

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission
Appellate Panel

Appellate Case No. 2017-002124

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SC Court of Appeals

Edmund Dillon, Employee,.....Appellant,

v.

FleetPride, Employer, and Gallagher Bassett as
TPA for American Zurich Insurance Company, Carrier,.....Respondents.

RECORD ON APPEAL

VOLUME III OF III

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INDEX

Appellate Panel Decision and Order,
dated September 18, 2017 1

Decision and Order of Commissioner McCaskill,
dated February 2, 2016 33

Form 52, dated March 19, 2015 47

Form 53, dated April 9, 2015 48

Form 27, dated August 24, 2015 51

Hearing Notice dated April 26, 2016 for
For June 10, 2016 54

Claimant's Pre-Hearing Brief/APA Submissions,
Dated May 25, 2016 56

Defendant's Pre-Hearing Brief/APA Submissions,
Dated May 31, 2016 220

Defendants' Amended Pre-Hearing Brief/APA
Submissions, dated June 6, 2016 234

Defendants' Second Amended Pre-Hearing Brief/
APA Submissions, dated June 7, 2016 240

Hearing Reset Notice dated June 8, 2016
For August 30, 2016 992

Transcript of Deposition of
Michael Sribnick, MD, JD dated June 9, 2016 993

Transcript of Deposition of
Jacob Vandersteenhoven, MD dated August 16, 2017 1,081

Claimant's Memorandum In Support of Coverage,
Dated August 30, 2016 1,136

Respondent's Memorandum of Law, Dated
August 30, 2016 1,142

Form 30 Request For Commission Review	
Dated February 15, 2017	1,171
Claimant/Appellant's Brief to the Full Commission,	
Dated April 17, 2017	1,176
Defendants'/Respondents' Brief to the Full	
Commission, dated May 2, 2017	1,196
Transcript of Proceedings,	
Dated August 30, 2016	1,209
Transcript of Full Commission Hearing,	
Dated May 15, 2017	1,263
Request for Proposed Order,	
Dated September 20, 2016	1,282
Request for Proposed Order,	
Dated June 13, 2017	1,287
Certificate of Counsel	1,289

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Page 1

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Edmund Dillon, Dec'd,

Employee/Claimant,) WCC No. 1501382

-vs-

Raffles (FleetPride),

Employer,)

and)

Gallagher Bassett as TPA for)
American Zurich Insurance)
Company,)

Defendants.)

Given before Elaine G. McLeod, Court Reporter and
Notary Public, at the offices of Brian Dumas, Attorney,
LLC, 718 Clemson Road, Columbia, South Carolina, on
Thursday, June 9, 2016, commencing at 9:14 a.m.

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A P P E A R A N C E S

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ELAINE G. MCLEOD (803)603-4128

INDEX TO EXAMINATIONS:

DIRECT EXAMINATION BY MR. PRIDY: 7

INDEX TO EXHIBITS:

MEDICAL INFORMATION FROM THE MAYO INSTITUTE MARKED
AS DEFENDANT'S EXHIBIT NO. 1 5

ELAINE G. MCLEOD (803)603-4128

1 It was stipulated by and between
2 counsel for the parties that this
3 deposition is taken pursuant to notice and
4 that all questions as to notice are
5 waived; that all objections, save as to
6 the form of the question, are reserved
7 until the time of trial; that the
8 deposition is taken pursuant to the South
9 Carolina Rules of Civil Procedure, for the
10 purposes allowed therein; and that the
11 deponent was explained his right to read
12 and sign the deposition and did not waive
13 that right.

14 (Michael Sribnick, MD, JD, being duly
15 sworn, testified as follows:)

16 MR. PRIDDY: Dr. Sribnick, how are you
17 today?

18 DR. SRIBNICK: I'm fine.

19 MR. PRIDDY: My name is Sam Priddy and
20 I'm here representing the employer and the
21 insurance company in this Workers'
22 Compensation claim. And you have written
23 an expert witness report --

24 DR. SRIBNICK: I have.

25 MR. PRIDDY: -- for the Claimant, and

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1 obviously we're here to talk about that.
2 I have printed off -- this is just some
3 medical research I did from the Mayo
4 Clinic. I may reference it at times. I
5 printed off a copy for everyone.

6 DR. SRIBNICK: Okay.

7 MR. PRIDDY: And we'll just mark this
8 as Exhibit 1.

9 (MEDICAL INFORMATION FROM THE MAYO
10 INSTITUTE MARKED AS DEFENDANT'S EXHIBIT
11 NO. 1)

12 MR. PRIDDY: And then I also have --
13 this is just a copy of some of the medical
14 records that were in the file that --

15 MR. DUMAS: Hold on a minute. Let's
16 take them one by one. And I'm assuming
17 that the Mayo Clinic records --

18 MS. DOOLEY: They were our
19 submissions, too.

20 MR. DUMAS: They were submissions that
21 are numbered. Let me just make sure. You
22 sent a -- just so that we all keep
23 referring to the same documents --

24 MS. DOOLEY: Sure.

25 MR. DUMAS: -- in the same place at
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1 the same time. I see a -- let me flip to
2 the right ones. The Mayo Clinic starts at
3 what has been marked D0810 as part of the
4 additional submissions going to D0834; is
5 that correct?

6 MS. DOOLEY: Yes.

7 MR. DUMAS: Okay. So that would be
8 the package that you handed on the Mayo
9 Clinic printouts.

10 MR. PRIDDY: Yes.

11 MS. DOOLEY: Correct.

12 MR. DUMAS: The other materials that
13 you have just handed Dr. Sribnick are
14 what?

15 MR. PRIDDY: These are medical records
16 that were provided by you. These are the
17 EMS report, some of the Palmetto Health
18 records.

19 MR. DUMAS: Well, do we want to --

20 MR. PRIDDY: I don't know how you want
21 to -- I just labeled them off because, you
22 know, there's a thousand pages of records.

23 MR. DUMAS: Well, and I understand
24 that.

25 MR. PRIDDY: I figured --

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1 MR. DUMAS: I just -- the last thing I
2 want us all to do is to be sitting here
3 referring to -- you know, not talking
4 about the same thing at the same time.

5 MS. DOOLEY: Sure.

6 MR. DUMAS: So, if we're talking EMS
7 records -- bear with me a second and let
8 me pull -- because what I'm going to have
9 to do is let me pull my laptop or let me
10 pull my submission folder and let's just
11 make sure we are referring to the same
12 pages.

13 MS. DOOLEY: Are these from his or
14 from ours? You might want to go off the
15 records just a minute.

16 MR. PRIDDY: We'll go off the record.

17 MS. DOOLEY: Yeah.

18 (Deposition went off the record.)

19 MR. PRIDDY: All right.

20 DIRECT EXAMINATION BY MR. PRIDDY:

21 Q. Dr. Sribnick, could you just kind of briefly
22 explain your qualifications to serve as an
23 expert in this case?

24 A. I'm a board certified internist with over 25
25 years of experience. I graduated from

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1 Vanderbilt Medical School and did all my
2 training there.

3 Q. And when did you go to law school?

4 A. I went to law school, I believe, in 2005. I'm
5 not absolutely sure. It is on my CV that can
6 be found at my website
7 www.michaelsribnicklaw.com.

8 Q. And were you able to practice medicine while
9 you were in law school?

10 A. Uh-huh. Not -- while I was in law school?
11 Yeah, in the summers I was.

12 Q. But during school?

13 A. No.

14 Q. And did you practice while you studied for the
15 bar?

16 A. No.

17 Q. And since you have started practicing law, kind
18 of what's your -- if you could break it down
19 week by week kind of your hourly -- how much
20 time do you spend as an expert witness and how
21 much time do you spend as a lawyer and how --

22 A. I spend very little time as an expert witness.

23 Q. So how much time would you say you spend as a
24 lawyer versus a medical doctor?

25 A. Well, I'm not that busy as a lawyer yet. I

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1 have only been a lawyer for five years. Maybe
2 until about -- well, you can look, again, look
3 at my CV. I mean, look at
4 www.michaelsribnicklaw.com. I have worked more
5 recently as a doctor at that.

6 Q. And what is your medical practice like now?

7 A. I don't have a medical practice. I do locums
8 when I do it.

9 Q. And could you kind of explain what that is?

10 A. Locums means that when, say, a doctor is on
11 vacation or a company needs a doctor for a few
12 days, I fill in when I can and when I want to.

13 Q. And how often do you do that?

14 A. Again, that's on my CV.

15 Q. But if you could generalize it.

16 A. Probably one to two days a month, but I haven't
17 worked as a doctor since probably, I believe
18 October, but I could be wrong. I'm getting
19 timesheets from Barton & Associates. And I'm
20 looking at a part-time medical job now.

21 Q. You are looking to get into a part-time medical
22 job?

23 A. Yeah. Two or three days a week is as much
24 medicine as I can do.

25 Q. How many times have you served as an expert

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- 1 witness?
- 2 A. I'd say probably three to four times.
- 3 Q. In what sort of cases have you been an expert
- 4 witness for?
- 5 A. Well, I have been in a criminal case when I
- 6 worked at the prison where a guy was stabbed.
- 7 I have been an expert witness for the defense
- 8 in a Coumadin case and was deposed, and we won.
- 9 And a couple of other times, I believe. But I
- 10 have not done a lot of expert witness work to
- 11 be honest with you. I'm not a professional
- 12 expert witness at this point. I would like to
- 13 be, but I'm not.
- 14 Q. Have you ever been an expert for Attorney
- 15 Dumas?
- 16 A. Huh-uh. No, this is the first time.
- 17 Q. Have you ever been sued for medical
- 18 malpractice?
- 19 A. Have I ever been sued when I was in the prison?
- 20 Are you kidding? No one won. I have never
- 21 paid one cent in settlement fees or been found
- 22 guilty of malpractice. But, yeah, you get sued
- 23 all the time when you work in a prison for two
- 24 years.
- 25 Q. Well, as a doctor I assume in any practice you

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are going to get sued at some point.

A. No, I never did get sued. I have zero reports on the National Practitioner Data Bank.

Q. And what documents -- we're going to kind of move into this case now. What documents did you review when you were coming to your conclusion?

A. Okay. The things that Brian gave me, which I have got on the computer here. I have looked at your expert's report, the Springwood medical record. Make sure I reviewed this. That 1994 Kershaw report. The Affidavit of Josiah Fludd. The Death Certificate, of course. Your Defendant's Medical Record Summary. I don't know who prepared this. That includes Columbia Skin Clinic and all that. Donna Crider's report. Donna Crider's J -- what do you call it? JPG? She has a picture, which is correct. The OSHA report that your client received.

Wait a second. I'm out of my thing here. I said Death Certificate, right? Kershaw County medical records. I may be repetitious. I said Donna Crider already. The records from Palmetto Richland twice. The Death Certificate, which I may, again, be

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repetitious. Richland County EMS record. We are almost through. The surface weather conditions of Columbia that day and the transcript of the deposition of Josiah Fludd.

Q. So you said you looked at the '94 report from Kershaw?

A. Uh-huh.

Q. So you are aware that the -- that Mr. Dillon had a history of syncope?

A. No.

MR. DUMAS: Objection, leading.

A. No, no, no. He didn't have a history of. On that particular day he had a syncopal episode. I'm aware of that on that particular day. Unless you have other records indicating a history, all I know is on that particular day he had a syncopal episode.

Q. But he did have one in the past.

A. Obviously, in 1994. This is 2016.

Q. In your report you noted that the Claimant slipped and fell. Did you rely on that statement for --

A. I relied largely on what a patient says. It's been my experience that when a patient wants treatment they tell the truth. Yes, I relied

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- 1 on what he said particularly to the ER
- 2 physician in that H&P when he was lucid.
- 3 Q. And how would you classify this injury?
- 4 A. I think he slipped and fell in the rain.
- 5 Q. But how would you classify his head injury?
- 6 A. He fell backwards. He hit the back of his
- 7 head, which causes an acceleration injury to
- 8 the front of his head and a deceleration injury
- 9 to the back of his head.
- 10 Q. But would you say this was a minor head trauma?
- 11 A. No, I'd say it's -- obviously it's major head
- 12 trauma.
- 13 Q. So a major TBI?
- 14 A. Yes.
- 15 Q. And are you aware that Mr. Dillon lost
- 16 consciousness after his fall?
- 17 A. No. He said he did not lose consciousness
- 18 after his fall. And your records -- I'm just
- 19 sort of a matter of fact man, so please forgive
- 20 me if I sound -- slipped and fell and hit the
- 21 back of his head. Where do you see that he
- 22 lost consciousness after the fall?
- 23 Q. I believe it was in one of the medical reports.
- 24 A. I believe it's in Josiah Fludd's.
- 25 Q. And it may be in that, too.

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1 A. Yeah.

2 Q. But you are of the opinion he did not lose
3 consciousness at all?

4 A. Based on the records that I reviewed, I'm of
5 the opinion that he didn't lose consciousness.
6 But I think it's irrelevant to the -- to this
7 because he either slipped and fell or he had a
8 syncopal episode. That's what we're here for.

9 Q. Right.

10 A. I mean, I don't look for zebras when I hear
11 hoof beats. I think of horses.

12 Q. So you have admitted he had a massive head
13 trauma.

14 A. He died.

15 Q. Right. Would you say -- or how --

16 A. I would say that's, that's pretty significant.

17 Q. How reliable, in your opinion, is a patient in
18 recollecting events shortly --

19 A. Very reliable.

20 Q. -- shortly after a massive head trauma?

21 A. Very reliable. When he has a Glasgow Coma
22 Score of 18, he's totally coherent. And I
23 believe somewhere in the medical records he
24 states that he didn't blackout.

25 Q. Well, according to the EMS report, he had a

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1 Glasgow Coma Score of 15.

2 A. Okay. Then 15.

3 Q. But you are of the opinion that after a massive
4 head trauma you are still going to have --

5 A. He --

6 Q. -- great recall of events?

7 A. No, no, no. Please don't tell me what to say.
8 I mean, I'm, I'm a nice guy. Don't tell me
9 what to say. When he got to the emergency room
10 he was lucid. He gave a history. He denied
11 syncope, according to the emergency room
12 physician.

13 Syncope would be loss -- syncope can be
14 associated with loss of consciousness. But I
15 think he gave them the facts. I think a
16 patient desiring treatment tells the truth.
17 That's been my experience.

18 Now, patient's who, you know, they messed
19 around may -- may be difficult to get the truth
20 sometimes, you know, if they have VD or
21 something like that. But patients, in my 25
22 years, tell me the truth because they want
23 help.

24 Q. And I generally would agree with that, but you
25 don't think hitting your head severely on

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1 concrete could cause you to have some short
2 term memory issues?

3 A. No, he went down in the emergency room over
4 time, okay? And that's why the traumatic --
5 when the neurosurgery team sees him they get
6 most of the records from the family and from
7 the previous report. I think when he arrived
8 at the emergency room -- and what do I say
9 here? Let me, let me just look real quick.

10 Page 157 of 633; in the emergency room.
11 2/23/16 by Dr. Ford. You have this. This is
12 my testimony. History of present illness.
13 "This is a 56-year-old man presenting after he
14 fell. He states he slipped and fell, hit the
15 back of his head."

16 "He states he wanted to go back to work,
17 but his firm would not let him. Patient says
18 he has not felt well over the last several
19 days. Has not been eating well and did notice
20 his skin had changed color, but attributed this
21 to that. States he has had vomiting and
22 diarrhea and just not felt well, but today he
23 had a mechanical fall."

24 To most -- although, that is a junk term,
25 to most emergency room physicians it means an

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- 1 external fall. And did not have any syncopal
- 2 symptoms which leads me to believe that the
- 3 doctor didn't think he knew what the word
- 4 "syncope" means, but it does lead me to believe
- 5 that he explained what a syncopal episode was
- 6 to the patient and the patient denied it.
- 7 Q. And I'm not denying that --
- 8 A. And that is page 157 of 633.
- 9 Q. -- he said that, but I still find it hard to
- 10 believe that you could have -- you could fall
- 11 hard enough to hit your head to eventually
- 12 succumb and --
- 13 A. No, because --
- 14 Q. -- not suffer --
- 15 A. -- of subdural -
- 16 Q. -- any sort of memory loss or potentially have
- 17 some sort of confusion.
- 18 A. Sir, he declined. Okay? He didn't have -- I
- 19 mean, he had a decent Glasgow Coma Score when
- 20 he got to the hospital. He subsequently
- 21 deteriorated.
- 22 Q. What is a Glasgow Coma Score?
- 23 A. It's a measure of -- I'll pull it up on the
- 24 cell phone for you if you want to know exactly
- 25 what it is. But it's a way to determine how

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1 well a patient's doing --

2 Q. And how do they measure --

3 A. -- from a neurosurgical standpoint. Okay?

4 Q. How do they measure that?

5 A. All right. I'll pull it up.

6 DR. SRIBNICK: Do we have -- can I get
7 on your internet?

8 MR. DUMAS: Sure.

9 DR. SRIBNICK: Okay.

10 MR. DUMAS: Guest2015 would be the one
11 -- would be the access code. Want to go
12 off the record a moment?

13 MR. PRIDDY: Sure.

14 MS. DOOLEY: Sure.

15 (Deposition went off the record.)

16 A. It assesses a bunch of different features and
17 you arrive at a score.

18 Q. And does it use motor, verbal, and eye
19 movements to get to a score?

20 A. Okay, we will go through the whole thing. It
21 uses eye responses. It uses verbal responses
22 and it uses motor responses.

23 Q. And do you know why the test was developed?

24 A. To assess level of consciousness.

25 Q. So it's used more as kind of like a predictor

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- 1 of outcome amongst unconscious --
- 2 A. Well, it can be used as a predictor of outcome.
- 3 It can also be used as a way to say how
- 4 conscious the patient was at the time you were
- 5 talking to the patient.
- 6 Q. And how reliable is the scale?
- 7 A. It's pretty reliable. It's used -- it's a
- 8 standard practice in the medical -- in the
- 9 neurosurgical industry, I believe.
- 10 Q. Can it miss subtle changes?
- 11 A. If you are asking me if anything is possible,
- 12 the answer is yes.
- 13 Q. And with all that being said, is the Glasgow
- 14 Coma Scale, or score, a good test of a
- 15 patient's memory?
- 16 A. No, it's a test of the patient's neurologic
- 17 ability at that time and place.
- 18 Q. But it doesn't test whether they remember
- 19 events appropriately or not.
- 20 A. You would have to ask a neurosurgeon that. I'm
- 21 not going to answer that question. But I would
- 22 assume -- my assumption is that it would.
- 23 Q. And so, it's your opinion that --
- 24 A. I mean, the man gave a history. He was lucid.
- 25 He was awake and he gave a history.

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- 1 Q. And I believe in your report you stated that
2 you didn't see any underlying conditions that
3 could have caused the fall or any peculiar
4 conditions?
- 5 A. No, I didn't. Where, where did I say that?
6 Tell me where I said that.
- 7 Q. "In the absence of any significant symptoms
8 that would lead to any conclusion that a
9 condition --
- 10 A. Where is that?
- 11 Q. It's the last part of your paragraph. It's the
12 last --
- 13 A. Yeah, I say, "I do not find to a reasonable
14 degree of medical certainty that any of his
15 underlying conditions as related in the medical
16 records caused the fall at work that resulted
17 in the head injury that caused his death."
- 18 That's what I said. I didn't say that all
19 these conditions didn't complicate matters,
20 because obviously they did complicate matters
21 as far as his having surgery.
- 22 Q. But you go on to say, "I particularly noted in
23 my review of the records where the patient
24 stated he slipped and fell or fell at work, in
25 the absence of any significant symptoms that

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- 1 would lead to any conclusion that a condition
- 2 peculiar to him caused him to fall at work."
- 3 A. Yeah, I said that.
- 4 Q. Okay. Would you agree that Mr. Dillon had
- 5 evidence of liver failure?
- 6 A. I -- no, he had evidence of chronic liver
- 7 disease and went into liver failure, in my
- 8 opinion.
- 9 Q. But things such as jaundice and elevated bile
- 10 in the blood and --
- 11 A. Uh-huh.
- 12 Q. -- bile in the urine would suggest --
- 13 A. These are complicating conditions, yes.
- 14 Q. Moving towards liver failure?
- 15 A. No. I believe he developed liver failure after
- 16 this entire series of events. He had chronic
- 17 liver disease prior to that.
- 18 Q. But --
- 19 A. He drank. The man drank.
- 20 Q. But you agree he was jaundiced on arrival?
- 21 A. That's what the, that's what the record says.
- 22 Q. And that he had elevated bile in his blood? I
- 23 can't pronounce the word. Hyper?
- 24 A. Bilirubin?
- 25 Q. Hyper?

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- 1 A. Hyperbilirubinemia. If that's what the man
- 2 said -- let's see, what do I say? I think I
- 3 reported everything positive and negative to
- 4 our -- to this case.
- 5 Q. And that's on your record, page three. Page
- 6 158 of 633. You do note it in your --
- 7 A. 158, yeah.
- 8 Q. Towards the bottom, the impression.
- 9 A. Yeah, hyperbilirubinemia was their impression.
- 10 And I think, yeah, he had an elevated
- 11 bilirubin.
- 12 Q. And low blood potassium? Is that hypokalemia?
- 13 A. Hypokalemia, yes.
- 14 Q. And what is hyponatremia?
- 15 A. Low sodium.
- 16 Q. So you agree he had all those?
- 17 A. I agree he had all those.
- 18 Q. And that he was severely dehydrated?
- 19 A. I agree he was dehydrated.
- 20 Q. Would you agree that he was severely
- 21 dehydrated?
- 22 A. Well, fluids are a very complicated thing. If
- 23 you want me to get into all that now, I will do
- 24 so. I -- it may be more than you can handle.
- 25 I don't mean that as an insult. You know the

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- 1 law better than I do. I know medicine and this
- 2 may get complicated.
- 3 Q. But would you say that the records stated that
- 4 he was severely dehydrated?
- 5 A. Yes.
- 6 Q. Okay. And he was suffering from vomiting and
- 7 diarrhea and nausea?
- 8 A. Well, obviously, it wasn't profuse nausea,
- 9 vomiting, and diarrhea or I would think a good
- 10 employer would send him home, okay? If I saw a
- 11 yellow man coming to work I would send him
- 12 home. I think the reasonable person would send
- 13 a man like that home. If he was running every
- 14 five minutes to the bathroom with nausea,
- 15 vomiting and diarrhea; how can he effectively
- 16 work in the workplace?
- 17 Q. But you can't say that that wasn't happening.
- 18 Just because you would have sent him home
- 19 doesn't mean that everyone would.
- 20 A. I think the reasonable man would have sent him
- 21 home, yeah.
- 22 Q. But the records do state that the --
- 23 A. The records do state what you have stated.
- 24 Q. Okay. Could you describe what syncope is?
- 25 A. Syncope?

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- 1 Q. Syncope, yes.
- 2 A. It's a collapse. It doesn't necessarily mean
- 3 loss of consciousness. You crumble.
- 4 Q. Okay. And what --
- 5 A. Okay? And I don't know why -- I've, I've
- 6 explained it.
- 7 Q. And what can induce a syncopal episode?
- 8 A. Lots of things. A brain tumor, heart disease.
- 9 Electrolyte imbalance usually does not cause
- 10 syncope.
- 11 Q. How about --
- 12 A. Even in your own -- the stuff that you got off
- 13 the internet from the Mayo Clinic. It could
- 14 cause a seizure. But hyponatremia can cause a
- 15 seizure. But I don't think syncope, especially
- 16 if it's chronic -- if these conditions were
- 17 chronic, and we don't know because there were
- 18 no blood tests drawn prior to this event. So
- 19 we don't know whether this was acute or
- 20 chronic. And I think the man had chronic
- 21 disease and was getting along, going to work
- 22 every day.
- 23 Q. But can you suffer it from having too little
- 24 food?
- 25 A. Can you suffer what, syncope?

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- 1 Q. Can you have a syncopal episode from having too
- 2 little food?
- 3 A. Yes, but a syncopal episode doesn't cause loss
- 4 of consciousness necessarily.
- 5 Q. And I'm not saying that it does.
- 6 A. And I don't know what the man --
- 7 Q. And you're saying --
- 8 A. I don't know what --
- 9 Q. -- he didn't lose consciousness, so --
- 10 A. I have no idea what the man ate. It's not
- 11 listed what he ate.
- 12 Q. And I'm not saying what he ate. I'm just
- 13 asking you the question.
- 14 A. Yeah.
- 15 Q. Can having too little water cause you to have a
- 16 syncopal episode?
- 17 A. Well, if he had too little water why was he
- 18 hyponatremic?
- 19 Q. I'm just -- I'm not relating this to Mr. Dillon
- 20 right now. I'm just asking whether that could
- 21 cause someone to have a syncopal episode.
- 22 A. Dehydration?
- 23 Q. Dehydration.
- 24 A. Yeah. If you run soldiers on the battlefield
- 25 and they get dehydrated they could have a

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- 1 syncopal episode, yeah.
- 2 Q. So dehydration can cause --
- 3 A. Exertion. Exertion can cause it. Lots of
- 4 things can cause these things.
- 5 Q. Low blood pressure?
- 6 A. I mean, it is a myriad. Low blood pressure.
- 7 But he didn't have low blood pressure in the
- 8 emergency room. And no one bothered to take a
- 9 lying and standing blood pressure, which I
- 10 routinely do. No one.
- 11 Q. Can anyone suffer from syncope?
- 12 A. Can anyone faint?
- 13 Q. Uh-huh.
- 14 A. Yeah, anyone can faint. Under the right
- 15 circumstances. Let me add that.
- 16 Q. And there are a bunch of different
- 17 circumstances that can lead to a syncopal
- 18 episode?
- 19 A. Right.
- 20 Q. And earlier we were kind of talking about some
- 21 of Mr. Dillon's conditions; suffering from
- 22 severe dehydration according to the --
- 23 A. Uh-huh.
- 24 Q. -- the records and low sodium levels and things
- 25 of that nature.

ELAINE G. MCLEOD (803)603-4128

- 1 A. Uh-huh.
- 2 Q. And I just kind of want to ask you a few
- 3 questions about --
- 4 A. Absolutely.
- 5 Q. -- these different conditions he presented
- 6 with. And I believe he was suffering from some
- 7 anemia based on the records?
- 8 A. Uh-huh.
- 9 Q. And I -- this is --
- 10 A. And it -- again, it depends on whether that was
- 11 acute or chronic.
- 12 Q. Okay.
- 13 A. Because understand if something is chronic a
- 14 person gets along with it, okay? If something
- 15 happens acutely they could have -- they could
- 16 pass out.
- 17 Q. And you can't say one way or the other?
- 18 A. They could possibly pass out. Neither can you.
- 19 Q. I'm not saying I can.
- 20 A. Nothing, nothing was done.
- 21 Q. That was just --
- 22 A. There are no labs, sir.
- 23 Q. So, from the records there's no way to
- 24 determine whether it was chronic or acute?
- 25 A. I believe it was chronic.

ELAINE G. MCLEOD (803)603-4128

- 1 Q. But you, you just said you --
- 2 A. He was a chronic drinker.
- 3 Q. But you just said you can't prove that.
- 4 A. I can't prove it.
- 5 Q. Okay.
- 6 A. But I, I can tell you to a reasonable degree of
- 7 medical certainty that I believe it was
- 8 chronic.
- 9 Q. What type of symptoms can arise from someone
- 10 who has anemia?
- 11 A. It depends on their, their overall health
- 12 condition. For example, if a patient has
- 13 congestive heart failure. Anemia is worse than
- 14 a patient with a normal heart. So it depends
- 15 on their overall status.
- 16 Q. Right. But can it cause you to look jaundiced?
- 17 A. Can anemia cause you to look jaundiced?
- 18 Shouldn't, unless you are hemolyzing.
- 19 Q. So you --
- 20 A. Which means destruction of red blood cells.
- 21 Q. Can it cause --
- 22 A. That would raise your -- because bilirubin is
- 23 part heme -- because -- I, I want to say this
- 24 right. If you were hemolyzing red blood cells,
- 25 in other words, they were being destroyed; it

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- 1 could conceivably cause you to look jaundiced.
- 2 Q. Can anemia cause weakness?
- 3 A. Anemia can cause weakness.
- 4 Q. Can it cause dizziness?
- 5 A. We're going through your sheet, right?
- 6 Q. We are.
- 7 A. Mayo Clinic's. Okay. So let's, let's be
- 8 straight from it. It can cause fatigue. It
- 9 can cause weakness. It can cause pale or
- 10 yellowish skin. It can cause an irregular
- 11 heartbeat. It can cause shortness of breath.
- 12 It can cause dizziness or lightheadedness. It
- 13 can cause chest pain; but that would be in a
- 14 person, in my opinion, that suffered angina.
- 15 Q. Okay.
- 16 A. Okay? It can certainly cause cold hands and
- 17 feet. And I've not had anyone with anemia that
- 18 causes headache, but your Mayo Clinic records
- 19 indicate that it does.
- 20 Q. Do you agree with the Mayo Clinic on most of --
- 21 at least most of those symptoms?
- 22 A. I think this is done for the public.
- 23 Q. But do you agree that --
- 24 A. For most of the symptoms, yeah.
- 25 Q. Particularly dizziness or lightheadedness?

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- 1 A. Not particularly. I agree with all of it in
- 2 general.
- 3 Q. Okay. And we'll just kind of keep on going
- 4 through this packet if you want to.
- 5 A. Let's do it. But you notice nowhere under
- 6 "Anemia" does it say syncope.
- 7 Q. No, it doesn't, but --
- 8 A. Correct.
- 9 Q. -- do you believe if one was lightheaded enough
- 10 that they could faint?
- 11 A. Where does it say lightheaded?
- 12 Q. "Dizziness or lightheadedness."
- 13 A. "Dizziness or lightheadedness." If one was
- 14 anemic enough it is possible that they could
- 15 faint if the anemia was acute. Acute means
- 16 sudden onset. Chronic means over time.
- 17 Q. And on page six, thrombo --
- 18 A. Cytopenia.
- 19 Q. And that is low platelet count; is that
- 20 correct?
- 21 A. Right. His platelet count wasn't -- I believe
- 22 it was, what?
- 23 Q. It was low.
- 24 A. No, no. It was mildly low. If they had
- 25 thought it was low they would -- should have

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- 1 given him platelets while they were doing the
- 2 surgery, which they did not. But I believe I
- 3 have it in my note what his platelet count was.
- 4 I have it somewhere here.
- 5 Q. This may be the sheet.
- 6 A. Just one second. All right.
- 7 Q. This is page 18.
- 8 A. On the 23rd?
- 9 Q. And that's page 18 of --
- 10 A. Where is it dated the 23rd, sir?
- 11 Q. I don't know if that is the --
- 12 A. That's the 25th.
- 13 Q. Okay.
- 14 A. I need to see what it was on the 23rd. 120 --
- 15 127,000 platelets is not that low. I would
- 16 have, had I been doing -- had I been a
- 17 neurosurgeon -- my son is, I'm not -- I would
- 18 have given him platelets if I thought his
- 19 platelet count was that severely low.
- 20 Q. But he was diagnosed with having a low platelet
- 21 count?
- 22 A. Anything -- I mean, you know, if a normal
- 23 platelet is a hundred and -- 140,000; 130,000
- 24 -- 139,000 would be low. So, yes.
- 25 Q. And do you agree that that can cause jaundice

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- 1 or fatigue?
- 2 A. No. With hemolysis I told you it could cause
- 3 that.
- 4 Q. And you --
- 5 A. Of red blood cells, not platelets.
- 6 Q. Okay. And do you agree that he had low
- 7 potassium?
- 8 A. Where, where are we?
- 9 Q. This is --
- 10 A. Are we going through your --
- 11 Q. Yeah. It's page 12.
- 12 A. Where? In this Mayo stuff?
- 13 Q. Yes.
- 14 A. Page?
- 15 Q. 12.
- 16 A. 12. Okay. Page 12 there. Yeah.
- 17 Q. And we have already discussed --
- 18 A. I agree he had low potassium. It wasn't that
- 19 low. 3.3, to the best of my recollection.
- 20 Q. And do you agree that --
- 21 A. Do you know what it was exactly?
- 22 Q. I don't have that figure right in front of me,
- 23 no.
- 24 A. See, a lot of this I'm going by memory. I can
- 25 look it up if you want me to look up the exact

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- 1 figures.
- 2 Q. You can look up his figure.
- 3 A. Then I'd want to go over it again and look up
- 4 every figure. Okay?
- 5 Q. Okay.
- 6 A. Okay. Let's start with platelets. And that's
- 7 why I brought my computer because obviously 633
- 8 pages of documents I cannot -- 638 pages of
- 9 documents, I can't do it all in my head. I'm
- 10 doing a Control-F on this if you are wondering
- 11 what I'm doing. Okay.
- 12 I'm trying to find out what his studies
- 13 were on 2/23. And if you can help me, I'd
- 14 greatly appreciate it, sir.
- 15 Q. I'm looking.
- 16 A. And I'm sorry this is taking so long, but it's
- 17 important to get it right. On 2/23, his INR,
- 18 which is elevated, was 1.6. His PTT was 37.3.
- 19 I'm trying to find --
- 20 Q. 127,000?
- 21 A. Where do you see that? On page?
- 22 Q. 158 of 633.
- 23 A. 158?
- 24 Q. Yes, sir.
- 25 A. Let me get to that. Thank you, sir. 158. I'm

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- 1 close.
- 2 Q. I can show you this copy if it would be --
- 3 A. I'm going to find it. 158 of 633, I'm on it.
- 4 Okay. Platelets were 127,000. Is that Dr.
- 5 Jones?
- 6 Q. It is.
- 7 A. Thank you. And that is low, but obviously the
- 8 neurosurgeons didn't think it was low enough to
- 9 give him a platelet transfusion.
- 10 Q. And do you agree he had low potassium,
- 11 hypokalemia, which on that same page was an
- 12 impression of the doctor?
- 13 A. Yes. Is it listed on that page --
- 14 Q. 158.
- 15 A. -- where the potassium was? Potassium was 3.1.
- 16 Yeah, that's a low potassium. That's not a --
- 17 I've seen worse.
- 18 Q. But it is low?
- 19 A. It is low. So are we going to hypokalemia now?
- 20 Hypokalemia?
- 21 Q. It's page 12.
- 22 A. Weakness, fatigue, muscle cramps, and
- 23 constipation. I wouldn't argue with any of
- 24 that.
- 25 Q. Okay. And would you agree he had low sodium in

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- 1 his blood?
- 2 A. I would. What page?
- 3 Q. Finding our rhythm here.
- 4 A. Yes, we are.
- 5 Q. Page 14.
- 6 A. You're a good man. Weakness, fatigue, muscle
- 7 cramps, and constipation.
- 8 Q. That's the potassium one again.
- 9 A. Oh, I'm sorry.
- 10 Q. Page 14.
- 11 A. Page 14? Hyponatremia? Nausea and vomiting,
- 12 headache, confusion, loss of energy and
- 13 fatigue, restlessness and irritability. Muscle
- 14 weakness, spasm or cramps, seizures and coma.
- 15 He didn't have a seizure. He didn't have -- he
- 16 wasn't in a coma at that time.
- 17 Q. I agree with that.
- 18 A. Okay. And it doesn't say syncope.
- 19 Q. No, but it's -- you do agree it can cause
- 20 nausea and vomiting?
- 21 A. Uh-huh.
- 22 Q. And perhaps confusion?
- 23 A. Uh-huh.
- 24 Q. So, you agree that --
- 25 A. But we don't know what it was -- whether this

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- 1 was chronic or acute.
- 2 Q. Right. But you do agree it can cause nausea
- 3 and vomiting, which he was suffering from?
- 4 A. I agree with the Mayo Clinic's assessment which
- 5 is meant for lay-people.
- 6 Q. And that includes confusion. And you agree
- 7 that --
- 8 A. The man was not confused. It says clearly in
- 9 the medical records that he was alert and
- 10 oriented times three.
- 11 Q. But you agree that if you have low sodium you
- 12 could potentially be confused, which you stated
- 13 earlier.
- 14 A. Yeah.
- 15 Q. Okay. And you agree that he had liver failure
- 16 or liver disease?
- 17 A. Liver -- chronic liver disease from drinking
- 18 alcohol. He had fatty liver infiltrate.
- 19 That's the first step in liver disease.
- 20 Q. Okay.
- 21 A. In other words, if a man drinks too much, or in
- 22 a diabetic, or in somebody with metabolic
- 23 syndrome. Okay? Liver -- end stage liver
- 24 disease is cirrhosis of the liver.
- 25 Q. Which he ended up having, correct?

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- 1 A. No, I don't recall where -- you show me where
- 2 it says he had cirrhosis of the liver.
- 3 Q. I don't have that in front of me right now
- 4 A. You're not going to find it.
- 5 Q. Okay. But for liver disease, do you agree with
- 6 the symptoms on page 19?
- 7 A. Page 19.
- 8 Q. It can cause jaundice?
- 9 A. Absolutely. Abdominal pain and swelling. It
- 10 can certainly cause ascites. I suspect this
- 11 man was a drinker. This was chronic liver
- 12 disease. Swelling in the legs and ankles;
- 13 yeah, if you've got fluid in the stomach you
- 14 could certainly -- in the most deep-ended part,
- 15 the legs and ankles. You could have itchy skin
- 16 from bile salts, yes. Dark urine color from
- 17 bilirubin -- hyperbilirubinuria, yes. Pale
- 18 color stool. Bloody or tar-colored stool, yes.
- 19 Chronic fatigue, nausea or vomiting, loss of
- 20 appetite, tendency to bruise easily.
- 21 Q. You agree with all this?
- 22 A. Yeah.
- 23 Q. And he was suffering from a good amount of
- 24 those which --
- 25 A. He was suffering from chronic liver disease.

