THE STATE OF SOUTH CAROLINA
In the Supreme Court

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S.C. SUPREME COURT

APPEAL FROM THE APPELLATE PANEL
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

APPELLATE CASE NO. 2017-002236

Clarence B. Winfrey, Jr., Employee, ... Petitioner,

v.

Archway Services, Inc., Employer,
And American Fire & Casualty Insurance Company,
Carrier, ...Respondents.

AMENDED PETITION FOR WRIT OF CERTIORARI

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CERTIFICATE OF COUNSEL

Counsel for Petitioner certifies that the Petition for Rehearing was made and finally ruled on by the Court of Appeals on September 28, 2017.

QUESTIONS PRESENTED

I. Where after the injury, the insurance carrier accepted and paid compensation and medical care and then under a S.C. Code §42-9-260(B)(1-6) exception 118 days later stopped all benefits, "without a hearing" using only a mailed WCC Form checking a box for the reason at the reinstatement hearing where the sole issue is whether benefits were properly stopped, is the insurance carrier the moving party and as such do they have the burden to produce evidence to prove the claimed exception; or is it sufficient that they merely "represent", state, to the Commission they conducted "a good faith investigation" and had formed a "belief" there was a, "basis" for denial; and does the Commission decision that a "representation" and, "belief" are sufficient to meet their burden and at the same time requiring the disabled worker to "provide evidence" they did not conduct a good faith investigation shift the burden of proof to the worker in violation of due process?

II. Where the insurance carrier stopped payment of benefits without a hearing on September 12, 2013 and gave Notice by letter dated that same day to the disabled worker, did the Commission err as a matter of law by:

A. excluding all evidence after September 12, 2013 from the disabled worker, thus denying him due process of law?

B. basing the Commission's Decision on documentary evidence over objection and admittedly filed untimely and in violation of the Commission's Regulations.

III. Where the insurance carrier's assigned managing agent stopped payment without a hearing on September 12, 2013 and where Petitioner served Notice of Deposition with Subpoena on September 18th for the adjuster/file, did the Commission deny Petitioner due process of law by not ruling on the discovery deposition/subpoena until the hearing on November 13, 2013 and by then denying Petitioner the right to take the adjuster's deposition; and also on November 13th by ordering production of documents, including the adjusters file, but only AFTER that hearing for which discovery was sought?

IV. Did the Commission err as a matter of law by making Findings of Fact, #4 through #11, and specifically #6, #10, which are not supported by the evidence and upon which the Commission found as a fact that the insurance carrier had met its burden of proof (evidence) where it had only:

> "**represented** to the Commission they had conducted a good faith investigation,";

and that they had formed, "a belief" based on that investigation for denial, and at the same time finding Petitioner,

> "did not provide any **evidence**" they had not conducted an investigation in good faith;

and thus, did the Commission thereby as a matter of law shift the burden of proof from the insurance carrier to Petitioner as to proving (evidence of) a "Good Faith Investigation"?

V. Is the Commission's Decision the subject of surmise, speculation and innuendo where it is not based on substantial evidence on the essential issues for decision: whether the insurance carrier conducted a good faith investigation and whether there was evidence to support the reason for denial?

STATEMENT OF THE CASE

On May 22, 2013, while working on a rotisserie at Publix, Petitioner's left hand came in contact with a 240-480-volt line resulting in a severe electrical shock entering his left hand, running throughout his arm, left shoulder, neck and upper left quadrant of his chest with immediate, continual and worsening pain in those areas thereafter. After the injury, which was immediately reported to his employer, his pain continued to intensify over several days and he went to and from the Minute Clinic to Doctor's Care, to a cardiologist and then immediately across the street via ambulance to the Emergency Room where he was hospitalized. (App., p. 163-169). The insurance carrier

accepted the claim, authorized medical care, and started Temporary Total Disability benefits. On June 5th, Petitioner filed a claim with the SC Workers' Compensation Commission. (App., pp. 150-151). On June 12th, the Commission informed the carrier they had not properly filed a First Report of Injury and forms noting the starting of benefits and on July 23rd, Respondents paid a $200.00 fine to the Commission. (App., pp. 727-729).

