10 Durrett?
11 A I'm not sure.
12 Q How long did your conversation last; was it pretty
13 brief?
14 A I don't -- about four or five minutes.
15 Q Okay. What else did you all talk about? Did he
16 tell you where he was?
17 A I asked, I said, "Where you going to," and I
18 remember him asking and that's how I knew which
19 hospital to go to.
20 Q Okay. So you actually went to Richland and saw Mr.
21 Durrett which he was there?
22 A No, sir. When I got there, he was already there.
23 He was already in triage, what they said, you know,
24 when I got there. And, I said, wait around there
25 for, I don't know, quite a while. And they said he

1 was still in there. So I run and grabbed something
2 to eat. When I got back, that's when they said he
3 wasn't in this room, they sent us down to the heart
4 section and --
5 Q Did you ever see Mr. Durrett that day?
6 A No. I don't think I did that day. I believe it may
7 have been the next day before I saw him. I can't
8 say for sure whether it was that night or the next
9 day, because I stayed all night long.
10 Q Was anyone else there with you?
11 A I had a friend that met me up there, but --
12 Q Who --
13 A -- but he didn't know what was going on or nothing.
14 He just -- he was just another friend of mine that
15 was up this way.
16 Q Who was your friend?
17 A Fellow named Robbie Robertson.
18 Q Robbie Robertson?
19 A Uh-huh.
20 Q Did he know Mr. Durrett or did he just know you?
21 A He knew Scott, but like I said, I'd know him -- I'd
22 known him longer than I knew Scott so.
23 Q Did Robbie stay with you all night as well?
24 A No. Huh-huh. No. He just -- you know -- I called
25 when I was up there and then he came up there. It

1 was just
2 Q All right. Did Mr. Durrett have any other family or
3 any other friends that were there that evening?
4 A Tell you the truth, I can't remember when anybody
5 else come up there. I don't remember.
6 Q Do you remember anyone else ever coming up there
7 besides you?
8 A Yes. I'm not sure whether it was that day or when I
9 come back because like I said, you know, I went back
10 and forth. I was there all night most of the night.
11 I went back and come back and forth about every day.
12 And because he had the shop over here and I was
13 helping take care of it.
14 Q And in other times you came and visited Mr. Durrett
15 at the hospital, were there any other friends or
16 family members there that you're aware of?
17 A Seemed like -- seemed like his brother was there one
18 time and --
19 Q What's his brother's name, do you know?
20 A I can't remember.
21 Q That's okay.
22 A I got blank on it.
23 Q Anyone else that you can remember?
24 A Not really. Not specifically.
25 Q On the first day that you were there, did you ever

1 speak with any of the nurses or the doctors to tell
2 you anything that was going on?
3 A Must have been a nurse or somebody because there was
4 a -- told me his heart had stopped and they sent him
5 to the heart unit, went down there and they said he
6 wasn't down there. So I went -- I had to go back to
7 the other end of the hospital. And you know, was
8 trying to find out what was going on.
9 Q Okay.
10 A But like I said, I don't remember the details of it.
11 You know, it was just -- seemed like I was getting
12 the run around there for a while, you know. And
13 really, you know, I was beginning to wonder if was
14 alive or dead, you know because if they'd said, you
15 know, he'll be out of triage in -- or whatever it
16 was, you know. They said his heart had stopped, you
17 know. Didn't know why.
18 Q You believe this was a nurse that told you this?
19 A I couldn't tell you whether it was a nurse or
20 somebody that was working on the floor or, you know,
21 a desk. You know, I was just trying to find out
22 where he was at.
23 Q Okay. So you didn't see Mr. Durrett at all the
24 first day that he was admitted to the hospital?
25 A I don't -- I don't believe so. You know, unless