ELAINE G. MCLEOD (803)603-4128

- 1 Q. But he was presenting with a lot of those
- 2 symptoms such as nausea and vomiting, loss of
- 3 --
- 4 A. No, he gave a history of nausea and vomiting.
- 5 Q. And loss of appetite.
- 6 A. No, let's get --
- 7 Q. And being jaundiced.
- 8 A. Just one second. If I'm at work -- I'm at your
- 9 work. I'm an associate with your law firm.
- 10 Every three minutes I run to the bathroom to
- 11 vomit. I have diarrhea. I'm not getting any
- 12 work done. Are you going to send me home or
- 13 are you going to let me finish my stuff?
- 14 You're a reasonable person.
- 15 Q. But that doesn't mean that happened in this
- 16 situation.
- 17 A. Sir --
- 18 Q. You can't just make assumptions. You can't
- 19 just assume.
- 20 A. The law is full of assumptions, okay?
- 21 MR. DUMAS: Can we take a break for
- 22 just a moment?
- 23 MS. DOOLEY: Sure.
- 24 (Deposition went off the record.)
- 25 Q. (By Mr. Priddy) And you would agree that he

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1 presented dehydrated?

2 A. I would agree that's what the record says and I
3 had -- and I didn't examine him.

4 Q. And you agree that the records say he was
5 severely dehydrated?

6 A. Well, a -- here again we get into the
7 physiology, okay? Symptom -- the -- what the
8 guy described sounds like dehydration. If you
9 lose only water you develop hypernatremia. You
10 would develop hyperkalemia because it all
11 depend -- see, the body is made of electrolytes
12 and water. That's what it is.

13 For example, if you vomit you develop a
14 metabolic alkalosis usually. If you lose more
15 sodium than water, you get hyponatremic. If
16 you lose more potassium than water, you get
17 hypokalemic. This is not as easy -- as cut and
18 dry as, as you and your expert believe.

19 If you have diarrhea and you just lose
20 water you would become, first of all, acidotic.
21 It causes a metabolic acidosis. In other
22 words, the pH of your blood is different. It
23 goes down. Whereas in alkalosis it goes up.
24 And depending upon what electrolytes you are
25 losing, that's the result. So from the -- from

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- 1 looking at the report, he was dehydrated.
- 2 Q. And the report says severely dehydrated?
- 3 A. Where does it say severely dehydrated? Why
- 4 don't you show me.
- 5 Q. This page. This is just page 22 in that
- 6 report. In that history of present illness.
- 7 A. Is this Dr. Ford again? I mean, Dr. Jones?
- 8 Q. It's in the second paragraph of the HPI, 22 of
- 9 633.
- 10 A. I'm not going to argue with what the treating
- 11 physician said.
- 12 Q. Okay.
- 13 A. But I would think, once again, if you are
- 14 severely dehydrated, if you are running to the
- 15 bathroom to vomit every five minutes or
- 16 diarrhea; you are not doing much work. And he
- 17 worked. He worked all through this. I would
- 18 send a person home. He's of no good --
- 19 Q. Okay. Well --
- 20 A. If I'm an employer. And I think a reasonable
- 21 employer would have done exactly what I'm
- 22 saying. You would have done it. You would
- 23 have done it. You would have done it. You
- 24 would have done it.
- 25 Q. Let's move to page 30 of the --

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1 MR. DUMAS: Page 30 of what?

2 Q. Of the Mayo Clinic. I'm sorry.

3 A. Mayo Clinic.

4 MS. DOOLEY: The exhibit. Exhibit 1.

5 Q. The exhibit. Defendant's Exhibit 1.

6 A. Page 30. Dehydration. Dry, sticky mouth;
7 sleepiness or tiredness; thirst; decreased
8 urine output; no wet diapers for three hours
9 for infants. I'm going to read it all. Few or
10 no tears when crying, dry skin, headache,
11 constipation, dizziness or lightheadedness.
12 Syncope is not listed.

13 Q. I understand. But do you agree with all those?

14 A. Yeah.

15 Q. And do you agree that if you become very
16 lightheaded you could faint?

17 A. I think if you acutely become dehydrated, yes.
18 But over -- but chronic, if you have adjusted
19 to it, no.

20 Q. And to be clear, the list you just read is for
21 mild to moderate dehydration. Do you want to
22 read the list for severe dehydration?

23 A. Oh, I'm sorry. Extreme thirst; extreme
24 fussiness or sleepiness in infants and
25 children; irritability and confusion in adults;

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1 very dry mouth, skin, and mucous membranes;
2 little or no urination; any urine that is
3 produced will be darker than normal; sunken
4 eyes -- they don't describe that; shriveled and
5 dry skin that looks -- lacks elasticity and
6 doesn't bounce back when pinched into a fold;
7 in infants, sunken fontanelles, the soft spots
8 of the top of the baby's head; low blood
9 pressure; rapid heartbeat; rapid breathing; no
10 tears when crying; fever; in most serious
11 cases, delirium or unconsciousness. Okay? And
12 I will say the same thing as I have said, if
13 that happens acutely --

14 Q. You agree.

15 A. -- it is possible to have those symptoms.

16 Okay? That's going to be acutely.

17 Chronically, if that's what you are used to --
18 this is a steady hard drinking man, but he goes
19 to work every day like my dad did.

20 Q. But you agree that it can cause all those
21 symptoms including unconsciousness in a severe
22 case?

23 A. Yeah. I'm not going to argue with --

24 Q. So with all the different conditions we just
25 went over and talked about with the symptoms --

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1 ones including fatigue, and weakness, and
2 jaundice --

3 A. Uh-huh.

4 Q. -- lightheadedness, dizziness; you don't think
5 there's any underlying conditions that could
6 cause him to faint?

7 A. I don't believe he fainted.

8 Q. There are none that could have caused him just
9 to get really dizzy and lightheaded and fall
10 over?

11 A. I think the man from his own mouth tells you
12 what happened. The emergency report says work
13 related. They must have -- there must be some
14 reason they said that.

15 Q. It could be that he was at work.

16 A. Oh, come on. They must have gotten some
17 history from him. And they told -- as a matter
18 of fact, they told the people at the hospital
19 that he slipped and fell or that it was a
20 mechanical fall. He himself conscious says he
21 tripped and fell and hit the back of his head.

22 The -- Dr. Jones -- I think it was Dr.
23 Jones states -- I'm sorry, Dr. Ford states this
24 is a 56-year-old black male presenting after he
25 fell. States he slipped and fell, hit the back

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1 of his head. States he slipped and fell.

2 That's what he's saying. Why is he going
3 to lie? Is he smart enough to lie? Why is he
4 working for Saleeby -- for FleetPride if he's
5 so intelligent that he's going to lie? Says he
6 wanted to go back to work, but his firm would
7 not let him. So he's not a brilliant man to
8 begin with. He's a truthful man.

9 Patient states that he has non -- that he
10 has not -- I'm assuming this is not felt well
11 over the last several days and has not been
12 eating well and did notice that his skin had
13 changed color, but attributed this to that.
14 States that he had vomiting and diarrhea and
15 just not felt well, but today he had a
16 mechanical fall.

17 Mechanical fall is a hodgepodge of terms,
18 but what it basically means to the emergency
19 room, emergency room physician is that it's an
20 external fall. Okay?

21 Q. I will --

22 A. And did -- wait, let me finish. Did not have
23 syncopal symptoms. The doctor is very smart to
24 say that. Because he doesn't say the patient
25 understood syncope. He says he gave him

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- 1 symptoms of syncope and the patient denied
- 2 those.
- 3 Q. Would you say that a reasonable person with all
- 4 these conditions could have a syncopal episode?
- 5 A. I think it's more likely that this man tripped
- 6 and fell. I'm not going to change.
- 7 Q. But --
- 8 A. It's my -- my opinion is the patient tells the
- 9 truth. He slipped. It was raining that day.
- 10 He slipped and fell. I see no reason for a
- 11 patient to lie.
- 12 Q. And you did see the affidavit and deposition of
- 13 the witness who said he was not moving?
- 14 A. Mr. Fludd?
- 15 Q. Yes.
- 16 A. That's full of inconsistencies, sir. I may
- 17 have only been a lawyer for five years, but
- 18 it's full of inconsistencies.
- 19 Q. But he does state that he was not moving?
- 20 A. He states all sorts of things. Do you want to
- 21 go through that deposition, that affidavit?
- 22 Q. No, but the affidavit --
- 23 A. And Mr. Dumas' cross?
- 24 Q. We don't need to go through that. That's
- 25 already in the record.

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- 1 A. Right. Well, I have and it's full of
- 2 inconsistencies.
- 3 Q. And you discussed a mechanical fall versus non-
- 4 mechanical fall?
- 5 A. Right. And I know from the literature that a
- 6 lot of people don't like that term. They think
- 7 it's a copout. But a mechanical fall in
- 8 general to an ER physician means from extrinsic
- 9 reasons, not intrinsic reasons. So regardless
- 10 of what has been published -- and I already
- 11 knew this. Regardless of what has been
- 12 published, a mechanical fall to the average ER
- 13 physician means from an extrinsic cause.
- 14 Q. Do you disagree with the article that I've
- 15 included --
- 16 A. No.
- 17 Q. -- that the term is just used --
- 18 A. It's a hodgepodge term.
- 19 Q. It's not used accurately?
- 20 A. Lots of, lots of things in medicine are
- 21 hodgepodge terms. Lots of things in law are
- 22 hodgepodge terms.
- 23 Q. So you agree that it doesn't -- it's used
- 24 inconsistently?
- 25 A. No, well, I agree -- no, it's not used

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1 inconsistently. When a, when a doctor says
2 mechanical fall what he means is an extrinsic
3 fall. Now, he's incorrect in stating that. I
4 agree that that's incorrect because it, it
5 absolves you from having to find out the, the
6 exact etiology of the fall.

7 Q. But there are a bunch of doctors out there who
8 don't like the use of that term versus non-
9 mechanical?

10 A. Oh, there are doctors that don't like a lot of
11 things.

12 Q. And once it's been reported as mechanical the
13 first time in the emergency department is it
14 likely they'll just keep reusing that term in
15 all the records after that?

16 A. Yeah.

17 Q. Okay.

18 A. But I think they took their own histories, I
19 would hope, to the best of their ability.

20 Q. You would agree that a lot of the history is --
21 that were taken after he had that subsequent
22 decline, so --

23 A. But the good history was taken by -- a good
24 history, the important history, the thing that
25 goes to the meat of this whole thing is Dr.

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- 1 Ford's history. He doesn't say that. He says
2 -- and I'm going to do it again --
- 3 Q. You don't have to read it again.
- 4 A. -- because we keep -- well, then we don't need
5 to keep doing this.
- 6 Q. We'll move on to one last thing I want to
7 discuss and that would be you obviously don't
8 put any weight into the affidavit. In his
9 emergency --
- 10 A. I don't think he wrote the affidavit. Mr.
11 Fludd you're talking about?
- 12 Q. Yes, sir.
- 13 A. I don't believe he wrote the affidavit. I
14 don't think Mr. Fludd could define "collapse"
15 to me any more than you could explain diabetes
16 insipidus to me.
- 17 Q. I'm not asking you about that right now. In
18 the emergency documentation by Dr. Ford when he
19 first arrived, the note you keep referencing,
20 they start to mention some abrasions on his
21 body, on his back, his sacrum --
- 22 A. He fell, he fell backwards.
- 23 Q. -- and his head. No mention of any abrasions
24 on his arms or hands suggesting he tried to
25 catch himself.

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1 A. Sir, if you are falling backwards you don't try
2 to catch yourself. If you are falling
3 backwards it's very difficult to catch
4 yourself. If you are falling forwards you
5 would brace yourself, in my opinion, okay?

6 Q. You don't think you would put your hands back
7 and try to catch yourself?

8 A. No. No, I don't think you would put your hands
9 back. That would be an exercise in futility.

10 Q. I hope you don't fall backwards, then.

11 A. I don't. Matter of fact, I just had my
12 physical. I'm in A-1 shape.

13 MR. PRIDDY: Do you have anything
14 else?

15 MS. DOOLEY: Nothing else.

16 MR. PRIDDY: I've got nothing further.
17 Thank you for your time.

18 DR. SRIBNICK: Thank you, sir.
19 Pleasure. Thank you, ma'am. Pleasure.

20 MR. DUMAS: I have nothing.

21 (Deposition concluded at 10:33 a.m.)
22
23
24
25

ELAINE G. MCLEOD (803)603-4128

1 STATE OF SOUTH CAROLINA)
2 : C-E-R-T-I-F-I-C-A-T-E
3 COUNTY OF LEXINGTON)

4 I, Elaine G. McLeod, Court Reporter and Notary
5 Public, certify that I did have Michael Sribnick, JD,
6 LLC, to appear before me at 9:20 a.m. on Thursday, June
7 9, 2016, at the offices of Brian Dumas, Attorney, LLC,
8 718 Clemson Road, Columbia, South Carolina; that the
9 witness was sworn and cautioned to tell the truth, the
10 pages constitute a true and accurate transcript of the
11 testimony given at that time and place.

12 I further certify that I am not of counsel or kin to
13 any of the parties to this cause of action, nor am I
14 interested in any manner in its outcome.

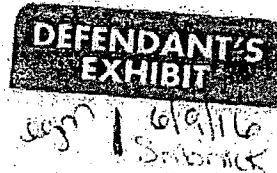
15 IN WITNESS WHEREOF, I have hereunto set my hand and
16 seal this the 13th day of June, 2016.

17
18 

19
20 _____
21 Notary Public for South Carolina

22 My Commission Expires: 07/24/2025
23
24
25

ELAINE G. MCLEOD (803)603-4128



Anemia

Symptoms and causes

By Mayo Clinic Staff

Symptoms

Anemia signs and symptoms vary depending on the cause of your anemia. They may include:

- Fatigue
- Weakness
- Pale or yellowish skin
- Irregular heartbeats
- Shortness of breath
- Dizziness or lightheadedness
- Chest pain
- Cold hands and feet
- Headache

At first anemia can be so mild that it goes unnoticed. But symptoms worsen as anemia worsens.

When to see a doctor

Make an appointment with your doctor if you're feeling fatigued for unexplained reasons. Some anemias, such as iron deficiency anemia or vitamin B-12 deficiency, are common.

Fatigue has many causes besides anemia, so don't assume that if you're tired you must be anemic. Some people learn that their hemoglobin is low, which indicates anemia, when they go to donate blood. If you're told that you can't donate blood because of low hemoglobin, make an appointment with your doctor.

Causes

Anemia occurs when your blood doesn't have enough red blood cells. This can happen if:

- Your body doesn't make enough red blood cells
- Bleeding causes you to lose red blood cells more quickly than they can be replaced
- Your body destroys red blood cells

What red blood cells do

Your body makes three types of blood cells — white blood cells to fight infection, platelets to help your blood clot and red blood cells to carry oxygen throughout your body.

Red blood cells contain hemoglobin — an iron-rich protein that gives blood its red color. Hemoglobin enables red blood cells to carry oxygen from your lungs to all parts of your body and to carry carbon dioxide from other parts of the body to your lungs so that it can be exhaled.

Most blood cells, including red blood cells, are produced regularly in your bone marrow — a spongy material found within the cavities of many of your large bones. To produce hemoglobin and red blood cells, your body needs iron, vitamin B-12, folate and other nutrients from the foods you eat.

Causes of anemia

Different types of anemia and their causes include:

- **Iron deficiency anemia.** This is the most common type of anemia worldwide. Iron deficiency anemia is caused by a shortage of iron in your body. Your bone marrow needs iron to make hemoglobin. Without adequate iron, your body can't produce enough hemoglobin for red blood cells.

Without iron supplementation, this type of anemia occurs in many pregnant women. It is also caused by blood loss, such as from heavy menstrual bleeding, an ulcer, cancer and regular use of some over-the-counter pain relievers, especially aspirin.

- **Vitamin deficiency anemia.** In addition to iron, your body needs folate and vitamin B-12 to produce enough healthy red blood cells. A diet lacking in these and other key nutrients can cause decreased red blood cell production.

Additionally, some people may consume enough B-12, but their bodies aren't able to process the vitamin. This can lead to vitamin deficiency anemia, also known as pernicious anemia.

- **Anemia of chronic disease.** Certain diseases — such as cancer, HIV/AIDS, rheumatoid arthritis, kidney disease, Crohn's disease and other chronic inflammatory diseases — can interfere with the production of red blood cells.
- **Aplastic anemia.** This rare, life-threatening anemia occurs when your body doesn't produce enough red blood cells. Causes of aplastic anemia include infections, certain medicines, autoimmune diseases and exposure to toxic chemicals.
- **Anemias associated with bone marrow disease.** A variety of diseases, such as leukemia and myelofibrosis, can cause anemia by affecting blood production in your bone marrow. The effects of these types of cancer and cancer-like disorders vary from mild to life-threatening.
- **Hemolytic anemias.** This group of anemias develops when red blood cells are destroyed faster than bone marrow can replace them. Certain blood diseases increase red blood cell destruction. You can inherit a hemolytic anemia, or you can develop it later in life.
- **Sickle cell anemia.** This inherited and sometimes serious condition is an inherited hemolytic anemia. It's caused by a defective form of hemoglobin that forces red blood cells to assume an abnormal crescent (sickle) shape. These irregular blood cells die prematurely, resulting in a chronic shortage of red blood cells.
- **Other anemias.** There are several other forms of anemia, such as thalassemia and malarial anemia.

Risk factors

These factors place you at increased risk of anemia:

- **A diet lacking in certain vitamins.** Having a diet that is consistently low in iron, vitamin B-12 and folate increases your risk of anemia.
- **Intestinal disorders.** Having an intestinal disorder that affects the absorption of nutrients in your small intestine — such as Crohn's disease and celiac disease — puts you at risk of anemia.
- **Menstruation.** In general, women who haven't experienced menopause have a greater risk of iron deficiency anemia than do men and postmenopausal women. That's because menstruation causes the loss of red blood cells.
- **Pregnancy.** If you're pregnant and aren't taking a multivitamin with folic acid, you're at an increased risk of anemia.
- **Chronic conditions.** If you have cancer, kidney failure or another chronic condition, you may be at risk of anemia of chronic disease. These conditions can lead to a shortage of red blood cells.

Slow, chronic blood loss from an ulcer or other source within your body can deplete your body's store of iron, leading to iron deficiency anemia.

- **Family history.** If your family has a history of an inherited anemia, such as sickle cell anemia, you also may be at increased risk of the condition.
- **Other factors.** A history of certain infections, blood diseases and autoimmune disorders, alcoholism, exposure to toxic chemicals, and the use of some medications can affect red blood cell production and lead to anemia.
- **Age.** People over age 65 are at increased risk of anemia.

Complications

Left untreated, anemia can cause many health problems, such as:

- **Severe fatigue.** When anemia is severe enough, you may be so tired that you can't complete everyday tasks.
- **Pregnancy complications.** Pregnant women with folate deficiency anemia may be more likely to experience complications, such as premature birth.
- **Heart problems.** Anemia can lead to a rapid or irregular heartbeat (arrhythmia). When you're anemic your heart must pump more blood to compensate for the lack of oxygen in the blood. This can lead to an enlarged heart or heart failure.
- **Death.** Some inherited anemias, such as sickle cell anemia, can be serious and lead to life-threatening complications. Losing a lot of blood quickly results in acute, severe anemia and can be fatal.

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Diseases and Conditions

Thrombocytopenia (low platelet count)

By Mayo Clinic Staff

Thrombocytopenia is a condition in which you have a low blood platelet count. Platelets (thrombocytes) are colorless blood cells that help blood clot. Platelets stop bleeding by clumping and forming plugs in blood vessel injuries.

Thrombocytopenia often occurs as a result of a separate disorder, such as leukemia or an immune system problem. Or it can be a side effect of taking certain medications. It affects both children and adults.

Thrombocytopenia may be mild and cause few signs or symptoms. In rare cases, the number of platelets may be so low that dangerous internal bleeding occurs. Treatment options are available.

Thrombocytopenia signs and symptoms may include:

- Easy or excessive bruising (purpura)
- Superficial bleeding into the skin that appears as a rash of pinpoint-sized reddish-purple spots (petechiae), usually on the lower legs
- Prolonged bleeding from cuts
- Bleeding from your gums or nose
- Blood in urine or stools
- Unusually heavy menstrual flows
- Fatigue
- Enlarged spleen
- Jaundice

When to see a doctor

Make an appointment with your doctor if you have any warning signs that worry you.

Bleeding that won't stop is a medical emergency. Seek immediate help if you experience bleeding that can't be controlled by the usual first-aid techniques, such as applying pressure to the area.

If for any reason your blood platelet count falls below normal, the condition is called thrombocytopenia. Normally, you have anywhere from 150,000 to 450,000 platelets per microliter of circulating blood. Because each platelet lives only about 10 days, your body continually renews your platelet supply by producing new platelets in your bone marrow.

Thrombocytopenia can be inherited or it may be caused by a number of medications or conditions. Whatever the cause, circulating platelets are reduced by one or more of the following processes: trapping of platelets in the spleen, decreased platelet production or increased destruction of platelets.

Trapped platelets

The spleen is a small organ about the size of your fist located just below your rib cage on the left side of your abdomen. Normally, your spleen works to fight infection and filter unwanted material from your blood. An enlarged spleen — which can be caused by a number of disorders — may harbor too many platelets, causing a decrease in the number of platelets in circulation.

Decreased production of platelets

Platelets are produced in your bone marrow. If production is low, you may develop thrombocytopenia. Factors that can decrease platelet production include:

- Leukemia
- Some types of anemia
- Viral infections, such as hepatitis C or HIV
- Chemotherapy drugs
- Heavy alcohol consumption

Increased breakdown of platelets

Some conditions can cause your body to use up or destroy platelets more rapidly than they're produced. This leads to a shortage of platelets in your bloodstream. Examples of such conditions include:

- **Pregnancy.** Thrombocytopenia caused by pregnancy is usually mild and improves soon after childbirth.

- **Bacteria in the blood.** Severe bacterial infections involving the blood (bacteremia) may lead to destruction of platelets.
- **Thrombotic thrombocytopenic purpura.** This is a rare condition that occurs when small blood clots suddenly form throughout your body, using up large numbers of platelets.
- **Hemolytic uremic syndrome.** This rare disorder causes a sharp drop in platelets, destruction of red blood cells and impairment of kidney function. Sometimes it can occur in association with a bacterial *Escherichia coli* (E. coli) infection, such as may be acquired from eating raw or undercooked meat.
- **Medications.** Certain medications can reduce the number of platelets in your blood. Sometimes a drug confuses the immune system and causes it to destroy platelets. Examples include heparin, quinine, sulfa-containing antibiotics and anticonvulsants.

Dangerous internal bleeding can occur when your platelet count falls below 10,000 platelets per microliter. Though rare, severe thrombocytopenia can cause bleeding into the brain, which can be fatal.

Start by seeing your primary care doctor if you have any signs or symptoms that worry you. Most cases of thrombocytopenia can be managed by your doctor. In certain situations, he or she may recommend that you see a specialist in blood diseases (hematologist).

Because appointments can be brief, and because there's often a lot of ground to cover, it's a good idea to be well-prepared for your appointment. Here's some information to help you get ready and what to expect from your doctor.

What you can do

- **Be aware of any pre-appointment restrictions.** At the time you make the appointment, be sure to ask if there's anything you need to do in advance, such as restrict your diet.
- **List the warning signs you've noticed,** such as any unusual bruising or bleeding or any rashes. Include any signs that may seem unrelated to the reason for which you scheduled the appointment.
- **List key personal information,** including any recent illnesses or medical procedures such as a blood transfusion, major stresses or recent life changes.
- **Make a list of all medications, vitamins and supplements** that you're taking.

- **Take along a family member or friend.** It can be difficult to remember all the information provided during an appointment. The person who accompanies you may remember something that you forgot or missed.
- **List questions to ask your doctor.** List your questions from most important to least important, in case time runs out.

For thrombocytopenia, some questions you may want to ask include:

- How many platelets do I have in my blood?
- Is my platelet count dangerously low?
- What is causing my thrombocytopenia?
- Do I need more tests?
- Is my condition likely temporary or chronic?
- What are my treatment options?
- What will happen if I do nothing?
- What are the possible side effects of the treatments you're suggesting?
- Are there any restrictions that I need to follow?
- Is there a generic alternative to the medicine you're prescribing?
- Do you have any brochures or other printed material that I can take with me?
- What websites do you recommend?

Your doctor may use the following tests and procedures to determine whether you have thrombocytopenia:

- **Blood test.** A complete blood count determines the number of blood cells, including platelets, in a sample of your blood. In adults, normal platelet count is 150,000 to 450,000 platelets per microliter of blood. If the complete blood count finds you have fewer than 150,000 platelets, you have thrombocytopenia.
- **Physical exam, including a complete medical history.** Your doctor will look for signs of bleeding under your skin and feel your abdomen to see if your spleen is enlarged. He or she will also ask you about illnesses you've had and the types of medications and supplements you've recently taken.

Your doctor may suggest that you undergo other tests and procedures to determine the cause of your condition, depending on your signs and symptoms.

People with mild thrombocytopenia may not need treatment. For example, they may not have symptoms or the condition clears up on its own.

Some people develop severe or long-term (chronic) thrombocytopenia. Depending on what's causing your low platelet count, treatments may include:

- **Treating the underlying cause of thrombocytopenia.** If your doctor can identify a condition or a medication that's causing your thrombocytopenia, addressing that cause may clear up your thrombocytopenia.

For example, if you have heparin-induced thrombocytopenia, your doctor will direct you to stop using heparin and prescribe a different blood-thinning drug. Your thrombocytopenia may persist for a week or more despite stopping all heparin therapy.

- **Blood or platelet transfusions.** If your platelet level becomes too low, your doctor can replace lost blood with transfusions of packed red blood cells or platelets.
- **Medications.** If your condition is related to an immune system problem, your doctor may prescribe drugs to boost your platelet count. The first-choice drug may be a corticosteroid. If that doesn't work, he or she may try stronger medications to suppress your immune system.
- **Surgery.** If other treatment options don't help, your doctor may recommend surgery to remove your spleen (splenectomy).
- **Plasma exchange.** Thrombotic thrombocytopenic purpura can result in a medical emergency requiring plasma exchange.

If you have thrombocytopenia, try to:

- **Avoid activities that could cause injury.** Ask your doctor which activities are safe for you. Contact sports, such as boxing, martial arts and football, carry a high risk of injury.
- **Drink alcohol in moderation, if at all.** Alcohol slows the production of platelets in your body. Ask your doctor whether it's OK for you to drink alcohol.
- **Use caution with over-the-counter medications.** Over-the-counter pain medications, such as aspirin and ibuprofen (Advil, Motrin IB, others) can impair platelet function.

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Symptoms

Low potassium (hypokalemia)

By Mayo Clinic Staff

Low potassium (hypokalemia) refers to a lower than normal potassium level in your bloodstream. Potassium is a chemical (electrolyte) that is critical to the proper functioning of nerve and muscles cells, particularly heart muscle cells.

Normally, your blood potassium level is 3.6 to 5.2 millimoles per liter (mmol/L). A very low potassium level (less than 2.5 mmol/L) can be life-threatening and requires urgent medical attention.

Low potassium (hypokalemia) has many causes. The most common cause is excessive potassium loss in urine due to prescription water or fluid pills (diuretics). Vomiting or diarrhea or both can result in excessive potassium loss from the digestive tract. Only rarely is low potassium caused by not getting enough potassium in your diet.

In most cases, low potassium is found by a blood test that is done because of an illness, or because you are taking diuretics. It is rare for low potassium to cause isolated symptoms such as muscle cramps if you are feeling well in other respects.

Low potassium symptoms may include:

- Weakness
- Fatigue
- Muscle cramps
- Constipation

Abnormal heart rhythms (arrhythmias) are the most worrisome complication of very low potassium levels, particularly in people with underlying heart disease.

Talk to your doctor about what your results mean. You may need to change a medication that's affecting your potassium level, or you may need to treat another medical condition that's causing your low potassium level.

Treatment of low potassium is directed at the underlying cause and may include potassium supplements. Don't start taking potassium supplements without talking to your doctor first.

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Diseases and Conditions

Hyponatremia

By Mayo Clinic Staff

Hyponatremia is a condition that occurs when the level of sodium in your blood is abnormally low. Sodium is an electrolyte, and it helps regulate the amount of water that's in and around your cells.

In hyponatremia, one or more factors — ranging from an underlying medical condition to drinking too much water during endurance sports — causes the sodium in your body to become diluted. When this happens, your body's water levels rise, and your cells begin to swell. This swelling can cause many health problems, from mild to life-threatening.

Hyponatremia treatment is aimed at resolving the underlying condition. Depending on the cause of hyponatremia, you may simply need to cut back on how much you drink. In other cases of hyponatremia, you may need intravenous fluids and medications.

Hyponatremia signs and symptoms may include:

- Nausea and vomiting
- Headache
- Confusion
- Loss of energy and fatigue
- Restlessness and irritability
- Muscle weakness, spasms or cramps
- Seizures
- Coma

When to see a doctor

If you have a medical condition that increases your risk of hyponatremia, or you have other risk factors for hyponatremia, such as participating in high-intensity activities, and you have the signs and symptoms of low blood sodium, see your doctor.

Sodium plays a key role in your body. It helps maintain normal blood pressure, supports the work of your nerves and muscles, and regulates your body's fluid balance.

A normal sodium level is between 135 and 145 milliequivalents per liter (mEq/L) of sodium. Hyponatremia occurs when the sodium in your blood falls below 135 mEq/L.

Many possible conditions and lifestyle factors can lead to hyponatremia, including:

- **Certain medications.** Some medications, such as some water pills (diuretics), antidepressants and pain medications, can cause you to urinate or perspire more than normal.
- **Heart, kidney and liver problems.** Congestive heart failure and certain diseases affecting the kidneys or liver can cause fluids to accumulate in your body, which dilutes the sodium in your body, lowering the overall level.
- **Syndrome of inappropriate anti-diuretic hormone (SIADH).** In this condition, high levels of the anti-diuretic hormone (ADH) are produced, causing your body to retain water instead of excreting it normally in your urine.
- **Chronic, severe vomiting or diarrhea.** This causes your body to lose fluids and electrolytes, such as sodium.
- **Drinking too much water.** Because you lose sodium through sweat, drinking too much water during endurance activities, such as marathons and triathlons, can dilute the sodium content of your blood. Drinking too much water at other times can also cause low sodium.
- **Dehydration.** Taking in too little fluid can also be a problem. If you get dehydrated, your body loses fluids and electrolytes.
- **Hormonal changes.** Adrenal gland insufficiency (Addison's disease) affects your adrenal glands' ability to produce hormones that help maintain your body's balance of sodium, potassium and water. Low levels of thyroid hormone also can cause a low blood-sodium level.
- **The recreational drug Ecstasy.** This amphetamine increases the risk of severe and even fatal cases of hyponatremia.

The following factors may increase your risk of hyponatremia:

- **Age.** Older adults may have more contributing factors for hyponatremia, including age-related changes, taking certain medications and a greater likelihood of developing a chronic disease that alters the body's sodium balance.
- **Certain drugs.** Medications that increase your risk of hyponatremia include thiazide diuretics as well as some antidepressants and pain medications. In addition, the recreational drug Ecstasy has been linked to fatal cases of hyponatremia.
- **Conditions that decrease your body's water excretion.** Medical conditions that may increase your risk of hyponatremia include kidney disease, syndrome of inappropriate anti-diuretic hormone (SIADH) and heart failure, among others.
- **Intensive physical activities.** People who drink too much water while taking part in marathons, ultramarathons, triathlons and other long-distance, high-intensity activities are at an increased risk of hyponatremia.

In chronic hyponatremia, sodium levels drop gradually over 48 hours or longer — and symptoms and complications are typically more moderate.

In acute hyponatremia, sodium levels drop rapidly — resulting in potentially dangerous effects, such as rapid brain swelling, which can result in coma and death.

Premenopausal women appear to be at the greatest risk of hyponatremia-related brain damage. This may be related to the effect of women's sex hormones on the body's ability to balance sodium levels.

Seek emergency care for anyone who develops severe signs and symptoms of hyponatremia, such as nausea and vomiting, confusion, seizures, or lost consciousness.

Call your doctor if you know you are at risk of hyponatremia and are experiencing nausea, headache, cramping or weakness. Depending on the extent and duration of these signs and symptoms, your doctor may recommend seeking immediate medical care.

If you have time to prepare, here's some information to help you get ready for your appointment, and what to expect from your doctor.

What you can do

- **List any symptoms you or your loved one has been experiencing** and for how long.
- **Write down key medical information**, including other medical problems for which you are being treated and the names of all medications, vitamins, supplements or other natural remedies you are taking.
- **Take a family member or friend along**, if you are the one with symptoms of low blood sodium. Someone who accompanies you can help remember all of the information and provide support if you need immediate medical care.
- **Write down questions to ask your doctor.**

For hyponatremia, some basic questions to ask your doctor include:

- What's the most likely cause of my symptoms?
- What causes hyponatremia?
- How severe is the condition?
- What treatment do you recommend?
- How soon do you expect my symptoms will begin to improve?
- Am I at risk of any long-term problems?
- How can I prevent a recurrence of this condition?
- Do I need to make any changes to how much fluid I usually drink?

What to expect from your doctor

Being ready to answer your doctor's questions may reserve time to go over any points you want to talk about in-depth. Your doctor may ask:

- What are your symptoms and when did they start?
- Have you started taking any new medications?

- Have your symptoms been getting any better or worse since they first developed?
- Have your symptoms included any mental changes, such as feeling confused, agitated or depressed?
- Have you had nausea, vomiting or diarrhea?
- Have you felt faint, had seizures or lost consciousness?
- Have you had a headache? If yes, has it gotten progressively worse?
- Have your symptoms included weakness, fatigue or lethargy?
- Do you use recreational drugs? If yes, which drugs?

Your doctor will start by asking about your medical history and doing a physical examination.

However, because the signs and symptoms of hyponatremia occur in many conditions, it's impossible to diagnose the condition based on a physical exam alone. To confirm low blood sodium, your doctor will order blood tests and urine tests.

Hyponatremia treatment is aimed at addressing the underlying cause, if possible.

If you have moderate, chronic hyponatremia due to your diet, diuretics or drinking too much water, your doctor may recommend temporarily cutting back on fluids. He or she also may suggest adjusting your diuretic use to increase the level of sodium in your blood.

If you have severe, acute hyponatremia, you'll need more-aggressive treatment. Options include:

- **Intravenous fluids.** Your doctor may recommend IV sodium solution to raise the sodium levels in your blood. This often requires a stay in the hospital.
- **Medications.** You may take medications to manage the signs and symptoms of hyponatremia, such as headache, nausea and seizures.

The following measures may help you prevent hyponatremia:

- **Treat associated conditions.** Getting treatment for conditions that contribute to hyponatremia, such as adrenal gland insufficiency, can help prevent low blood sodium.
- **Educate yourself.** If you have a medical condition that increases your risk of hyponatremia or you take diuretic medications, be aware of the signs and symptoms of low blood sodium. Always talk with your doctor about the risks of a new medication.
- **Take precautions during high-intensity activities.** Athletes should drink only as much fluid as they lose due to sweating during a race. Thirst is generally a good guide to how much water or other fluids you need.
- **Consider drinking sports beverages during demanding activities.** Ask your doctor about replacing water with sports beverages that contain electrolytes when participating in endurance events such as marathons, triathlons and other demanding activities.
- **Drink water in moderation.** Drinking water is vital for your health, so make sure you drink enough fluids. But don't overdo it. Thirst and the color of your urine are usually the best indications of how much water you need. If you're not thirsty and your urine is pale yellow, you are likely getting enough water.

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Diseases and Conditions

Liver disease

By Mayo Clinic Staff

The liver is an organ about the size of a football that sits just under your rib cage on the right side of your abdomen. The liver is essential for digesting food and ridding your body of toxic substances.

Liver disease can be inherited (genetic) or caused by a variety of factors that damage the liver, such as viruses and alcohol use. Obesity is also associated with liver damage. Over time, damage to the liver results in scarring (cirrhosis), which can lead to liver failure, a life-threatening condition.

Signs and symptoms of liver disease include:

- Skin and eyes that appear yellowish (jaundice)
- Abdominal pain and swelling
- Swelling in the legs and ankles
- Itchy skin
- Dark urine color
- Pale stool color, or bloody or tar-colored stool
- Chronic fatigue
- Nausea or vomiting
- Loss of appetite
- Tendency to bruise easily

When to see a doctor

Make an appointment with your doctor if you have any persistent signs or symptoms that worry you. Seek immediate medical attention if you have abdominal pain that is so severe that you can't stay still.

Liver disease has many causes.