September 12, 2013, (approximately 118 days after injury) Petitioner's attorney was notified by letter and WCC Form 15(II) that the insurance adjuster had stopped payment of benefits (App., pp. 153-154). The Workers' Compensation Commission Form 15 was checked, "based on a Good Faith Investigation, the claim is denied". No required documentation explanation for stop payment was attached.

September 18th Petitioner via hand delivery to the Commission filed a WCC Form 15(III) Request for Hearing to Reinstate Benefits. (App., pp. 40-42). Also, September 18th, Notice of the adjuster's deposition (for 10/2/13), as Managing Agent, and a Subpoena for production records (for 9/30/13) was personally served. A Motion to Quash the Deposition and production subpoena was filed that same date (App., pp. 163-172); but no ruling before October 2nd.

September 27th, a Hearing Notice for November 13th was served (App., p. 173).

October 7th, Petitioner filed Reply to Defendants' Motion to Quash. (App., pp. 174-179). October 21st, a Motion for

Continuance/Postponement was filed in part because Petitioner had filed a Declaratory Judgment Action challenging the constitutionality of SC Code §42-9-260 (B)(1-6) allowing for stop payment without a hearing (App., pp. 184-191). Although only required to file 10 days before hearing, October 30th, Petitioner filed his Pre-Hearing Brief and APA Submissions. (App., pp. 266-299).

November 4th by letter, **9** days before hearing, Respondents late filed their Pre-Hearing Brief and Notice of Witnesses and written medical reports (App., pp. 325-381). November 5th, **8** days before the hearing, Respondents late filed an Amended Pre-Hearing Brief and Supplemental Notice of Witnesses and Written Medical Reports. (App., pp. 382-388). November 7th, Petitioner filed formal Objections to both belated Pre-Hearing Briefs/APA Submissions. (App., pp. 738-740).

At the November 13th hearing prior to going on the Record, the Commissioner held a two-hour off-the-Record conference (scheduled 1:45 p.m.; started 3:50 p.m., App., p. 173, 491) in which he decided the Motions, made numerous evidence rulings and admitted the late filed Pre-Hearing Briefs and APA Submissions all confirmed in Orders on the Motions and the Form 15(III). (App., pp. 117-122; 491-499). The only hearing issue being Reinstatement, 14 days after hearing, Petitioner filed a Request for status of the Form 15(III) decision. (App., pp. 741-742).

December 5th, the Commissioner issued two Orders: "Order on Parties' Motions"; and order denying reinstatement. (App., pp. 117-122; pp. 123-131). December 18th a Form 30 Request for

Commission Review was filed as to both Orders. (App., pp. 389-408). After briefing, a hearing was held on May 19, 2014. (App., pp. 409-435; pp. 436-454; pp. 699-726). The Full Commission Order was filed July 25th. (App., pp. 132-149). Petitioner filed Notice of Intent to Appeal August 25th. (App., pp. 455-472). This Appeal was one of three Appeals from three separate Orders of the Commission including this appeal from the two Orders from the Form 15 (III) Hearing, two Appeals, one from the Decision of Commissioner Barden finding compensable injury and awarding Petitioner reinstatement/ continuing temporary total disability and medical care and one from the Full Commission Order affirming her Award. Mediation resulted in an impasse and the rescheduling of briefing. All Appeals were decided by the Court of Appeals through Unpublished Opinions on August 2, 2017. A Petition for Rehearing was filed on this Appeal August 17, 2017 which was denied by Order on September 28, 2017. (App P757-796; P819) This Petition for Writ of Certiorari followed. The separate Declaratory Judgment Action as to the constitutionality of SC Code §42-9-260(B), (1-6) is still pending in the Court of Appeals.

ARGUMENTS

I. Where after injury, the insurance carrier accepts and pays compensation and medical care and then 118 days later stops benefits under a S.C. Code §42-9-260(B)(1-6) exception "without a hearing" using only a mailed WCC Form checking a box for the reason, at the hearing on reinstatement where the sole issue is whether the benefits were properly stopped, the insurance carrier is the moving party [67-612(B)(4)] and as such has the burden to produce evidence to prove the claimed exception and it is not sufficient to merely "represent" to the Commission they conducted "a good faith investigation" and formed a "belief"

there was a "basis" for denial; and the decision by the Commission that a "representation" and, "belief" are sufficient to meet their burden and at the same time requiring the disabled worker to "provide evidence" they did not conduct a good faith investigation is an error of law and shifts the burden of proof to the worker in violation of due process.