1 maybe walked in the room, but he was in a coma for,
2 seems like, 12, 13 days, you know. So all the times
3 I went up there, I didn't talk to him. I knew he
4 was, like I said, seems like it was like 12, 13
5 days, you know, before he actually come to.
6 Q Okay.
7 A So wasn't no talking to him, you know, after he went
8 in, you know. And that's what baffled me because he
9 was -- I was talking to him on the phone and it
10 wasn't like he was, you know, knocked out or -- or
11 whatever. He had a broke leg. And then they tell
12 me his heart had stopped and like I said, seems like
13 they sent me down to the heart wing. And they said
14 he wasn't down there. Then they sent me back to --
15 then -- and they had him in -- what's it, intensive
16 care?
17 Q And when was the first time that you saw him? Was
18 is it the next day or when?
19 A Sir, I can't remember whether I see him in ICU that
20 night or the next day. I don't remember.
21 Q It was in ICU, the first time you saw him?
22 A Yes, sir.
23 Q And was he responsive?
24 A No, sir. He was in a coma for, like I said -- I
25 might be wrong, but it seems like it was 12, 13

1 days.
2 Q And when you saw him in the ICU, did you have any
3 conversations with any of the nurses or the doctors,
4 and ask any questions about what was going on?
5 A Trying to remember who it was. Somebody said that
6 he had asphyxiated or asphyxiated -- when it goes
7 back down in your lungs when they put the trachea
8 tube in him. And they had to put him under and I
9 can't remember the word. It's asphyxiation or --
10 and they had put a trachea tube in him.
11 Q Do you know what caused him to asphyxiate?
12 A According to what they told me, was whenever they
13 stuck the trachea tube down in his throat. It
14 makes, I guess, you know, gag or -- and then when
15 you suck it back down your lungs, it gives you
16 pneumonia or something. They wasn't wanting to tell
17 a whole lot, didn't seem like.
18 Q And would you come see him every day?
19 A Yes, sir.
20 Q And would anyone else be in the room?
21 A Seems like I run into his father, maybe, and his
22 brother. I'm not sure if I run into his ex-wife
23 there or not because I'd run by there and then go to
24 the shop and try to take care of everything at the
25 shop.

1 Q How long would you spend in -- in the room when you
2 would see Mr. Durrett on these occasions?
3 A Probably 15 to 45 minutes. You know, so while he
4 was laying there, there's nothing really you can do
5 and he was breathing and, you know -- because I know
6 it was several days when they finally worked on his
7 leg and said his leg was broke. And he told me it
8 was broke on the phone that day.
9 Q Okay.
10 A But I can't tell you who I talked to or -- it was
11 just -- I know it was probably the nurses, you know,
12 when he was in the ICU, but, you know I couldn't
13 tell you which one or nothing.
14 Q Did any of the hospital staff ever tell you that Mr.
15 Durrett was in a coma?
16 A You could see he was in a coma.
17 Q Okay.
18 A You know.
19 Q He was unconscious?
20 A He was unconscious.
21 Q Do you know difference between being unconscious and
22 being in a coma?
23 A Well, what I understand, it's like an induced coma,
24 sometimes, you know. Yeah.
25 Q And do you know why he was an induced coma?

1 A Not exactly. Not medically.
2 Q You're going to leave that up to the medical
3 professionals?
4 A Yes, sir.
5 Q Okay. So did you ever talk to Mr. Durrett while he
6 was conscious in the hospital?
7 A Yes.
8 Q Okay. And was that about 12 or 13 days that you
9 were telling me about?
10 A Yeah. Uh-huh.
11 Q Okay. And was he conscious at the time he had
12 surgery on his leg?
13 A No. Huh-uh. No, I don't think so because seems
14 like what I remember, it was -- it was, like, half
15 way through that part, that they said, well, he had
16 a broke leg, whatever.
17 Q Did you ever have any conversations with a physician
18 or any of the nurses about his broken leg or what
19 they did to fix it?
20 A Not the -- no, sir. Not as far as what they did to
21 fix nothing.
22 Q So you would come -- you were coming from
23 Summerville to Columbia then every day?
24 A Yes, sir.
25 Q Okay. And you would help work at his shop?