Infection

Parasites and viruses can infect the liver, causing inflammation and that reduces liver function. The viruses that cause liver damage can be spread through blood or semen, contaminated food or water, or close contact with a person who is infected. The most common types of liver infection are hepatitis viruses, including:

- Hepatitis A
- Hepatitis B
- Hepatitis C

Immune system abnormality

Diseases in which your immune system attacks certain parts of your body (autoimmune) can affect your liver. Examples of autoimmune liver diseases include:

- Autoimmune hepatitis
- Primary biliary cirrhosis
- Primary sclerosing cholangitis

Genetics

An abnormal gene inherited from one or both of your parents can cause various substances to build up in your liver, resulting in liver damage. Genetic liver diseases include:

- Hemochromatosis
- Hyperoxaluria and oxalosis
- Wilson's disease

Cancer and other growths

Examples include:

- Liver cancer
- Bile duct cancer
- Liver adenoma

Other

Additional, common causes of liver disease include:

- Chronic alcohol abuse
- Fat accumulating in the liver (nonalcoholic fatty liver disease)

Factors that may increase your risk of liver disease include:

- Heavy alcohol use
- Injecting drugs using shared needles
- Tattoos or body piercings
- Blood transfusion before 1992
- Exposure to other people's blood and body fluids
- Unprotected sex
- Exposure to certain chemicals or toxins
- Diabetes
- Obesity
- High levels of triglycerides in your blood

Complications of liver disease vary, depending on the cause of your liver problems. Untreated liver disease may progress to liver failure, a life-threatening condition.

You may be referred to a doctor who specializes in the liver (hepatologist).

What you can do

- **Be aware of any pre-appointment restrictions**, such as not eating solid food on the day before your appointment.
- **Write down your symptoms**, including any that may seem unrelated to the reason why you scheduled the appointment.
- **Make a list of all your medications**, vitamins and supplements.
- **Write down your key medical information**, including other conditions.
- **Write down key personal information**, including any recent changes or stressors in your life.
- **Ask a relative or friend to accompany you**, to help you remember what the doctor says.
- **Write down questions to ask your doctor.**

Questions to ask your doctor

- What's the most likely cause of my symptoms?
- What kinds of tests do I need? Do these tests require any special preparation?

- Are my liver problems likely temporary or chronic?
- What treatments are available?
- Should I stop taking certain medications or supplements?
- Should I avoid alcohol?
- I have other health conditions. How can I best manage these conditions together?

In addition to the questions that you've prepared to ask your doctor, don't hesitate to ask other questions during your appointment.

What to expect from your doctor

Your doctor is likely to ask you a number of questions. Being ready to answer them may make time to go over points you want to spend more time on. You may be asked:

- When did you first begin experiencing symptoms, and how severe are they? Have your symptoms been continuous or occasional?
- What, if anything, seems to improve or worsen your symptoms?
- Have you had a fever?
- Have you ever had your skin or eyes turn yellow?
- What medications and supplements do you take?
- How many days of the week do you drink alcohol? Do you have any tattoos?
- Does your job involve exposure to chemicals, blood or body fluids?
- Have you ever had a blood transfusion?
- Have you been told that you have had liver problems before?
- Has anyone in your family ever been diagnosed with liver disease?

Finding the cause and extent of liver damage is important in guiding treatment.

Your doctor is likely to start with a health history and thorough physical examination. Your doctor may then recommend:

- **Blood tests.** A group of blood tests called liver function tests can be used to diagnose liver disease. Other blood tests can be done to look for specific liver problems or genetic conditions.
- **Imaging tests.** CT scan, MRI and ultrasound can show liver damage.
- **Tissue analysis.** Removing a tissue sample (biopsy) from your liver may help diagnose liver disease. Liver biopsy is most often done using a long needle inserted through the skin to extract a tissue sample. It is then analyzed in a laboratory.

Treatment for liver disease depends on your diagnosis. Some liver problems can be treated with lifestyle modifications, such as stopping alcohol use or losing weight, typically as part of a medical program that includes careful monitoring of liver function. Other liver problems may be treated with medications or may require surgery.

Treatment for liver disease that causes liver failure may ultimately require a liver transplant.

No alternative medicine therapies have been proved to treat liver disease. Some studies — notably of Chinese herbal medicine treatments for clearance of hepatitis B virus — have indicated benefits. But the quality of these research studies has been questioned.

On the other hand, some herbal supplements used as alternative medicine treatments can harm your liver. More than a thousand medications and herbal products have been associated with liver damage, including:

- Jin bu huan
- Ma-huang
- Germander
- Valerian
- Mistletoe
- Skullcap
- Chaparral
- Comfrey
- Kava
- Pennyroyal oil

To protect your liver, it's important to talk to your doctor about the potential risks before you take any complementary or alternative medicines.

To prevent liver disease:

- **Drink alcohol in moderation.** For healthy adults, that means up to one drink a day for women of all ages and men older than age 65, and up to two drinks a day for men age 65 and younger. Heavy or high-risk drinking is defined as more than three drinks on any day or more than seven drinks a week for women and for men older than age 65, and more than four drinks on any day or more than 14 drinks a week for men age 65 and younger.
- **Avoid risky behavior.** Get help if you use illicit intravenous drugs, and don't share needles used to inject drugs. Use a condom during sex. If you choose to have tattoos or body piercings, be picky about cleanliness and safety when selecting a shop.

- **Get vaccinated.** If you're at increased risk of contracting hepatitis or if you've already been infected with any form of the hepatitis virus, talk to your doctor about getting the hepatitis A and hepatitis B vaccines.
- **Use medications wisely.** Take prescription and nonprescription drugs only when needed and only in recommended doses. Don't mix medications and alcohol. Talk to your doctor before mixing herbal supplements or prescription or nonprescription drugs.
- **Avoid contact with other people's blood and body fluids.** Hepatitis viruses can be spread by accidental needle sticks or improper cleanup of blood or body fluids.
- **Take care with aerosol sprays.** Make sure the room is ventilated, and wear a mask when spraying insecticides, fungicides, paint and other toxic chemicals. Always follow the manufacturer's instructions.
- **Protect your skin.** When using insecticides and other toxic chemicals, wear gloves, long sleeves, a hat and a mask.
- **Maintain a healthy weight.** Obesity can cause nonalcoholic fatty liver disease.

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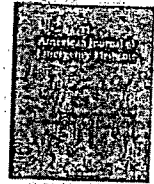
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Brief Report

Is there such a thing as a mechanical fall?☆

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ABSTRACT

Objectives: The term *mechanical falls* is commonly used in the emergency department (ED), yet its definition and clinical implications are not established. It may be used to attribute falls to extrinsic factors in the environment exonerating clinicians from conducting a thorough assessment of the fall's underlying intrinsic causes. We conducted this study to determine how clinicians assess "mechanical" and "nonmechanical" falls; we explored conditions, fall evaluation, and outcomes associated with these diagnoses.

Methods: This study was a secondary analysis of a retrospective study at 1 urban ED. Data were obtained from medical records of patients aged 65 years and older who presented to the ED for a fall. We compared the associated conditions/causes, the ED fall evaluation, mortality, ED revisits, subsequent hospitalizations, and recurrent falls between the 2 terms.

Results: We had a sample size of 350 patients: 218 (62.3%) with "mechanical falls" and 132 (37.7%) with nonmechanical falls. There was little difference among associated conditions between the 2 fall labels other than mechanical falls had more associated environmental causes but fewer syncope causes. However, more than a quarter of nonmechanical falls had associated environmental factors as well. Similarly, there was little difference in the fall evaluation, ED revisit rates, recurrent falls, subsequent hospitalizations, and death between the 2 groups.

Conclusions: The term *mechanical fall* is unclear, inconsistently used, and not associated with a discrete fall evaluation and does not predict outcomes. We propose eliminating the term because it inaccurately implies that a benign etiology for an older person's fall exists.

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1. Introduction

The term *mechanical falls* has become commonly used in emergency departments (EDs), yet its definition and clinical implications have not been established. It may be used to attribute falls to extrinsic factors in the environment and excuse clinicians from conducting a thorough assessment of underlying intrinsic causes in the patient. Given that a third of older adults in the United States fall annually and 2.3 million nonfatal falls were treated in EDs in 2010 [1], a figure that is likely to increase as the elderly population grows [2], it is important to understand what is often termed *mechanical falls* in the ED.

The term *mechanical fall* is not well defined in academic research, and it is open to interpretation what differentiates a mechanical from a nonmechanical fall [3,4]. The term implies that an external mechanical force or object caused the fall. Although more than 25% of community-dwelling older adults have falls related to slipping, tripping, or stumbling [5,6], external factors are seldom the sole cause of an elderly patient's fall. In almost all cases, patients' comorbidities and health status are involved; a younger person in the same environment probably would not have fallen. Because elderly fall patients are at high risk for recurrent falls [7,8], evaluation of fall patients should determine modifiable fall risk factors. We hypothesized that the use of the term *mechanical fall* may lead to a less thorough evaluation of the elderly fall and may not adequately assess elderly fall etiology.

We conducted this secondary analysis of a retrospective study to determine what ED clinicians do to assess what they call "mechanical" and "nonmechanical" falls; we explored what conditions or pathologies ED clinicians attribute to these labels, whether the labels led to a specific fall evaluation approach, and what outcomes are associated with these diagnoses.

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2. Methods

2.1. Study setting

This “mechanical fall” study was a secondary analysis of a retrospective study that described the evaluation of ED fall patients presenting to 1 urban, level 1 trauma center, academic hospital ED [9].

2.2. Study population

We included patients aged 65 years and older who presented to the ED for a fall from January 1, 2012, through December 31, 2012, who had been assigned an *International Classification of Diseases, Ninth Revision*, “E” code of a fall (E880–E886 and E888) and had visited a primary care physician affiliated within the hospital’s network in the past 3 years. We excluded patients who were transferred from other hospitals to reduce the potential of missing study data.

2.3. Data collection

We adapted our data collection form from the recommendations of the American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons 2010 [10] and the Geriatric Emergency Department (GED) Guideline [11]. Details of the adaption have been described elsewhere [9].

One emergency physician and 1 research assistant performed the data abstraction. We met once a week to clarify terms and discuss the progression of data collection. The study’s principal investigator (SL) supervised data collection and monitored the quality of data abstraction. We randomly sampled 5% of 350 patient’s charts to test for interrater agreement using Cohen κ coefficient.

There is no standard definition for what constitutes a “mechanical fall.” “Mechanical fall” is a subjective term which is often associated with a slip or trip leading to a fall. We did not define “mechanical fall” ourselves; rather, we recorded the number of falls which were described as a “mechanical fall” by clinicians (ED residents and/or ED attending) in the patients’ electronic charts.

2.4. Outcomes

We first examined conditions/factors associated with mechanical vs nonmechanical falls. The categories for conditions associated with the fall were taken from the practice guideline of Baraff et al for elder falls [12]. Data for such conditions/factors were taken from the history of the present illness section of the clinician note.

We then explored whether patients labeled as having a mechanical fall vs patients who were not described as having had a mechanical fall had discrete ED evaluations. We examined the ED evaluation of elderly fall patients in 4 categories: (1) history, (2) physical examination (PE), (3) diagnostic evaluation, and (4) safety assessment. Key history elements consisted of factors associated with falls as identified by the GED Guideline [11] and included the location of fall, comorbidities and other health problems, fall history, loss of consciousness or alteration of mental status immediately before or after the fall, activities of daily living, alcohol consumption, and certain medications. Key elements of the PE included an examination of gait, balance, foot problems, orthostatic hypotension, muscle strength, and cognition. Key elements of the diagnostic evaluation include complete blood count, electrolyte panel, electrocardiogram (ECG), x-ray, and computed tomography (CT). Finally, key elements of the safety assessment before discharge are a get-up and go test (a test for assessing physical mobility) [13] in the ED and a physical therapy (PT) evaluation (gait, balance, and muscle strength) before disposition from ED. Finally, we explored whether mechanical vs nonmechanical labels predicted follow-up events, 30-day and 6-month mortality, frequency of ED revisits, subsequent hospitalizations, and recurrent falls.

2.5. Data analysis

We compared differences in associated conditions/factors of the fall, evaluation, and follow-up events between mechanical- and nonmechanical-labeled patients. Proportions were presented for categorical data and compared using χ^2 or Fisher exact test. Continuous data were presented as means with SDs if normally distributed and medians with interquartile ranges (IQRs) if nonnormally distributed; a t test was used to compare data if normally distributed and Wilcoxon rank sum test was used for nonnormal data. We analyzed all data using STATA software (version 13.0).

3. Results

A total of 450 patients were eligible for inclusion in this study. One hundred were excluded: 40 because they were improperly assigned an *International Classification of Diseases, Ninth Revision*, code; 29 because they were transferred from other hospitals; 22 because they revisited for the same fall; 8 because they were duplicate charts; and 1 because the chart was inaccessible due to legal reasons. Our final analysis was based on 350 patients. In terms of reliability of chart review, the κ value was 0.84 (95% confidence interval, 0.67–1.00).

Two hundred eighteen patients (62.3%) had what was described as a mechanical fall, and 132 patients (37.7%) had nonmechanical falls. Mechanical and nonmechanical falls were similar in terms of age, sex, race/ethnicity, primary insurance, residence, and Charlson comorbidity index score (Table 1).

Overall, there was no clear discrete difference in the associated conditions between the 2 fall labels other than mechanical falls had more associated environmental factors than nonmechanical falls (57.3% vs 28.8%; $P < .01$) but fewer syncope causes (0.9% vs 12.9%; $P < .01$). However, more than a quarter of nonmechanical falls also had associated environmental factors. Mechanical fall patients fell indoors less frequently than nonmechanical fall patients (54.1% vs 70.4%; $P < .01$) and had fall location recorded less frequently (22.9% vs 13.6%; $P = .03$). Mechanical fall patients lost consciousness or had an altered mental state less frequently than nonmechanical fall patients (4.6% vs 25.0%; $P < .01$) and also had a lower rate of dementia (9.6% vs 18.9%; $P = .01$).

Table 1
Demographic data between mechanical and nonmechanical fall patients

Variable	Mechanical, n = 218 (%)	Nonmechanical, n = 132 (%)	P
Age, mean $\pm$ SD	80.5 (8.9)	79.3 (8.4)	.20
Sex (male), n (%)	145 (66.5)	80 (60.6)	.26
Race/ethnicity, n (%)			
White	201 (92.2)	126 (95.5)	.23
Black	6 (2.7)	4 (3.0)	1.00
Hispanic	4 (1.8)	0 (0)	.30
Asian	8 (3.7)	2 (1.5)	.24
Other	1 (0.5)	0 (0)	1.00
Primary insurance, n (%)			.08
Medicare	191 (87.6)	143 (85.6)	
Commercial	14 (6.4)	14 (10.6)	
Company	7 (3.2)	0	
Welfare	0 (0)	1 (0.8)	
Self-pay	5 (2.3)	4 (3.0)	
Other	1 (0.5)	0	
Residence, n (%)			.68
Home with relative(s)	77 (35.3)	39 (29.5)	
Home alone	106 (48.6)	76 (57.6)	
Assisted living	28 (12.8)	15 (11.3)	
Skilled rehab facility	4 (1.8)	1 (0.8)	
Acute rehab facility	1 (0.5)	0	
Homeless	1 (0.5)	0	
Unknown	0	1 (0.8)	
Charlson comorbidity index, mean (SD)	6.8 (3.0)	6.6 (2.9)	.49
ED length of stay, median (IQR), h	5 (3–7)	6 (4–8)	.01
Hospital length of stay, median (IQR), d	3 (1–5)	2 (1–4)	.12

Overall, there was no difference between the frequencies of recommended PE between patients termed mechanical vs nonmechanical fall (Table 2). Emergency department clinicians examined gait, balance, orthostatic hypotension, and foot problems in less than a quarter of all elderly fall patients.

More than half of all elderly fall patients had some diagnostic investigation. Although the rate at which ECGs and CTs were performed for mechanical fall patients was less than for nonmechanical fall patients, there were no differences in the number of patients with abnormal ECGs (ECG abnormalities [11.6% vs 5.2%; $P = .23$] or CT abnormalities [40.4% vs 31.3%; $P = .20$]). The most common ECG abnormality that we found was atrial fibrillation (6/

11 [54.5%]). Few elderly fall patients had a PT evaluation or performed the get-up and go test before disposition from the ED (Table 2).

In terms of disposition and short- and long-term outcomes, the ED disposition of patients was similar in terms of discharge to place of pre-admission residence, admission to the hospital, and admission to the observation unit. There were similar ED revisit rates, recurrent falls, subsequent hospitalizations, and death between mechanical and nonmechanical fall patients (Table 3).

4. Discussion

Our exploration of the term *mechanical fall* revealed that mechanical vs nonmechanical falls are not clearly differentiated by the associated conditions/factors surrounding the fall nor do the terms guide a fall evaluation or predict outcomes.

The term *mechanical fall* implies that an external force (eg, environmental) caused the patient to fall and/or that there is no underlying pathology of concern and/or the patients did not pass out first. Our exploratory data show that these implications are often not true of falls which are described as mechanical in nature. Both mechanical and nonmechanical fall patients had high rates of worrisome causes, such as poor balance, and high rates of comorbidities associated with them. Furthermore, our study found that the term *mechanical fall* was not used consistently; a quarter of nonmechanical fall patients had an environmental cause for their fall.

Our study showed little overall difference between the fall evaluations of the 2 groups indicating labeling patients as having mechanical falls does not lead to a distinct evaluation approach. In some instances, the evaluation of mechanical fall patients was less comprehensive than the evaluation of nonmechanical fall patients. In our study, ED clinicians asked fewer mechanical fall patients about their fall history than they asked of nonmechanical fall patients. A history of previous falls is one of the most important key history items for elderly fall patients [6–8]. This information can help prevent future falls and substantial morbidity, and many studies have recommended asking elderly fall patients this key history element [6–8]. Evaluating a patient's fall risk factors is not any more or less applicable for elderly patients based on the cause of their fall. Mechanical falls may seem reassuring but are still a sign of potential decline.

For follow-up events, there were similar rates of ED revisits; subsequent hospitalization; recurrent falls; and death at 7 days, 30 days, and 6 months after discharge from the ED. More importantly, there

Table 2

The conditions/associated factors of fall and the key evaluation elements among mechanical and nonmechanical older adult ED fall patients

	Mechanical, n = 218 (%)	Nonmechanical, n = 132 (%)	P
Conditions/associated factors of fall			
Environment	125 (57.3)	38 (28.8)	<.01
Poor light source	7 (3.2)	0	.05
Uneven or slippery surfaces	77 (35.3)	22 (16.7)	<.01
Loose rugs	13 (6.0)	2 (1.5)	.06
Steep stairs	10 (4.6)	3 (2.3)	.39
Objects in pathway	12 (5.5)	7 (5.3)	.94
Lack of handrails	4 (1.8)	1 (0.8)	.65
Inappropriate furniture	5 (2.3)	2 (1.5)	.72
Aging/functional decline	59 (27.0)	44 (33.3)	.21
Weakness	12 (5.5)	14 (10.6)	.08
Poor balance	48 (22.2)	33 (25.0)	.52
Vision impairment	2 (0.9)	0	.53
Syncope and presyncope	2 (0.9)	17 (12.9)	<.01
Other medical problems	4 (1.8)	9 (6.8)	.02
Delirium	3 (1.4)	6 (4.6)	.09
Foot and footwear problem	4 (1.8)	1 (0.8)	.65
Unclear	38 (17.4)	39 (29.6)	<.01
History key elements			
Indoor	118 (54.1)	93 (70.4)	.01
Outdoor	50 (22.9)	21 (15.9)	.01
Not recorded	50 (22.9)	18 (13.6)	.03
Fall history asked about	60 (27.5)	57 (43.2)	<.01
Loss of consciousness/Altered mental status	10 (4.6)	33 (25.0)	<.01
Alcohol use	42 (19.3)	26 (19.7)	.92
Polypharmacy (≥5 medications), n (%)	151 (71.6)	95 (71.9)	.93
Independence with ADLs	90/115 (78.3)	47/73 (64.4)	.04
Dementia	21 (9.6)	25 (18.9)	.01
Prior hip fracture	18 (8.2)	7 (5.3)	.29
Physical examination key elements			
Gait and/or balance evaluation	35 (16.1)	25 (18.9)	.49
Orthostatic evaluation	22 (10.1)	21 (15.9)	.11
Cognitive assessment (orientation to time, place, person)	216 (99.1)	130 (99.5)	.61
Muscle strength test	132 (60.5)	67 (50.8)	.07
Foot problem evaluation	3 (1.4)	2 (1.5)	.08
Investigation evaluation			
Complete blood count	116 (53.2)	83 (62.9)	.07
Electrolyte panel	116 (53.2)	83 (62.9)	.07
ECG, n = 127	69 (53.6)	58 (43.9)	.02
New ECG abnormalities, n = 11	8 (11.6)	3 (5.2)	.23
Atrial fibrillation	5 (7.2)	1 (1.7)	.24
Sinus bradycardia	2 (2.9)	1 (1.7)	1.00
ST abnormality	1 (1.5)	1 (1.7)	1.00
X-ray, n = 275	178 (64.7)	97 (73.5)	.07
CT, n = 184	104 (47.7)	80 (60.6)	.02
CT abnormality, n = 67	42 (40.4)	25 (31.3)	.20
Head CT abnormality, n = 56	33 (31.7)	23 (28.8)	.66
Soft tissue injury	17 (16.4)	8 (10.0)	.21
Fracture	10 (9.6)	5 (6.3)	.41
Subarachnoid hemorrhage	1 (1.0)	5 (6.3)	.09
Subdural hematoma	1 (1.0)	4 (5.0)	.17
Cerebral hemorrhage	1 (1.0)	0	1.00
Cerebral contusion	1 (1.0)	0	1.00
Safety assessment before ED disposition			
Get-up and go test	8 (3.7)	0	.08
Patients have PT evaluation	26 (11.9)	20 (15.2)	.39

Abbreviation: ADLs, activities of daily living.

Table 3
The outcomes among mechanical fall and nonmechanical fall

ED disposition place	Mechanical fall, n = 218 (%)	Nonmechanical, n = 132 (%)	P
Discharge to place of preadmission residence, n = 187	120 (55.1)	67 (50.8)	.74
Transfer to hospital, n = 92	57 (26.2)	35 (26.5)	.94
Discharge to place of preadmission residence, n = 38	19 (33.3)	19 (55.9)	.04
Discharge to skill rehab facility, n = 53	38 (66.7)	15 (44.1)	.04
Institutionalization, n = 1	0	1 (2.9)	.90
Transfer to observation, n = 67	37 (16.9)	30 (22.7)	.19
Discharge to place of preadmission residence, n = 38	23 (62.2)	26 (86.7)	.02
Discharge to skill rehab facility	14 (37.8)	3 (17.7)	.02
Discharge to nursing home	0	1 (3.3)	
New nursing home, n = 4	4 (0.9)	0	.63
Revisit within 30 d	34 (15.6)	28 (21.2)	.18
Revisit within 6 mo	54 (43.1)	55 (41.7)	.70
Recurrent fall in 30 d	14 (6.4)	12 (9.1)	.36
Recurrent fall in 6 mo	45 (20.6)	34 (25.8)	.27
Subsequent hospitalization in 30 d	23 (10.6)	16 (12.1)	.85
Subsequent hospitalization in 6 mo	71 (32.7)	38 (28.8)	.46
Death within 30 d	1 (0.5)	1 (0.8)	1.00
Death within 6 mo	3 (1.4)	6 (4.6)	.07

were very high rates of recurrent falls, ED revisits, and hospitalizations in the mechanical fall group, indicating that there is likely some underlying pathology in these so-called mechanical falls.

Our study shows that nothing distinguishes a mechanical fall from a nonmechanical fall. The terms *mechanical* and *nonmechanical* are not clearly defined. There are no particular conditions/etiologies associated with them, and there are no associated discrete, nonoverlapping evaluations of mechanical and nonmechanical fall patients. The terms also do not predict outcomes, suggesting that they are not useful. In past years, the terms *intrinsic* and *extrinsic* have been used to describe falls. However, it is clear now that falls are multifactorial. All fall patients need a thorough evaluation at least following GED guideline to determine the etiology of the fall to impact outcomes.

5. Limitations

This study was conducted at a single hospital. The results of this study may not be generalizable to EDs in other areas. Our sample size was relatively small. The number of patients with undesirable outcomes was limited. In addition, chart reviews are limited in their ability to accurately measure quality of care. There is a potential for missing data if the patients sought care outside our hospital's network. Causes of falls were based on ED charts and not some independent criterion standard evaluation. Finally, the rate of recurrent falls may be lower than the actual rate depending on how often patients reported these events to their health care provider.

6. Conclusion

In conclusion, our data show that the term *mechanical fall* is unclear and inconsistently used; the terms *mechanical* and *nonmechanical falls* overlap to a great extent and do not describe distinct entities, nor do they lead to a specific evaluation or predict outcomes. We propose eliminating the term *mechanical fall*. A fall, mechanical or not, is often a sentinel event leading to a decline in the older patient.

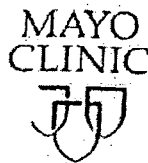
Acknowledgments

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<http://dx.doi.org/10.1016/j.ajem.2015.12.009>

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Diseases and Conditions

Dehydration

By Mayo Clinic Staff

Dehydration occurs when you use or lose more fluid than you take in, and your body doesn't have enough water and other fluids to carry out its normal functions. If you don't replace lost fluids, you will get dehydrated.

Common causes of dehydration include vigorous exercise, especially in hot weather; intense diarrhea; vomiting; fever or excessive sweating. Not drinking enough water during exercise or in hot weather even if you're not exercising also may cause dehydration. Anyone may become dehydrated, but young children, older adults and people with chronic illnesses are most at risk.

You can usually reverse mild to moderate dehydration by drinking more fluids, but severe dehydration needs immediate medical treatment. The safest approach is preventing dehydration in the first place. Keep an eye on how much fluid you lose during hot weather, illness or exercise, and drink enough liquids to replace what you've lost.

Mild to moderate dehydration is likely to cause:

- Dry, sticky mouth
- Sleepiness or tiredness — children are likely to be less active than usual
- Thirst
- Decreased urine output
- No wet diapers for three hours for infants
- Few or no tears when crying
- Dry skin
- Headache
- Constipation
- Dizziness or lightheadedness

Severe dehydration, a medical emergency, can cause:

- Extreme thirst
- Extreme fussiness or sleepiness in infants and children; irritability and confusion in adults

- Very dry mouth, skin and mucous membranes
- Little or no urination — any urine that is produced will be darker than normal
- Sunken eyes
- Shriveled and dry skin that lacks elasticity and doesn't "bounce back" when pinched into a fold
- In infants, sunken fontanel — the soft spots on the top of a baby's head
- Low blood pressure
- Rapid heartbeat
- Rapid breathing
- No tears when crying
- Fever
- In the most serious cases, delirium or unconsciousness

Unfortunately, thirst isn't always a reliable gauge of the body's need for water, especially in children and older adults. A better indicator is the color of your urine: Clear or light-colored urine means you're well hydrated, whereas a dark yellow or amber color usually signals dehydration.

When to see a doctor

If you're a healthy adult, you can usually treat mild to moderate dehydration by drinking more fluids, such as water or a sports drink (Gatorade, Powerade, others). Get immediate medical care if you develop severe signs and symptoms such as extreme thirst, a lack of urination, shriveled skin, dizziness and confusion.

Treat children and older adults with greater caution. Call your family doctor right away if your loved one:

- Develops severe diarrhea, with or without vomiting or fever
- Has bloody or black stool
- Has had moderate diarrhea for 24 hours or more
- Can't keep down fluids
- Is irritable or disoriented and much sleepier or less active than usual
- Has any of the signs or symptoms of mild or moderate dehydration

Go to the nearest hospital emergency room or call 911 or your emergency medical number if you think a child or older adult is severely dehydrated. You can help prevent dehydration from becoming severe by carefully monitoring someone who is sick and giving fluids, such as an oral rehydration solution (CeraLyte, Pedialyte, others), at the first sign of diarrhea, vomiting or fever and by encouraging children to drink plenty of water before, during and after exercise.

Dehydration occurs when there isn't enough water to replace what's lost throughout the day. Your system literally dries out. Sometimes dehydration occurs for simple reasons: You don't drink enough because you're sick or busy, or because you lack access to safe drinking water when you're traveling, hiking or camping.

Other dehydration causes include:

- **Diarrhea, vomiting.** Severe, acute diarrhea — that is, diarrhea that comes on suddenly and violently — can cause a tremendous loss of water and electrolytes in a short amount of time. If you have vomiting along with diarrhea, you lose even more fluids and minerals. Children and infants are especially at risk. Diarrhea may be caused by a bacterial or viral infection, food sensitivity, a reaction to medications or a bowel disorder.
- **Fever.** In general, the higher your fever, the more dehydrated you may become. If you have a fever in addition to diarrhea and vomiting, you lose even more fluids.
- **Excessive sweating.** You lose water when you sweat. If you do vigorous activity and don't replace fluids as you go along, you can become dehydrated. Hot, humid weather increases the amount you sweat and the amount of fluid you lose. But you can also become dehydrated in winter if you don't replace lost fluids. Preteens and teens who participate in sports may be especially susceptible, both because of their body weight, which is generally lower than that of adults, and because they may not be experienced enough to know the warning signs of dehydration.
- **Increased urination.** This may be due to undiagnosed or uncontrolled diabetes. Certain medications, such as diuretics and some blood pressure medications, also can lead to dehydration, generally because they cause you to urinate or perspire more than normal.

Anyone can become dehydrated if they lose too many fluids. But certain people are at greater risk, including:

- **Infants and children.** Infants and children are especially vulnerable because of their relatively small body weights and high turnover of water and electrolytes. They're also the group most likely to experience diarrhea.
- **Older adults.** As you age, you become more susceptible to dehydration for several reasons: Your body's ability to conserve water is reduced, your thirst sense becomes less acute, and you're less able to respond to changes in temperature. What's more, older adults, especially people in nursing homes or living alone, tend to eat less than younger people do and sometimes may forget to eat or drink altogether. Disability or neglect also may prevent them from being well nourished. These problems are compounded by chronic illnesses such as diabetes, dementia, and by the use of certain medications.
- **People with chronic illnesses.** Having uncontrolled or untreated diabetes puts you at high risk of dehydration. But other chronic illnesses, such as kidney disease and heart failure, also make you more likely to become dehydrated. Even having a cold or sore throat makes you more susceptible to dehydration because you're less likely to feel like eating or drinking when you're sick. A fever increases dehydration even more.
- **Endurance athletes.** Anyone who exercises can become dehydrated, especially in hot, humid conditions or at high altitudes. But athletes who train for and participate in ultramarathons, triathlons, mountain climbing expeditions and cycling tournaments are at particularly high risk. That's because the longer you exercise, the more difficult it is to stay hydrated. During exercise, your body may lose more water than it can absorb. With every hour you exercise, your fluid debt increases. Dehydration is also cumulative over a period of days, which means you can become dehydrated with even a moderate exercise routine if you don't drink enough to replace what you lose on a daily basis.
- **People living at high altitudes.** Living, working and exercising at high altitudes (generally defined as above 8,200 feet, or about 2,500 meters) can cause a number of health problems. One is

dehydration, which commonly occurs when your body tries to adjust to high elevations through increased urination and more rapid breathing — the faster you breathe to maintain adequate oxygen levels in your blood, the more water vapor you exhale.

People working or exercising outside in hot, humid weather. When it's hot and humid, your risk of dehydration and heat illness increases. That's because when the air is humid, sweat can't evaporate and cool you as quickly as it normally does, and this can lead to an increased body temperature and the need for more fluids.

Dehydration can lead to serious complications, including:

- **Heat injury.** If you don't drink enough fluids when you're exercising vigorously and perspiring heavily, you may end up with a heat injury, ranging in severity from mild heat cramps to heat exhaustion or potentially life-threatening heatstroke.
- **Swelling of the brain (cerebral edema).** Sometimes, when you're getting fluids again after being dehydrated, the body tries to pull too much water back into your cells. This can cause some cells to swell and rupture. The consequences are especially grave when brain cells are affected.
- **Seizures.** Electrolytes — such as potassium and sodium — help carry electrical signals from cell to cell. If your electrolytes are out of balance, the normal electrical messages can become mixed up, which can lead to involuntary muscle contractions and sometimes to a loss of consciousness.
- **Low blood volume shock (hypovolemic shock).** This is one of the most serious, and sometimes life-threatening, complications of dehydration. It occurs when low blood volume causes a drop in blood pressure and a drop in the amount of oxygen in your body.

Kidney failure. This potentially life-threatening problem occurs when your kidneys are no longer able to remove excess fluids and waste from your blood.

- **Coma and death.** When not treated promptly and appropriately, severe dehydration can be fatal.

You're likely to start by seeing your or your child's doctor. However, in some cases when you call to set up an appointment, the doctor may recommend urgent medical care. If your child or an adult who you care for is showing signs of severe dehydration, such as lethargy or reduced responsiveness, seek immediate care at a hospital.

If you have time to prepare for your appointment, here's some information to help you get ready, and what to expect from the doctor.

What you can do

- **Write down any symptoms you're (or the person you're caring for) is experiencing,** including any that may seem unrelated to the reason for which you scheduled the appointment. If you or the person you're caring for has been vomiting or has had diarrhea, the doctor will want to know when it began and how frequently it's been occurring.
- **Write down key personal information,** including any recent trips you've taken or life changes you've made. Also include a description of your typical daily diet and any foods you've recently eaten that you suspect may have caused illness. In addition, your doctor will want to know if you or the person you're caring for has recently been exposed to anyone with diarrhea.
- **Make a list of key medical information,** including other conditions you or the person you're caring for is being treated for and the names of the medications being taken. Include on your list

prescription and over-the-counter drugs, as well as any vitamins and supplements.

- **Write down questions to ask your doctor.**

For dehydration, some basic questions to ask the doctor include:

- What's causing these symptoms?
- What kinds of tests are needed?
- What treatment do you recommend?
- How soon after treatment will there be improvement?
- Are there any activity or dietary restrictions?
- Is there anything I can do to prevent a recurrence of dehydration?
- I have these other health conditions. Do I need to change the treatments I've been using?
- What steps can I take to prevent this from happening again?
- Are there any brochures or other printed material that I can take home with me? What websites do you recommend visiting?

What to expect from your doctor

Your doctor is likely to ask you a number of questions, such as:

- When did the symptoms begin? What were you doing?
- How frequently have you been experiencing loose bowel movements or vomiting?
- How recently have you urinated?
- Are you able to keep down any food or drink?
- Do you also have other symptoms, such as abdominal cramping, fever, headache or muscle aches? How severe are these symptoms?
- Has there been blood in your stools?
- Have you recently eaten any food that you suspect was spoiled?
- Has anyone gotten sick after eating the same food that you did?
- Have you recently been exposed to someone who you know was experiencing diarrhea?
- What medications are you currently taking?
- Have you recently traveled to another country?
- Do you know what your or your child's weight was before symptoms started?

What you can do in the meantime

If your child is sick, continue offering him or her small amounts of an oral rehydration solution containing electrolytes (Pedialyte, others) while you wait for your appointment. Ask your doctor to recommend the amount and frequency. Don't try to replenish fluids in a child with only water, which doesn't treat the electrolyte imbalance associated with dehydration in children, and may make symptoms worse. If you or another adult is sick, try to replenish fluids with water, an oral rehydration solution or a sports drink (Gatorade, Powerade, others).

Your doctor can often diagnose dehydration on the basis of physical signs and symptoms such as little or no urination, sunken eyes, and skin that lacks its normal elasticity and resilience when pinched. If you're dehydrated, you're also likely to have low blood pressure, especially when moving from a lying a standing position, a faster than normal heart rate and reduced blood flow to your extremities.

To help confirm the diagnosis and pinpoint the degree of dehydration, you may have other tests, such as:

- **Blood tests.** Blood samples may be used to check for a number of factors, such as the levels of your electrolytes — especially sodium and potassium — and how well your kidneys are working.
- **Urinalysis.** Tests done on your urine can help show whether you're dehydrated and to what degree.

If it's not obvious why you're dehydrated, your doctor may order additional tests to check for diabetes and for liver or kidney problems.

The only effective treatment for dehydration is to replace lost fluids and lost electrolytes. The best approach to dehydration treatment depends on age, the severity of dehydration and its cause.

Treating dehydration in sick children

Your doctor can offer specific suggestions for treating dehydration in your child, but some general guidelines include the following:

- **Use an oral rehydration solution.** Unless your doctor advises otherwise, use an oral rehydration solution such as Pedialyte for infants and children who have diarrhea, vomiting or fever. These solutions contain water and salts in specific proportions to replenish both fluids and electrolytes. They're also designed for easier digestion. Oral rehydration products are readily available in most drugstores, and many pharmacies carry their own brands. Begin giving fluids early in the course of an illness instead of waiting until the situation becomes urgent.

Be sure to give enough solution. Your doctor may suggest specific amounts, depending on your child's age and degree of dehydration, but a general rule of thumb is to keep giving liquids slowly until your child's urine becomes clear in color. When your child is vomiting, try giving small amounts of solution at frequent intervals — try a spoonful or so every few minutes, for instance. If your child can't keep this down, wait 30 to 60 minutes and try again. Room temperature fluids are best.

- **Continue to breast-feed.** Don't stop breast-feeding when your baby is sick, but offer your baby an oral rehydration solution in a bottle as well. If you give your baby formula, try switching to one that's lactose-free until diarrhea improves — lactose can be difficult to digest during diarrhea, making diarrhea worse. Never dilute formula more than the instructions advise. Your doctor may suggest substituting an oral rehydration solution for the formula for a short time.
- **Avoid certain foods and drinks.** The best liquid for a sick child is an oral rehydration solution — plain water doesn't provide essential electrolytes, and although sports drinks replenish electrolytes, they replace those lost through sweating, not through diarrhea or vomiting. Milk, caffeinated beverages, fruit juices or gelatins don't relieve dehydration and may make children's diarrhea symptoms worse.