The Commission found both as a Matter of Fact and law that because Respondents,

> "**represented** to the Commission they conducted a Good Faith Investigation of the claim" . . .

and that because,

> "the Claimant did not provide **any evidence** that Defendants conducted their investigation in anything other than good faith"

and that

> "Therefore, **a belief** of Defendants formed following a Good Faith Investigation that claimant had not met his burden of proving compensability is adequate grounds for denial of the claim by the Defendants." (Emp. add.) (App., pp. 13-'c'; 'd'; 'f').

and again that because Petitioner, "did not provide any **evidence**," to the contrary (App., p. 128, #10) that this was sufficient to justify stopping benefits without a hearing. The finding that, a "representation" and a "belief" without supporting evidence are sufficient as a matter of law to meet a burden of proof is beyond belief.

Under the statute and Commission Regulations, the Respondents are the moving party and have the burden of proof. SC Code §42-9-260(B) provides in pertinent part,

> "once temporary disability benefits are commenced, the payments may be terminated... **if**:"

one of the six (6) enumerated exceptions is proven. One of those is that a Good Faith Investigation reveals a grounds for denial.

"If" is defined in Webster's Dictionary as a word, "used to say that something must happen before another thing can happen". The Statute creates a condition precedent meaning that to stop temporary disability benefits without a hearing they can do that **"if"** they establish one of the conditions precedent; e.g. a Good Faith Investigation. Plain English for Drafting Statutes and Rules, Chapter 13, §(C) "Conditions and Exceptions" (1)(a) "**If**" p. 121, Matthew Bender 2012. The fact that Respondents have the burden of proof to stop benefits without a hearing is made clear by the Commission's Regulations. Regulation 67-504(A) requires Respondents to attach documentation stating, "the reason for termination". Regulation 67-612(B)(4) specifically states that in a WCC Form 15(III) hearing,

> "the Carrier shall be deemed **the moving party** in all hearings scheduled pursuant to a request under R. 67-504(C)."

Even the Commissioner noted this at the hearing. (App., p. 497, ll. 21-22). The moving party has the burden of going forward as well as the burden of persuasion in an administrative hearing." 73A CJS, Public Administrative Law and Procedure §240, "Burden of Proof". (emp. added.)

The party claiming the benefit of a Statute has the burden of proof and this burden is one of "persuasion" by a preponderance of the "**evidence**", Pike v. SCDOT, 343 S.C. 224, 540 S.E.2d 87 (2000); Trial Handbook for South Carolina Lawyers, 5th Ed. (2012-2013) §9.3 "Burden of Proof", and §9.4, "Statutory Allocation of Burden of Proof". One who claims the benefit of an exception has the burden of proof to prove they come within the limited class for whose benefit the exception was established. Sutherland Statutes and Statutory Construction, 7th Ed. (2014), "Intrinsic Aids", §47.11 "Exceptions".

Thus, under both the Statute and the Commission's Regulations, Respondents had the burden of proof (evidence) to prove the condition precedent that they had conducted a Good Faith Investigation which would allow them to obtain the benefit of the Statute; i.e. to stop benefits without a hearing. Therefore, where Respondents had started benefits, they could only stop those benefits under a specifically listed statutory "exception" and they had the burden, i.e., to submit evidence, to prove the exception applied. This was the specific holding of the Court of Appeals in Martin v. Rapid City Plumbing, 369 S.C. 278, 631 S.E.2d 547 (SC App 2006) wherein the Court held:

> "However, the statute is explicit that even under a Form 15 an employer can only terminate or suspend temporary compensation **if one of the specified conditions is met**." (Emp. added).

The Commission as a matter of law by holding Respondents meet their burden of persuasion by merely "representing" (not evidence) that a Good Faith Investigation was conducted, and at the same time requiring Petitioner to provide, "evidence" Respondents did not conduct a Good Faith Investigation is an oxymoron and is a violation of fundamental due process. Any decision must be based on evidence. SCACR Rule 242(b)(3,4); Ham v. Mullins Lumber Co., 193 S.C. 66, 7 S.E.2d 712 (1940), "indefinitely multiplied" reaffirmed in the opinions of this Court through today, Clemmons v. Lowe's Home Centers, Inc., 420 S.C. 282, 803 S.E.2d 268 (2017).