1 A Yes, sir.
2 Q How many people did Mr. Durrett have working for him
3 in his shop at that time?
4 A He had one person working for him. Or helping out.
5 We were just trying to keep things from shutting
6 down.
7 Q Do you know how long, total, Mr. Durrett was in the
8 hospital?
9 A I can't remember.
10 Q Were you there they day that he was discharged; or
11 do you remember?
12 A I don't remember.
13 Q Now, it's your understanding that he broke his leg
14 in the motor vehicle accident?
15 A Yes. Because first thing he said to me when he come
16 to was get me out of here and he still had trachea
17 tube in him and all that. I said I can't get you
18 out of here right now.
19 Q And how long after Mr. Durrett got out of the
20 hospital was it before he went back to work again?
21 I mean, were you maintaining the shop until he came
22 back to work?
23 A I'd do what I could. Like I said, you know, I was
24 trying to run between the business down there and
25 coming up here and, you know, I had a couple other

1 friends, you know, that just -- just tried to help
2 out however they could.
3 Q Work on the bikes?
4 A We wasn't doing no work on the bikes. No, we were
5 just trying to -- we were talking to the customers,
6 telling them what had happened. It'd be a while
7 before Scott get back to work on them because I'm
8 not mechanic, no like he is.
9 Q Okay. And how long was it before he could go back
10 to work; do you know? Do you remember?
11 A No, sir. I don't remember.
12 Q But eventually, he was able to?
13 A Yeah, eventually. Yes, sir. Still limps today
14 because of it though.
15 Q Pardon me?
16 A He still limps today because of it.
17 Q Were you present for any conversations Mr. Durrett
18 may have had with any physicians prior to him being
19 discharged?
20 A Not that I remember.
21 Q Did Mr. Durrett ever have any conversations with you
22 about having some type of allergic reaction while he
23 was at Richland?
24 A Yes.
25 Q Tell me about that. What did he tell you?

1 A Just that -- that he was telling them not to put him
2 under and, you know, and that was his problems. You
3 know, when they put him under. He was allergic to
4 it.
5 Q So he told them he was allergic to --
6 A He had problems anytime he was put under.
7 Q And do you know, and you may not, but do you know
8 specifically what type of problems he had when he
9 was put under?
10 A No, sir. Not specifically.
11 Q Do you have any idea generally what would happen to
12 him if he got put under? I mean, you may not.
13 A I mean not really.
14 Q Okay. Now, other than at Richland and at the time
15 at Charleston you told me about, his motorcycle
16 accident, are you aware of any other surgeries that
17 Mr. Durrett has had for any reason? Any other
18 accidents he may have been in? Anything else?
19 A Not that I'm aware of. No, sir.
20 Q Now, after Mr. Durrett got out of the hospital, were
21 you still coming up here daily?
22 A No.
23 Q Did that kind of stop at that time and you went back
24 to your regular job?
25 A Yeah. Uh-huh.

1 Q You were still seeing though, Mr. Durrett, on a
2 fairly frequent basis; is that right?
3 A Yeah. Yeah, I've talked -- there's very few days go
4 by I don't -- we doing speak over the phone, you
5 know. Just, you know, we're just casual calling,
6 hey, how you doing, what's happening, you know.
7 Because he's got family that lives down in
8 Charleston, his daughter and, you know, if there was
9 anything that I can do to help him with his daughter
10 down there or, you know, if she breaks down or
11 anything, you know, he'll call me and I'll take care
12 of that too.
13 Q Okay. Are you aware of any other instances in which
14 Mr. Durrett had an allergic reaction to anesthesia?
15 A No, sir. Not that I know of. I can't say, you
16 know. There's very few people that I know all their
17 medical history, so you know.
18 Q And are you aware whether or not anyone was in the
19 car with Mr. Durrett on that day of this accident?
20 A No.
21 Q Okay. Do you know what time of day it occurred?
22 A It was before lunch. That's all I can -- I remember
23 it was before lunch, first part of the day.
24 Q And about how long would it have taken you to get
25 from Summerville to the hospital?