Treating dehydration in sick adults

Most adults with mild to moderate dehydration from diarrhea, vomiting or fever can improve their condition by drinking more water or other liquids. Certain liquids, such as fruit juices, carbonated beverages or coffee, can make diarrhea worse.

Treating dehydration in athletes of all ages

For exercise-related dehydration, cool water is your best bet. Sports drinks containing electrolytes and a carbohydrate solution also may be helpful. There's no need for salt tablets — too much salt can lead to hyponatremic dehydration, a condition in which your body not only is short of water but also carries an excess of sodium. Avoid drinking carbonated beverages, such as colas or other types of soda.

Treating severe dehydration

Children and adults who are severely dehydrated should be treated by emergency personnel arriving in an ambulance or in a hospital emergency room, where they can receive salts and fluids through a vein (intravenously) rather than by mouth. Intravenous hydration provides the body with water and essential nutrients much more quickly than oral solutions do — something that's essential in life-threatening situations.

To prevent dehydration, drink plenty of fluids and eat foods high in water such as fruits and vegetables. Letting thirst be your guide is an adequate daily guideline for most healthy people. Fluids can be obtained not just from water but also from other beverages and foods. But, if you're exercising, don't wait for thirst to keep up with your fluids.

Under certain circumstances, you may need to take in more fluids than usual:

- **Illness.** Start giving extra water or an oral rehydration solution at the first signs of illness — don't wait until dehydration occurs. And although they might sound appealing, traditional "clear fluids" such as ginger ale or other sodas contain too much sugar and too little sodium to replenish lost electrolytes.
- **Exercise.** In general, it's best to start hydrating the day before strenuous exercise. Producing lots of clear, dilute urine is a good indication that you're well hydrated. Before exercising, drink 1 to 3 cups (0.24 to 0.70 liters) of water. During the activity, replenish fluids at regular intervals and continue drinking water or other fluids after you're finished.

Keep in mind that drinking too much not only can cause bloating and discomfort but also may lead to a potentially fatal condition in which your blood sodium becomes too low (hyponatremia). This occurs when you drink more fluids than you lose through sweating.

- **Environment.** You need to drink additional water in hot or humid weather to help lower your body temperature and to replace what you lose through sweating. You may also need extra water in cold weather if you sweat while wearing insulated clothing. Heated, indoor air can cause your skin to lose moisture, increasing your daily fluid requirements. And altitudes greater than 8,200 feet (2,500 meters) also can affect how much water your body needs. If dehydration occurs when you're exercising in hot weather, get into a shady area, recline, and start drinking water or a sports drink. Young athletes should be encouraged to let their coaches know if they're having symptoms of dehydration.

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Feb. 12, 2014

Original article: <http://www.mayoclinic.org/diseases-conditions/dehydration/basics/symptoms/con-20030056>

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COPY

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Edmund Dillon, Dec'd,)
Employee/Claimant,) WCC No. 1501382
-vs-) EXPEDITED
Raffles (FleetPride),) DEPOSITION OF:
Employer,) JACOB VANDERSTEENHOVEN, MD
and)
Gallagher Bassett as TPA for)
American Zurich Insurance)
Company,)
Defendants.)

Given before Elaine G. McLeod, Court Reporter and
Notary Public, at the offices of Turner, Padgett, Graham
& Laney, P.A., 1901 Main Street, 17th Floor, Columbia,
South Carolina, on Tuesday, August 16, 2016, commencing
at 8:57 a.m.

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INDEX TO EXAMINATIONS:

DIRECT EXAMINATION BY MR. DUMAS:	7
CROSS-EXAMINATION BY MR. PRIDY:	29
CROSS-EXAMINATION BY MS. DOOLEY:	41

INDEX TO EXHIBITS:

SC WORKERS' COMPENSATION COMMISSION UPDATED FIRST REPORT MARKED AS CLAIMANT'S EXHIBIT NO. 1	12
MEDICAL RECORDS STAMPED 000024 MARKED AS CLAIMANT'S EXHIBIT NO. 2.	15
MEDICAL RECORD STAMPED 000035 MARKED AS CLAIMANT'S EXHIBIT NO. 3.	15
DEATH CERTIFICATION DATED MARCH 04, 2015 MARKED AS CLAIMANT'S EXHIBIT NO. 4	16
DEATH CERTIFICATION DATED JUNE 05, 2015 MARKED AS CLAIMANT'S EXHIBIT NO. 5	17
DEPOSITION OF JOSIAH FLUDD PAGES 17-30 MARKED AS CLAIMANT'S EXHIBIT NO. 6	19

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1 It was stipulated by and between
2 counsel for the parties that this
3 deposition is taken pursuant to notice and
4 that all questions as to notice are
5 waived; that all objections, save as to
6 the form of the question, are reserved
7 until the time of trial; that the
8 deposition is taken pursuant to the South
9 Carolina Rules of Civil Procedure, for the
10 purposes allowed therein; and that the
11 deponent was explained his right to read
12 and sign the deposition and did not waive
13 that right.

14 (JACOB VANDERSTEENHOVEN, MD, Ph.D.,
15 being duly sworn, testified as follows:)

16 MR. DUMAS: Doctor, my name is Brian
17 Dumas. I am the attorney for the Claimant
18 in this Workers' Compensation matter which
19 is currently pending and set to be heard
20 at the end of this month. I'm here to ask
21 you some questions primarily concerning a
22 report that you issued on behalf of the
23 employer in this case.

24 Have you ever had your deposition
25 taken before?

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1 DR. VANDERSTEENHOVEN: Yes, I have.

2 MR. DUMAS: How many times?

3 DR. VANDERSTEENHOVEN: Maybe three or
4 four times.

5 MR. DUMAS: Okay. Then in that case,
6 I'm just going to go over very briefly the
7 general rules.

8 If you don't understand something,
9 please tell me. Basically, I'm here to
10 ask you some questions and if you don't
11 understand the question please ask me to
12 restate it. I'll be happy to do so.

13 DR. VANDERSTEENHOVEN: Okay.

14 MR. DUMAS: The court reporter
15 generally has trouble with any non-verbal
16 responses, so please keep your -- if I see
17 a shrug or something like that and ask for
18 a verbal response I'm not trying to harass
19 you or give you any grief, I just need
20 something for the record.

21 And the biggest problem that most
22 court reporters seem to have is with "uh-
23 huh's" and "huh-uh's". So if I ask you to
24 avoid that, please understand, again, I'm
25 not trying to give you any real grief in

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1 this, fair enough?

2 DR. VANDERSTEENHOVEN: Fair enough. I
3 understand.

4 MR. DUMAS: And I'm also going -- if
5 you don't ask me to explain the question,
6 I'm going to assume you understood it; is
7 that fair?

8 DR. VANDERSTEENHOVEN: Yes.

9 MR. DUMAS: Okay. Generally, I'm
10 going to ask you a couple of very brief
11 background questions that I ask every
12 expert witness and then we will go
13 directly into the testimony.

14 Let me just make sure I am pronouncing
15 your name correctly.

16 DR. VANDERSTEENHOVEN: You haven't
17 pronounced it yet.

18 MR. DUMAS: Well, I want to hear you
19 say it so that I get it right from the
20 beginning.

21 DR. VANDERSTEENHOVEN:
22 Vandersteenhoven.

23 MR. DUMAS: Okay. So,
24 Vandersteenhoven. Is that a correct
25 pronunciation?

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1 DR. VANDERSTEENHOVEN: Yes, it is.

2 MR. DUMAS: Thank you very much.

3 DIRECT EXAMINATION BY MR. DUMAS:

4 Q. You received your undergraduate education
5 where?

6 A. Undergrad from the -- it was called the College
7 of Notre Dame, it's now Notre Dame de Namur
8 University in Belmont, California in 1978.

9 Q. Okay. And you went to medical school where?

10 A. I went to medical school at the Medical
11 University of South Carolina in Charleston.

12 Q. Graduated when?

13 A. I graduated from medical school in 1987.

14 Q. And then you did your residency where?

15 A. I did my residency at Duke University in
16 anatomic and neuropathology.

17 Q. Okay. Generally, just a brief outline from
18 after the completion of your residency to
19 present day for your employment.

20 A. Uh-huh.

21 Q. If you could just give me a kind of bullet
22 point. Bring us up to date starting from after
23 your residency and internship to the present.

24 A. After residency I went to Dallas, Texas and
25 worked at the Presbyterian Hospital in Dallas.

ELAINE G. MCLEOD (803)603-4128

1 Then left -- after a couple of years left to do
2 a fellowship in cytopathology at the University
3 of Texas at Southwestern. And then went to
4 work with ProPath, which is another large
5 pathology group in Dallas, Texas, and I was
6 there until 2001. And then in 2001 I came to
7 Columbia, South Carolina, worked at Palmetto
8 Health Richland for ten years. And then about
9 five years ago moved to Lexington Medical
10 Center and I have been there since.

11 Q. Okay. And you are also a specialist, I
12 believe, in pathology; is that correct?

13 A. Yes, I would say so. I'm Board certified in
14 anatomic pathology, clinical pathology,
15 cytopathology and neuropathology.

16 Q. I checked it out, of course, so there was no
17 point in arguing over your qualifications.

18 So, in terms of pathology, in a layman's,
19 just putting it in layman's terms, what
20 generally is the speciality of pathology?

21 A. The speciality of pathology involves biopsy
22 interpretation, tissue biopsy interpretation,
23 management of a clinical laboratory; autopsies,
24 both forensic and non-forensic cases. We call
25 those medical for non-forensics. And my work

ELAINE G. MCLEOD (803)603-4128

- 1 is primarily of surgical pathology which
2 involves diagnosis of using cytologic methods
3 and surgical pathology methods.
- 4 Q. Okay. Over the last five years how many times
5 have you testified as an expert witness?
- 6 A. In the last five years?
- 7 Q. Sure.
- 8 A. I believe once.
- 9 Q. Okay. And who retained you as an expert
10 witness, do you recall?
- 11 A. It was a legal case recently in December of --
12 January or December of -- no, it was January of
13 2016. I was retained by the defense.
- 14 Q. And was that an insurance carrier?
- 15 A. It was a medical legal case, so, yes.
- 16 Q. I guess my question is who cut you a check for
17 your services?
- 18 A. The attorneys did.
- 19 Q. Okay. And what law firm was that?
- 20 A. The Hood Law Firm in Charleston, South
21 Carolina.
- 22 Q. So, you were defending what I would imagine
23 would have been a medical malpractice case?
- 24 A. That's correct.
- 25 Q. Okay. Now, you were given certain -- you

ELAINE G. MCLEOD (803)603-4128

- 1 issued a report, which I have a copy of -- do
- 2 you have a copy of this?
- 3 A. I do.
- 4 Q. Okay. And that was signed by you May 21st,
- 5 2016, is that correct, concerning the matter of
- 6 Edmund Dillon; is that correct?
- 7 A. That's correct.
- 8 Q. And you listed at the very top of that the
- 9 items that you reviewed in terms of coming to
- 10 your opinion; is that correct?
- 11 A. That's correct.
- 12 Q. And my question to you is this, when is the
- 13 last time you treated a live patient?
- 14 A. Oh, I'd say as a senior medical student.
- 15 Q. So that was how many years ago?
- 16 A. That was 30 something years ago.
- 17 Q. Okay. And what's the importance of the
- 18 patient's input in terms of diagnosing the
- 19 problem or the etiology of their current
- 20 problem?
- 21 A. It's very important.
- 22 Q. Okay. And in this case -- bear with me a
- 23 moment.
- 24 A. Uh-huh.
- 25 Q. There is no question but that the patient,

ELAINE G. MCLEOD (803)603-4128

1 Edmund Dillon, related to EMS that he slipped
2 and fell, correct?

3 A. Correct.

4 Q. And there is no question that he also related
5 the very same thing to the ER doctors, correct?

6 A. That's correct.

7 Q. And basically in coming to your conclusion you
8 have completely disregarded that input from the
9 patient, correct?

10 A. I don't believe I disregarded the input.

11 Q. Well, tell me how then you come to the
12 conclusion -- based upon what objective medical
13 evidence you came to the conclusion that he had
14 a syncopal episode which caused the fall rather
15 than he slipped and fell as the patient related
16 to EMS and the ER doctors.

17 A. I wasn't there. The patient has a view on what
18 happened, but there is a witness that stated
19 that he was standing motionless, idle, and then
20 collapsed.

21 Q. Okay. Now, there also was another witness.
22 Were you given this document? And I'm going to
23 put in front of you --

24 MR. DUMAS: Let's mark this as
25 Claimant's Exhibit One.

ELAINE G. MCLEOD (803)603-4128

(SC WORKERS' COMPENSATION COMMISSION
UPDATED FIRST REPORT MARKED AS CLAIMANT'S
EXHIBIT NO. 1 FOR IDENTIFICATION.)

Q. I'm going to ask you, have you ever seen this?

A. No, I have not.

Q. And this was a document submitted by the employer to the Workers' Compensation Commission through their electronic system dated February 27th, 2015. And will you look down to the bottom --

A. Uh-huh.

Q. -- where it says, "Describe employee's activities when injury occurred with details of how event occurred." Could you please read what it says there?

A. "He was leaving his car heading toward the building when he tripped and fell hitting his head knocking him unconscious as witnessed by a customer John" -- doesn't say.

Q. That would be "John @" and then there's a number, isn't there?

A. There's a phone number.

Q. Correct. Were you given this information prior to giving your opinion?

A. No, I was not.

ELAINE G. MCLEOD (803)603-4128

1 Q. Think this might have weighed somewhat into
2 your conclusions had you been given this
3 information?

4 A. Well, then it would be conflicting because we
5 have a witness, Mr. Fludd, that stated that he
6 observed Mr. Dillon standing and now we have
7 another, another supervisor or director
8 stating, I guess, by either some communication
9 that there's a little difference in the story.

10 Q. So, now we have, and just correct me if I'm
11 wrong, we now have the patient himself saying
12 to two different medical care providers I
13 slipped and fell and we've got a report of a
14 witness saying he slipped and fell, correct?

15 A. Correct.

16 MR. PRIDDY: Can we go off the record
17 for a second?

18 MR. DUMAS: Just a moment. I would
19 like to move that into evidence. That was
20 submitted into evidence as part of the APA
21 and it's Dillon Exhibits 000093. I'd like
22 that admitted as an exhibit to this
23 deposition.

24 May we talk outside of the witness?

25 MS. DOOLEY: Sure, sure.

ELAINE G. MCLEOD (803)603-4128

(Deposition went off the record.)

MS. DOOLEY: We are going to object to this line of questioning based on the fact that the witness that is in this statement by prior deposition of Gene Lane identified this as Josiah Fludd, which is the same person. Even though it has on this report "John" this is Josiah Fludd, who you did have the information from.

MR. DUMAS: And I, of course, dispute that. I think that's a matter of fact for the Commission to determine.

MS. DOOLEY: We continue with our objection through this line of questioning.

MR. DUMAS: I understand, sure.

Q. (By Mr. Dumas) Just for the record also, as earlier testimony -- and you've reviewed the medical records, Doctor. You wouldn't dispute that the EMS records as shown by "Dillon Medical 000024" relates that EMS said he slipped and fell? And that would be at the very top, "Per EMS, patient slipped and fell."

A. I see it.

Q. That would be correct from the EMS, correct?

ELAINE G. MCLEOD (803)603-4128

1 A. "Per EMS", that's correct.

2 Q. Okay.

3 MR. DUMAS: I would like to introduce
4 that as Claimant's Two.

5 (MEDICAL RECORD STAMPED 000024 MARKED
6 AS CLAIMANT'S EXHIBIT NO. 2 FOR
7 IDENTIFICATION.)

8 Q. We also have, and just correct me if I'm wrong,
9 I don't want to be unduly repetitious. I think
10 you have already testified that the ER doctor
11 himself stated that the patient stated he had
12 slipped and fallen, correct?

13 A. I don't recall that. Testify?

14 Q. Attending physician notes of Mark A. Jones.
15 Dillon Medical 000035. The very top. Chief
16 complaint, fall. History of present illness.

17 A. May I see this again?

18 Q. Sure.

19 A. What do you want me to do with this?

20 Q. Oh, no, I mean, you do recall reviewing that?

21 A. Yes, I do.

22 MR. DUMAS: I'd like that put in as
23 Claimant's Three.

24 (MEDICAL RECORD STAMPED AS 000035
25 MARKED AS CLAIMANT'S EXHIBIT NO. 3 FOR
ELAINE G. MCLEOD (803)603-4128

IDENTIFICATION.)

Q. There are also -- and I don't know that you actually saw this. Originally, there was a death certificate that was issued that stated -- bear with me just one moment.

I'm going to show you a death certificate that was issued March 4th, 2015 and I want you to look at how the injury occurred. Just above the certifier name. What does it say there?

A. It says, "Fall from ladder with closed head trauma."

Q. Right. And that would be Dillon Exhibits 000001. Were you ever shown this before you issued your report?

A. I have seen this, yes.

Q. Okay.

MR. DUMAS: I would like that introduced as Defendant's (sic) Five. I think that's Five.

COURT REPORTER: It's Four.

MR. DUMAS: Four, okay. I don't count very well.

(DEATH CERTIFICATE DATED MARCH 04, 2015
MARKED AS CLAIMANT'S EXHIBIT NO. 4 FOR
IDENTIFICATION.)

ELAINE G. MCLEOD (803)603-4128

1 Q. So, now we have got several witnesses saying
2 several different things, correct?

3 A. That's correct.

4 Q. And then we have a correction because we have a
5 new death certificate issued June 5, 2015 that
6 simply says, "Fall head trauma". Dillon
7 Exhibits, five zeroes and then a two; is that
8 correct? It just says, "Fall head trauma" as
9 to how it occurred.

10 A. That's correct. That's what's stated.

11 Q. Okay.

12 MR. DUMAS: Number Five.

13 (DEATH CERTIFICATE ISSUED JUNE 05,
14 2015 MARKED AS CLAIMANT'S EXHIBIT NO. 5
15 FOR IDENTIFICATION.)

16 Q. Now, essentially, you also stated before that
17 you understood -- that you had read the
18 deposition testimony of Josiah Fludd; is that
19 correct?

20 A. That's correct.

21 Q. And Mr. Fludd, and just correct me if I'm wrong
22 because I'm just going to it, it wasn't a
23 lengthy deposition, was it?

24 A. I have no familiarity about depositions and
25 lengths.

ELAINE G. MCLEOD (803)603-4128

1 Q. 27 pages. But, in any event, would it be fair
2 to say that sometimes that Mr. Fludd wasn't
3 exactly staring at Mr. Dillon at the time the
4 collap -- the -- at the time he fell?

5 A. I don't know about the words, but he was
6 observing him, observed him through a window of
7 his truck, so.

8 Q. Okay. And his view was partially obscured,
9 correct?

10 A. That's correct.

11 Q. And he was paying attention to keeping his
12 paperwork dry.

13 A. So he said, yes.

14 Q. Okay. And until he fell he didn't have any
15 particular reason to be observing Mr. Dillon,
16 did he?

17 A. I can't really speak to that.

18 Q. Well, isn't that what he said himself? I'm
19 going to call to your attention page 20, line
20 20 of the deposition. I've just got a
21 condensed version. Right down there.

22 A. Yes, that's what he says.

23 Q. Okay.

24 MR. DUMAS: I would like to introduce
25 this as Claimant's, I think, Six?

ELAINE G. MCLEOD (803)603-4128

1 COURT REPORTER: Six, yes.

2 MR. DUMAS: At least I'm numbering
3 properly.

4 (DEPOSITION OF JOSIAH FLUDD PAGES 17-
5 30 MARKED AS CLAIMANT'S EXHIBIT NO. 6 FOR
6 IDENTIFICATION.)

7 Q. Now, you earlier testified as to the importance
8 of the patient's -- history that the patient
9 gives in terms of a diagnosis of their
10 condition and the etiology of the problem,
11 correct?

12 A. Correct.

13 Q. So, --

14 A. In most cases the patient is true, is correct.

15 Q. Okay.

16 A. And in this particular case, based on what I
17 had Mr. Fludd's deposition indicating that he
18 was observed to be standing in position and
19 collapsing without movement, hitting his head.

20 Mr. Dillon had a serious head injury and
21 very often with patients, although they may
22 seem oriented, they may tell you something at
23 the time of the initial presentation, they very
24 often have amnesia to a certain degree either
25 prior to the event or post -- after the event.

ELAINE G. MCLEOD (803)603-4128

And, so, the patient may say one thing, but in the case of traumatic brain injury, or injury to the head, there's always a reason to sort of question that particular history.

Q. But isn't what Mr. Dillon said corroborated by the employer's own document, which they submitted, talking about a witness, John, who said he slipped and fell in Claimant's One?

A. I don't know how that information got to the supervisor.

Q. But isn't the testimony of the Claimant being corroborated by that witness and the employer's own document? That he slipped and fell?

A. That's what's stated.

Q. Well, I'm at a loss.

A. I'm just saying.

Q. Bear with me, sir, I'm at a loss here. You tell me, and correct me if I'm wrong, that the testimony of the patient is usually reliable, correct?

A. It usually is reliable.

Q. Okay. We now have, according to the employer's own documents, at least a reflection of some testimony that corroborates the patient's version, correct?

ELAINE G. MCLEOD (803)603-4128

- 1 A. That's correct.
- 2 Q. The only contrary witness says he wasn't
- 3 exactly paying attention prior to the fall,
- 4 correct?
- 5 A. That's what's stated in the deposition.
- 6 Q. Well, that's what Mr. Fludd says, isn't it?
- 7 A. That's right.
- 8 Q. Okay. And he also ultimately states, and feel
- 9 free to review this again and just read the
- 10 rest of it, because the portions I gave you are
- 11 port -- pages 17 through 27 that ultimately he
- 12 saw the fall but doesn't know why. Isn't that
- 13 what -- the sum and substance of Mr. Fludd
- 14 says?
- 15 A. Yes, basically that's correct.
- 16 Q. Okay. And he admitted to an obstructed view.
- 17 A. That's correct.
- 18 Q. And he admitted to paying attention to his
- 19 paperwork at the time, correct?
- 20 A. He happened to be tending to his paperwork and
- 21 just observed Mr. Fludd (sic) apparently
- 22 through the door -- through the window of the
- 23 door.
- 24 Q. Okay.
- 25 A. And for whatever reason he noticed him, but

ELAINE G. MCLEOD (803)603-4128

then it does say in his deposition that he was standing idle, motionless, and collapsed.

Q. Well, doesn't he actually say, and I call to your attention -- bear with me just a moment. Doesn't he say, looking at page 21 of his deposition testimony, starting at line 15, "Question. You were actually watching him? Answer, no. I was watching that direction. Oh, okay. But (sic) I assume the motion is what caught your eye? Answer, yes. Question. The motion of the fall? Answer, yes." Page 21, starting at line 15.

A. Yes, I see that.

Q. Okay. You would agree that's what Mr. Fludd says?

A. In this section, yes, that's correct.

Q. Okay. Let's talk for a moment. What objective -- other than -- can you tell me other than the syncopal episode that Mr. Dillon had in 1994 as reflected in the Kershaw County medical records --

A. Yes.

Q. -- what objective medical evidence in your review of this record points to the existence of a syncopal episode causing this fall?

ELAINE G. MCLEOD (803)603-4128

- 1 A. The fact is the way he fell was basically
- 2 without any guarding, he was unconscious at the
- 3 time Mr. Fludd came to him. So that speaks to
- 4 a momentary loss of consciousness and body
- 5 posture which is typical for syncope and then
- 6 with rapid recovery basically from the
- 7 unconsciousness.
- 8 Q. Well, didn't Mr. Dillon deny any loss of
- 9 consciousness according to his history as taken
- 10 by both the EMS and the emergency room?
- 11 A. He denied a loss of consciousness, but Mr.
- 12 Fludd and other people recognized that he had
- 13 been unconscious. Or at least Mr. Fludd had
- 14 recognized he was unconscious at the time.
- 15 Q. Okay. But there is nothing in the record of --
- 16 so your testimony is that it's Mr. Fludd who
- 17 said he went -- that he was unconscious. Now,
- 18 was that before the fall or after the fall?
- 19 A. After the fall.
- 20 Q. Okay.
- 21 A. But part of the syncopal episode involves loss
- 22 of consciousness.
- 23 Q. How do you tell the difference between a loss
- 24 of consciousness after hitting your head on a
- 25 concrete sidewalk as opposed to before?

ELAINE G. MCLEOD (803)603-4128

- 1 A. Part of the syncopal episode involves loss of
- 2 consciousness and postural tone.
- 3 Q. Okay. I guess my question comes down to this,
- 4 other than, leaving aside Mr. Fludd --
- 5 A. Uh-huh.
- 6 Q. -- it is true, isn't it, that there is no
- 7 objective evidence in the medical records you
- 8 reviewed other than the 1994 Kershaw County
- 9 medical records of the existence of a syncopal
- 10 episode that preceded the fall?
- 11 A. No, there is no objective evidence to say that
- 12 he had a syncopal episode.
- 13 Q. Okay. Prior to the fall. Within the, within
- 14 the short time span of the fall?
- 15 A. I'm not sure I understand the question,
- 16 rephrase that, please.
- 17 Q. Okay. Isn't it true that there's no objective
- 18 medical evidence in the record to suggest that
- 19 Mr. Dillon had a syncopal episode that --
- 20 within one hour of his preceding his fall?
- 21 A. That's correct.
- 22 Q. Okay. And you also -- other than that one fall
- 23 in, that one syncopal episode in 1994, there is
- 24 no objective evidence in this record that you
- 25 reviewed of any prior falls either, is there?

ELAINE G. MCLEOD (803)603-4128

- 1 A. No objective evidence, that's correct.
- 2 Q. Okay. And according to EMS when they arrived
- 3 on the scene, and as you reflect in your
- 4 report, his Glasgow Coma Scale was normal at
- 5 that time, correct?
- 6 A. That's correct.
- 7 Q. So according to his coma scale there would have
- 8 been nothing, at least as would have been
- 9 revealed by that, as to his inability to
- 10 accurately reflect how the fall occurred?
- 11 A. No, that's not a, that's not a measurement of
- 12 somebody's memory, so to speak.
- 13 Q. Okay. Tell me what objective finding in this
- 14 record reflects that he was -- Mr. Dillon at
- 15 the time he was being treated by the EMS was
- 16 unable to give an accurate history of his fall.
- 17 A. There's nothing in there, in the record that
- 18 suggests he could not give an accurate history.
- 19 Q. Okay.
- 20 A. He said what he said.
- 21 Q. Okay. And there's nothing in the ER record
- 22 that would suggest he was unable to give an
- 23 accurate record or an inaccurate recollection
- 24 of how the fall occurred either, is there?
- 25 A. His recollection in the ER is as Mr. Dillon

ELAINE G. MCLEOD (803)603-4128

1 said, stated.

2 Q. Well, that's not my question. My question is,
3 there's nothing in the medical records that
4 would reflect objectively that he was unable to
5 give an accurate recall of the events of his
6 fall, is there?

7 A. Initially, no, that's correct.

8 Q. What do you mean initially, no?

9 A. Well, he decompensated very quickly, so.

10 Q. After he gave that statement?

11 A. Yes.

12 Q. Okay. But at the time he gave it there was no
13 objective evidence that he could not accurately
14 recall and relate the circumstances of his
15 fall?

16 A. Well, there is one issue in terms of, you know,
17 telling what happened, what -- being truthful
18 in terms of what occurred. When he came in he
19 gave a completely negative review of systems.
20 He didn't complain about diarrhea, fever, or
21 anything, any other symptomatology other than
22 smoking and that he slipped and fell.

23 Q. But the record also doesn't reflect he was
24 asked those questions, does it?

25 A. Well, in the review of systems that's what,

ELAINE G. MCLEOD (803)603-4128

- 1 what basically happens.
- 2 Q. Well, I understand --
- 3 A. You ask the patient, the review of systems,
- 4 have you had this symptom or these signs. It's
- 5 a verbal thing. If a patient can't provide a
- 6 review of systems then they say unable to
- 7 provide a review of systems.
- 8 Q. Well, there's nothing in the medical records of
- 9 the ER or the EMS that would reflect that they
- 10 actually asked the question that he did not
- 11 answer, is there?
- 12 A. All I'm saying is the review of systems is what
- 13 you ask the patient --
- 14 Q. Okay.
- 15 A. -- and that it is completely negative.
- 16 Q. But you don't know because you weren't there
- 17 and it's not in these records, is it?
- 18 A. Other than the review of systems it is. But
- 19 EMS goes with what, what people tell them.
- 20 What the patient tells them, what people around
- 21 them tell about the circumstances to give them
- 22 a head up to basically dealing with the
- 23 patient.
- 24 Q. Okay.
- 25 A. So there aren't any other specific questions,

ELAINE G. MCLEOD (803)603-4128

1 per se.

2 Q. Okay. Are you familiar, Doctor, with any of
3 the studies concerning eyewitness reliability
4 of events?

5 A. Peripherally.

6 Q. And when you say peripherally, you are aware,
7 of course, of the number of studies that have
8 been performed which relate to the inaccuracy
9 of eyewitness testimony.

10 A. That's correct.

11 Q. And just as a kind of example of that, we got
12 two different death certificates, we got
13 eyewitnesses saying different things. I mean,
14 wouldn't that be the perfect example of it?

15 A. It would seem.

16 Q. Okay. And the one consistent thing we have is
17 the patient relating that he slipped and fell,
18 correct?

19 A. That's correct.

20 MR. DUMAS: I have nothing further.

21 MR. PRIDDY: Do you want to take a
22 quick break?

23 MS. DOOLEY: Sure.

24 MR. PRIDDY: Can we take a quick
25 break?

ELAINE G. MCLEOD (803)603-4128

1 MR. DUMAS: Sure.

2 (Deposition went off the record.)

3 CROSS-EXAMINATION BY MR. PRIDDY:

4 Q. Okay. Doctor, you went through all of your
5 qualifications with the opposing counsel. Can
6 you just kind of briefly touch on how often you
7 review medical records and do autopsies and
8 review the records and make determinations on
9 causation?

10 A. With respect to doing autopsies and reviewing
11 records, I have served as a medical examiner in
12 the State of North Carolina, in Durham County,
13 when I was a resident and did autopsies, review
14 of medical records when I was a pathologist in
15 Dallas, and I reviewed medical records and done
16 forensic cases for the Richland County Coroner
17 and more recently the Lexington County Coroner.
18 I've been doing this since 1992.

19 Q. And are you also a professor currently?

20 A. Yes, I am currently a clinical professor of
21 Neurology at the University of South Carolina
22 where I am responsible for teaching
23 neuropathology to the neurology residents. And
24 I've been a professor in the Department of
25 Neurosurgery in the past as well as

ELAINE G. MCLEOD (803)603-4128

ophthalmology in the past.

MR. PRIDDY: We would just like to stipulate he's an expert on pathology and neuropathology.

MR. DUMAS: I am not going to dispute that.

Q. Now, opposing counsel has made a big distinction between what the patient said and perhaps some objective statements in the record saying he tripped and fell. Would you classify this fall as a traumatic brain injury?

A. Yes, I would.

Q. Can you kind of explain potentially memory issues or antegrade or retrograde issues that could surround this?

A. I don't think the mechanisms, per se, are fully elucidated, but it is well known that people who have experienced traumatic brain injury, certainly of this caliber, often have a certain degree of amnesia, loss of memory prior to the event as well as after the event, an antegrade. So there's retrograde and antegrade memory loss.

And then depending on the injury and also the circumstances and the degree of brain

ELAINE G. MCLEOD (803)603-4128

1 injury that's involved they may either gain
2 their memory entirely or they can have deficits
3 that persist for the rest of their lives.

4 Q. And can they come to from a syncopal episode
5 and think they know what happened --

6 A. Well, --

7 Q. -- and be wrong, inaccurate?

8 A. In just a general syncopal episode, without any
9 brain injury, that's sort of the definition of
10 syncope is a loss of consciousness,
11 instantaneous loss of consciousness and
12 postural tone, which means basically muscle
13 tone to be able to keep you upright if you were
14 in a standing position and then you collapse
15 and then you regain your loss of consciousness
16 very quickly.

17 Usually people can recollect what's been
18 going on prior to that. But in the setting of
19 Mr. Dillon, who has had a significant bump on
20 the head, that's the question. I mean, you
21 take the history, or you listen to what the
22 patient says, but you also -- in the case where
23 somebody that's had traumatic brain injury you
24 like to be a little cautious in terms of, well,
25 that might not be the whole story.

ELAINE G. MCLEOD (803)603-4128

1 Q. And I believe when the EMS arrived they
2 provided a Glasgow Coma Score. Can you explain
3 what that is?

4 A. That's really a prognostic marker, an
5 assessment test. It's based on eye motion,
6 motor motion, and verbal responses and you get
7 scores for each different category and it's a
8 total of 15 is a normal person with a brain
9 injury and then when you start losing some of
10 the function of the eye, motor, and verbal you
11 deduct scores and you get lower scores and then
12 starts going into different grades of brain
13 trauma, so to speak, and prognostic --

14 Q. And does it show memory at all, or is it really
15 just --

16 A. No, it's not. It's not really a memory test,
17 it's just more of an assessment of the brain
18 injury at the time.

19 Q. So, would you say that even though Mr. Dillon
20 had a normal Glasgow Coma Score that it would
21 affect --

22 MR. DUMAS: I'm going to object to the
23 leading at this point.

24 A. Can you rephrase the question?

25 Q. Did anything in his scale show any memory --

ELAINE G. MCLEOD (803)603-4128

1 A. Well, it's not a memory test, it's just a
2 prognostic, I'd say, test to evaluate
3 somebody's brain injury and the potential for
4 recovery.

5 Q. Can you discuss what underlying conditions,
6 based on the records that you reviewed, that
7 Mr. Dillon had that could potentially lead to a
8 syncopal episode?

9 A. Well, Mr. Dillon, unfortunately, was a very ill
10 man. He had what we would call acute-on-
11 chronic liver failure as a result of his
12 alcoholism. So, he had liver failure as
13 manifest by his jaundice, his ascites, his
14 coagulopathy, which means basically his INR,
15 his PT, his ability to clot --

16 DR. VANDERSTEENHOVEN: I'm sorry if
17 I'm talking too fast.

18 A. His ability to clot was abnormal and that's a
19 function of the liver -- of a liver capacity to
20 make the appropriate coagulation factors. He
21 was, he was hypovolemic, meaning he was low on
22 blood volume. He was anemic, meaning basically
23 he didn't have enough red cells to carry oxygen
24 and to oxygenate his body. His metabolites
25 were way out of sync. Basically just

ELAINE G. MCLEOD (803)603-4128

completely -- metabolically deranged is kind of the term. So, yeah, there were a lot of things going on with Mr. Dillon at the time.

Certainly at the time when he was admitted to the ED.

Q. And those could lead to a syncopal episode?

A. Yeah, --

MR. DUMAS: Objection, leading.

A. -- there are a number of things that could lead to a syncopal episodes, there's hypotension, his hypovolemia, his anemia, his metabolic abnormalities. All of those can cause someone to pass out.

Q. Can you explain what acute-on-chronic liver failure is?

A. It's basically -- it's a term that's typically used with alcoholics, with people who have chronic liver disease. When they present they basically -- they have an exacerbation of their current chronic disease.

So, his liver was having -- basically his liver was being inflamed, or was being damaged, was expressing changes of damage by elevation of his LFT's, which were markedly elevated, and all of the other symptoms, the jaundice, the

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1 icterus, and all those things. Those
2 reportedly were things that started to develop
3 in a short period of time prior to his
4 admission and injury.

5 Q. When Mr. Dumas was talking to you you all were
6 talking about the review of symptoms (sic).
7 This is a medical note, page 157 of 633,
8 provider, Dr. Ford, discussing the review of
9 symptoms (sic).

10 MR. DUMAS: I think we introduced
11 that.

12 MR. PRIDY: And you may have. I just
13 knew where it was in my --

14 MR. DUMAS: I understand. I think
15 that's it. Yeah, that's it.

16 MR. PRIDY: What exhibit number is
17 that?

18 DR. VANDERSTEENHOVEN: Number three.

19 Q. So, in Exhibit Number Three, do you see where
20 it says review of symptoms (sic)?

21 A. Yes.

22 Q. What does it say there?

23 A. Do you want me to read through the whole thing?

24 Q. Just the review of symptoms (sic) part, or
25 systems, excuse me.

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1 A. That's all right. Yeah, he denies any recent
2 urinary complaints. Denies any chest pain,
3 shortness of breath. Rest of review of
4 systems, negative.

5 Q. What does that mean to you?

6 A. Basically a negative review of systems. He has
7 nothing else -- nothing else that he's
8 reporting other than his current injury.

9 Q. Would you say that means they asked him those
10 questions?

11 A. Yes.

12 MR. DUMAS: I'm going to object on the
13 grounds of speculation, but you've already
14 answered it.

15 DR. VANDERSTEENHOVEN: Well, very
16 specifically, as review of systems, it
17 says denies any recent urinary complaints,
18 so I'm assuming they are asking.