II. Where the insurance carrier stopped payment of benefits without a hearing on September 12, 2013 and gave Notice by letter dated that same day by regular mail to the disabled worker, the Commission erred as a matter of law by:

A. excluding all evidence after September 13, 2013 from the disabled worker, thus denying him due process of law.

It is uncontested that Petitioner's first notice Respondents were stopping payment of compensation and medical benefits was by letter dated September 12th, received September 15th. At hearing, the Commissioner not only excluded all evidence from Respondents after September 13th but excluded all evidence from Petitioner after September 13th.

Assuming arguendo the Commissioner was correct in ruling Petitioner had to "provide evidence" that the Respondents did not conduct a, "Good Faith Investigation", this ruling

foreclosed him from presenting any evidence whatsoever on that issue, especially where the adjuster did not testify; the Motion to Quash her deposition was not heard until and was granted at the hearing; and where the Respondents were not required to produce any records until long after the hearing. Thus, Petitioner had no way of knowing what Respondents did/did not know and/or do as far as conducting a Good Faith Investigation prior to and upon which they allegedly stopped benefits on September 12th. The Petitioner had no way of proving anything even if that was his burden which it was not.

The Commission also found, based on the late filed APA medical records, speculatively that it was, "possible" Respondents, "could" have formed a, "good faith belief", from their reading of the records which without testimony or even documentary evidence was a sufficient, "basis" to stop benefits. (App., p. 130, #4). By excluding all evidence after September 13th, the Commission excluded all the opinions issued after September 13th from the treating doctors to the contrary. Thus, the Commission denied Petitioner the right to confront and cross-examine the adjuster; the right to review Respondents records before the hearing (September 18th Subpoena required production by September 30th App., p. 159); and denied him the right to put in favorable evidence (doctor's opinions) tending to prove the lack of a Good Faith Investigation and medical opinion that he

had suffered a compensable injury: all obtained after September 15th. Petitioner is entitled under due process to the disclosure of evidence, to have a meaningful opportunity to be heard, and to confront, examine and cross-examine witnesses in a meaningful way. The Commission's Rulings (App., p. 128-131) and exclusionary rulings (App., p. 119-120) denied him that right including the right to submit evidence to disprove the "representation" and "belief" "argued" presented at hearing by Respondents. Brown v. SC State Bd. of Education, 301 S.C. 326, 391 S.E.2d 866 (1990), (where important decisions turn on questions of fact due process requires cross-examination of adverse witnesses and the disclosure of evidence to an individual so he has the opportunity to show it is not true); Smith v. SC Dept. of Mental Health, 329 S.C. 485, 494 S.E.2d 630 (SC App. 1997) (where important decisions turn on questions of fact due process at least requires the opportunity to present favorable witnesses). Not a kangaroo court and kangaroo decision. Rideau v. State of LA., 373 U.S. 723, 83 S.Ct. 1417 (1963).

II. B. Basing the Commission's decision on documentary evidence admittedly filed untimely and in violation of the commission's regulations.

The Commission abused its discretion by admitting and basing its decision on Respondents' late-filed APA Submissions in violation of WCC Reg. 67-612(B)(1)(4 E, J); the Administrative Procedures Act; and due process.

An abuse of discretion occurs where the ruling is based on an error of law or where the ruling is grounded upon factual findings without evidentiary support. Where there is an exercise of discretion, the reviewing Court must consider whether or not the exercise of that discretion is prejudicial to a party. Trotter v. Trane Coil Facility, 393 S.C. 637, 714 S.E.2d 289 (2011).

Here by Statute and Regulation, Respondents are the moving party and not only have the burden of proof, but Regulation 67-612(B) requires that they "**shall**", file their APA Submissions (documentary evidence) at least fifteen (15) days before hearing. Rule 67-611 requires all attorneys "**shall**" file a WCC Form 58 (Pre-Hearing Brief),

> "at least ten (10) days before the hearing with the Hearing Commissioner's office identified on the Hearing Notice." and "**shall**; serve the opposing party."