1 A Probably about 50, 55 minutes because I was driving
2 140, 150 miles an hour.
3 Q Okay.
4 A I had a Chevrolet pickup running 165 miles an hour
5 and I drove it that way.
6 Q We're not going to give a copy of this to the police
7 or anything.
8 A I've got a ticket reads 155 plus in a 55 zone, so I
9 mean --
10 Q We may want this on the record.
11 A Because I made it quick from Columbia to Charleston.
12 Q Okay. Are you aware whether or not Mr. Durrett has
13 ever used any type of recreational drugs?
14 A Not that I know of.
15 Q And you don't really recall having any specific
16 conversations with any of the doctors or the nurses
17 at -- at Richland --
18 A No, sir. I don't.
19 Q -- about Mr. Durrett?
20 A Not that I can recall. No, sir.
21 Q Any you didn't tell anyone at the hospital staff
22 about any allergies that Mr. Durrett --
23 A No, sir.
24 Q And you don't remember the names of any of the
25 doctors who may have treated Mr. Durrett, do you?

1 A No, sir.
2 Q Or any other nurses for that matter?
3 A No. I remember there was two blondes they called
4 Barbie twins. That's all I know, the one thing.
5 Q Anything else about this accident or Mr. Durrett's
6 hospitalization that you know we may not have
7 discussed or is that about it?
8 A That's all I know. Like I said, it was very -- very
9 little, really.
10 MR. CHAMBERS: All right. I think that's all
11 the questions I got.
12 CROSS EXAMINATION
13 BY MR. BANNISTER:
14 Q In the phone call that you made to Scott, did he
15 seem to be coherent?
16 A Oh, yeah.
17 Q Could you understand what he was saying?
18 A Yes. Uh-huh.
19 Q Did he appear to understand what you were saying?
20 A Oh, yeah.
21 Q Did he tell you how the accident happened?
22 A He told me he run into an ambulance.
23 Q He actually -- he told you he ran into an ambulance?
24 A Yes.
25 Q Okay.

1 A And told me his leg was broke.
2 Q And after you got over to the hospital and you went
3 from one place to another in -- inside the hospital,
4 why were you going from one place to the other?
5 A Trying to find out where he was at and, you know,
6 what's happening with him.
7 Q So somebody in the hospital said he might be over
8 here?
9 A Well, to start with, he was in the emergency room or
10 triage of whatever they call it. And said it's be a
11 while. And like I said, went and grabbed something
12 to eat and come back. And that's when seemed like
13 they didn't know where he was at. And first, they
14 said his heart had stopped and they sent him down --
15 that's what, you know --
16 Q Somebody told you his heart had stopped?
17 A Yes. But I don't remember who it was.
18 Q And that was somebody, medical personnel at the
19 hospital?
20 A Yes, it must have been.
21 Q And who told you he had breathing problems?
22 A I'm not sure whether it was -- I can't -- I can't
23 recall.
24 Q Was it somebody medical personnel at the hospital?
25 A Yes, but I'm not sure if it was that day or the next

1 day. You know it was --
2 Q Okay. And the coma that you mentioned he was in, do
3 you know what caused the coma?
4 A No, sir.
5 Q Do you know if the doctors induced a coma on
6 purpose?
7 A I can't say for certain.
8 MR. BANNISTER: I don't have anything further
9 for him.
10 MR. CHAMBERS: I don't think I do either.
11 Thank you. Appreciate it, Mr. Charpia.
12 THE WITNESS: All right.
13 (Deposition concluded at 1:39 PM)
14
15
16
17
18
19
20
21
22
23
24
25