19 MR. DUMAS: I understand. I just want
20 a running objection.

21 DR. VANDERSTEENHOVEN: Okay.

22 Q. And you reviewed Dr. Sribnick's deposition; is
23 that correct?

24 A. Yes, I did.

25 Q. In his deposition he testified essentially that

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1 if one were to fall backwards they would not
2 brace themselves. Can you speak to any reflex
3 that one might have?

4 MR. DUMAS: I'm going to object here.
5 The witness has been qualified as a
6 pathologist and a neurology expert. I
7 don't believe he has been qualified as a
8 biomechanical expert.

9 DR. VANDERSTEENHOVEN: Shall I answer
10 it?

11 MR. PRIDDY: You can answer it.

12 MR. DUMAS: And I just want a running
13 objection to it.

14 A. I would only say that, you know, neurology and
15 neuropathology have to deal with function of
16 the brain and all its processes. But a normal
17 individual would have what is sometimes called
18 a righting reflex. So, anytime somebody feels
19 like they are falling it has to do with their
20 vestibular system and feedback to the brain via
21 the cerebellum about where someone is in
22 position. So, if you were to fall, or feel
23 like you are falling, you have an automatic
24 reflex to sort of brace yourself. And that
25 happens whether you are falling forward or

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1 falling backward. It's harder to perhaps catch
2 yourself if you are falling backward
3 mechanically. But very often people break
4 their wrists by just sticking their hands out
5 and falling.

6 Q. Did you see anything in the record that
7 suggests that he tried to catch himself?

8 A. Well, usually you look for other signs of
9 injury like abrasions on the hands, the elbows,
10 back, shoulder, legs. You know, there were
11 none as I recall.

12 Q. Have you reviewed the report from nurse Donna
13 Crider?

14 A. Some time back, yes, I have.

15 Q. Do you remember if you disagreed with any of
16 her findings?

17 A. May I see what her --

18 MR. DUMAS: Yeah, let me just see it
19 because I didn't bring that record with
20 me. Okay. And it's part of the record.

21 MR. PRIDDY: I didn't know if --

22 MR. DUMAS: That's fine. And he
23 didn't indicate, I believe, that he had
24 reviewed it in his report. And I assume
25 that Dr. Vandersteenhoven would have done

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so had he reviewed it.

MR. PRIDDY: Well, he didn't have it at the time he --

MR. DUMAS: I understand that.

A. So, how would you like for me to respond?

Q. Did you notice any --

A. Oh, well, I guess start with the last. She made a comment about -- Ms. Crider makes a comment about abnormal liver values. Specifically, "His liver values were abnormal but dehydration can cause liver enzymes to appear elevated because the circulating blood would be concentrated due to dehydration."

Well, he clearly was dehydrated based on other findings, specifically his electrolytes. But dehydration can cause some elevation of electrolytes, but his liver enzymes were, I think, up to ten times higher than normal. So that's not likely.

And then she says on the second, third statement which is, "He did not have any syncopal episodes prior to the fall." Well, that's just -- I guess I'm just going back to he has had at least one documented syncopal episode, or at least through the ED back in

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1 '94. But, yes, does not relay any syncopal
2 episodes in more recent history.

3 And then the second comment was, "If
4 nausea and vomiting had been so severe it is
5 unlikely that he would not miss work." I mean,
6 I just kind of get a sense that Mr. Dillon is a
7 pretty hardworking individual and I don't know
8 how she could come up with that he unlikely
9 would not have missed work.

10 And then I guess her last thing is, "In my
11 conclusion, to a reasonable degree of
12 certainty, that Mr. Dillon did not have any
13 definitive medical conditions stated in the
14 records that caused him to faint and fall, but
15 to die as a direct result from the fall
16 sustained while he was at his place of
17 employment."

18 Well, I disagree with that. I think he
19 had lots of comorbidities that potentially set
20 him up for a syncopal episode and caused him to
21 fall.

22 Q. Have you reviewed Dr. Sribnick's report?

23 A. Yes, I have.

24 Q. Could you maybe discuss some of his
25 conclusions? Do you want to see the --

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MR. DUMAS: I guess I just -- I guess I should have done this earlier, but I guess I need to interpose an objection as to pitting of witnesses.

A. Well, I would only disagree in the point that he says specifically in a quote, I particularly noted in my review of the records where the patient stated he slipped and fell, or fell at work, in the absence of any significant symptoms that would lead to any conclusion that condition peculiar to him caused him -- caused his fall at work.

Well, again, I, I -- again, Mr. Dillon was very ill, had a number of comorbidities that would potentially set up a syncopal episode.

MR. PRIDDY: Do you have anything?

CROSS-EXAMINATION BY MS. DOOLEY:

Q. So, --

MR. DUMAS: Excuse me, not to be picky, but, shouldn't we -- isn't it limited to one attorney doing the questioning on the side?

MS. DOOLEY: No, sir, not that I'm aware of.

MR. DUMAS: Okay. I just --

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1 Q. Just to make sure that we are clear and since
2 the Commissioner -- this will be the only thing
3 the Commissioner gets to see as far as your
4 expert testimony is concerned.

5 It is your expert -- can you give us from
6 start to finish why you think on the day that
7 this accident occurred what you think happened
8 leading up to it and what then happened
9 afterwards and why so that the Commissioner is
10 clear?

11 A. Well, Mr. Dillon was a long known, a long time,
12 or had a long known history of chronic
13 alcoholism due to ethanol. That's fully
14 documented. Also by his admission. And has
15 seen physicians more recently for trying to do
16 something about the alcoholism. He did have a
17 fall in the past, in 1994, which was a syncopal
18 episode and had a head injury. He apparently
19 hit his head on the vanity at that time.

20 In the subsequent evaluation of Mr. Dillon
21 in the hospital there was a note commenting on
22 his recent subdural, but also that he had,
23 again, acute-on-chronic subdurals indicating
24 that he may have had subdurals in the past.
25 How those occurred, we don't know. But, then

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1 again, in chronic alcoholics subdurals are not
2 an uncommon finding.

3 More recently, apparently Mr. Dillon was
4 starting to feel ill, poorly, had diarrhea,
5 vomiting. He noticed his skin color was
6 changing. He basically was becoming what we
7 call icteric, or yellow, and that's from a
8 higher bilirubin level in the blood, or
9 basically bilirubin not being able to be
10 cleared correctly from the body and that also
11 relates to his now active or increasing liver
12 disease.

13 So, Mr. Dillon apparently was at work,
14 again, I'm assuming he was not feeling well,
15 and then the contention is whether he slipped
16 and fell or was standing outside -- and I
17 believe he was smoking, correct me if I'm wrong
18 on that. But standing outside and collapsed or
19 fell. He then impacted the back of his head
20 which then led to a subdural hematoma, which is
21 basically a development of blood, blood
22 bleeding into the brain. Outside the brain
23 first and then into the brain. He had kind of
24 classic injuries of a subdural on imaging.
25 Basically when you hit the back of your head

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1 you have some impact injury on the back of your
2 head but then you have a contralateral injury
3 on the front of the brain that's called coup
4 and contrecoup. And that's more prevalent with
5 a posterior skull impact.

6 So, he developed a subdural with
7 subsequent complications, one of which was
8 bleeding in the brain, and then the amount of
9 blood that's developing in the brain pushing
10 the brain to one side, that's called a midline
11 shift. And that creates all kinds of other
12 abnormalities. You start getting pupillary
13 dilatation. Basically the risk of that is --
14 and they took him to the emergency room to
15 alleviate that, is to evacuate the hematoma
16 before it causing brain herniation.

17 And then in the hospital Mr. Dillon,
18 again, partly related to his -- probably
19 related to his comorbidities, did not fair very
20 well. He progressed as far as his liver
21 failure. They did the surgical procedure, but
22 that could not stop some of the bleeding. The
23 bleeding is a consequence of his underlying
24 liver disease, the coagulopathy, the low
25 platelets that he had.

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1 So, a very, very complicated medical
2 picture, very difficult to recovery from. And
3 then it seems that Mr. Dillon then went into
4 hepatorenal failure, which is another common
5 complication of liver failure is that the
6 kidneys start to shutdown and eventually multi-
7 system failure, all the organs started to
8 shutdown, and then Mr. Dillon passed away.

9 MS. DOOLEY: That's all I have.

10 MR. DUMAS: I have nothing further.

11 Thank you very much.

12 (Deposition concluded at 10:00 a.m.)
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ELAINE G. MCLEOD (803)603-4128

1 STATE OF SOUTH CAROLINA)

2 : C-E-R-T-I-F-I-C-A-T-E

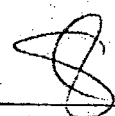
3 COUNTY OF LEXINGTON)

4 I, Elaine G. McLeod, Court Reporter and Notary
5 Public, certify that I did have Jacob Vandersteenhoven,
6 M.D., Ph.D. to appear before me at 8:57 a.m. on Tuesday,
7 August 16, 2016, at the offices of Turner, Padgett,
8 Graham & Laney, P.A., 1901 Main Street, Suite 1700,
9 Columbia, South Carolina; that the witness was sworn and
10 cautioned to tell the truth, the pages constitute a true
11 and accurate transcript of the testimony given at that
12 time and 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 18th day of August, 2016.

18
19
20
21
22
23
24
25



Notary Public for South Carolina

My Commission Expires: 07/24/2025

ELAINE G. MCLEOD (803)603-4128

02/17/15
FALR10024568

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION R03
SDI CREATED/UPDATED FIRST REPORT

CONTAINS ALL ITEMS REQUIRED BY OSHA FORM 101 (Enter all dates in MM/DD/YY format)

LOYER: FLEETRIE
1631 SHOR ROAD
COLUMBIA, SC 29201

CARRIER CLAIM#: 000714030164WCD1

SCWCC CLAIM#: 1501352 9999

PAID CODE: 134122

FED. TAX I.D. NO: 630661070

INSURANCE AMERICAN SWIRICH INSURANCE CO

CARRIER: Zurich North America

P.O. Box 958084

Schaumburg, IL 60196-8080

CARRIER ID: 00435

CARRIER FEIN: 363141762

CLAIMS GALLAGHER BASSETT SERVICES INC

ADMIN: SANDRA LUMSDEN

8731 RED OAK BLVD

SUITE 240

CHARLOTTE, NC 28217-4062

EMPLOYEE NAME (Last, First, Middle)
DILLON, EDMUND

SOCIAL SECURITY NUMBER

PHONE NO.

(600) 938-4404

ADDRESS:

DATE OF BIRTH

MARITAL STATUS: M

MADE/FEMALE: M

DEPENDENT CHILDREN: 0

DATE OF HIRE: 09/11/97

OCCUPATION: COUNTRY

WAGE INFORMATION

RATE: \$400.00

WAGE PERIOD:

DATE RETURNED TO WORK:

-FULL DAY PAY FOR DAY OF INJURY: Y

DID SALARY CONTINUE: N

OCCURRENCE

PLACE OF ACCIDENT OR OCCURRENCE: 29201-4947

DATE OF INJ: 02/23/15

TIME OF INJ: 12:00 PM

EMPLOYER'S PREMISES: N

LAST WORKDATE: 02/23/15

DATE EMPLOYER NOTIFIED: 02/23/15

RISE NATURE OF INJURY OR ILLNESS IN DETAIL

CAUSE: 29 ON SAME LEVEL

NATURE: 07 CONCUSSION

LOCATION: 10 Multiple Head Injury

DESCRIBE EMPLOYEE'S ACTIVITIES WHEN INJURY OCCURED WITH DETAILS OF HOW EVENT OCCURED

HE WAS LEAVING HIS CAR HEADING TOWARD THE BUILDING WHEN HE TRIPPED AND FELL
HITTING HIS HEAD KNOCKING HIM UNCONCIOUS AS WITNESSED BY A CUSTOMER JOHN E
603-872-7497

IF FATAL GIVE DATE OF DEATH:

** Created **

ELECTRONIC FILING

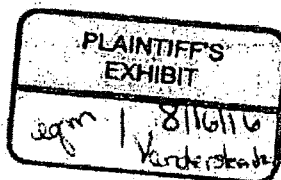
ORIGINAL DATE SENT:

TRADING PARTNER: Gallagher Bassett Services

Two Pierce Place

Itasca, IL 60143

<1> <2>
DATE PROCESSED: 02/27/15



Dillon Exhibits 000093

Facility Info: Palmetto Health Richland
3 Richland Medical Park
Columbia, SC 29203

Attending Physician: Jones MD Mark A
Admitting Physician: Jones MD Mark A

Patient Info: DILLON, EDMUND

MRN: R012715285

FIN: R150540 015

Pl. Age:

Date of Birth:

CMRN: 001375680

Nursing Documentation

Contact Numbers: wife=April Dillon 803-727-7497
daughter=Robin Dillon 803-767-1442

Chief Complaint: Per EMS, pt tripped and fell, denies LOC on arrival of scene; jaundice noted, swollen abdomen noted, rectal bleeding noted MO at bedside and aware. pt states he has been yellow, no appetite and diarrhea for 2 weeks.
Meds given w/in 24 hrs prior to hosp arrival: None of the Above

Looney RN, Marisa A - 02/24/2015 03:33

Mode of Arrival: LOR/PACU

Looney RN, Marisa A - 02/23/2015 19:55

Information Source/Admission: Patient

(HEMS) previously charted by Looney RN, Marisa A at 02/23/2015 19:55

Orientation: Hospital, Unit, Room, Orientation Packet, Patient rights-responsibilities

Who Was Oriented: Patient

Type of Housing: Home

Lives With: Significant Other

Education Level: Can Read and Write

Highest Grade Completed: 12th

Patient's Preferred Language: English

Modes of Communication: Verbal

Communication Barriers: None

Valuables or Belongings Collected: None Collected

Looney RN, Marisa A - 02/24/2015 03:33

Advanced Directives

Advanced Directives: No Living Will, No Health Care Power of Attorney

Treatment Restrictions: No Restrictions

Looney RN, Marisa A - 02/23/2015 19:55

Latex Screen

Diagnosed as Latex Allergic: No

Problem-Allergic Rxn to Rubber?: No

Medical Cond. Requiring Many Surgeries: No

Allergic Rxn to any foods: None listed below

Hx of Spina Bifida: No

Rxn During Surgery or Procedure: No

Looney RN, Marisa A - 02/23/2015 19:55

Allergies

Allergy Information: Allergy Information Complete

Looney RN, Marisa A - 02/23/2015 19:55

Allergies (Active)

NKA

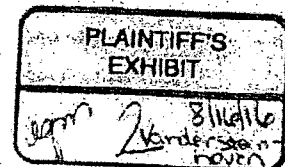
Estimated Onset Date: Unspecified, Created By: Looney RN,
Marisa A, Reaction Status: Active, Category: Drug Allergy:
Substance: NKA, Type: Allergy, Updated By: Looney RN,
Marisa A, Reviewed Date: 02/23/2015 19:56

Looney RN, Marisa A - 02/23/2015 19:55
(As Of: 02/23/2015 19:59:35 PM EST)

Psychosocial-Cultural

Alcohol Frequency: Daily

Alcohol Amount per Day: Wife unsure of amount



Patient Name: DILLON, EDMUND

Page 43 of 533

Print Date/Time: 5/14/2015 12:33 EDT

Dillon Medical 000024

Facility Info: Palmetto Health Richland
5 Richland Medical Park
Columbia, SC 29203

Attending Physician: Jones MD, Mark A
Admitting Physician: Jones MD, Mark A

Patient Info: DILLON EDMUND

MRN: R012719296

FIN: R1505401814

Pl. Age: 56

Date of Birth: 01/11/56

CMRN: 001376880

ED Documentation

ACCOUNT NUMBER: 1505401814

ATTENDING PHYSICIAN: David J. Ford, MD

CHIEF COMPLAINT: Fall.

HISTORY OF PRESENT ILLNESS: This is a 56-year-old male presenting after he fell. States he slipped and fell, hit the back of his head. Says he wanted to go back to work, but his firm would not let him. Patient states that he has nontender, felt well over the last several days, has not been eating well and did notice that his skin had changed colored, but attributed this to that. States that he has had vomiting and diarrhea and just not felt well, but that today he had a mechanical fall, did not have any syncopal symptoms. Denies any headache, chest pain or increased shortness of breath. He has an abrasion to his back. Patient denies any weakness, any abdominal pain or other complaints.

REVIEW OF SYSTEMS: Denies any recent urinary complaints. Denies any chest pain, shortness of breath. Rest of review of systems negative.

PAST MEDICAL HISTORY: None.

MEDICATIONS: None.

SOCIAL HISTORY: Patient does endorse daily drinking but denies any tobacco or alcohol use.

FAMILY HISTORY: Hypertension.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 98.3, heart rate 79, respiratory rate 18, pulse ox 100 percent on room air, blood pressure 121/79.

GENERAL APPEARANCE: Patient is alert, in full spinal precautions.

HEENT: Abrasions at the back of the occiput, which is currently oozing.

Pupils: are equal but sclerae are icteric. Slightly dry mucous membranes.

NECK: Supple. No midline step-off or deformity.

LUNGS: Clear to auscultation bilaterally. No wheezes, rales or rhonchi.

HEART: Regular rate and rhythm. No murmurs, rubs or gallops.

ABDOMEN: Soft, distended with hepatomegaly.

EXTERNAL GENITALIA: Patient does have bruising along his sacrum and rectum with rectal prolapse that is reducible. Does have some bright red bleeding due to irritation of the rectum.

MUSCULOSKELETAL: No edema clubbing, cyanosis.

SKIN: The patient is significantly jaundiced.

NEUROLOGICAL: GSC 15.

MEDICAL DECISION MAKING: The patient has no medical history, but given his endorsement of daily alcohol use as well as his physical exam, concern for

PLAINTIFF'S
EXHIBIT

Sam 3 8/16/16
Vanderhoven

CERTIFICATION OF VITAL RECORD

DEATH CERTIFICATION

STATE FILE NUMBER : 139-15-007973

DECEDENT'S NAME: *EDMUND JOHN DILLON*

AKA'S: NA

ARMED FORCES: NO

DATE OF BIRTH:

SEX: MALE

SOCIAL SECURITY NUMBER:

AGE: 36

COUNTY OF DEATH: RICHLAND

TYPE OF PLACE OF DEATH: HOSPITAL - INPATIENT

NAME AND ADDRESS OF PLACE OF DEATH: PALMETTO HEALTH RICHLAND, COLUMBIA, SC 29203

PLACE OF DISPOSITION: POWERS CREMATORY LLC

DISPOSITION LOCATION: LUGOFF, SOUTH CAROLINA

METHOD OF DISPOSITION: CREMATION

DECEDENT'S RESIDENCE:

PLACE OF BIRTH: VIRGINIA

MARITAL STATUS: MARRIED

SURVIVING SPOUSE'S NAME: APRIL PATRICIA WOODWARD

FATHER'S NAME: WILLIAM VINCENT DILLON

MOTHER'S NAME PRIOR TO FIRST MARRIAGE: MARY VERONICA NOVAK

INFORMANT'S NAME: APRIL DILLON

RELATIONSHIP: FAMILY MEMBER

MAILING ADDRESS:

FUNERAL HOME: POWERS FUNERAL HOME, LLC, 832 RIDGEWAY ROAD, LUGOFF, SC, 29078

FUNERAL DIRECTOR: ROBERT ALLEN POWERS SR

LICENSE NUMBER: 2381

EMBALMER'S NAME: ROBERT ALLEN POWERS SR

LICENSE NUMBER: 2381

ACTUAL OR PRESUMED DATE OF DEATH: FEBRUARY 27, 2015

MANNER OF DEATH: ACCIDENT

ACTUAL OR PRESUMED TIME OF DEATH: 1230

CAUSE OF DEATH - PART I

CARDIOPULMONARY FAILURE

SUBDURAL HEMATOMA WITH MASS EFFECT

SUBARACHNOID HEMORRHAGE

OTHER SIGNIFICANT CONDITIONS - PART III:

NA

CORONER CONTACTED? YES

AUTOPSY PERFORMED? NO

AUTOPSY AVAILABLE? NA

DATE OF INJURY: FEBRUARY 23, 2015

TIME OF INJURY: 1513

INJURY AT WORK? YES

PLACE OF INJURY: UNKNOWN

LOCATION OF INJURY: UNKNOWN, COLUMBIA, RICHLAND COUNTY, SC, 29203

HOW THE INJURY OCCURRED?

FALL FROM LADDER WITH CLOSED HEAD TRAUMA

CERTIFIER NAME AND TITLE: MD JASON K. BARBER

LICENSE NUMBER: 28996

CERTIFIER'S ADDRESS: 14 RICHLAND MEDICAL PARK, SUITE 320, COLUMBIA, SC, 29203

DATE FILED: FEBRUARY 28, 2015

DATE OF ISSUANCE: MARCH 04, 2015

SPECIAL INSTRUCTIONS:

NA

PLAINTIFF'S
EXHIBIT

John L. Stille
Landover

SC04254874

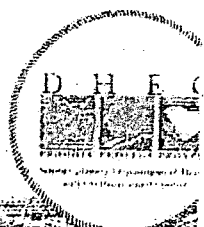
This is a true certification of the facts on file in the Division of Vital Records, SC Department of Health and Environmental Control.

Catherine Templeton
Catherine Templeton
Director and State Registrar

Barbara E. Derrick
Barbara E. Derrick
Assistant State Registrar

This copy is not valid unless prepared on an engraved border displaying the state seal and issuing agency logo.

Revision Date: 09/10/2014



DEATH CERTIFICATION

STATE FILE NUMBER: 139-15-007973 AMENDED

DECEDENT'S NAME: *EDMUND JOHN DILLON*

AKA's: NA

ARMED FORCES: NO

DATE OF BIRTH: [REDACTED]

TYPE OF PLACE OF DEATH: HOSPITAL INPATIENT

NAME AND ADDRESS OF PLACE OF DEATH: PALMETTO HEALTH RICHLAND, COLUMBIA, SC 29203

PLACE OF DISPOSITION: POWERS CREMATORY LLC

DISPOSITION LOCATION: LUGOFF, SOUTH CAROLINA

METHOD OF DISPOSITION: CREMATION

DECEDENT'S RESIDENCE: [REDACTED]

PLACE OF BIRTH: VIRGINIA

SURVIVING SPOUSE'S NAME: APRIL PATRICIA WOODWARD

FATHER'S NAME: WILLIAM VINCENT DILLON

MOTHER'S NAME PRIOR TO FIRST MARRIAGE: MARY VERONICA NOVAK

INFORMANT'S NAME: APRIL DILLON

MAILING ADDRESS: [REDACTED]

FUNERAL HOME: POWERS FUNERAL HOME, LLC, 832 RIDGEWAY ROAD, LUGOFF, SC, 29078

FUNERAL DIRECTOR: ROBERT ALLEN POWERS SR

EMBALMER'S NAME: ROBERT ALLEN POWERS SR

ACTUAL OR PRESUMED DATE OF DEATH: FEBRUARY 27, 2015

ACTUAL OR PRESUMED TIME OF DEATH: 1230

CAUSE OF DEATH - PART I

CARDIOPULMONARY FAILURE

SUBDURAL HEMATOMA WITH MASS EFFECT

SUBARACHNOID HEMORRHAGE

OTHER SIGNIFICANT CONDITIONS - PART II:

NA

CORONER CONTACTED? YES

DATE OF INJURY: FEBRUARY 23, 2015

PLACE OF INJURY: UNKNOWN

LOCATION OF INJURY: UNKNOWN, COLUMBIA, RICHLAND COUNTY, SC, 29203

HOW THE INJURY OCCURRED?

FALL HEAD TRAUMA

CERTIFIER NAME AND TITLE: MD JASON K. BARBER

CERTIFIER'S ADDRESS: 14 RICHLAND MEDICAL PARK, SUITE 320, COLUMBIA, SC, 29203

DATE FILED: FEBRUARY 28, 2015

DATE OF ISSUANCE: JUNE 05, 2015

SPECIAL INSTRUCTIONS:

INJURY DESCRIPTION AMENDED BY: DHEC 627 PER JASON K. BARBER, MD,

SEX: MALE

SOCIAL SECURITY NUMBER: [REDACTED]

AGE: [REDACTED]

COUNTY OF DEATH: RICHLAND

MARITAL STATUS: MARRIED

RELATIONSHIP: FAMILY MEMBER

LICENSE NUMBER: 2381

LICENSE NUMBER: 2381

MANNER OF DEATH: ACCIDENT

AUTOPSY PERFORMED? NO

TIME OF INJURY: 1513

AUTOPSY AVAILABLE? NA

INJURY AT WORK? YES

LICENSE NUMBER: 28996

PLAINTIFF'S
EXHIBIT

pgm 5 8/16/16
Katherine Templeton

SC04468850

This is a true certification of the facts on file in the Division of Vital Records, SC Department of Health and Environmental Control.

Catherine Templeton
Catherine Templeton

Director and State Registrar

Barbara E. Derrick
Barbara E. Derrick

Assistant State Registrar

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Revision Date: 09/10/2014

Dillon Exhibits 000002

DEPOSITION OF JOSIAH FLUDD

Sheet 5 Page 17

17

1 kind of like stood around.

2 I believe Ed went to the telephone and got a
3 telephone number. They was trying to find a contact.
4 So they called the contact. I went back on the inside.
5 And it was a rainy day, so I got a piece of cardboard.
6 We wanted to kind of like cover him from the -- from
7 the -- it was like a misty rain.

8 Q. Sure.

9 A. So they kind of like covered him because he
10 was on -- on the sidewalk. Basically that's what it
11 was.

12 Q. Okay. And if we had to just summarize your
13 testimony, and I want to make sure we're accurate, you
14 don't know why he fell. Is that correct?

15 A. No, I don't know. No, sir.

16 Q. You don't know why he fell?

17 A. I don't know the cause. No, sir.

18 Q. Okay. And you just know that you saw him
19 fall?

20 A. Yes.

21 Q. You saw him only -- you didn't see him from
22 about a little bit below the waist down. Correct?

23 A. Yes.

24 Q. You saw him hit the ground?

25 A. Yes.

Page 19

19

1 A. Yes, sir.

2 Q. The Affidavit that you signed was drafted by
3 someone other than you. Correct?

4 A. Yes, sir.

5 Q. And do you remember what -- was it in an
6 office that you signed this?

7 A. In a UPS store.

8 Q. In a UPS store. Do you remember who it was
9 that -- do you have any idea who prepared this?

10 A. No, sir.

11 Q. But it wasn't your own words?

12 A. It was my word -- that's what I described to
13 them, yes.

14 Q. Okay. You described to someone exactly what
15 you just told us today?

16 A. Yes.

17 Q. And because you didn't -- I noticed in your
18 testimony, you said that he just fell.

19 A. Yes.

20 Q. And the reason I ask that is because you
21 didn't necessarily use the word "collapse." You said
22 "fell."

23 A. Okay.

24 Q. And I just want to make sure that, from what
25 you saw, in your words, what you saw was him fall.

Page 18

18

1 Q. You saw that he was injured?

2 A. Yes.

3 Q. You saw him get help? Or rather, you called
4 for help?

5 A. Yes.

6 Q. Were you still there when EMS showed up?

7 A. Yes.

8 Q. And did they strap him down? Or tell me what
9 you remember.

10 A. I don't know if they strapped him down or
11 not. I was trying to get out of there.

12 Q. Okay. Okay. Because you knew he was in good
13 hands? The medical team was there.

14 A. Yes.

15 Q. You had already gotten help.

16 A. Yes.

17 MR. DUMAS: Can I have just a moment --

18 MR. COOK: Sure.

19 MR. DUMAS: -- to talk with Mr. Dillon
20 for just a moment? And we may be able
21 to wrap up.

22 MR. COOK: Okay.

23 (OFF THE RECORD FROM 2:13 P.M. TO 2:14 P.M.)

24 BY MR. DUMAS:

25 Q. Just very briefly, Mr. Fludd.

Page 20

20

1 A. I describe a fall as a -- the same -- I would
2 -- my definition of a fall and a collapse is about the
3 same thing.

4 Q. Okay.

5 A. You know?

6 Q. Okay. Mainly because you have no idea how or
7 why it happened?

8 A. Yeah.

9 Q. Okay. How long did you see Mr. -- about how
10 long, if you remember, did you see Mr. Dillon before he
11 fell?

12 A. I saw him once on the inside of the building.

13 Q. Uh-huh.

14 A. And one was on the outside from where I was,
15 from putting parts in and out the truck. May have
16 taken ten minutes.

17 Q. Okay. But you were obviously busy with what
18 you were doing. Correct?

19 A. Yes.

20 Q. Because you weren't -- you didn't have any
21 reason to be watching Mr. Dillon for any particular
22 reason. Did you?

23 A. No, sir.

24 Q. So I guess what I'm asking is do you remember
25 how long you observed him before he fell? Or is it the

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PLAINTIFF'S
EXHIBIT

6 8/10/16

DEPOSITION OF JOSIAH FLUDD

Sheet C Page 21

21

1 act of falling that caught your eye?

2 A. I saw him maybe a minute before he -- before
3 he fell.

4 Q. Okay. Were you actually watching him for
5 that full minute?

6 A. No. How I was putting paperwork inside my
7 truck had me looking that direction.

8 Q. Okay. So you were just kind of looking in
9 that general direction?

10 A. Yes, sir.

11 Q. So what was it? Maybe you might have seen
12 him one or two seconds before he fell, if that long?

13 A. No, I probably saw him probably about a
14 minute before he fell.

15 Q. You were actually watching him?

16 A. No. I was watching that direction.

17 Q. Oh, okay. And I assume the motion is what
18 caught your eye?

19 A. Yes.

20 Q. The motion of the fall?

21 A. Yes.

22 MR. DUMAS: I have nothing further.

23 REDIRECT EXAMINATION

24 BY MR. COOK:

25 Q. Mr. Fludd, just to be clear. You know, every

Page 23

23

1 seeing him from the waist up. So did you see him from
2 his torso, about where his belt would be, all the way
3 up?

4 A. No, sir. A little bit farther down.

5 Q. A little bit farther down?

6 A. Yeah.

7 Q. Could you see any portion of his legs?

8 A. I could see, if this is called, a thigh area.

9 Q. Thigh area.

10 And when you observed his thigh areas
11 immediately before he collapsed, were his thighs
12 stationary?

13 A. Yes.

14 Q. Were his thighs idle?

15 A. Yes.

16 Q. Were his thighs moving in a manner consistent
17 with walking immediately before he fell?

18 A. No, sir.

19 Q. In your opinion, can somebody walk without
20 their thighs moving?

21 A. No, sir.

22 Q. Based on what you observed in the thigh area,
23 do you have any reason to believe that he slipped on
24 anything?

25 A. No, sir. I couldn't -- no, sir.

Page 22

22

1 story has a beginning and a middle and an end.

2 A. Yes, sir.

3 Q. And the same is true with Mr. Dillon. Were
4 you facing Mr. Dillon before he collapsed?

5 A. Yes.

6 Q. Did you see Mr. Dillon before the act of
7 collapsing started to commence?

8 A. Yes.

9 Q. So to state it another way, did you see the
10 beginning of this event?

11 A. Yes.

12 Q. And you saw him go all the way down, which I
13 would characterize as being the middle?

14 A. I saw him fall all the way until I couldn't
15 see him from the tailgate.

16 Q. And then you came around the tailgate?

17 A. Yes. I ran around to him.

18 Q. And was he on the ground?

19 A. Yes.

20 Q. And that was the end of his fall?

21 A. Yes.

22 Q. Is it fair to say that you saw the beginning
23 and the middle and the end?

24 A. Yes.

25 Q. Now, Counsel had asked you earlier about

Page 24

24

1 MR. COOK: I have nothing further.

2 RECROSS-EXAMINATION

3 BY MR. DUMAS:

4 Q. But just to be clear, sir, you don't know if
5 he slipped on anything or not. Do you?

6 A. No, sir.

7 Q. Okay. And you were about how far away from
8 him? And I know most people are notoriously bad on
9 gauging distance.

10 A. Whatever the distance from here to that
11 corner. No further than that.

12 Q. Okay.

13 MR. COOK: The corner of the table?

14 THE WITNESS: The corner of the building
15 right there.

16 BY MR. DUMAS (RESUMING):

17 Q. And you were -- part of your view was
18 obstructed. You couldn't -- in other words, you
19 couldn't see everything because something was blocking
20 a portion of your view?

21 A. Yes, sir.

22 Q. What was blocking a portion of your view?

23 A. My truck.

24 MR. DUMAS: Okay. And Counsel, it would
25 be fair to say we're talking about maybe

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DEPOSITION OF JOSIAH FLUDD

Sheet 1 Page 25

Page 27

1 15 yards?
2 MR. COOK: I wouldn't -- 15 yards would
3 be 45 feet. I don't think it's --
4 MR. DUMAS: Okay.
5 MR. COOK: Are you pointing to this
6 corner?
7 THE WITNESS: This corner right there.
8 Yes, sir.
9 MR. DUMAS: Of the room?
10 MR. COOK: Of the room?
11 THE WITNESS: Of the room.
12 MR. DUMAS: Maybe about 30 feet, 10
13 yards?
14 MR. COOK: I would say 10 yards, a first
15 down at the most.
16 MR. DUMAS: Okay. About a first down?
17 MR. COOK: Yes.
18 BY MR. DUMAS (RESUMING):
19 Q. Okay. But your truck was blocking a portion
20 of the view?
21 A. The tailgate from the bed of the truck down
22 was blocking the bottom half.
23 Q. And your primary attention, at this point in
24 time, was in -- you stop me if I'm wrong: Your primary
25 focus was in keeping your paperwork dry, and completely

1 MR. COOK: Nothing further. That will
2 conclude your deposition, Mr. Fludd.
3 (FURTHER DEPONENT SAYETH NOT.)
4 (THE DEPOSITION OF JOSIAH FLUDD
5 CONCLUDED AT 2:21 P.M.)
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Page 26

Page 28

1 your work and your job?
2 A. Yes.
3 Q. Because you had no particular reason to be
4 paying any attention at all to Mr. Dillon?
5 A. No, sir.
6 Q. Okay. Nothing further.
7 REDIRECT EXAMINATION
8 BY MR. COOK:
9 Q. Mr. Fludd, I understand from your testimony
10 that obviously you were concerned about the business
11 that you had at hand.
12 A. Yes, sir.
13 Q. Would I be wrong to say that your business at
14 hand distracted you from the point that you somehow did
15 not get an accurate accounting or a view of Mr. Dillon
16 collapsing? Or did you see him clearly, despite what
17 you had going on?
18 A. I saw him clearly.
19 MR. COOK: Thank you. Nothing further.
20 RECROSS-EXAMINATION
21 BY MR. DUMAS:
22 Q. But what you saw clearly was what you've
23 described to us today?
24 A. Yes.
25 MR. DUMAS: Okay. Thank you.

1 CERTIFICATE OF REPORTER
2 I, MELISSA M. WHITLOCK, COURT REPORTER AND NOTARY
3 PUBLIC FOR THE STATE OF SOUTH CAROLINA, DO HEREBY CERTIFY
4 THAT I REPORTED THE DEPOSITION OF JOSIAH FLUDD ON
5 THURSDAY, THE 15TH DAY OF OCTOBER, 2015, THAT THE WITNESS
6 WAS FIRST DULY SWORN BY ME AND THAT THE FOREGOING 21
7 PAGES CONSTITUTE A TRUE AND CORRECT TRANSCRIPTION OF MY
8 VERBATIM REPORT OF SAID DEPOSITION.
9 I FURTHER CERTIFY THAT I AM NEITHER ATTORNEY NOR
10 COUNSEL FOR, NOR RELATED TO OR EMPLOYED BY ANY OF THE
11 PARTIES CONNECTED WITH THIS ACTION, NOR AM I FINANCIALLY
12 INTERESTED IN SAID CAUSE.
13 I FURTHER CERTIFY THAT THE ORIGINAL OF SAID
14 TRANSCRIPT WAS THEREAFTER SEALED AND DELIVERED TO
15 MATTHEW R. COOK, TURNER PADGET GRAHAM & LANEY, P.A., 1901
16 MAIN STREET, SUITE 1700, COLUMBIA, SOUTH CAROLINA 29201,
17 WHO WILL RETAIN THIS SEALED TRANSCRIPT AND SHALL BE
18 RESPONSIBLE FOR FILING SAME WITH THE COURT PRIOR TO TRIAL
19 OR ANY HEARING WHICH MIGHT RESULT IN A FINAL ORDER ON ANY
20 ISSUE.
21 IN WITNESS WHEREOF, I HAVE SET MY HAND AND SEAL THIS
22 29TH DAY OF OCTOBER, 2015.
23
24 MELISSA M. WHITLOCK, COURT REPORTER
25 MY COMMISSION EXPIRES MARCH 12, 2024

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DEPOSITION OF JOSIAH FLUDD

Sheet 8 Page 29

29

VERIFICATION OF DEPONENT

I, JOSIAH FLUDD, HAVE READ THE FOREGOING DEPOSITION TESTIMONY, WHICH WAS REPORTED BY MELISSA M. WHITLOCK, COURT REPORTER AND NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA, ON OCTOBER 15, 2015.

I FIND THE TRANSCRIPT OF THE DEPOSITION TO BE A TRUE AND ACCURATE TRANSCRIPT ACCORDING TO MY TESTIMONY ON THAT DATE, WITH THE EXCEPTION OF ____ CORRECTIONS AS LISTED ON THE ATTACHED ERRATA SHEET, WHICH WAS COMPLETED BY ME.

JOSIAH FLUDD

DATE

Page 30

30

ERRATA SHEET

PAGE # / LINE # CORRECTION (INCLUDE EXPLANATION)

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JOSIAH FLUDD

DATE

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SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1501382

Edmund Dillon, Dec'd,

Employee,

Claimant,

vs.