The Regulation also requires compliance with the Administrative Procedures Act (APA). SC Code §1-23-330, provides written evidence can only be submitted where, "the interests of the parties will not be prejudiced substantially.", (emp. added).

The provisions of R. 67-611(B) are mandatory. There is absolutely no discretion for the Commissioner to accept a late filed Pre-Hearing Brief (PHB)which sets out: 1) the issues of fact and law for decision; 2) the position of the parties; and

3) notification of witnesses and evidence to be submitted. The only actions the Commissioner may take for failure to file a PHB are: 1) if good cause is shown, postpone the hearing or 2) assess a fine against the attorney.

The Commissioner ruled he had discretion to admit the APA written evidence which is not true. While the exclusion of such evidence under Reg. 67-612 is not mandatory, the Commissioner can only exercise his discretion admitting written evidence in accordance with: 1) the Regulations, specifically 67-611, 67-612(E, J); 2) the APA; and 3) due process.

Under Reg. 67-611; 67-612 (E, J), a party may move for adjournment but must show good cause under Reg. 67-613. There was no motion or showing of good cause for the late filings. Therefore, the Commissioner had no discretion to accept the Pre-Hearing Briefs' or written evidence.

As APA submissions their admission was "substantially" prejudicial to Petitioner's interest and their admission constituted an abuse of discretion being controlled by an error of law.

Due process requires the right to cross examine and to contest this evidence. Barring admission of these APA Submissions, there is a complete failure of evidentiary support for Respondents' stop payment without a hearing.

The Commission's decision that Respondents, "could" have formed a good faith, "belief" that Petitioner had not sustained a compensable injury is based on this evidence (?) alone. (App., p. 130, #4). Thus, its submission was in violation of Regulations; highly prejudicial to Petitioner, violated due process and its admission under the guise of discretion was error.

III. Where the insurance carrier's assigned managing agent, the adjuster stopped payment without a hearing on September 12, 2013; and where Petitioner served Notice of Deposition with Subpoena on September 18th for the adjuster/file; the Commission denied Petitioner due process of law by not ruling on the discovery deposition/subpoena until the hearing on November 13, 2013 and by then denying Petitioner the right to take the adjuster's deposition as the managing agent and by ordering at the hearing production of documents including the adjuster's file but only AFTER that hearing for which discovery was sought.

The Commission denied Petitioner the right to take the deposition of the adjuster/managing agent, who completed, issued and signed the WCC Form 15 stopping his benefits without a hearing. (App. pp. 153-155). That denial is clearly contrary to our Court Rules, case law and due process. Schenk v. National Health Care, Inc., 322 S.C. 316, 471 S.E.2d 736 (SC App 1996).

First, the Commission's decision is based on legal arguments outside of those made by the parties. Since the Commission is a quasi-judicial body of lay and attorney Commissioners and since the specific basis for the decision, is a legal one, see Appendix p. 119, where did that legal

argument/basis come from? A review of the Motion to Quash (App., pp. 163-167), Respondent's Pre-Hearing Brief (App., p. 326, p. 383), and Hearing Transcript (App., p. 494-497) will establish this basis for the decision is nowhere to be found nor is there even any reference to SCRCP Rule 30(B)(6) in any of these. Under S.C. Code §42-3-250 Commissioners are subject to the Code of Judicial Conduct; Rule 501, Cannon 3(B)(7)(b), provides a Judge shall base his/her decision on the evidence and arguments made to him and shall not consider ex parte communications or consult with outside legal experts concerning issues of law

> "unless the Judge gives notice to the parties of the person consulted and/or the substance and advice sought and affords the parties a reasonable opportunity to respond."

Where is the SCRCP Rule 30(B)(6) argument made?

Next, the subpoena was for the adjuster as a party's, "Managing Agent", as evidenced by the September 12th Form 15, stopping benefits (App., pp. 153-155). The Commission is a creature of statute and its powers/ authority are only those set out in the statute. The authority for: 1) Subpoenas for production of books, records and witnesses is set out in S.C. Code §42-3-140; 2) S.C. Code §42-3-150 provides for attendance of witnesses, taking depositions and production of records "in conjunction with" proceedings; and 3) §42-3-160 allows for the

taking of witness depositions either "within or without the state" and are taken pursuant to the Circuit Court Rules, i.e. S.C. Rules of Civil Procedure (SCRCP).