1 STATE OF SOUTH CAROLINA)
2 : C-E-R-T-I-F-I-C-A-T-E
3 COUNTY OF RICHLAND)
4
5 I, KATHRYN BOSTROM, Court Reporter and Notary
6 Public, certify that I did have MICHAEL CHARPIA to
7 appear before me at 12:55 pm on WEDNESDAY, MARCH 12,
8 2014 at TURNER PADGET GRAHAM AND LANEY, COLUMBIA, South
9 Carolina; that the witness was sworn and cautioned to
10 tell the truth, the pages constitute a true and accurate
11 transcript of the testimony given at that time and
12 place.
13 I further certify that I am not of counsel or kin to
14 any of the parties to this cause of action, nor am I
15 interested in any manner in its outcome.
16 IN WITNESS WHEREOF, I have hereunto set my hand and
17 seal this the 26TH day of MARCH, 2014.
18
19
20
21 ______________________
22 Kathryn B. Bostrom
23 Notary Public for South Carolina
24 My Commission Expires: AUGUST 28, 2022
25

STATE OF SOUTH CAROLINA **IN THE COURT OF COMMON PLEAS**

COUNTY OF RICHLAND

Phillip Durrett, Plaintiff, -VS- Palmetto Health Alliance d/b/a Palmetto Richland Memorial, Defendants.	**CA NO.: 2013-CP-40-1259**

Deposition of **MATT HANCOCK**, a witness called by Counsel on behalf of the Defendants, pursuant to the applicable provisions of the South Carolina Rules of Civil Procedure, taken before Cynthia L. Weathers, a Professional Court Reporter and Notary Public in and for the State of South Carolina, on June 13, 2014 at Richland County Emergency Services, 1410 Laurens Street, Columbia, South Carolina, commencing at the hour of 10:00 a.m.

1 A. That's correct.

2 Q. We'll get to that in just a second. Immediately
3 below the treatment procedures is the section that
4 corresponds to drugs used. And there's nothing
5 listed here; correct?

6 A. Correct.

7 Q. And so no narcotic medication, no pain relievers,
8 no sedatives, anything like that?

9 A. None.

10 Q. Okay. Now I apologize in advance, because the copy
11 that we have is probably not the best copy. But
12 under the Advanced Procedure section, can you
13 decode this or tell me what you indicated in this
14 block?

15 A. Yes. I can. It indicates that we put him on the
16 monitor, and that he was in a sinus rhythm. It
17 indicates the time of that application was at 1407.

18 Q. Okay. When you indicate that someone's in a sinus
19 rhythm, is that significant? Tell me why you noted
20 that.

21 A. A sinus rhythm is the normal heart rhythm that a
22 person would have in a normal resting position.

23 Q. Okay. And that's the information that the EKG
24 monitor provided to you; correct?

25 A. Correct.

1 A. Correct.
2 Q. And the 278 that's listed there, is that a number
3 that was assigned to you, or what does that mean?
4 A. That would be a supervisor's vehicle, typically a
5 pick-up truck. And the supervisor would have also
6 responded.
7 Q. As we sit here today, do you know who that was?
8 A. I do not.
9 Q. Okay. All right. Moving further to the right on
10 this form under Vital Signs, it looks like you took
11 vitals twice in transport; is that right?
12 A. That's correct.
13 Q. Once at 1410 and again at 1420.
14 A. Correct.
15 Q. And that's just military time; correct?
16 A. That's correct.
17 Q. A little bit after two in the afternoon?
18 A. 2:10 and 2:20, --
19 Q. Right.
20 A. -- p.m.
21 Q. Walk me through that, if you would. I think I can
22 read this, but I just want to make sure we have it
23 right for the blood pressure, pulse, respirations
24 and pupil at both of those intervals.
25 A. The blood pressure was palpated at 112. The pulse