Raffles (FleetPride),

Employer,

AND

Gallagher Bassett as TPA for American
Zurich Insurance Company,

Carrier,

Defendants.

MEMORANDUM OF LAW

ISSUE PRESENTED

Whether Edmund Dillon's (hereinafter "Decedent") death subsequent to a collapse at work arose out of the Decedent's employment rendering the injury compensable?

FACTS

The Decedent was at work on the morning of February 23, 2015. While at work, he was observed by the sole eye witness, Josiah Fludd, to collapse outside the front of the building. He was observed to have fallen while standing idle without any attempt to stop himself or break his fall. Decedent hit his head on the concrete and lost consciousness.

EMS arrived, and the Decedent was taken to the hospital. While at the hospital, his condition deteriorated rapidly. The records show that the Decedent suffered from many conditions, including Anemia, Thrombocytopenia (low platelet count), Hypokalemia (low

potassium), Hyponatremia, Liver Disease, and severe dehydration. The Decedent's medical history, as provided by the Decedent and family members, show that the Decedent had a known history of alcohol abuse. In addition, he had been suffering from bouts of diarrhea, nausea and vomiting in the weeks leading up to the fall. Finally, the Decedent had been observed to be jaundice, frail, and weak. As a result of the hit to the head, the Decedent passed away on February 27, 2016.

DISCUSSION

For an accidental injury to be compensable, it must "arise out of and in the course of employment." S.C. Code Ann. §42-1-160(A) (Supp. 2013). "An injury arises out of employment if it is proximately caused by the employment." *Nicholson v. S.C. Dep't of Social Servs.*, 411 S.C. 381, 385, 769 S.E.2d 1, 3 (2015). (citing *Douglas v. Spartan Mills, Startex Div.*, 245 S.C. 265, 269, 140 S.E.2d 173, 175 (1965)). "Therefore 'it must be apparent to the rational mind, considering all the circumstances, that a causal relationship exists between the conditions under which the work is performed and the resulting injury.'" *Id.* (quoting *Hall v. Desert Aire, Inc.*, 376 S.C. 338, 350, 656 S.E.2d 753, 759 (Ct. App. 2007)).

In South Carolina, there are numerous cases on idiopathic falls and compensability. "An idiopathic fall is one that is 'brought on by a purely personal condition unrelated to the employment, such as a heart attack or seizure.'" *Barnes v. Charter 1 Realty*, 411 S.C. 391, 395–96, 768 S.E.2d 651, 653 (2015). "Idiopathic falls are excepted from the general rule that a work-related injury is compensable." *Id.* "The idiopathic fall doctrine is based on the notion that an idiopathic injury does not stem from an accident, but is brought on by a condition particular to the employee that could have manifested itself anywhere." *Id.* There is no accident, and, thus no compensable accident.

In *Miller v. Springs Cotton Mills*, the employee injured her knee when getting up from a table, but prior to falling. 225 S.C. 326, 331, 82 S.E.2d 458, 459 (1954). The court noted that this was merely an internal injury and not an injury arising from an accident. *Id.* The Court noted that to allow recovery for this type of injury would open the floodgates for holding that "every internal failure suffered by an employee in the course of his employment becomes an accident just because it happens." *Id.* The Court felt this was not the intent of the Workers' Compensation Act. *See id.*

In *Bagwell v. Ernest Burnwell, Inc.*, the employee died as a result of a fall at work. 277 S.C. 444, 88 S.E.2d 611 (1955). The evidence presented in the case through eye-witnesses showed that the employee was standing at a counter when he fell backward without attempting to catch himself or break his fall. *Bagwell*, 277 S.C. at 448-49, 8 S.E.2d at 612-13. The employee passed away and an autopsy was performed and the physician agreed that the cause of death was a subdural hemorrhage. 277 S.C. at 449, 8 S.E.2d at 613. However, the physicians could not determine the cause of the fall. *Id.* One physician suggested the employee could have fainted but could not state definitively. *Id.* Further, there was no evidence that the employee slipped and fell. *Id.* The Court stated that being at work was not enough to justify an award, but it must be shown "either that the cause of the fall or the resulting injury bore some special relation to his work or to the conditions under which it was performed. The Court further noted that "while the cause of [the employee's] fall may be unexplained, the circumstances of his fall are fully covered by testimony of eyewitnesses." 277 S.C. at 452, 8 S.E.2d at 613. Further, the Court did not find that the employment contributed to the effect. *Id.* The Court examined whether there was a work related hazard after determining the injury was otherwise not compensable. *Id.* The Court noted

that the employee hitting his head on concrete was not enough for the employment to have contributed. *Id.* Therefore, the claim was ruled non-compensable.

In *Crosby v. Wal-Mart*, the employee fell in the aisle while walking. 330 S.C. 489, 499 S.E.2d 253 (Ct. App. 1998). However, the fall was not unexplained, as the employee was able to state what happened. 330 S.C. at 491, 499 S.E.2d at 254. The employee told a co-worker that her leg gave out of her. *Id.* Therefore, the court held that it was idiopathic and therefore not compensable as there was no causal relation between her fall and her employment. 330 S.C. at 496, 499 S.E.2d at 257.

In *Nicholson v. S.C. Dep't of Social Services*, the employee tripped when her foot caught on the hall carpet while she was on her way to a meeting. 411 S.C. 381, 383, 769 S.E.2d 1, 2 (Ct. App. 2015). The court reviewed the law for idiopathic falls and determined the fall was causally related to her work. 411 S.C. at 390, 769 S.E.2d at 5. The court noted that the cause of her fall was quite simple; she tripped on her way to a work meeting. *Id.* There was no evidence of an internal breakdown. *Id.* Since the fall was not caused by a condition peculiar to her, her injuries arose out of her employment and was compensable. *Id.*

Finally in *Barnes v. Charter 1 Realty*, the employee tripped and fell down a hallway while checking email. 411 S.C. 391, 768 S.E.2d 651 (2015). There was no evidence of either any irregularity in the carpet or any condition peculiar to the employee. 411 S.C. at 394, 768 S.E.2d at 652. *Barnes* relied on *Crosby* and noted that *Crosby* "is in harmony with how our courts have consistently applied the idiopathic exception – the circumstances of the fall were not simply unexplained, but indicated the cause was internal." 411 S.C. at 396, 768 S.E.2d at 653. The Court overruled the appellate panel's decision that it was idiopathic because there was no evidence of

an internal breakdown, and, therefore, found the claim to be compensable because the employee was performing a work task when the fall happened. 411 S.C. at 397, 768 S.E.2d at 654.

ANALYSIS

Based on the facts of this case and the medical records there is evidence in this case that suggest there was an internal breakdown. Therefore, this case falls under the law of idiopathic injuries. Claimant's attorney will likely argue that this case is similar to *Nicholson* or *Barnes*; however, in those cases, there was no internal breakdown. Here, there is significant evidence of an internal breakdown. Therefore, this claim turns on whether the Claimant fell as a result of a condition peculiar to him.

This case is more like *Bagwell*. As noted above, in *Bagwell*, the employee was standing at a counter and fell backward. He did not try to catch himself or break his fall. There were two eye-witnesses that saw the employee fall rigid. The physicians could not determine the cause of the fall and speculated it could have been from fainting. Here, we have one eyewitness who saw the fall. Just like in *Bagwell*, our Decedent did not attempt to break his fall or catch himself. He merely fell backward and hit his head. The medical records show that there was a cut on the head and abrasions on his back. The records do not show abrasions to the hands, wrists, elbows, or arms, which suggests that he did not try to catch himself as Josiah Fludd testified to. In addition, Dr. Vandersteenhoven indicates in his report and testimony that the Decedent was suffering from numerous conditions peculiar to him, any of which could have led to a syncopal episode.

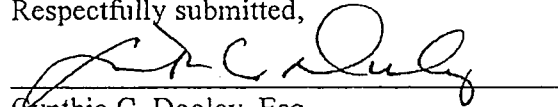
Claimant's attorney relies on the statement of the Decedent shortly after suffering a severe head injury that he tripped and fell while at work. However, while this statement is written down in various medical histories, that is the only evidence that supports Claimant's position that this was a compensable work place accident. Conversely, the greater weight of the

evidence supports the fact that this fall was the result of a condition peculiar to the Decedent. The medical records illustrate an ill individual. In addition, the Decedent's co-employees testify that the Decedent had been sick and had been suffering from nausea, vomiting and diarrhea. The Decedent had lost weight and had turned jaundice. In addition, the eyewitness, Josiah Fludd, witnessed the fall and described the Decedent as standing idle before collapsing. The evidence in this case points to an individual who collapsed at work as a result of medical conditions peculiar to him and that his employment did not cause or aggravate the injury.

CONCLUSION

For all the above reasons, the Claimant is not entitled to compensation as a result of an idiopathic fall while at work due to the purely personal cause of the collapse while at work.

Respectfully submitted,



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Attorneys for the Employer/Carrier

August 30, 2016
Columbia, South Carolina

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1501382

Edmund Dillon, Dec'd.
Employee,

Claimant,

vs.

Raffles (FleetPride),

Employer,

AND

Gallagher Bassett as TPA for American
Zurich Insurance Company,
Carrier,

Defendants.

MEMORANDUM IN SUPPORT OF
COVERAGE

I. UNDISPUTED FACTS

Edmund John Dillon was originally employed by Employer on September 15, 1997, working for the Employer until February 23, 2015 when he was injured, carried by Richland County EMS to Palmetto Health Richland, hospitalized, and then died on February 27, 2015. There is no question from any and all of the evidence that his death resulted from injuries received in a fall on the Employer's premises while working for the Employer.

II. THIS INJURY/DEATH IS COMPENSABLE

The three most recent reported cases involving compensability where the injury is on the job and the Employer/Carrier attempts to disclaim coverage claiming the injury was unrelated to the job and therefore not compensable are *Nicholson v. S.C. Department of Social Services*, 411 S.C. 381, 769 S.E.2d 1 (2015), *Barnes v Charter 1 Realty*, 411 S.C. 391, 768 S.E. 2d 651(2015) and *Thomas v 5 Star Transportation*, 412 S.C. 1, 770 S.E. 183 (Cl. App. 2015) where the Courts stated the requirements and distinctions for coverage.

Nicholson, supra, 411 S.C. at 3, and *Barnes, supra*, 411 S.C. at 395, state:

Workers' compensation law is to be liberally construed in favor of coverage to serve the beneficent purpose of the Workers' Compensation Act; therefore, only exceptions and *395 restrictions on coverage are to be strictly construed. *James v Ann's Inc.*, 390 S.C. 188, 198, 701 S.E.2d 730, 735 (2010).

The actual "test" according to *Nicholson, supra*, 411 S.C. at 5-6 is:

Quite simply, Nicholson was at work on the way to a meeting when she tripped and fell. The circumstances of her employment required her to walk down the hallway to perform her responsibilities and in the course of those duties she sustained an injury. We hold these facts establish a causal connection between her employment and her injuries—the law requires nothing more. Because Nicholson's fall happened at work and was not caused by a condition peculiar to her, it was causally connected to her employment. Therefore, her injuries arose out of her employment **6 as a matter of law and she is entitled to workers' compensation.

Later that same year the Court of Appeals, in interpreting *Nicholson* and *Barnes* in a situation where an employee was a tour bus driver who died due to injuries from a traffic collision where the bus he was driving left the road and collided with a tree and the autopsy noted that the employee was "witnessed to slump over and become unresponsive prior to driving off the road". The Court of Appeals in interpreting *Nicholson* and *Barnes* after a lengthy analysis concluded in *Thomas, supra*, 412 S.C. at 10:

"In [one] type of idiopathic fall, employment does not cause the fall but it significantly contributes to the injury by placing the employee in a position which increases the dangerous effects of the fall. These injuries are compensable." *Nicholson v. S.C. Dep't of Soc. Servs.*, 411 S.C. 381, 388, 769 S.E.2d 1, 4 (2015) (alteration by court) (internal quotation marks omitted). When a fall is unwitnessed or purely unexplained, as in situations where the employee dies before he has an opportunity to relate the occurrence, and there are no eyewitnesses to the occurrence itself, our courts have tended to affirm an award of compensation, deferring to the fact finding discretion of the commission. The Court of Appeals then went further:

In this case, the Appellate Panel found George's death arose out of and in the course of employment because he was placed in an increased danger by driving a bus at a high rate of speed on an interstate. Dr. Sehandl's testimony, report, and memorandum all indicate George's death was due to the injuries from the motor vehicle accident, not the brain aneurysm. 5 Star did not present any evidence to the contrary but instead argued Emily did not prove the aneurysm occurred after the accident, not before. Although Dr. Seandl could not determine if the aneurysm occurred before the accident, thus causing the accident, or after the crash, because of the accident, she testified two-thirds of people experiencing such an aneurysm would survive. Accordingly, substantial evidence supports the Appellate Panel's finding George's death was in the course and scope of his employment.

Thomas, supra, 412 S.C. at 12.

Furthermore, the Appellate Panel of the Workers' Compensation Commission in one subsequent opinion interpreting the above case law where the Claimant's employment required the employee to get up and down steps to get to work area and she slipped on the stairs and jammed her right knee the Commission found compensability. *Reames v. QVC, Inc. and Liberty Mutual*, WCC File No. 1409226, October 22, 2015. In another case, the employee was working at the Richland County Coroner's Office fell and injured her shoulder and right ankle, and both the Appellate Panel and the Commissioner found compensability despite a seizure prior to the fall with the Commission finding that the injuries to the left shoulder would not have occurred without the presence of a desk and chair provided by the Employer. Additionally, the Commission found

that the desk and chair involved were not common to the neighborhood and were peculiar to her employment. In short, the finding was affirmed for compensability. *Sullivan v. Richland County and SC Association of Counties SIF*, WCC File No. 1411717, January 12, 2016.

The only case where compensation was denied was in the case of *Foran v. Murphy USA and Liberty Insurance Corporation*, WCC File No. 1405375, July 14, 2015 where the employee had a significant medical history of prior ankle weakness and a videotape of the incident clearly showed the employee standing still with her ankle giving way thus causing the injury.

III. CONCLUSION

In applying the above cases to the facts in this case there is no question but that the Employee himself reported to EMS that he slipped and fell at work denying loss of consciousness (Claimant APA, Med. Evid., #3, Report of Looney, RN, pg. 24), Employee reported the same to the treating physician and denied syncopal symptoms (Claimant APA Med. Evid. 3, Report of Ford, MD, pg 35 Defendant's APA). One witness reported to the Employer that the Employee had slipped and fallen (Claimant APA, EDI First Report, Exh. #13, pg. 93) and another report resulted in an initial death certificate that he fell from a ladder (Claimant's APA, Exh. 1). Josiah Fludd in his deposition could only state clearly that he partially saw the Employee fall but did not know why (Claimant's APA, Exhibit 6, pp. 21-27). The medical evidence before the Commission is that there is no reasonable medical evidence to support the conclusion that a preexisting medical condition caused a fainting or syncopal episode (Claimants APA-Crider, RN, Med. Evid #4, pp. 48-57, and Sribnick, MD, Med. Evid. #5, pp.58-63). Even the Employer's medical expert concedes that other than a 1994 syncopal episode, there is no objective medical evidence to support a conclusion that there was a syncopal episode prior to the fall that resulted in the injury and death to the employee (Employer APA, Vandersteenhoven deposition, pp. 24-25).

Under these circumstances both the law and the facts compel only one conclusion, that full compensation for the death of Edmond Dillon as a work related accident should be awarded.

RESPECTFULLY SUBMITTED,

By:

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Columbia, South Carolina
August 30, 2016

2015 WL 7422321 (S.C. Work.Comp.Comm.)

Appellate Panel of the Workers' Compensation Commission

State of South Carolina

KHALILAH REAMES, RESPONDENT CLAIMANT

v.

QVC, INC., EMPLOYER

AND

LIBERTY MUTUAL, CARRIER, DEFENDANTS/APPELLANTS

WCC File No. 1409226

October 22, 2015

*1 Appellate Panel Review held in Columbia, South Carolina, on June 15, 2015 per notices timely and properly served upon all parties of interest.

Appellate Panel Decision and Order filed October 22nd, 2015

Appearances:

Respondent Khalilah Reames, Claimant, of Florence, South Carolina, Represented by Stephen J. Wukela, Esquire.
Defendants/Appellants Represented by John Gabriel Coggiola, Esquire of Willson Jones Carter & Baxley, P.A. in Columbia, South Carolina.

STATEMENT OF THE CASE

Claimant alleges to have suffered an injury by accident to her right knee arising out of and in the course of her employment while coming down the steps at work at the end of her shift on June 27, 2014. On September 5, 2014, Claimant filed a Form 50 Request for Hearing, seeking a determination of compensability and award of medical treatment and additional benefits under the Act. Defendants timely filed Form 51 responsive pleadings, denying that Claimant sustained a compensable injury to her knee arising out of and in the course of her employment on the date alleged.

A hearing was scheduled before Commissioner Wilkerson on November 20, 2014. After resolving several pre-hearing by matters by consent, the only issue on the record for determination at the hearing was the compensability of Claimant's alleged June 27, 2014 knee injury.

At the hearing, Claimant took the position that while walking down the stairs to leave work, her heel slipped on the front of a step, causing her to jar her right knee on the step below. As a result of the accident, Claimant alleged she was entitled to TTD benefits and ongoing casually related treatment. Defendants took the position that the evidence showed Claimant suffered an idiopathic fall that did not arise out of and in the course of her employment. In support of their argument, Defendants cited the South Carolina Court of Appeals holding in Nicholson v. South Carolina Dept. of Social Services, which precluded recovery of benefits if a claimant's accident arose from a hazard to which an employee would have been equally exposed apart from employment, 748 S.E.2d 256 (S.C. Ct.App. 2013). Defendants also cited Crosby v. Wal Mart as further controlling case law on idiopathic falls. (Def. Pre-Hearing Brief, #5, "Legal Issues Involved"). In the alternative, Defendants argued that if Claimant's accident was deemed compensable, Claimant suffered an aggravation of a pre-existing condition, and Claimant failed to meet her burden in providing sufficient evidence of a compensable aggravation as required by S.C. Code Ann. § 42-9-35.

On December 19, 2014, Commissioner Wilkerson issued Order instructions, finding that although stairs, like steps, are uneven, claimants are equally exposed to them apart from their employment. Based on the controlling Court of Appeals decision in Nicholson at that time, Commissioner Wilkerson found that Claimant failed to prove by a preponderance of the

evidence that the cause of Claimant's injury was peculiar to work and not common to the neighborhood. As a result, Claimant's request for benefits was denied.

*2 Attorney for the Defendants drafted a proposed Order pursuant to Commissioner Wilkerson's instructions and forwarded it to Claimant's attorney on January 7, 2015. On January 15, 2014, the parties emailed Commissioner Wilkerson requesting clarification of his findings about how the Claimant's accident took place. Since there was competing medical evidence on the question, the parties sought clarification on whether the Commissioner specifically found that Claimant sustained an injury accident as a result of her heel slipping off a step and causing her to jar her knee, or if the Commissioner found that Claimant suffered from an accident in which Claimant experienced an onset of pain while walking down the stairs from work.

On January 14, 2014, the South Carolina Supreme Court reversed the Court of Appeals decision in Nicholson, and issued new opinion, together with a related opinion addressing the issue of "unexplained falls." (see Nicholson v. S.C. Dept. of Social Services, Opinion No.: 27478, (S.C. 2015), and Barnes v. Charter 1 Realty, Opinion No.: 27479 (S.C. 2015)). As a result of the new case law, the parties were instructed by Commissioner Wilkerson to submit supplemental briefs outlining their arguments in light of the Supreme Court's new holdings. Following receipt of supplemental briefs from both parties, Commissioner Wilkerson emailed correspondence to both parties on 02/12/15 with the written notation, "Agree with Wukela and his brief." As a result, Claimant's attorney drafted a new Decision and Order that was approved by Commissioner Wilkerson on 03/16/15, wherein he issued the following Findings of Fact, Conclusions of Law, and Order:

FINDINGS OF FACT

1. I find the parties to the proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with Khalilah Reames being the Claimant, and QVC, Inc. being the Employer.

This finding is based upon stipulation of the parties at the commencement of the hearing.

2. I find that pursuant to S.C. Code § 42-1-40 the Claimant's average weekly wage is Three Hundred Twenty and 87/100 (\$320.87) Dollars a week resulting in a compensation rate of Two Hundred Thirteen and 92/100 (\$213.92) Dollars.

This finding is based on the parties' stipulation, and the Defendants' Form 20.

3. I find that pursuant to S.C. Code § 42-15-160 the Claimant sustained an injury by accident, arising out of and in the course of her employment, to her right knee on June 27, 2014, when, while coming down stairs at her workplace, her right foot slipped off the end of the stair causing her to jam her right knee.

A. INJURY BY ACCIDENT

I find that the back of the Claimant's right foot slipped on the stairs and jammed causing her injury to her right knee. This description was in Claimant's testimony. (Hr. Tr., p. 15), in the employer's first report to their carrier, (Claimant's Exhibit #1), in her report to Dr. Runyan (APA#7, p. 000189), and in her report to Carolinas Rehab. (APA#8, p. 000193).

*3 Defendant's point out that there was no mention of a slip or a twist in the hospital records on the date of the accident. (APA#4, p. 000134); (APA #5, p. 000150, 000152, 000162).

While those records do not specifically describe her slipping and jamming her knee those records consistently describe her injuring her knee on June 27, 2014 while walking down stairs. At the trial, Claimant testified "I was not sure if actually said slip - or what, but I was just explaining to them, you know, that I was coming down the stairs and, you know, in doing that I was injured." (Hr. Tr., pp. 26-27). Claimant went on to testify that she did not mention anything about slipping down on her heel to the hospital because "I didn't think I had to, you know, mention every exact detail, I was just explaining in general what happened." (Hr. Tr., p. 30).

Further based on her testimony, Claimant told the employer about that back of her heel clipping the stairs in her report of the

injury the day after the accident on June 28, 2014. (Claimant's Exhibit #1).

Defendants further point to McLeod Occupational Medical History Form that the Claimant filled out on June 30, 2014 upon seeing Occupational Health for the first time. Defendants point out that the form asked "have you ever been hurt on the job while working for any employer" and the Claimant responded negatively. (APA#5, p. 000149).

Defendants also point out that on the same form dated June 30, 2014, the Claimant marked yes in response to the question "Have you ever had chronic or recurring pain, abnormal sensation, tingling or numbness associated with: knees." (APA No. 5, p. 148).

At the hearing, Claimant testified that she understood the question on that form to be asking for information about prior on the job injuries with other employers. (Hr. Tr., p. 29).

Claimant consistently described to every treating physician and her employer that she suffered an injury to her right knee while coming down the stairs. Most compelling however is Claimant's Exhibit #1, where the employer themselves noted the day after the accident that "back of heel clipped on stairs." (Claimant's Exhibit #1).

The preponderance of the evidence supports the conclusion that the Claimant sustained an injury by accident when her right foot slipped off the end of the stairs on June 27, 2014 causing her to jam her right knee.

B. ARISING OUT OF AND IN THE COURSE AND SCOPE OF EMPLOYMENT

There is no dispute that the Claimant's injury occurred during the course and scope of her employment. Defendants' dispute, however, that the injury arose out of her employment.

On January 14, 2015, after the hearing, but before this decision, the Supreme Court reversed the Court of Appeals decision in Nicholson v. S.C. Dept. of Soc. Servs., 2015 S.C. Lexis 3 (1/14/2015). There, the Supreme Court noted:

Despite how straightforward this issue appears to be, both the single commissioner and the court of appeals found Carolyn Nicholson, who fell while walking down the hallway on her way to a meeting, was not entitled to recover because her fall could have occurred anywhere. We reverse. Nicholson, 2015 S.C. Lexis 3, *1.

*4 In our view, [the Douglas requirement that "the causative danger must be peculiar to the work and not common to the neighborhood..."] simply establishes that an injury is not compensable absent some causal connection to the workplace. In other words, but for the claimant being at work, the injury would not have occurred. It does not require claimant to prove her injury is entirely unique to her employment, for any other interpretation would seriously undermine the law of workers' compensation. For example, a chef may cut himself with a knife, or a carpenter may fall off a ladder just as easily while at home rather than at work. However, this possibility alone does not remove such an accident from the scope of compensation if the accident occurred at work. Alleging an accident is not unique to employment, without more, is not a viable basis for denying compensation. Nicholson, 2015 S.C. Lexis 3, *5.

This Court has never stated an injury must stem from a particular hazard or risk of the employment. The court of appeals erred in requiring a claimant to prove the existence of a hazard or danger because it erroneously injected fault into workers' compensation law ...

Nicholson, 2015 S.C. Lexis 3, *9.

Therefore, an employee need only prove a causal connection between the conditions under which the work is required to be performed and the resulting injury. (Id.)

Quite simply, Nicholson was at work on the way to a meeting when she tripped and fell. The circumstances of her employment required her to walk down the hallway to perform her responsibilities and in the course of those duties she sustained an injury. We hold these facts establish a causal connection between her employment and her injuries -

the law requires nothing more. (*Id.*) (Emphasis added).

In a similar case of *Barnes v. Charter 1 Realty*, 2015 S.C. Lexis 4 (01/14/15), the Supreme Court, on the same date, reversed the Court of Appeals denial of compensability in a case in which a claimant hurrying down a hall to check an email, stumbled and fell, and sustained serious injuries. In *Barnes*, as in *Nicholson*, the Supreme Court held "... Barnes was performing a work task when she tripped and fell. Those facts alone clearly establish a causal connection between her employment and the injuries she sustained." *Barnes v. Charter 1 Realty*, 2015 S.C. Lexis 4, *6 (1/14/2015).

Here, the Claimant's employment required her to get up and down steps to get to her work area and in the course of those duties she slipped on the stairs and jammed her right knee, causing injury. I find that these facts, as in *Nicholson* and *Barnes* establish a causal connection between her employment and her injuries; therefore, Claimant's injury arose out of and in the course of her employment.

4. I find that, pursuant to S.C. Code § 42-9-35, the accident of June 27, 2014, aggravated the pre-existing degenerative condition of the Claimant's right knee.

*5 The Defendants argue that the Claimant failed, under S.C. Code § 42-9-35, to prove by expert opinion or testimony to reasonable degree of medical certainty that the accident aggravated a pre-existing condition. (Defendant's Brief, p. 6). Defendants discussion of S.C. Code § 42-9-35 makes no mention of the opinion of the Claimant's treating orthopaedic, Dr. Runyan after his visit with the Claimant on August 28, 2014. There Dr. Runyan indicated **"History and clinical findings consistent with right knee sprain/strain with possible internal derangement. This is in the setting of pre-existing degenerative joint disease. She has not had conservative treatment. Physical Therapy as prescribed. Oral medications as prescribed."** (APA# 7, p. 000191) (Emphasis added).

This evidence alone is sufficient to support a finding that the Claimant aggravated the pre-existing condition of her right knee within the meaning of S.C. Code § 42-9-35. Of course, this statement was not stated explicitly to a reasonable degree of medical certainty, however, such is not required under S.C. Code § 42-9-35 for the opinions of treating physicians in their records, as was the case here. (See *Michau v. Georgetown County*, 396 S.C. 589, 594-596 (2011) (Finding that similar language in S.C. Code § 42-1-172 allowed that "medical evidence" includes opinions in the documents, records, or other material of treating physicians which do not need to be stated to a reasonable degree of medical certainty, unlike "opinion or testimony" offered by a non-treating EVIE doctors.)).

Moreover, S.C. Code § 42-9-35 was intended by the Legislature as a non-allocation statute applicable in determinations of permanent disability, which provides that "the Commission may award compensation benefits to an employee who has a permanent physical impairment or preexisting condition and who incurs a subsequent disability from an injury arising out of and in the course of his employment for the resulting disability of the permanent physical impairment or preexisting condition and the subsequent injury." Thus, pursuant to S.C. Code § 42-9-35 in cases where the Claimant suffers permanent disability as a result of an injury on the job and has a preexisting permanent disability the Commission does not allocate between the two causes, if the Claimant proves preponderance of the evidence, including medical evidence, that the subsequent injury aggravated the pre-existing condition or vice versa.

This case does not involve a determination of permanency at all or any question of allocation of pre-existing disability to permanent work related disability. On the contrary, the issue before this Commissioner is simply whether the Claimant sustained a compensable injury by accident and whether she should receive medical treatment by the Employer and temporary compensation during the pendency of that treatment until she reaches maximum medical improvement. Thus, S.C. Code § 42-9-35 is inapplicable here.

5. I find that, pursuant to S.C. Code § 42-15-20, the Employer received notice of the accident on June 28, 2014, within ninety (90) days of the accident of June 27, 2014.

*6 This finding is based on the Claimant's Exhibit 1, entitled "QVC Air: Work Related Accident, Injury, or Illness Report Form". This document, provided notice to the Employer the day after the accident.

6. I find that pursuant to S.C. Code § 42-15-60 the Defendants are responsible for all medical treatment rendered to Claimant, including medical treatment rendered by McLeod Regional Medical Center, McLeod Occupational Health and Pee Dee Orthopaedics, and Carolinas Hospital System Rehab, from the date of the injury, June 27, 2014, to the date of this Order, and continuing for such additional time as will tend to lessen the period of disability.

This finding is based on the medical records and the above set out testimony. In particular, the Employer directed the Claimant to McLeod Occupational Health shortly after the accident, and all of the other treatment emanated from that treatment.

7. I find that Claimant is entitled to benefits pursuant to S.C. Code § 42-9-10 for the period beginning June 28, 2014, through the date of this Order, and continuing in a weekly amount of Two Hundred Thirteen and 92/100 (\$213.92) Dollars until further Order of this Commission.

This finding is based on the above set out evidence, including the records of McLeod Occupational Health who restricted the Claimant from stairs beginning June 30, 2014. (APA No. 5, pp. 154, 159, 169). Claimant testified that the Employer has offered no work within those restrictions.

RULINGS OF LAW

Accordingly, as provided in the South Carolina Code of Laws, 1976, as amended, § 42- 17-40, it is the determination of this Commissioner:

1. Under S.C. Code § 42-1-130, the Claimant was a covered Employee at the time in question; and under S.C. Code § 42-1-140, the Defendant-Employer was a covered Employer under the Act.
2. Under S.C. Code 42-1-40, the Claimant's average weekly wage is Three Hundred Twenty and 87/100 (\$320.87) Dollars a week resulting in a compensation rate of Two Hundred Thirteen and 92/100 (\$213.92) Dollars.
3. Under S.C. Code § 42-1-160, the Claimant sustained an injury by accident, arising out of and in the course of her employment, to her right knee on June 27, 2014, when, while coming down stairs at her workplace, her right foot slipped off the end of the stair causing her to jam her right knee.
4. Under S.C. Code § 42-15-20, the Employer received notice of the accident on June 28, 2014, within ninety (90) days of the accident of June 27, 2014.
5. Under S.C. Code § 42-15-20, the Employer received notice of the accident on June 28, 2014, within ninety (90) days of the accident of June 27, 2014.
6. Under S.C. Code § 42-15-60, the Defendants are responsible for all medical treatment rendered to Claimant, including medical treatment rendered by McLeod Regional Medical Center, McLeod Occupational Health and Pee Dee Orthopaedics, and Carolinas Hospital System Rehab, from the date of the injury, June 27, 2014, to the date of this Order, and continuing for such additional time as will tend to lessen the period of disability.
- *7. Under S.C. Code § 42-9-10, the Claimant is entitled to benefits for the period beginning June 28, 2014, through the date of this Order, and continuing in a weekly amount of Two Hundred Thirteen and 92/100 (\$213.92) Dollars until further Order of this Commission.

ORDER

IT IS, THEREFORE, ORDERED that the Form 50 regarding the injury of June 27, 2014, under the Workers' Compensation File No. 1409226 is found to be a compensable accident.

IT IS, FURTHER ORDERED that the Employer, QVC, Inc., and the Carrier, Liberty Insurance Corporation, shall pay all medical treatment rendered to Claimant, including medical treatment rendered by McLeod Regional Medical Center.

McLeod Occupational Health, Pee Dee Orthopaedic, and Carolinas Hospital System Rehab., from the date of the injury, June 27, 2014, to the date of this Order, and continuing for such additional time as will tend to lessen the period of disability.

IT IS FURTHER ORDERED that the Employer/Carrier shall pay to the Claimant benefits at the compensation rate of Two Hundred Thirteen and 92/100 (\$213.92) Dollars per week from June 28, 2014, until further Order of this Commission. No hearing costs are assessed in this instance.

Following receipt of the executed Decision and Order from Commissioner Wilkerson, counsel for the Defendants filed a Form 30 Application for Review in the case setting forth the following Assignments of Error:

1. Whether the Hearing Commissioner erred in Finding of Fact #3, finding that Claimant sustained a compensable injury by accident to the right knee on June 27, 2014, in accordance with § 42-1-160, when Claimant was coming down the stairs at her workplace, and her right foot slipped off the end of the stair, causing her to jam her right knee, when such finding is against the greater weight and preponderance of the substantial evidence in the record?
2. Whether the Hearing Commissioner erred in Finding of Fact #4, finding that pursuant to § 42-9-35, the Claimant sustained her burden in proving an aggravation of a pre-existing condition of the right knee, when such finding is against the greater weight and preponderance of the substantial evidence in the record?
3. Whether the Hearing Commissioner erred in Finding of Fact #6, finding that pursuant to § 42-15-60, Defendants are responsible for all medical treatment rendered to the Claimant from the date of injury, June 27, 2014, and continuing for such additional time as will tend to lessen the period of disability, when such finding is against the greater weight and preponderance of the substantial evidence in the record?
4. Whether the Hearing Commissioner erred in Finding of Fact #7, finding that pursuant to § 42-9-10, Claimant is entitled to temporary total disability benefits beginning on June 28, 2014 and continuing until further ordered by the Commission, when such a finding is against the greater weight and preponderance of the substantial evidence in the record?
- *8 5. Whether the Hearing Commissioner erred in Ruling of Law #3 that the Claimant sustained an injury by accident arising out of and in the course of her employment to the right knee on June 27, 2014, while coming down the stairs from her workplace, when her right foot slipped off the end of the stair, causing her to jam her right knee, when such finding is not in accordance with § 42-1-160 and against the greater weight and preponderance of the substantial evidence in the record and is based upon erroneous legal conclusions?
6. Whether the Hearing Commissioner erred in Ruling of Law #6 that Defendants are responsible for all medical treatment rendered to the Claimant from the date of injury and continuing for such additional time as will tend to lessen the period of disability, when such finding is against the greater weight and preponderance of the substantial evidence and is based upon erroneous legal conclusions?
7. Whether the Hearing Commissioner erred in Ruling of Law #7 that the Claimant is entitled to weekly benefits beginning June 28, 2014 and continuing until further Order of this Commission, when such finding is against the greater weight and preponderance of the substantial evidence in the record and is based upon erroneous legal conclusions?

Copies of the above assignments of error were furnished to all interested parties prior to oral arguments before the Full Commission Appellate Panel on June 15, 2015.

Pursuant to S.C. Code Ann. § 42-17-50 (1985), the Appellate Panel reviewed the Award and weighed the evidence in the record as presented at the initial hearing. The Panel also considered all issues raised in the briefs of both parties.

After careful review of the issues in the present case, the Appellate Panel of the South Carolina Workers' Compensation Commission has determined that the Order of the Hearing Commissioner is hereby **AFFIRMED IN PART AND DENIED IN PART**.

FINDINGS OF FACT

Based upon the documentary evidence submitted by the respective parties, pursuant to the Administrative Procedures Act, and the Commission's file relative to this claim, WE, THE APPELLATE PANEL, FIND THE FOLLOWING AS FACT:

1. We find the parties to the proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with Khalilah Reames being the Claimant, and QVC, Inc. being the Employer.
2. We find that pursuant to S.C. Code § 42-1-40 the Claimant's average weekly wage is Three Hundred Twenty and 87/100 (\$320.87) Dollars a week resulting in a compensation rate of Two Hundred Thirteen and 92/100 (\$213.92) Dollars.
3. We find that pursuant to S.C. Code § 42-15-160 the Claimant sustained an injury by accident, arising out of and in the course of her employment, to her right knee on June 27, 2014, when, while coming down stairs at her workplace, her right foot slipped off the end of the stair causing her to jam her right knee.
4. We find that, pursuant to S.C. Code § 42-15-20, the Employer received notice of the accident on June 28, 2014, within ninety (90) days of the accident of June 27, 2014.
5. We find that Claimant failed to meet her burden in proving that her injury by accident aggravated her preexisting condition, as required by S.C. Code Ann. § 42-9-35.
6. We find that the evidence presented includes a note from a treating physician, Dr. Chad Runyan at Pee Dee Orthopaedics.
7. We find that in accordance with Michau v. Georgetown County, if evidence is from a treating physician and not from an independent medical evaluation, it is not required to be in the form of a statement to a reasonable degree of medical certainty, but can be based on the records of a treating physician.
8. We find that the evidence as presented in this case still fails to meet the burden of proving that Claimant aggravated her preexisting condition in her June 27, 2014 injury by accident.
9. We find that Claimant is to be evaluated and treated for any new injury caused by her June 27, 2014 injury by accident, but any treatment that would be related to her preexisting condition or aggravation thereof is denied.
10. We find that Claimant is entitled to benefits pursuant to S.C. Code § 42-9-10 for the period beginning June 28, 2014, through the date of this Order, and continuing in a weekly amount of Two Hundred Thirteen and 92/100 (\$213.92) Dollars until further Order of this Commission.