Under SCRCP Rule 45(a), a subpoena for a deposition shall issue from the Court designated in the "Notice of Deposition" and provides for different treatment as to a person, "who is not a party or an officer, director or **managing agent of a party**". Subsection (b) provides service may be made in the same manner as prescribed for service, "of a summons and complaint in Rule 4(d) or (j)". SCRCP Rule 4(d)(3), corporations, provides the Complaint may be served by delivering it to, "an officer, **a managing or general agent**" or any other agent authorized to receive service. Under this Supreme Court's decisions even a timber agent is considered a managing agent for service. The adjuster was subpoenaed as a party's managing agent on the file. James v SC DOT, 393 S.C. 440, 711 S.E.2d 919 (S.C. App., 2011).

The notice of stopping payment of benefits filed with the Commission on September 12, 2013 **was issued by Ms. Terri Hughes**, Senior Claims Specialist II for Liberty Mutual Insurance Company. **Ms. Hughes certified** by her signature on the form/ line, "signature of claims administrator" that she had served the form per Rule 67-211. **Ms. Hughes** attached a Form 19 asserting she was the, "employer's representative". (App., pp. 153-155). The subpoena caption and to whom it was directed was

as follows "TERRI HUGHES, SENIOR CLAIMS SPECIALIST II, as Managing Agent for the Insurance Carrier **and** as a 30(b)(6) Representative of the Insurance Carrier. (R., p. 43)."

In addition, the form subpoena, also checked and required the production of records but on a different date, September 30th, as compared to the date of the deposition set for October 2nd. There is no reference to the "deposition" being for a 30(b)(6) representative, in the deposition part of the Commission Form. Further, there was no objection to the subpoena as being an improper designation of a 30(b)(6) representative. SCRCP Rule 37(2) places on a corporation the responsibility to designate a 30(b)(6)(2) representative and specifically provides that the failure to do so can result in sanctions for failure to cooperate in discovery. Respondents simply sought to avoid Petitioner having the right to take the deposition of Ms. Hughes as the managing agent.

Without citation, this Court has always been committed to liberal discovery. How in the world can it be argued that Petitioner was not denied due process by not having the opportunity to perform discovery on the very person that signed the pleadings that stopped both his weekly checks and his entitlement to medical care at a time when he was totally disabled and had no other source of income to pay for the normal subsistence of life? Ms. Hughes signed the 15 II; Ms. Hughes

certified that she was the Claims Administrator; Ms. Hughes asserted to the Commission that she was the "employer's representative".

No Order of Protection was issued, the refusal to appear delayed discovery, and no decision on the Motion before hearing denied Mr. Winfrey the right of confrontation, cross-examination and discovery necessary to prepare for the hearing. S.C. Code §42-3-160; SCRCP Rule 26(c)and(d); Rule 45(a)(2) and (c),(d)and(e). The disclosure of evidence to an individual so he has the opportunity to show it is not true is fundamental. Brown v. SC State Bd. of Education, supra. Thus, the Order denying Petitioner the right to examine the adjuster denied him due process of law.

IV. The Commission erred as a matter of law by making rulings set out in its Findings of Fact, making Findings #4 through #11, and specifically #6, #10, which are not supported by the evidence, but upon which the Commission found as a fact and as a matter of law that the insurance carrier had to only; "Represent" and only state a "belief" which violated the substantial evidence Rule while requiring Petitioner to produce contrary evidence.

The Commission's decision must be based on evidence in the Record and cannot be based upon surmise, speculation or innuendo. Pleadings/forms are not evidence but in Finding of Fact No. 6, the Commission found:

> "termination was based on a denial of the claim following an investigation. **This is based on the Form 15, section II. dated September 12, 2013**." (App., p. 126, #6). (emp. added.)