1 was 78 per minute. Respirations, 30 per minute.
2 Both of those were regular. Pupils were equal and
3 reactive. His level of consciousness was alert.
4 Q. Okay. And that's the 1410; correct?
5 A. Correct.
6 Q. The time entry. All right. How about for the 1420
7 time entry?
8 A. It looks like his blood pressure was palpated at
9 110. A pulse rate was 80, strong and regular
10 respirations were 30, and regular pupils continued
11 to be equal and reactive. His level of
12 consciousness was still alert at 1420.
13 Q. And while we have some variances in the blood
14 pressure and the pulse rate, was there anything
15 about that that would give you any concern that his
16 condition might be declining?
17 A. Everything looked nominal at that point.
18 Q. And above that, before the Revised Trauma Score,
19 that area is blank. Is there a particular reason
20 for that?
21 A. That is -- should have been filled in.
22 Q. If someone is alert, their blood pressure is at a
23 normal range, the pulses are good, would that
24 indicate that the revised trauma score or Glasgow
25 score would have been a corresponding-type score, a

1 relatively good score?

2 A. That's correct.

3 Q. Okay. Now, when we get to the Comments section, if

4 you would -- and do it slowly so the court reporter

5 can take it down. I know sometimes the medical

6 terms can be a little tricky, but if you would read

7 this, and then I'll probably go back and ask you a

8 couple of questions about it.

9 A. Sure. "Patient chief complaint of left leg pain.

10 Patient also presented with bandaged left forearm.

11 Patient restrained driver of vehicle with heavy

12 front end damage. Patient entrapped by steering

13 wheel and dashboard. Patient refused O2 and C-

14 collar. Patient freed from vehicle. Patient to

15 long spine board. C-collar applied. Pulse

16 movement sensation in tact times four. Patient to

17 243. Vital signs taken. Life pack 10. Sinus tach

18 at 78 to 88 with no ectopy. Non-rebreather at 15

19 liters per minute. Patient is conscious, alert and

20 oriented times three. Skin warm and dry. Color

21 good. Strong radial pulse. Breath sounds clear

22 times four. Abdomen soft and non-tender. Pelvis

23 stable. IV of normal saline via 18 in right hand.

24 ER contacted. Patient to trauma number one.

25 Report to ER staff. Patient gave large amount of

1 what we have done en route, and our anticipated
2 time of arrival.
3 Q. Okay. Do you seek or do you have to have
4 permission to give medication by ER personnel?
5 A. Generally, we do not get permission to give certain
6 medications. Certain medications, we are required
7 to call first. In this instance, we did not give
8 him any medication.
9 Q. And do you know the reason why you didn't give him
10 any medication?
11 A. We didn't give him any medication because none was
12 needed.
13 Q. And who determined that none was needed?
14 A. It's generally dependent upon the patient
15 assessment.
16 Q. Did Mr. Durrett tell you that he did not want any
17 medication?
18 A. I don't recall.
19 Q. Is that possible?
20 A. It is possible.
21 Q. I believe you indicated that he declined oxygen.
22 A. Early on in the call here, I have "patient refused
23 O2 and C-collar." When we initially get to an
24 injured victim in a vehicle, we will begin to apply
25 our treatment protocol initially as the fire

1 Q. But you could talk with him and he could respond
2 and you could hear him?
3 A. Yes, sir.
4 Q. So at that point in time is when you would ask him
5 about his medical history?
6 A. You could at that point in time on the way to the
7 ER.
8 Q. And is that when he would have denied medications
9 if he did so?
10 A. He could.
11 Q. Would he have also been able to tell you whether or
12 not he was allergic to any medications?
13 A. Yes, sir.
14 Q. Do you remember whether he made any such statements
15 to you?
16 A. I don't recall.
17 Q. But in any sense, you did not supply him any
18 medication?
19 A. No, sir. I did not.
20 Q. Do you remember how he was dressed?
21 A. No, sir.
22 Q. I believe this was in August; is that correct?
23 A. Yes, sir. That would be right.
24 Q. So you don't remember whether he was in shorts or
25 long pants?