CONCLUSIONS OF LAW

In view of those Findings of Fact, and as provided in the South Carolina Code of Laws, WE, THE APPELLATE PANEL, CONCLUDE THE FOLLOWING AS MATTERS OF LAW:

1. Under S.C. Code § 42-1-130, the Claimant was a covered Employee at the time in question; and under S.C. Code § 42-1-140, the Defendant-Employer was a covered Employer under the Act.
2. Under S.C. Code § 42-1-40, the Claimant's average weekly wage is Three Hundred Twenty and 87/100 (\$320.87) Dollars a week resulting in a compensation rate of Two Hundred Thirteen and 92/100 (\$213.92) Dollars.
3. Under S.C. Code § 42-1-160, the Claimant sustained an injury by accident, arising out of and in the course of her employment, to her right knee on June 27, 2014, when, while coming down stairs at her workplace, her right foot slipped off the end of the stair causing her to jam her right knee.

4. Under S.C. Code § 42-15-20, the Employer received notice of the accident on June 28, 2014, within ninety (90) days of the accident of June 27, 2014.

5. Under S.C. Code § 42-9-35, Claimant failed to meet her burden in proving a compensable aggravation of a preexisting condition, and as a result, Defendants are not responsible for any medical treatment related to Claimant's preexisting condition or aggravation thereof.

6. Under S.C. Code § 42-15-60, the Defendants are responsible for providing an evaluation and medical treatment causally related to a new injury sustained in Claimant's June 27, 2014 work accident; however, Defendants are not responsible for any treatment related to Claimant's preexisting condition or aggravation thereof.

*10 7. Under S.C. Code § 42-9-10, the Claimant is entitled to benefits for the period beginning June 28, 2014, through the date of this Order, and continuing in a weekly amount of Two Hundred Thirteen and 92/100 (\$213.92) Dollars until further Order of this Commission.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law.

IT IS, THEREFORE, ORDERED Claimant sustained a compensable injury by accident arising out of and in the course of her employment on June 27, 2014.

IT IS FURTHER ORDERED that Claimant failed to prove a compensable aggravation of a preexisting condition in accordance with S.C. Code Ann. § 42-15-35.

IT IS FURTHER ORDERED that Defendants are to provide Claimant with an evaluation and medical treatment for any new injury sustained in her June 27, 2014 work accident; however, Defendants are not responsible for any treatment that would be related to her preexisting condition or aggravation thereof.

IT IS FURTHER ORDERED that Defendants are to provide Claimant with Temporary Total Disability ("TTD") beginning June 28, 2014 and continuing in weekly amount of Two Hundred Thirteen and 92/100 Dollars (\$213.92) until properly stopped by agreement of the parties or by Order of the Commission.

AND IT IS SO ORDERED.

South Carolina Workers' Compensation Commission

R. Michael Campbell, II
Commissioner
For the Full Commission

WE CONCUR:

Melody L. James
Commissioner
Gene McCaskill
Commissioner

2015 WL 7422321 (S.C. Work.Comp.Comm.)

KHALILAH REAMES. RESPONDENT CLAIMANT QVC,.... 2015 WL 7422321...

2016 WL 881336 (S.C. Work Comp. Comm.)

Appellate Panel of the Workers' Compensation Commission

State of South Carolina

VERONICA SULLIVAN, EMPLOYEE/CLAIMANT/RESPONDENT

v.

RICHLAND COUNTY, EMPLOYER

AND

SC ASSOCIATION OF COUNTIES SIF, CARRIER, DEFENDANT(S)/APPELLANTS

WCC File No. 1411717

January 12, 2016

*1 Appellate Panel Review Held in Columbia, South Carolina, on September 22, 2015, Per Notices Timely and Properly Served Upon All Parties of Interest.

Appellate Panel Decision and Order filed on: January 12th, 2016

Appearances:

Claimant/Respondent Represented by Daniel E. Peagler, Esquire

Defendant(s)/Appellant(s) Represented by B. Gibbs Leaphart, Jr., Esquire

AFFIRMED

STATEMENT OF THE CASE

The parties were heard by Commissioner I. Scott Beck on February 26, 2015, in Columbia, South Carolina. As a result of the Hearing, the single Commissioner issued an Order dated June 24, 2015 from which the Defendants, as Appellants, sought review pursuant to S.C. Code Ann. § 42-17-50 (as amended). Within the statutory period, counsel for the Defendants filed an Application for Review in the case setting forth assignments of error, copies of which were furnished to all interested parties prior to oral argument presented before the Appellant Panel on July 8, 2015, as set forth below:

1. Did the Hearing Commissioner err { sic } in finding the claimant sustained a compensable injury by accident; said error being that the greater weight of the evidence in the record fails to support the claimant's injury was causally-related to her employment?
2. Did the Hearing Commissioner err in Finding of Fact #2, wherein he found as a fact that the claimant's right ankle injury arose out of and in the course of employment; said error being the greater weight of the evidence fails to support the same?
3. Did the Hearing Commissioner err in Finding of Fact #3, wherein he found as a fact that the claimant's left shoulder injury arose out of and in the course of employment; said error being the greater weight of the evidence fails to support the same?
4. Did the Hearing Commissioner err in finding that the seizure alone was not violent enough to cause the claimant's injury; said error being the greater weight of the evidence in the records fails to support same?
5. Did the Hearing Commissioner err in finding the claimant's left shoulder injury would not have occurred without the presence of the desk and chair provided by the employer; said error being the greater weight of the evidence in the record fails to support this finding?
6. Did the Hearing Commissioner err in finding the greater weight of the evidence in the record shows the claimant's right

ankle injury would not have occurred without the presence of the desk and chair provided by the employer; said error being there is no evidence in the record via witness testimony or otherwise to support same?

7. Did the Hearing Commissioner err in finding the claimant sustained a compensable injury by accident to her right ankle and left shoulder; said error being that there is no medical evidence to within a reasonable degree of medical certainty causally-linking the injuries to the desk and the chair in question?

*2 8. Did the Hearing Commissioner err in finding and concluding the claimant is entitled to additional medical care; said error being the greater weight of the evidence in the record supports that this is not a compensable injury by accident?

9. Did the Hearing Commissioner err in finding and concluding the claimant is entitled to temporary total disability; said error being the greater weight of the evidence in the record supports this is not a compensable injury by accident?

10. Did the Hearing Commissioner err failing to find the claimant was non-compliant with medical care, specifically weight bearing restrictions from her own chosen doctors; said error being the greater weight of the evidence in the record, including that of the treating physicians, supports the claimant was non-compliant with her weight bearing restrictions on more than one occasion?

11. Did the Hearing Commissioner err in failing to find and conclude the claimant's noncompliance resulted in a material worsening of her condition leading to additional surgeries which would not have been necessary from the alleged work incident alone?

12. Did the Hearing Commissioner err in failing to find the claimant sustained a subsequent intervening accident as a result of her noncompliance which broke the causal chain of connection between the original alleged accident and her need for multiple surgeries?

13. Did the Hearing Commissioner err in finding and concluding the claimant sustained a compensable injury by accident; said error being the greater weight of the evidence in the record support the desk and chair do not constitute a special hazard or danger inherent to her employment pursuant to the Supreme Court's decisions in Bagwell v. Burwell, Inc., 227 S.C. 444, 88 S.E.2d 611 (1955); and Nicholson v. S.C. Department of Social Services, 2015 WL 161719.

14. Did the Hearing Commissioner err in failing to find the desk and chair were common to the neighborhood and not peculiar to her employment; said error being the greater weight of the evidence supports same?

15. Did the Hearing Commissioner err in finding the claimant's injuries were caused by the desk and chair; said error being there is no medical evidence that the desk and the chair contributed to the effect of the fall or worsened her injury in any way?

All testimony and documentary evidence has been taken and delivered to the individual members of the Appellate Panel for their study and consideration. In addition, the parties have briefed and orally argued their positions before the Panel.

In an Appellate Panel review under S.C. Code Ann. § 42-17-50, the Commission's Appellate Panel shall review the award, weigh the evidence presented at the initial hearing, and, if good ground be shown therefore, make its own findings and conclusions consistent with or inconsistent with those of the Hearing Commissioner.

After careful review of the record in this case, the Commission, by unanimous vote, has determined that all of the Hearing Commissioner's Findings of Fact and Rulings of Law are correct as stated. The Hearing Commissioner's Order is affirmed in its entirety, and the Commissioner's Findings of Fact and Rulings of Law, as adopted below, are hereby the law of this case.

FINDINGS OF FACT

*3 1. The parties to the proceedings are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended to date, with Richland County as the Employer, and South Carolina Association of Counties as the insurance carrier; and the Claimant as the employee of the employer on August 18, 2014 while working at Richland

County Coroner's Office.

2. The Claimant, Veronica Sullivan, did sustain bodily injury on August 18, 2014, to her right ankle while employed by Richland County and such injury arose out of and in the course of her employment.
3. The Claimant, Veronica Sullivan, did sustain bodily injury on August 18, 2014, to her left shoulder while employed by Richland County and such injury arose out of and in the course of her employment.
4. The parties stipulate that the seizure is an idiopathic event.
5. I specifically find that claimant did not fall to the floor during the course of the seizure.
6. I found all witnesses to be credible in their testimony.
7. The Claimant, Veronica Sullivan, never fell to the floor as a result of her seizure.
8. The seizure was not violent enough to have caused the injuries to the Claimant in and of itself; the preponderance of the evidence clearly shows the injury to the Claimant's left shoulder would not have occurred without the presence of the desk and chair provided by the Claimant's employer.
9. The testimony of Ms. Williams confirms claimant's left arm struck the desk 2-3 times.
10. While there is no direct testimony regarding the Claimant's right ankle striking the chair, the testimony of witnesses compels me to find that it did; the seizure was not violent enough to have caused the injuries to the Claimant in and of itself; and the preponderance of the evidence clearly shows the injury to the Claimant's right ankle would not have occurred without the presence of the desk and chair provided by the Claimant's employer.
11. The testimony of Ms. Williams confirms claimant's left arm struck the desk 2-3 times.
12. The average weekly wage is \$417.78, and the weekly compensation rate is \$278.54.
13. The injury required medical care for the period from August 18, 2014, and continues; the Claimant has not reached maximum medical healing as of this date; and further medical care is necessary, as it will tend to lessen the period of disability.
14. The Claimant's incident where her prescribed wheelchair broke, causing her additional injuries, was related to the original accident in that the treatment which necessitated the wheelchair was originally caused by the work accident of August 18, 2014.
15. The Claimant has not reached maximum medical improvement, as additional medical care is necessary in order to lessen the period of disability.
16. The Claimant is entitled to temporary total disability benefits due to the injuries to her right leg/ankle and her left shoulder from August 18, 2014 to November 3, 2014, and from January 5, 2015 to the present and continuing until agreement of the parties or by order of the Commission.
- *4 17. I find that at the time of the accident, the Claimant was in the scope of her employment.
18. I find Defendant's non-compliance argument inapplicable in this matter.

CONCLUSIONS OF LAW

Accordingly, as provided in S.C. Code of Laws, (1976, as amended), § 42-17-40, it is the determination of this Commission

1. Under § 42-1-160, the Claimant did sustain injury by accident, said accident arising out of and in the course of her employment.
2. Under § 42-9-10 and § 42-1-120, the Claimant is entitled to compensation for temporary total disability.
3. Under § 42-15-60, the Claimant is entitled to medical care to her right ankle and left shoulder, as it will tend to lessen the period of disability.

After careful review of the record in this case, the Commission, by unanimous vote, has determined the following findings of fact and law should be added to the order of Chairman I. Scott Beck dated June 24, 2015:

ADDITIONAL FINDINGS OF FACT

19. We find the testimony showed the desk and chair involved in the injuries to the Claimant were not common to the neighborhood and peculiar to her employment.

ADDITIONAL CONCLUSIONS OF LAW

4. Based on the Supreme Court's decisions in Bagwell v. Burwell, Inc., 227 S.C. 444, 88 S.E.2d 611 (1955); and Nicholson v. S.C. Department of Social Services, 2015 WL 161719, the desk and chair do constitute a special hazard or danger inherent to her employment.

ORDER AND AWARD

THEREFORE, it is Ordered that the Defendants shall make the following payments:

1. The Defendants shall pay temporary total disability benefits in the amount of \$278.54 per week from August 18, 2014 to November 3, 2014, and from January 5, 2015 to the present and continuing until agreement of the parties or by order of the Commission.
2. The Defendants shall pay for charges for the Claimant's causally related medical care to her right ankle, right leg, and left shoulder (including but not limited to treatment provided by Palmetto Health Baptist, Dr. Coleman Fowble, Richland County EMS, Moore Orthopedics, and Midlands Orthopedics) from the date of the injury and continuing until further Order of this Commission.

DECISION AND ORDER OF THE COMMISSION ON APPEAL

IT IS THEREFORE ORDERED that the Decision and Order of the Hearing Commissioner is hereby affirmed by the Appellate Panel of the Commission with Findings of Fact and Law added.

AND IT IS SO ORDERED.

S.C. Workers' Compensation Commission

Avery B. Wilkerson, Jr.
Commissioner

CONCUR:

Gene McCaskill
Commissioner
Melody L. James

VERONICA SULLIVAN..... 2016 WL 881336 (2016)

Commissioner

2016 WL 881336 (S.C. Work.Comp.Comm.)

10/10/2016

10/10/2016 10:10:10 AM

2015 WL 4516884 (S.C. Work.Comp.Comm.)

Appellate Panel of the Workers' Compensation Commission

State of South Carolina

JENNA FORAN, EMPLOYEE, CLAIMANT/APPELLANT

v.

MURPHY USA, EMPLOYER

AND

LIBERTY INSURANCE CORPORATION, CARRIER, DEFENDANTS/RESPONDENTS

WCC File No. 1405375

July 14, 2015

*1 Appellate Panel Review held in Columbia, South Carolina, on April 21, 2015 per notices timely and properly served upon all parties of interest.

Appellate Panel Decision and Order filed July 14th, 2015

Appearances:

Claimant/Appellant Represented by C. Scott Masel, Esquire of Myrtle Beach, South Carolina.

Defendants/Respondents Represented by Anne Veatch Noonan, Esquire of Willson Jones Carter & Baxley, P.A., Mount Pleasant, South Carolina.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

This is a denied claim for an injury to the left ankle which occurred on April 29, 2014. The Claimant/Appellant contends the single Commissioner erred by denying the claim and concluding Claimant's injury was idiopathic and not a compensable injury in light of the recent South Carolina Supreme Court cases *Nicholson* and *Barney* and further contends the single Commissioner erred in giving greater weight to the testimony of Randolph Stokes Rogers, a witness for the Defendants, than to that of the Claimant, Jenna Foran. This incident was captured on video surveillance which was reviewed by the Appellate Panel and single Commissioner.

On October 31, 2014, a hearing was held before the Honorable Avery Wilkerson (hereinafter single Commissioner) in Conway, South Carolina to resolve the issues raised by the Claimant's request for hearing via Form 50.

The Claimant contends she was injured on April 29, 2014 while she was working as a cashier. She contends that while stocking cigarettes, she went to stand up and stepped half on and half off of the mat that was located on the floor behind the register. As a result of this, her ankle rolled on the uneven surface causing her to suffer torn ligaments and requiring surgery. She further contends this is not an idiopathic injury and that her injury is a result of a specific incident and is therefore compensable.

The Defendants contend Claimant suffered an idiopathic injury on April 29, 2014 when she rolled her ankle due to a pre-existing chronic instability of her left ankle documented in the medical records. The video of the incident shows Claimant was standing flat footed on the mat when her ankle merely gave way. The Claimant had pre-existing issues with her left ankle and was having ankle problems with an altered gait at the time immediately preceding this injury. These left ankle issues were originally documented in 2005 when the Claimant underwent surgical repair of the ankle. At the time of the surgery, Dr. Kane, of Hackensack University Medical Center, diagnosed Claimant with chronic instability of the left ankle. (APA 1 p. 1.) Additionally, Dr. Kane noted that the surgery was due to a protracted "history of recurrent injuries to the left ankle" and indicated that Claimant had "failed conservative treatment including physical therapy." (*Id.*)

*2 The Defendants relied on video taken from the store cameras from April 29, 2014, which clearly shows that the floor mat did not cause Claimant's injury and was not involved in her ankle giving out. Claimant was merely standing at the register when her left ankle gave way. Defendants further argue that there is no special risk associated with the Claimant's work that caused this accident and it is therefore idiopathic in nature.

Prior to the hearing, a review of the video surveillance for the date of accident was viewed with all parties present. The floor mat from the video was also reviewed by Commissioner Wilkerson as provided by the store manager.

On January 14, 2015, the single Commissioner issued a Decision and Order with the following Findings of Fact, Conclusions of Law, and Order/Award:

FINDINGS OF FACT

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Jenna Foran as Employee-Claimant and Murphy USA as Employer and Liberty Insurance Corporation as Carrier, Defendants.
2. That the average weekly wage of Employee at the time of the above-described accident was \$168.84, and his compensation rate was \$112.57.
3. Order directives and instructions were sent to all parties on October 31, 2014.
4. The Claimant's testimony is very confusing as to her description of this accident. She verified her personal description multiple times which was different than what the video shows actually happened. The video also clearly shows that after the Claimant was in a kneeling position, her ankle did not roll and she was able to walk over to the other side of the counter. The Claimant's testimony was therefore untrue and inaccurate based on the video surveillance showing this incident.
5. The Claimant described the mat as being well over an inch thick causing her to fall. This was inconsistent after personally viewing the mat at the hearing.
6. The manager of the store, Stokes Rogers, did authenticate the mat and brought it to the hearing. This was the mat in question shown in the video which Claimant states caused her ankle to roll. This mat was personally viewed by the Commissioner.
7. Photographs of the mat were taken at the hearing and agreed upon by all parties.
8. The mat which Claimant indicates caused her injury is possibly a quarter to half an inch thick at most.
9. Stokes Rogers, II, manager of this Murphy Oil station, indicated that he was never told by the Claimant that she felt she had an accident caused by the mat at the store until two weeks before the hearing date when informed by his counsel that that was the Claimant's testimony. The Claimant specifically reported to Mr. Rogers that she went to get up and hurt her left ankle. Mr. Rogers was also aware that the Claimant suffered from a bad left ankle as she generally walked with a significant and noticeable limp on the left side prior to April 29, 2014.
- *3 10. The medical report from Coastal Orthopedics dated June 12, 2014 specifically shows the Claimant reported to Dr. Taylor that her left ankle pain began after slipping and falling. She did not discuss or describe to Dr. Taylor that she slipped while half on and half off of a mat.
11. APA #1, pages 1-5 specifically document the Claimant's prior left ankle issues and chronic instability.
12. The medical records from Doctor's Care indicate the Claimant reported that her injury occurred when she stood up and may have caught on a mat twisting her left ankle. The Claimant's description of accident to her medical providers all indicate that her injury occurred while she was rising from a kneeling or lower position. This is supported by all of the medical records from Doctor's Care pages 6-47.

13. The Claimant submitted as APA #3, pg. 53 a letter signed only by the Claimant's attorney. I therefore do not give any weight to this letter as it is not signed by a medical physician. Even if the medical reports did indicate that the Claimant slipped half on and half off of a mat, this is inconsistent with the video evidence clearly showing this incident.

14. The video surveillance provided for this date of accident is key to the compensability of this case. The video evidence does not show an injury by accident arising out of or within the course and scope of employment. The Claimant is merely standing at the register with both feet forward when her left ankle rolls. The video shows that the ankle rolling is therefore idiopathic in nature regardless of the mat.

15. The Claimant testified that she had a total recovery from her previous ankle injury. However, the store manager described the Claimant with a chronic and noticeable limp on an everyday basis. Based on the Claimant's weakness of her foot and prior instability of her left ankle, I do not feel that the mat whether a quarter inch, half inch, or up to an inch caused her accident or was any type of increased special risk incurred by the Claimant.

16. I find the Claimant's testimony to be unclear as to what actually happened. The Claimant testified repeatedly that she was in a kneeling position and was trying to stand with her foot half off and half on the mat when her ankle rolled. Her description is unclear and is not consistent with the video surveillance. The Claimant was flipping around the gas station prior to this accident contrary to her own testimony. The medical evidence also does not match the Claimant's testimony that she had a 100% recovery from her chronic ankle instability and surgery in 2004.

17. I give greater weight and credibility to the employer witness, Stokes Rogers, than I do to the Claimant. The medical history shown in the medical records indicate the Claimant had chronic instability of the left ankle. I do not find she suffered a compensable injury by accident within the course and scope of her employment as the video shows her standing at the register when her left ankle merely gives out. Furthermore, I do not find the mat to be a special risk that contributed to her ankle giving out. The Claimant therefore suffered an idiopathic fall and is not entitled to benefits under the South Carolina Workers' Compensation Act.

CONCLUSIONS OF LAW

*4 Accordingly, as provided in § 42-17-40, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-1-160, Claimant did not suffer a compensable injury by accident within the course and scope of her employment. The Claimant's rolling of the left ankle was idiopathic in nature and not caused or aggravated by her work or any special risk found in her employment. I further find that the video surveillance supports the Claimant's ankle rolling was idiopathic only. Even if the Claimant's foot had been half on and half off of the mat, I do not feel that the mat caused or contributed to the Claimant's injury after personally reviewing the floor mat and the video surveillance of this incident.

ORDER AWARD

IT IS HEREBY ORDERED that this claim is denied.

IT IS SO ORDERED.

Claimant filed a Form 30, Application for Review, appealing the single Commissioner's findings regarding the idiopathic nature of her injury, the extent of her preexisting left ankle instability in light of medical and testimonial evidence, and the single Commissioner's award of greater weight and credibility to the testimony of the store manager. In response, Defendants contend Claimant had preexisting left ankle instability prior to the accident as evidenced by medical records and witness testimony regarding the Claimant's chronic limp. Based on her chronic left ankle instability, video surveillance showing Claimant's left ankle merely gave way while standing at the register, Claimant's testimony, and the testimony of the store

manger, the Defendants contend the single Commissioner's Decision and Order should be affirmed. Accordingly, the single Commissioner's Decision and Order is hereby AFFIRMED in full.

STANDARD OF REVIEW

In an Appellate Review, the Appellate Panel shall, pursuant to S.C. Code Ann. § 42-17-50, review the award, weigh the evidence as presented at the hearing and, if good grounds be shown therefore, make its findings of facts and reach its own conclusions of law consistent or inconsistent with those of the single Commissioner. See *Green v. Raybestos-Manhattan, Inc.*, 250 S.C. 58, 156 S.E.2d 318 (1967); see also *Low v. An-Can Transport Servs., Inc.*, 283 S.C. 534, 324 S.E.2d 87 (Ct.App. 1984).

STATEMENT OF THE FACTS

The Claimant, Jenna Foran, testified at the hearing on her own behalf. She stated that in 2004, she underwent surgery on her left ankle. However, she testified that her physician "cleared me at 100% out of medical; therefore, I was able to do everything and anything." Hrg. Tr. pg. 10, lines 13-17. The Claimant then testified that after her surgery in 2004, her left ankle was fully healed and she had no physical limitations.

The Claimant testified following her 2004 surgery, she worked as a cashier and a lifeguard. She testified that her ankle did not limit her job duties. She also was able to participate in recreational activities including volleyball and softball. She further testified that she was not limited with her left ankle in any way with activities at home or doing daily chores. She was able to do her job without any physical requirements prior to her accident.

*5 The Claimant testified she started working for Murphy Oil in December, 2013 as a third shift cashier. Her job duties included stocking cigarettes, stocking shelves, cleaning, and running the cash register. She worked part time from 11:00pm to 7:00am.

The Claimant testified that her ankle was really fine until I had stumbled onto the mat where my foot was half on, half off, and my ankle gave out." Hrg. Tr. pg. 12, lines 20-22. The Claimant testified that immediately preceding her stepping on the mat, she was stocking cartons of cigarettes to put on the shelves.

Claimant testified "I noticed I had grabbed -- grabbed too many cartons of cigarettes to put up at the time; therefore I was going to -- I was getting up to put them on the table or the counter behind -- on the other side of me to see what else I needed to grab from the back room; so, I would put those away as well while I was trying to get the others. And I went to get up and my foot was half on, half off, of the mat and my ankle just rolled underneath me." Hrg. Tr. pg. 13, lines 4-12. The Claimant then testified that the mat seen in the video is approximately an inch thick and three to four feet wide. She testified it is cushiony to give comfort to the cashiers around their feet. The Claimant testified that she has seen mats like this before in grocery stores and gas stations. She does not believe her ankle would have rolled but for the floor mat.

The Claimant then testified that she has never seen a mat like this at home and that they are not common to her neighborhood. She did testify that the store has mats such as this in the doorway where people walk from the parking lot into the store.

The Claimant testified that after she rolled her ankle, she got up and went right back to her duties. Her supervisor, Jean, came into the store later in the morning. She testified that she showed Jean that her ankle had rolled underneath her as she was stocking cigarettes. The Claimant testified that she was told by her supervisor that she would contact the store manager, Mr. Stokes (Mr. Randolph Stokes Rogers, II is referred to in Claimant's testimony as "Mr. Stokes"). Mr. Stokes told her that she needed to go to Doctors Care. Mr. Stokes then met the Claimant at Doctors Care.

The Claimant testified that she told Mr. Stokes "I was stocking the cigarettes; my foot was half on, half off, the mat and my ankle had rolled." Hrg. Tr. pg. 17, lines 22-24. The Claimant was then asked whether she had reviewed the store video tape for the time period when her fall took place. The Claimant testified that she had reviewed the video and that it was accurate. She also confirmed that the floor mat is shown in the video.

The Claimant testified she has been seen by Doctors Care and an orthopedist, Dr. Taylor. She testified she originally came back to work on light duty but was taken out of work by her doctor as of June 12, 2014. Dr. Taylor provided her the boot she was wearing at the hearing. She testified she wears her boot every day and sometimes to bed. The Claimant testified she is not able to walk without it and crawls around her house.

*6 On cross examination, the Claimant was asked specifically about her prior description of accident. She indicated she was kneeling while stocking the shelves, and that she got up from the kneeling position with her foot half on the mat and half off of the mat. The Claimant confirmed that her injury occurred while she was kneeling and went to stand up. When asked whether she would agree that the video actually shows that she had already stood up, turned around, gone over to where the cashier area was, the Claimant responded "I haven't -- I -- what I've seen was I was in the process of on the way up." Hrg. Tr. pg. 22, lines 17-21.

The Claimant then reiterated on cross examination that she was injured while "in the process of standing up my foot was half on, half off, and my ankle had rolled. Hrg. Tr. pg. 23, lines 2-3. When asked if she was still saying, contrary to the video evidence, that she was in the process of standing up from a kneeling position when she was injured, the Claimant testified "yes." Hrg. Tr. pg. 23, lines 4-7. Defense counsel referred the Commissioner to the video surveillance for the time of 5:33:47am.

Further on cross examination the Claimant was asked whether she testified in her deposition that her ankle just rolled while she was standing up. She indicated she was "down on one knee as if I was proposing, and I had leaned up with this foot was up propping me the other one was underneath me, and when I had gone up my foot was half on, half off, of the mat and it rolled as I was getting up." Hrg. Tr. pg. 24, lines 12-17. The Claimant again confirmed that this was the exact way in which she was injured. The Claimant was again asked whether she watched the video surveillance from the store and whether she thought it was accurate and consistent. The Claimant testified that yes she had seen the video and felt the video was accurate.

The Claimant was asked regarding her testimony that after her 2004 surgery, she was told by the doctor she was 100%. The Claimant denied that she was actually diagnosed instead with "chronic instability of the left ankle." Hrg. Tr. pg. 25, line 12. When asked whether she had been diagnosed by her current doctors with chronic instability of the left ankle, Claimant replied "no, they have not." Hrg. Tr. pg. 25, lines 16-19.

The Claimant then testified on cross examination that before this accident on April 29, 2014, she had not complained to anyone in the store about having left ankle pains and denied having any problems with her left ankle. She denied that any such complaints occurred. Hrg. Tr. pg. 26, line 2.

On redirect examination, the Claimant testified that she had reviewed the video of the actual accident and that she was facing the register when her foot was half on and half off of the mat.

Mr. Randolph Stokes Rogers, II, then testified on behalf of the Defendants. He testified he is the Manager of Store 8717 for Murphy Oil Corporation. He testified that this is the store where Ms. Foran works and that he has been with the company for four years. He testified the Claimant was hired in December, 2013.

*7 Mr. Stokes Rogers (referred to by Claimant in testimony as Mr. Stokes) testified that before this alleged accident on April 29, 2014, the Claimant would walk around the store with an obvious limp. He testified he asked her multiple times what was wrong with her left foot/ankle. He testified she always replied that "she had a car accident years ago and that's what was bothering her." Hrg. Tr. pg. 30, lines 19-22.

He further testified that he noticed that the Claimant walked with an apparent limp about every time he saw her. He does not recall whether there was ever a day that she walked without a limp. He also testified that before this alleged accident, she complained multiple times about having a "bad ankle." Hrg. Tr. pg. 31, line 7.

Mr. Rogers further testified that on the date of the alleged accident, he spoke with the Claimant. He specifically stated "she told me she was stocking some cigarettes down on the floor level and that she got up and she hurt her ankle." Hrg. Tr. pg. 32, lines 7-9. He further testified that she never mentioned anything about catching her foot on the mat or being half on and half off of the mat. In fact, he testified that the mat had actually never come up before this case was in litigation. Hrg. Tr. pg. 32,

lines 14-17.

Mr. Rogers then produced the floor mat in question from the store. He testified the mat is not an inch or even close to an inch in thickness. Hrg. Tr. pg. 33, lines 20-22.

Commissioner Wilkerson then inspected the mat and instructed defense counsel to take photographs of the mat on the floor. Commissioner Wilkerson noted on the record that the mat was not an inch thick and was possibly quarter to a half inch raised off the floor. Hrg. Tr. pg. 37, lines 11-16. Multiple photographs from all angles were taken at the hearing in the presence of all parties.

On cross examination, Mr. Rogers testified that prior to April 29, 2014 the Claimant was able to perform her job every time he asked her about the pain in her left ankle. Mr. Rogers then testified on cross examination that prior to this alleged injury, he did not know of any restrictions Claimant had that prevented her from doing her job duties. Mr. Rogers further testified as to his conversation with the Claimant after her alleged accident. He testified that he asked her how she was injured and she stated "she was stocking cigarettes and when she went to get up her ankle kind of gave way." Hrg. Tr. pg. 45, lines 23-25. He was then asked whether she said anything regarding the mat and whether the mat caused her injury. Mr. Rogers testified he had no idea about the mat until a couple of weeks ago as she only told him she was stocking cigarettes and went to get up when her ankle rolled. Hrg. Tr. pg. 46, lines 1-12.

Mr. Rogers further testified that the mat brought in today was the mat from the store and was the one in the video surveillance. They use it as a cushion mat kept behind the register for cashiers to stand on instead of concrete. He testified he believes it helps their legs that they do not have to stand on concrete all day. When asked if he has a mat like that at home, he indicated he does not.

*8 Ms. Amber Goss then testified on behalf of Defendants. Ms. Goss testified she is the District Manager for Murphy Oil, USA. She testified that she is not a mat expert, but she has seen these types of mats before outside of work. They sell them in stores and she actually has one in her kitchen. They are soft, squishy, kind of cushiony mats and they are decorative but also a comfort mat. Hrg. Tr. pg. 51, lines 9-14.

The medical records included in the file are those from Hackensack University from December 2005. These records reflect the Claimant was seen December 6, 2005 with a protracted history of recurrent injuries to the left ankle with now chronic instability that has failed conservative treatment. She underwent Open Watson-Jones reconstruction of the lateral ligament complex of the left ankle. APA #1, pg. 1.

The medical records from Doctors Care from April 29, 2014 through May 23, 2014 were submitted into evidence. The medical report from the date of injury indicates the Claimant's history is significant for tendon reconstruction in the left ankle in 2004 (states after history of "multiple sprains") but since surgery, had been pregnant working and has had no issues until today. X-rays were reviewed and it was agreed that there was no evidence for any acute boney trauma, changes consistent with prior surgery and referred to a sub-specialist for continued symptoms. APA #2, pg. 15.

The medical records from Dr. Ross Taylor at Coastal Orthopedics were submitted into evidence for dates June 12, 2014 through August 15, 2014. However, included with these reports is a letter dated August 15, 2014 on letterhead of Palmetto Injury Lawyers signed by the Claimant's attorney only. APA #3, pg. 52-53. This document is not a medical record and not signed by a medical doctor. The report dated June 12, 2014 from Dr. Taylor indicates the Claimant "admits to having complete loss of sensation distal to the mid cap area since her previous surgery. This is not related to her most recent injury." APA #3, pg. 48. Dr. Taylor found that the Claimant's previous repair was ruptured and recommended a revision lateral ankle ligament reconstruction using an allograft. APA #3, pg. 48. The Claimant was taken out of work on June 12, 2014. APA #3, pg. 50.

The same medical report dated June 12, 2014 from Dr. Taylor indicates the Claimant was seen with pain in her left ankle that "began when she was at work after slipping and falling." APA #4, pg. 65. He diagnosed her with ankle instability, status post fall left ankle. Defendants further submitted the entire video surveillance for the store from two separate cameras showing the morning of April 29, 2014. These videos were reviewed in detail by the Commissioner. The video surveillance clearly shows that at 5:33am, the Claimant turned around with her back to the register and squatted down on the ground stocking cigarettes.

She then stood up without any incident whatsoever and did not roll her ankle. The Claimant turned around and went back to the register where she was standing on the mat. The Claimant partially stepped off of the mat and then stepped fully back on the mat with her left foot. While standing at the register on the floor mat, the Claimant's left ankle then rolled, causing her to lean forward into the counter, left ankle rolled, both of her feet were placed forward. The video surveillance also shows that Claimant was not rising from a crouching position such as a man proposing on one knee. The Claimant also was not half on half off of the mat when her ankle rolled. Photographs of the floor mat further were included with the evidence showing a thin slightly cushioned mat.

DECISION/ANALYSIS

1. Even in light of the recent South Carolina Supreme Court decisions in *Barnes* and *Nicholson*, the single Commissioner did not err in finding the injury was idiopathic and consequently, not compensable.

*9 In *Barnes v. Charter I Realty* and *Nicholson v. S.C. Department of Social Services*, the South Carolina Supreme Court was presented with an opportunity to "clarify the idiopathic exception to workers' compensation benefits." *Barnes v. Charter I Realty*, Opinion No. 27479, 2015 WL 161731 at 1 (S.C. S. Ct. Jan. 14, 2015); *Nicholson v. S.C. Dep't of Social Servs.*, Opinion No. 27478, 2015 WL 161719 (S.C. S. Ct. Jan. 14, 2015) (emphasis added). While the legal process for evaluating idiopathic injuries has changed, *Barnes* and *Nicholson* illustrate that the legal principles and policies behind idiopathic injuries remain intact. The holding in *Barnes* and *Nicholson* reaffirms the existing doctrine that an idiopathic injury is (1) brought on by a condition particular to the employee that could have manifested itself anywhere and (2) does not stem from an accident. *Barnes*, Op. No. 27479 at 4 (emphasis added). It is on these unchanged principles that the Panel finds that the single Commissioner correctly based his decision in favor of the Defendants.

a. Claimant's injury was idiopathic because the chronic instability and weakness of her left ankle was an internal condition particular to her, and the internal breakdown of the left ankle caused her injury.

The holding in *Barnes* establishes that an idiopathic injury is one that is brought on by a condition particular to the employee that could have manifested itself anywhere. Specifically, such a condition is characterized by a result of an internal failure or breakdown. *Barnes*, Op. No. 27479 at 4. The Court even provides an additional, broader category—permitting that such conditions could be classified as a "weakness." *Barnes*, Op. No. 27479 at 5. This is explicitly laid out by the statement in *Barnes*, which finds that "whether [the Claimant] tripped because she was hurrying or she tripped over her own feet, neither [instance is] an internal breakdown or weakness that falls within the ambit of idiopathy." *Id.* (emphasis added). This statement shows that an idiopathic injury can even be based upon a weakness. Similarly, the facts in *Crosby v. Wal-Mart Store, Inc.* illustrate that the Claimant's fall was characterized as idiopathic because it was a result of an internal breakdown of the knee. 330 S.C. 489, 499 (Ct. App. 1998). *Barnes* confirms the holding in *Crosby* because the accident was "not simply unexplained, but indicated the cause was internal." *Barnes*, Op. No. 27479 at 4 (finding that the holding in *Crosby* was in harmony with how the courts have consistently applied the idiopathic exception—the circumstances of the fall were not simply unexplained, but indicated the cause was internal). The court in *Barnes* was careful to differentiate that an idiopathic fall was not simply an injury where no cause could be identified, but instead, as laid out in *Crosby*, was one that was caused by an internal failure, breakdown, or weakness. *Barnes*, Op. No. 27479 at 4-5.

*10 Here, the Claimant's assertion that the Commissioner made no findings of an internal failure or breakdown is incorrect. The single Commissioner specifically found that medical history showed chronic instability of the left ankle, and that the video surveillance shows Claimant's ankle "giving out" while she was simply standing at the register. (FOF 17.)