There is no evidence in the Record of an investigation; only "representations" made by Respondents counsel. In Finding of Fact No. 7, (App., p. 127) the Commission found that the, "evidence" in the Record was sufficient to establish Respondents had the medical records in the APAs in their possession prior to September 13th and that those provided "a basis for the Defendant's knowledge and good faith denial." (App., p. 144). In the Conclusions of Law, not the Findings of Fact the Commission found that Respondents "**represented**" to the Commission that their grounds for denial was a "good faith investigation"; that the Claimant had failed to meet the burden of compensable injury; and that under the Act, "**Claimant bears the burden of proving by a preponderance of the evidence**" (App., p. 146).

There is no, "evidence" in the Record setting forth, proof of or supporting the findings of, any investigation. There is no, "evidence" they contacted the authorized treating physicians to determine their opinion prior to September 13th. There is no, "evidence" that they contacted any medical doctor or medical professional such as even a nurse to determine whether or not the cause of the Claimant's problem was the work-related accident. There is no testimony from an investigator, the adjuster nor any other insurance carrier representative or of any investigation or of an, "evidentiary" basis for denial.

There are simply medical records and "**representations**" by Defense Counsel that those medical records constituted the investigation and "basis" for the stoppage of benefits. In Finding of Fact No. 13 The Commissioner held the Petitioner is "alleging a medically complex condition resulting from an injury by accident" and further that, "the causal relation between Claimant's alleged electrical shock and his current medical condition, **is one that can best be determined by review of the expert medical reports"**. So, where they accepted the claim as compensable, started benefits and were the moving party stopping benefits, where is the evidence as part of their alleged investigation that Respondents contacted any doctors prior to September 13th, much less Petitioner's authorized treating physicians, or that there is any medical evidence in this, as alleged by the Commission, "medically complex case" to establish any cause, as the cause of injury, other than the electrocution. There is no "evidence" of investigation or of a "basis" for decision. Our whole system of justice is based upon the presentation of evidence, and assuming arguendo proper admission, there is simply no "evidence" (e.g. medical opinion) linking any information found in the medical records to a basis for decision to deny benefits.

V. The Commission decision is the subject of surmise, speculation and innuendo where it is not based on substantial evidence in the Record on the essential issues for decision: whether the

insurance carrier conducted a good faith investigation and was there evidence to support the reason for denial.

The Commission found as a fact an investigation was conducted. (App., pp. 142-143). Respondents put up no testimonial evidence concerning an investigation being conducted or the basis for denial. The only testimonial evidence submitted was that of the Petitioner who testified he had not been contacted. (App., pp. 510-511). There is no documentary evidence of any investigation concerning compensability. Assuming proper admission, the medical records are simply that: medical records which contain no medical opinion or objective statement even implying non-compensability. There is no testimony or evidence these records were even considered by Respondents as part of any investigation. There is simply no, "evidence" an investigation was actually conducted or what was considered during investigation or that allowed Respondents to form a, "good faith belief" they had grounds for denial. Without evidence it was surmise, speculation and conjecture for the Commission to find an investigation was conducted.

The Commission decision must not be based upon surmise, speculation or conjecture and must be based on evidence in the Record. Glover v. Columbia Hospital of Richland County, 236 S.C. 410, 114 S.E.2d 565 (1960). There is simply no evidence to support the Commission's decision and where there is no

evidence, the decision will be reversed as a matter of law. Clemmons v. Lowe's Home Improvement, supra; Pierre v. Seaside Farms, Inc., 386 S.C. 534, 689 S.E.2d 615 (2010); Davaut v. University of South Carolina, 418 S.C. 627, 795 S.E. 2d 678 (2016).

CONCLUSION

After acceptance, taking away the money and medical care, the very means by which to live from a critically injured worker without a hearing, then denying the worker any discovery and then not requiring evidence to support the decision that stopped benefits cannot be countenanced in a civilized society. Due process requires more. Goldberg v. Kelly, 397 U.S. 254, 90 S.Ct. 1011 (1970). For the forgoing reasons, the Petition should be granted on all questions presented.

Respectfully submitted,

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March 15, 2018

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PROOF OF SERVICE

I certify that I have served the **AMENDED PETITION FOR WRIT OF CERTIORARI** on the Respondents by depositing a copy of it in the United States Mail, postage prepaid, addressed to their attorney of record:

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Dated: 3/15/2018

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