L45

DHEC PATIENT CARE FORM

TRIP NO 634878

PATIENT IDENTIFICATION (Please Print)

LAST NAME (10-29) Durrett FIRST NAME (30-45) Scott MI (46) P Mr

STREET (47-71)

CITY (72-87) Cola STATE (88-89) SC ZIP CODE (90-94) 29206

SEX (104): 1 ☒ Male 2 ☐ Female 3 ☐ Undetermined

RACE (105): 1 ☒ White 2 ☐ Black 3 ☐ Am. Indian 4 ☐ Hispanic 5 ☐ Asian 6 ☐ Other

AGE (106-109): 047 CHECK ONE 1 ☒ YRS. 2 ☐ MOS. 3 ☐ DAYS

DISPOSITION (110-111): 01 ☐ TREAT/NO TRANS. 02 ☐ DOA AT SCENE 03 ☒ HOSPITAL ER 04 ☐ HOSP. DIR. ADMIT. 06 ☐ PATIENT'S HOME 07 ☐ NURSING HOME 08 ☐ DR.'S OFFICE 09 ☐ OUTPATIENT 10 ☐ PT. REFUSED TREAT. 13 ☐ EMS TRANSFER

TYPE OF INCIDENT

TRAUMA (112): 1 ☒ MVA 2 ☐ MC 3 ☐ BIKES 4 ☐ PED 5 ☐ ASSAULT 6 ☐ FALL 7 ☐ FIRE 8 ☐ INTERFAC 9 ☐ OTHER

MEDICAL (113): 1 ☐ ENVIRON 2 ☐ BEHAV 3 ☐ OB/GYN 4 ☐ RESP 5 ☐ CARDIAC 6 ☐ INTERFAC 7 ☐ OTHER

CALL / PATIENT STATUS

TO SCENE (114): 1 ☒ EMERGENT 2 ☐ NONEMERGENT CODE 03

ON SCENE (115): 1 ☒ URGENT 2 ☐ NON URGENT

FROM SCENE (116): 1 ☐ URGENT 2 ☒ NON URGENT CODE 01

INCIDENT LOCATION

ST. OR HWY. NAME OR NO. I-20 @ 68

CITY Cola SC

County (117-118) 40 Zip Code (119-123) 29203

SAFETY EQP (124): 1 ☒ Seatbelts 2 ☐ Helmets 3 ☐ Airbags 4 ☐ Child Seat 5 ☐ None 6 ☐ Unkn.

SITE OF INCIDENT (125): 1 ☒ ROADWAY 2 ☐ RESIDENCE 3 ☐ INDUSTRIAL 4 ☐ RECREATIONAL 5 ☐ AGRICULTURAL 6 ☐ OTHER

PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (126-137)

003 ☐ Seizure 004 ☐ Diabetic 011 ☐ Abrasion/Contusions 013 ☐ Laceration 023 ☒ Fracture 024 ☐ Multitrauma/Shock 030 ☐ Head Injury 032 ☐ Spinal Injury 084 ☐ Stroke 051 ☐ G.I. Problems 074 ☐ Respiratory Distress 080 ☐ Coronary Problems 083 ☐ Cardiac Arrest

Other 172 Other 023

PRIMARY IMPRESSION (138-140): 023

TREATMENT PROCEDURES (141-174)

01 ☐ Dressing Applied 02 ☒ Limb Splinted 03 ☒ Spine Immobilized 04 ☒ Neck Immobilized 05 ☐ OB Assistance 06 ☐ Oral Airway Used 07 ☒ Oxygen Given 08 ☐ Suction Used 09 ☐ Antishock Trousers 10 ☐ Airway Maintained 11 ☐ Antishock Treatment 12 ☐ Artificial Resp. 13 ☐ Cardiac Massage 14 ☐ Bleeding Controlled 15 ☐ Cold Application 16 ☐ Patient Restrained 17 ☒ Other (Use Comments) 18 ☐ Ventilator

HCFA CODES (175-180)

ADVANCED PROCEDURES (190-223)

1. ☒ EKG Monitored Rhythm SR Time 1407

[illegible]

DRUGS USED (226-241)

SITE OF TRAUMA (181-189): 1 ☐ Head 2 ☐ Face 3 ☐ Neck 4 ☐ Chest 5 ☐ Abdomen 6 ☐ Hip/Pelvis 7 ☐ Upper Extr. 8 ☐ Lower Extr.

REVISED TRAUMA SCORE

GCS: (242) EYES (243) VERBAL (244) MOTOR (245-246) GLASGOW (247-249) SBP (250-252) RR (253) ANATOMICAL INJ. 1 ☐ YES 2 ☐ NO RTS (254-255)

VITAL SIGNS

BP	PULSE RATE		RESPIRATIONS RATE		PUPIL	LEVEL OF CONSC.	TIME
140/80	78	☒ REG.	30	☒ REG.	E	A	1410
160/80	80	☒ REG.	30	☒ REG.	E	A	1420

EXPOSURE TO PT's BODY FLUIDS? (256) 1. ☐ YES 2. ☒ NO

1st Responder (257) 1. ☒ YES Name 278 2. ☐ NO

COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)

PT CC of (L) Leg pain, PT also presented c bandaged (L) forearm. PT restrained driver of vehicle c heavy front end damage. PT entrapped by steering wheel and dashboard. PT refused O2 and C-collar. PT freeded from vehicle. PT→LSB. C-collar applied. PMS intact x4. PT→243. VS taken. LP c ST @ 78-88. Ø Ectopy. NRB @ 15 LPM. PT is CAOx3, skin W/D color good, strong radial pulse. BS clear x4. Abd soft & non-tender, Pelvis stable. IV of LS via 18 in (R) hand. ER contacted. PT → Trauma #1 Report to ER staff. PT gave large amount of cash to ♀ companion. PT gave unknown object also @ ER

Patient Care Form Left In (258): 1. ☒ ED 2. ☐ ICU 3. ☐ OTHER ☐ See Page 2

TIME RECORD

RUN DATE (259-266): MONTH 08 DAY 09 YEAR 06

Call Received: (267-270)	1348
Call Dispatched: (271-274)	1348
Departed Base: (275-278)	[illegible]
Arrive Scene: (279-282)	1358
Departed Scene: (283-286)	[illegible]
Arrive Destination: (287-290)	1423

CAUSE OF DELAY

DHEC PERMIT NO (291-295): 04964

RECEIVING AGENCY (296-299): 2015

SENDING AGENCY (300-303)

PROVIDER TIME (OPTIONAL)

ATTENDANT'S SIGNATURE & CERTIFICATION NO. 84137

PRIMARY PATIENT ATTENDANT (304-308)

Stephen Loel 29601

2ND ATTENDANT/DRIVER (309-313)

3RD ATTENDANT/DRIVER (314-318)

(RECEIVING NURSE OR PHYSICIAN) Carly Brandenburg, RN

DH 1050 REV. (01/2004) EMS PROVIDER COPY REPORT NO. (1-9) 250413

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM RICHLAND COUNTY
Civil Court

Robert E. Hood, Circuit Court Judge

Case No. 2013-CP-40-01259
Appellate Case No. 2016-000429

Phillip Durrett ....Appellant

Palmetto Health Alliance d/b/a Palmetto Richland
Memorial..Respondent

CERTIFICATE OF COUNSEL

I hereby certify that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

Melvin D. Bannister
Post Office Box 6833
Columbia, South Carolina 29260
(803) 782-8688
Attorney for the Appellant

December 20, 2016

Other Counsel of Record:

Robert Gerald Chambers, Jr.
Carmelo B. Sammataro
Attorneys for the Respondent
P.O. Box 1473
Columbia, SC 29202