This finding of weakness or an internal failure, as required by *Barnes*, is further supported by other evidence in the case. Claimant specifically testified that she underwent surgery on her left ankle. (Hrg. Tr. p. 10.) That surgery, a left ankle arthroscopy and Watson-Jones ligament reconstruction, was performed by Dr. Kane at Hackensack University Medical Center. (APA 1 p. 5.) Those records indicate that the surgery was performed due to a history of recurrent sprains to the left ankle. (APA 1 p. 1.) Dr. Kane additionally noted that the left ankle had chronic instability. In spite of these medical records, at the hearing Claimant denied that she was actually diagnosed with "chronic instability of the left ankle." At Doctors Care on May 23, 2015, Dr. Denton specifically noted that "[the]re is significant weakness of these lateral ligaments. This is under the surgical scar of [the] tendon repair that patient had at 14 years of age. There is numbness to light touch of entire foot up to the ankle[,] which is old." (APA 3 p. 33.)

Additionally, it was the Claimant's testimony that she had not complained to anyone in the store about having left ankle problems and that she had not had any issues since the surgery. (Hrg. Tr. p.25.) She testified that she had no physical limitations, she was able to work as a lifeguard, cashier, and could play volleyball and Softball without limitation. (Hrg. Tr. p. 11). This testimony is contrary to that of Mr. Rogers, the store manager. Mr. Rogers testified that before the alleged accident on April 29, 2014, Claimant would walk around the store with an obvious limp. (Tr. 30.) He also testified that he asked her multiple times what was wrong with her left foot/ankle. (Tr. 30.) Additionally, he testified that before the alleged accident, she complained multiple times about having a "bad ankle." (Tr. 31.) Therefore, the Panel finds that because the Claimant was found to have a prior weakness in her left ankle, walked with a visible limp, and complained to her employer that she had a "bad ankle," the single Commissioner's finding that Claimant suffered from a chronic instability, which subsequently caused an idiopathic injury, was not in error.

b. There was no causal connection between the Claimant's injury and her employment, and instead, her injury was a result of an internal breakdown/weakness in her left ankle.

Nicholson sets forth a new standard in determining whether or not an injury arose out of, or was proximately caused by, the employment. Opinion No. 27478, 2015 WL 161719 (S.C. S. Ct. Jan. 14, 2015). In *Nicholson*, the Court found that when an employee tripped as she was hurrying down the hall, there was a causal connection between the "conditions under which the work [was] required to be performed and the resulting injury." *Nicholson*, Op. No. 27478 at 7. Additionally, the Court held that whether specific objects or conditions posed a special risk or hazard is now immaterial.

*11 The facts in *Nicholson* are starkly different from the case at hand. In *Nicholson*, the employee's injury was due to a trip and fall, not an internal condition or breakdown. *Nicholson*, Op. No. 27478 at 5. There is no mention in *Nicholson* about prior weakness or internal conditions that caused the employee to fall. In contrast to *Nicholson*, the video surveillance reveals that Claimant's ankle gave out when she was standing at the register with both of her feet placed forward. (FOF 14.) When Claimant was initially in a kneeling position, her ankle did not roll, and when she subsequently walked over to the other side of the counter and placed her feet on the mat, her ankle again, did not roll. Not until after she was stationary did the Claimant's ankle fail. *Id.*

The Claimant's testimony regarding how her ankle failed was also unclear and contrary to the video surveillance. She testified repeatedly that she was in a kneeling position and she stated that when she "had gone up my foot was half on, half off, of the mat and it rolled." (Hrg. Tr. p.24.) Based on this evidence, the single Commissioner found no causal connection between the conditions under which the work was required to be performed and the injury. (FOF 15.) The Claimant's injury did not stem from an accident and instead, arose from a purely personal physical weakness, unrelated to employment. Therefore, based on the single Commissioner's findings and the Panel's review of the video evidence of the alleged accident, we find that the single Commissioner did not err in finding that the Claimant sustained an injury due to an internal breakdown. We also find that the single Commissioner did not err in finding that the Claimant's testimony regarding her injury was unclear and inconsistent with the actual video.

II. The single Commissioner did not err in determining Claimant's testimony was untrue and inaccurate.

While "the final determination of witness credibility and the weight to be accorded evidence is reserved to the Appellate Panel," a single Commissioner's evaluation of credibility is given deference in evaluating a witness' testimony. See *Frame v. Resort Servs. Inc.*, 357 S.C. 520, 528 (Cl. App. 2004) (internal citation omitted).

Here, the single Commissioner reviewed all of the evidence and properly evaluated the Claimant and Mr. Rogers' testimony. For example, Claimant stated she had total recovery, yet Mr. Rogers testified that the Claimant had a chronic and noticeable limp on an everyday basis. Additionally, Mr. Rogers testified that the Claimant had told him that she had a "bad ankle," but Claimant later testified she had no issues with her ankle after the 2005 surgery. This testimony by Mr. Rogers was corroborated by Dr. Denton's note indicating Claimant had residual ankle numbness following the 2005 surgery. (APA 2 p. 33.) Claimant's credibility was also compromised by her inability to clearly state how she injured her left ankle and testifying that she "stumbled on the mat," despite clear video surveillance that shows otherwise. This inability to testify clearly about how her injury occurred is also illustrated in the medical records, which suggest that Claimant did not know how her ankle rolled. (APA 3 p. 8.) Mr. Rogers testified Claimant told him following this incident that her ankle gave way. The medical

records from Doctors Care state that Claimant "may" have gotten caught on a mat. *Id.* However, the video surveillance does not show any evidence of Claimant catching her foot or ankle on the mat. (FOF 14.) Therefore, we find the single Commissioner's finding that the Claimant's testimony was untrue and inaccurate was not in error.

FULL COMMISSION APPELLATE PANEL FINDINGS OF FACT

*12 After a thorough review of the evidence, including the hearing testimony, medical evidence, exhibits, video, and other documentary evidence submitted by the respective parties pursuant to the Administrative Procedures Act, the Commission File in this matter, and arguments of counsel, WE, THE APPELLATE PANEL, AFFIRM THE FINDINGS OF FACT OF THE SINGLE COMMISSIONER, IN FULL, AND FIND AS FOLLOWS:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Jenna Foran as Employee-Claimant and Murphy USA as Employer and Liberty Insurance Corporation as Carrier, Defendants.
2. That the average weekly wage of Employee at the time of the above-described accident was \$168.84, and his compensation rate was \$112.57.
3. Order directives and instructions were sent to all parties on October 31, 2014.
4. The Claimant's testimony is very confusing as to her description of this accident. She verified her personal description multiple times which was different than what the video shows actually happened. The video also clearly shows that after the Claimant was in a kneeling position, her ankle did not roll and she was able to walk over to the other side of the counter. The Claimant's testimony was therefore untrue and inaccurate based on the video surveillance showing this incident.
5. The Claimant described the mat as being well over an inch thick causing her to fall. This was inconsistent after the mat was personally viewed at the hearing.
6. The manager of the store, Stokes Rogers, did authenticate the mat and brought it to the hearing. This was the mat in question shown in the video which Claimant states caused her ankle to roll. This mat was personally viewed by the single Commissioner.
7. Photographs of the mat were taken at the hearing and agreed upon by all parties.
8. The mat which Claimant indicates caused her injury is possibly a quarter to half an inch thick at most.
9. Stokes Rogers, II, manager of this Murphy Oil station, indicated that he was never told by the Claimant that she felt she had an accident caused by the mat at the store until two weeks before the hearing date when informed by his counsel that that was the Claimant's testimony. The Claimant specifically reported to Mr. Rogers that she went to get up and hurt her left ankle. Mr. Rogers was also aware that the Claimant suffered from a bad left ankle as she generally walked with a significant and noticeable limp on the left side prior to April 29, 2014.
10. The medical report from Coastal Orthopedics dated June 12, 2014 specifically shows the Claimant reported to Dr. Taylor that her left ankle pain began after slipping and falling. She did not discuss or describe to Dr. Taylor that she slipped while half on and half off of a mat.
11. APA #1, pages 1- 5 specifically document the Claimant's prior left ankle issues and chronic instability.
- *13 12. The medical records from Doctors Care indicate the Claimant reported that her injury occurred when she stood up and may have caught on a mat twisting her left ankle. The Claimant's description of accident to her medical providers all indicate that her injury occurred while she was rising from a kneeling or lower position. This is supported by all of the medical records from Doctors Care pages 6-47.
13. The Claimant submitted as APA #3, pg. 53 a letter signed only by the Claimant's attorney. I therefore do not give any

weight to this letter as it is not signed by a medical physician. Even if the medical reports did indicate that the Claimant slipped half on and half off of a mat, this is inconsistent with the video evidence clearly showing this incident.

14. The video surveillance provided for this date of accident is key to the compensability of this case. The video evidence does not show an injury by accident arising out of or within the course and scope of employment. The Claimant is merely standing at the register with both feet forward when her left ankle rolls. The video shows that the ankle rolling is therefore idiopathic in nature regardless of the mat.

15. The Claimant testified that she had a total recovery from her previous ankle injury. However, the store manager described the Claimant with a chronic and noticeable limp on an everyday basis. Based on the Claimant's weakness of her foot and prior instability of her left ankle, we do not feel that the mat whether a quarter inch, half inch, or up to an inch caused her accident or was any type of increased special risk incurred by the Claimant.

16. We find the Claimant's testimony to be unclear as to what actually happened. The Claimant testified repeatedly that she was in a kneeling position and was trying to stand with her foot half off and half on the mat when her ankle rolled. Her description is unclear and is not consistent with the video surveillance. The Claimant was limping around the gas station prior to this accident contrary to her own testimony. The medical evidence also does not match the Claimant's testimony that she had a 100% recovery from her chronic ankle instability and surgery in 2004.

17. We give greater weight and credibility to the employer witness, Stokes Rogers, than to the Claimant. The medical history shown in the medical records indicate the Claimant had chronic instability of the left ankle. We do not find she suffered a compensable injury by accident within the course and scope of her employment as the video shows her standing at the register when her left ankle merely gives out. Furthermore, we do not find the mat to be a special risk that contributed to her ankle giving out. The Claimant therefore suffered an idiopathic fall and is not entitled to benefits under the South Carolina Workers' Compensation Act.

FULL COMMISSION APPELLATE PANEL CONCLUSIONS OF LAW

In view of these Findings of Fact, and as provided in the South Carolina Code of Law, WE, THE APPELLATE PANEL, AFFIRM THE CONCLUSIONS OF LAW OF THE SINGLE COMMISSIONER IN FULL:

*14 1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-1-160, Claimant did not suffer a compensable injury by accident within the course and scope of her employment. The Claimant's rolling of the left ankle was idiopathic in nature and not caused or aggravated by her work or any special risk found in her employment. We further find that the video surveillance supports the Claimant's ankle rolling was idiopathic only. Even if the Claimant's foot had been half on and half off of the mat, we do not feel that the mat caused or contributed to the Claimant's injury after personally reviewing the floor mat and the video surveillance of this incident.

ORDER/AWARD

IT IS, HEREBY, ORDERED that Commissioner Wilkerson's Decision and Order dated January 14, 2015, is affirmed, in full. Commissioner Wilkerson's Decision shall remain in effect.

IT IS SO ORDERED.

South Carolina Workers' Compensation Commission

T. Scott Beck
Commissioner
Chair

R. Michael Campbell, II

JENNA FORAN, EMPLOYEE, CLAIMANT/APPELLANT..., 2015 WL 4516884...

Commissioner
Susan S. Barden
Commissioner

2015 WL 4516884 (S.C. Work.Comp.Comm.)

File of Complaint

Work Compensation Commission

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

Proudly representing injured workers
for over 30 years.

Preston F. McDaniel

Matthew Robertson

Telephone (803) 771-7211

Facsimile (803) 252-0709

February 15, 2017

Amy Bracy, Judicial Director
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

RE: Edmund Dillon, Deceased, v. Raffles (FleetPride)
WCC File No.: 1501382

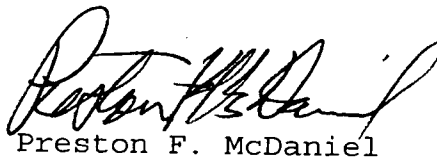
Dear Ms. Bracy:

Please be advised that I have been associated and retained along with Brian Dumas, Esquire to represent the Claimant in this matter.

Please find enclosed for filing with the Commission the Form 30 - Request for Commission Review in the above-referenced matter, along with the required \$150.00 filing fee. I am, by copy of this letter, serving opposing counsel with a copy of the Form 30.

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

Sincerely yours,



Preston F. McDaniel

PFM/kth
Enclosures

cc: Brian Dumas, Esquire
Cynthia C. Dooley, Attorney
Samuel V. Priddy, IV, Esquire



WCC File #: **1501382**
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

REQUEST FOR COMMISSION REVIEW

See Attachment.

P1171

ATTACHMENT TO FORM 30

Edmund Dillon, Deceased, v. Raffles (FleetPride)

WCC File No. 1501382

1. That pursuant to S.C. Code of Laws §42-17-40, the Claimant requests a review of all of the Findings of Fact, the Conclusions of Law, the Order and Award and of all rulings and decisions made by the Commissioner at the hearing, as contained in the Record or as made at any unrecorded pre-hearing conference, and in any communications concerning the claim, Order, Award and Decision rendered by the Hearing Commissioner in this matter.

2. That the Hearing Commissioner erred as a matter of law by trying to distinguish this case from the cases of Nicholson v. SCDSS, 411 S.C. 391, 769 S.E.2d 1 (2015); Barnes v. Chapter 1 Realty, 411 S.C. 391, 768 S.E.2d 651 (2015); and Thomas v. Five Star Transportation, 412 S.C. 1, 770 S.E.2d 183 (SC App. 2015) and by applying an idiopathic fall case which this is not, that being the case of Bagwell v. Ernest Burwell, Inc., 227 S.C. 444, 88 S.E.2d 611 (1955).

3. That the Hearing Commissioner erred as a matter of law by making Conclusion of Law #1 wherein the substantial evidence in the Record clearly establishes by a preponderance of the evidence that the Claimant sustained compensable injury by accident as defined under SC Law.

4. That the Hearing Commissioner erred as a matter of law in making Conclusion of Law #4 by finding that the Claimant did not establish as a matter of law that the Claimant had sustained compensable injury under §42-1-160 as defined by our Appellate Courts.

5. That the Hearing Commissioner erred as a matter of law by making Conclusion of Law #5 wherein the evidence established by a preponderance of the evidence that he sustained a compensable injury by accident resulting in his death and by basing that conclusion on Findings of Fact #16-21.

6. That the Hearing Commissioner erred as a matter of law in making Conclusion of Law #6 by finding that the Claimant sustained an idiopathic fall due to a pre-existing unrelated medical issue as described in the medical records and through witness testimony and basing that Conclusion of Law on and as set forth in his Findings of Fact #28-30.

7. That the Hearing Commissioner erred as a matter of law by making Conclusion of Law #7 wherein he found that the Claimant failed to meet his burden of proof and dismissed the claim with prejudice and basing that Conclusion of Law on Finding of Fact #32.

8. That the Hearing Commissioner erred as a matter of law in the Award portion by denying the Claimant benefits and dismissing the Claimant's case with prejudice.

9. That the Hearing Commissioner erred as a matter of fact and law in making of Findings of Fact #17-23 wherein all of these Findings of Fact concerned and are based on the testimony of Josiah Fludd and further and specifically in that these Findings of Fact make the testimony of Josiah Fludd's testimony conclusive one way or another as to the, "cause" of the fall. Further, the Commissioner's Findings are based on surmise, speculation and innuendo based on the actual testimony from Mr. Fludd.

10. That the Hearing Commissioner erred as a matter of fact and law by making contradictory Findings of Fact. He made on the one hand a Finding that Mr. Fludd could not testify as to whether or not the Claimant slipped, and on the other hand made the Finding under Finding of Fact #8 that on the day of his fall the Claimant reported that he slipped and fell. He then made Finding of Fact #24 that he was not persuaded that the Claimant slipped or tripped and by finding under Finding of Fact #25 that the Claimant simply collapsed.

11. That the Hearing Commissioner erred as a matter of law by failing to apply the concepts of present sense impression, excited utterance, then existing physical condition, and statement made for medical treatment in reference to the statements that were made by the Claimant (deceased) immediately following the accident and as part of medical treatment following the accident. All of those concepts require the fact-finder to give great weight to those statements wherein the law gives those statements great credibility due to their immediacy and relationship to the event and the condition of the Claimant at the time that they were made.

12. That the Hearing Commissioner erred as a matter of law in making Finding of Fact #23 where this Finding specifically establishes that this Finding by the Commissioner is the subject of being arbitrary, capricious and an abuse of discretion. The Finding that the testimony of Mr. Fludd as a witness under oath is entitled to greater weight because, "he does not stand to gain or lose based on his testimony in this case", does not

constitute a lawful basis for assigning greater weight to his testimony especially as compared to the EMS workers and doctors in reference to their findings and the statements they recorded as having been made to them by the deceased worker in this matter within thirty (30) minutes of his slip and fall.

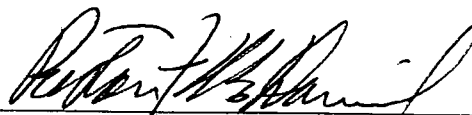
13. That the Hearing Commissioner erred as a matter of fact and law by basing his entire factual decision as to whether or not the Claimant sustained injury by accident upon the factual testimony and evidence of Mr. Josiah Fludd given in his discovery deposition wherein that testimony and evidence does not support the conclusions made from a factual standpoint by the Commissioner.

14. That the Hearing Commissioner erred as a matter of fact and law by making Finding of Fact #25 wherein the Hearing Commissioner gave undue weight to possible reasons for a collapse or fall as related by the medical evidence of the employer's expert witness and giving little or no weight to the evidence from the Claimant himself and the Claimant's expert medical witness who opined that preexisting conditions did not contribute to or cause the fall.

15. That the Hearing Commissioner erred as a matter of law in making Finding of Fact #28 wherein the Commissioner erred in placing an improper burden of proof on the Claimant in that the undisputed testimony of the Claimant to his medical providers at the time of the injury was that he slipped and fell. The evidence of Mr. Fludd and, in particular, his deposition, reveals that Mr. Fludd was loading a truck at the time, protecting his paperwork from the rain, his view was obscured, his primary focus was not on the Claimant until the Claimant began to fall, and all he really knows is that the Claimant fell, not why or how. The Hearing Commissioner placed too great of a weight on what Mr. Fludd did not see as opposed to what he did see.

The above-referenced Exceptions are subject to amendment upon receipt of the Transcript.

Respectfully submitted,



Preston F. McDaniel, Esquire
Attorney for the Claimant

February 15, 2017

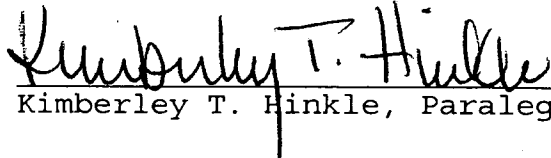
CERTIFICATE OF SERVICE

WCC File No. 1501382

I hereby certify that I have on this day served the following in the matter of Edmund Dillon, Deceased, v. Raffles (FleetPride) with a copy of the FORM 50 - REQUEST FOR COMMISSION REVIEW by depositing the same in the United States Mail, with adequate postage thereon, addressed as follows:

Amy Bracy, Judicial Director
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

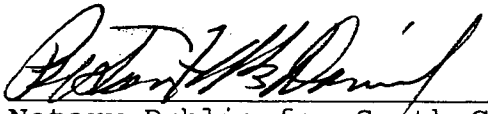
Cynthia C. Dooley, Attorney
Samuel V. Priddy, IV, Esquire
TURNER, PADGET
P.O. Box 1473
Columbia, SC 29202



Kimberley T. Hinkle, Paralegal

SWORN TO BEFORE ME this

15TH day of February, 2017.



(L.S.)
Notary Public for South Carolina

My Commission Expires: 10/28/18

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC FILE NO.: 1501382

EDMUND DILLON, Deceased)

Claimant,)

v.)

RAFFLES (FLEETPRIDE))

Employer,)

and)

GALLAGHER BASSETT as TPA)

For AMERICAN ZURICH)

INSURANCE COMPANY,)

Carrier,)

Defendants.)

**CLAIMANT/APPELLANT'S BRIEF
TO THE FULL COMMISSION**

The Defendants tried the Claimant not the facts.

STATEMENT OF THE CASE

While there were several errors in the application of the law to the facts in this case, this case is compensable based on the uncontradicted evidence in the Record from the only witness that testified as to what happened, that being the Claimant who lived to tell his story; and which makes it distinguishable from all of the idiopathic fall death cases where the Commission had only circumstantial evidence to rely on as to what happened. The direct evidence from the EMS drivers, the nurses and the attending physician and the 12A issued four days later all confirmed the undisputed evidence as to what happened:

①
EMS Report:

EMS arrives at 11:11 a.m. and at 11:16 a.m. records:

Neurological Report:

Level of Consciousness: Alert.
Neurological Present: Normal.
Mental Present: Normal.
Pupils: Size - left and right normal;
Reactive - left and right reactive.
Motor and Sensory: Normal.
Glasgow Coma Scale: 4/5/6 15 (totally normal).
(Claimant APA, p. 10 and 11; Defendant p. 63-64).

EMS Report:

Injury Details:

Reason for Encounter: Injury/Trauma.
Fall Height: 6.
Fall Surface: Hard.
Landed on: Head.
Work-Related: Yes.
Mechanism: Fall.
(All of this information was taken from the
Claimant).
(Claimant APA, p. 11; Defendant p. 64).

EMS Report:

Activity:

"He (Claimant) did not wish to go to
hospital but supervisor convinced him he needed
to go."

EMS Report:

Times:

Left scene at 11:19 a.m. and arrived at
hospital at 11:30 a.m. (Claimant APA, p. 10;
Defendant APA p. 63).

② Mr. Dillon arrived via ambulance at the hospital at 11:30 a.m. EST and at 11:35 a.m. EST, Nurse Jennifer Watson recorded the following:

Per EMS, "patient tripped and fell ... MD at bedside ..." (Claimant APA, p. 30,31).

③ Dr. David T. Ford, MD at 16:07 (4:07 p.m. EST) dictated the history Dr. Ford had taken from Mr. Dillon at 11:35 a.m. EST. as to Mr. Dillon's condition and what he said happened. That history is as follows:

"HISTORY OF PRESENT ILLNESS: This is a 56-year-old male presenting after he fell. States he slipped and fell, hit the back of his head. Says he wanted to go back to work, but his firm would not let him. Patient states that he has non-tender felt well over the last several days, has not been eating well and did notice that his skin has changed colors, but attributed this to that. States that he had had vomiting and diarrhea and just not felt well but that today he had a mechanical fall, did not have syncopal symptoms. Denies any headache, chest pain or any shortness of breath. He has an abrasion to his back. Patient denies any weakness, any abdominal pain or other complaints ...

The doctor further recorded:

EMERGENCY DEPARTMENT COURSE: Patient was seen upon arrival, full history and physical exam performed. Work-up was obtained as stated above and throughout his stay in the ER he continued to have progressive decline in his mental status ..."
(Claimant APA, p. 35,36; Defendant p. 117).*

*[The Claimant would also specifically ask the Commission to note that at the time this history was taken and recorded, Claimant's GCS (Glasgow Coma Scale) remained totally normal at 15. (APA as referenced above). Whereas, two hours later, it was noted to have deteriorated to less than 8, (Defendant APA, p. 123).]

Also, not only was Dr. Ford in attendance but also a Resident by the name of Dr. Emily Mackey and Dr. Ford recorded that he and M.D./Resident Mackey spent over 32 minutes with Mr. Dillon. (Defendant APA, p. 119).

In addition to the EMS personnel's reports: (1) of what Mr. Dillon told them; (2) and the emergency room nurse; and (3) the Resident and the emergency room doctor(s), as to what Mr. Dillon told them that: "he slipped and fell." The 12A Filed Four Days After Accident, February 27, 2015, which was admitted without objection stated:

400p He was leaving his car headed toward the building when he tripped and fell hitting his head, knocking him unconscious as witnessed by customer John at (803)272-7497 (APA p. 93 and Tr. p. 45)..;

This constitute both an admission against interests and creates an inference that if this witness (company employee who recorded this) under the control of the company were called as a witness that the witness would confirm this statement.

Ducksworth v. First National Bank 254 SC 263, 176 SC2d 297 (1970).

6 There were also pictures introduced as witness, Mr. Josiah Fludd, that partially v sideshow/indirectly witnessed part of Mr. I fall.

The position of Mr. Dillon's body and the injuries to his head are strong contradictory evidence to the picture the Defendants try to paint of Mr. Dillon and the fall. The Commission will note from two of the pictures found at Defendant's APA Submission, p. 840 and the picture at p. 842 that at the approximate location where the Claimant was seen to fall there is an unmarked curb cut directly adjacent to where Mr. Fludd's truck was parked.

As to what he observed as to the conditions and as to the fall and his ability to observe what occurred and what he was doing when he observed this fall, Mr. Fludd testified in deposition as follows:

Q. I called you after I saw this Affidavit.

A. Yes.

Q. Correct? And you and I spoke for a few moments on the phone. Is that correct?

A. Yes, sir.

Q. And I believe you told me then, and you just told us now, that you were loading and unloading your truck?

A. Yes, sir.

Q. I believe you were at the front of the FleetPride entrance.

A. Yes, sir.

Q. It had been raining that day.

A. Yes, sir.

Q. The ground was wet.

A. Yes, sir. (Deposition, p. 13 l. 11-p. 14, l. 1).

Q. And tell me what you actually saw, in your own words.

A. Well, I was loading my truck. I was putting the paperwork in my truck to keep from getting wet.

Q. Sure.

A. And turned to walk back towards the building. And that's when I saw Mr. Ed just stood there and just basically fell over.

Q. Okay.

A. That's what I saw.

Q. And in our discussion, you told me -- and you stop me if I'm wrong.

A. Okay.

Q. That all you saw was him from just below the waist up.
Is that correct?

A. Yes, sir.

Q. And that you couldn't say if he slipped or if he didn't.

A. Right.

Q. You just didn't know. Right?

A. No, sir.

Q. Okay. Is that correct?

A. Yes.

Q. Okay. So you don't know if he did slip. Right?

A. I didn't see any of his bottom movement.

Q. Okay. So you don't know whether he slipped or not.

Correct?

A. Correct.

Q. Okay. You -- to your knowledge, you have no idea why he fell. Do you?

A. No, sir.

Q. And you don't know if he passed out or what happened.

Right?

A. No, sir.

Q. Okay. So I am correct in that?

A. Yes, sir. (Deposition p. 14 l. 7 - p. 15 l. 13).

Q. Okay. But you were obviously busy with what you were doing. Correct?

A. Yes. (Deposition p. 20 ll. 17-19)

Q. Okay. Were you actually watching him for that full minute?

A. No. How I was putting paperwork inside my truck had me looking that direction.

Q. Okay. So you were just kind of looking in that general direction?

A. Yes, sir.

Q. Oh, okay. And I assume the motion is what caught your eye?

A. Yes.

Q. The motion of the fall?

A. Yes. (Deposition p. 21 l., 4, 10; l. 17-21).

Mr. Fludd, a customer, was at the business where Mr. Dillon worked buying supplies for his diesel repair shop and while putting paperwork in his truck while it was raining simply saw Mr. Dillon fall from a standing position from about his waist up. (standing still in the rain?) Mr. Dillon said he slipped and fell and was totally coherent at the time that he made those statements both to the emergency personnel, to the nurse and to the doctors.

Four days after the accident, the witness, John, told the employer Mr. Dillon "tripped and fell" (Claimant's APA p. 93). (note: John is either a separate witness or is Josiah Fludd). Mr. Dillon was not found on his back as if he had fallen backwards without trying to break his fall as the Defendants wanted to lead the Commission to believe but was found by Mr. Mogridge lying on his right side with bleeding above his right ear and in his opinion, "I figured that's the side that hit." (Tr. p. 33 l. 15 - p. 34 l. 10).

From the misapplication of the law and the misunderstanding of the facts before him as to the primary issue, this appeal follows.

I. THE COMMISSION SHOULD AWARD BENEFITS WHERE THE HEARING COMMISSIONER OVERLOOKED THE UNDISPUTED EVIDENCE AS TO WHAT

OCCURRED AND MISAPPLIED THE LAW AS ESTABLISHED BY OUR APPELLATE COURTS.

Counsel for both parties presented Memorandums of Law to the Hearing Commissioner in this matter. Defense Counsel's Memorandum while a basically accurate review on the idiopathic fall cases reiterated that line of Case Law serves as the defense in every case like this and cited the same worn out idiopathic fall cases that have been specifically reversed by the Supreme Court in cases like this one. Further, the Defendants point to the facts in those cases that are similar to Mr. Dillon's case but pointed away from the facts in those cases that are totally different from those in this case and specifically from the facts in this case that are on all-fours with the facts as decided by the Supreme Court in Nicholson v. South Carolina Department of Social Services, 411 SC 381, 769 S.E.2d 1. (2015) and Barnes v. Charter One Realty, 411 SC 391, 768 S.E.2d 651 (2015). As in all cases before the Commission where they assert the idiopathic defense, they harkin back to and rely on a case decided in 1955, Bagwell v. Ernest Burwell, Inc., 377 SC 444, 88 S.E.2d 611 (1955). In Bagwell, two witnesses saw Mr. Bagwell standing at a counter when he fell backwards without attempting to catch himself or break his fall. In using that case as a basis for the idiopathic fall concept, the Defendants always overlook one very important fact; Mr. Bagwell died without saying a word about what happened.

After telling the Bench and Bar that the Commission is required to consider **"the evidence most favorably from the claimant's standpoint"**. The Court distinguished Bagwell from the case where there is direct evidence from the claimant, citing Cagle v Judson Mills 195 SC 346, 11532d 376 (1940), as to what happened and there are casual indirect witnesses of the accident. In Cagle, Mr. Cagle lived long enough, where there were witnesses to his fall, but circumstances that could justify an Award but where appeared he just fainted, to say and tell his story, that "I felt a little weak" and "I wonder how come I do that." Based on his statements, there was no basis for finding an accident ever related to being overheated.

The Defendants also refer to Miller v. Springs Cotton Mills, 225 SC 326, 82 S.E.2d 458 (1954) which again is a 1954 case and was specifically distinguished by the Barnes v. Charter One Realty, supra decision. They also always fail to point out two things: First, the Supreme Court in that case specifically noted that the internal breakdown caused the near fall and not that the near fall caused the breakdown based on Ms. Miller's testimony and second, that the Supreme Court specifically noted that Ms. Miller, based on her testimony, was not doing any of her job functions but was in the cafeteria eating lunch and was not involved in any work activities at the time that her knee gave out on her. In other words, the Supreme Court's decision in Miller is based on her testimony as it was in the Court of

Appeals decision in Crosby v. Walmart, 330 SC 489, 499 S.E.2d 253 (SC App. 1998).

In, Barnes v. Charter One Realty, supra, the Supreme Court specifically debunked this line of argument in reference to the identical type of facts that we have in this case i.e., where there was evidence from the claimant above what happened. After stating in Barnes that idiopathic falls are an exception and that, "as an exception to workers' compensation coverage, the idiopathic doctrine should be strictly construed ..." the Court went through the distinguishing facts that are the same distinguishing facts in this case. Quoting from Barnes in reference to the Crosby decision, the Court held:

"In finding the unexplained nature of Barnes fall rendered it idiopathic, the Appellate Panel relied on the Court of Appeals Opinion in Crosby v. Walmart Store, Inc. (citation omitted). In Crosby, the Court affirmed the finding that the Claimant's fall was idiopathic, basing its conclusion on the fact that the fall was a result of an internal failure or breakdown in the knee. (Citation omitted). The Court specifically referenced testimony of another employee that Crosby had indicated her leg gave out to support this finding (Citation omitted). Thus, in Crosby, the Court did not find the cause of the fall was unknown, but found it was in fact occasioned by an internal and personal condition specific to Crosby and was therefore idiopathic in nature.

Even in Crosby, and while that decision was overturned by the Supreme Court in Barnes, the Commission's decision was based on the evidence, "including Claimant's own testimony" which indicated that the Claimant did not know the reason for the fall.

Therefore, the distinguishing characteristic between this case and all of the cases that the Defendants cite is that the decision to either grant benefits to the Claimant or to deny benefits to the Claimant is based upon the testimony that was presented and where the Claimant presented evidence in the form of statements and testimony given by other witnesses, as to what the claimant said, the Commission relied on that specific evidence. Ms. Miller testified to an internal breakdown; Mr. Cagle stated she just got weak; Mr. Bagwell was dead and did not state what happened before he died; Ms. Crosby stated that she knew of nothing that caused her fall. In both Barnes and Nicholson, Ms. Barnes and Ms. Nicolson testified that they tripped and fell and the Court found their injuries were not idiopathic. The undisputed testimony and evidence in this case is that Mr. Dillon told both the EMS workers and his treating doctor upon arrival at the emergency room in the presence of the treating nurse and a Resident that he had, "slipped and fell, and hit the back of his head." As in all other cases decided by this Commission and by our appellate courts, where the Claimant has testified, or stated to witnesses what happened, in every one of those, the Claimant would submit that this Commission has awarded benefits or has denied benefits based on the testimony and statements of the Claimant where those were available. Those were available in this case and Mr. Dillon, who was totally coherent at the time that he made those statements

stated that he slipped and fell. The circumstantial evidence was that he was near a curb cut and it was raining and the ground was wet when he fell. Mr. Fludd was quite honest and said he could not see Mr. Dillon from the waist down, that the ground was wet and that he was putting his paperwork into his truck when Mr. Dillon's "**fall**" drew his attention and he could not say whether or not he slipped or tripped or what caused his fall. This Commission should review the evidence and award benefits on this basis alone.

II. THE HEARING COMMISSIONER ERRED AS A MATTER OF LAW BY NOT APPLYING THE LAW AS ESTABLISHED BY THE SOUTH CAROLINA SUPREME COURT IN NICHOLSON AND BARNES.

As set forth above, the uncontested evidence is that Mr. Dillon slipped and fell. In his Conclusions of Law, the hearing Commissioner did not properly apply the decisions of the Supreme Court in reference to Nicholson and Barnes specifically in that the Claimant does not have to prove a cause of the slip and fall.

The Defendants submitted and allowed the hearing Commissioner to misunderstand this case to be an idiopathic fall type case wherein it is not an idiopathic fall because the cause of the fall is known in that Mr. Dillon's uncontested statements is that he slipped and fell. As in Nicholson and Barnes, he is not required to prove the reason that slip and fall occurred but is only required to prove that it is an unexpected result from work activity.

Further unlike cases involving the allegation of an idiopathic fall either causing death or injury, or involving the unexplained, un-witnessed death or injury presumption, the Court must rely on circumstantial evidence to substantiate that the injury arose out of the work activities and was accidental in nature, unless as there is in this case, there is testimony and or statements from the claimant presented through the testimony and evidence from other witnesses as to what occurred.

In this case, there is specific evidence as to what occurred and as Mr. Dillon stated repeatedly to numerous people and as one other witness within four days of the day of the accident recorded, he "tripped and fell". This case should be awarded based on the uncontradicted testimony and evidence from the claimant alone, but without question based on, as the Supreme Court has stated, "considering the evidence most favorably from the claimant's standpoint".

III. THE HEARING COMMISSIONER ERRED AS A MATTER OF LAW BY EXCLUDING THE EVIDENCE PRESENTED FROM THE LEGAL NURSE

The claimant submitted evidence from a legal nurse certified in the area of pathology and in legal analysis. She expressed the opinion with a reasonable degree of certainty as a registered nurse, legal nurse and pathologist, that there was nothing based on her Record's review that Mr. Dillon had any definitive medical condition, that caused him to faint and/or

fall but instead he died as a direct result of the fall sustained while at his place of employment.

While admitting a records review from the defendant's expert and from the claimant's expert, the Commissioner excluded this expert evidence. There is simply no basis in law or fact for excluding this expert evidence rendered by, as uncontested, a registered nurse who has a background and experience and is credentialed and trained and who is a board certified in the areas of pathology, nursing and legal nursing analysis. Again, there is simply no basis in law or fact to exclude this evidence and based on the Commissioner's findings in reference to the medical records and medical records review, this testimony and evidence could very well have been significant in the Commissioner's decision had it been submitted.

IV. THE HEARING COMMISSIONER ERRED A MATTER OF LAW BY FAILING TO RECITE IN HIS FINDING OF FACTS ANY REVIEW OF THE MEDICAL EXPERT TESTIMONY SUBMITTED BY THE CLAIMANT.

There was expert testimony presented by a board-certified physician on behalf of the claimant and expert medical evidence offered from a registered nurse concerning the facts as to the medical conditions of the claimant based on a review of the medical records from the claimant's hospitalization following his accident as to whether or not there was any causal relationship between his conditions and cause of his fall. While there is evidence in the Record to establish that the claimant had several pre-existing conditions, it is the subject of

surmise, speculation and based on the objective medical records or as established by the medical records and specifically in reference to all of the blood work and other diagnostic testing that was performed that day, the day of the accident, that would indicate that any condition was present and caused or would have caused the claimant to collapse. Whereas based on the expert medical evidence, there was a specific review of that evidence from both a registered nurse, which was excluded, and also from a board certified medical doctor, that there was nothing indicating or from which one could conclude that based upon the objective test results performed that day, that any of the pre-existing conditions caused a collapse.

V. WHERE THE CLAIMANT SPECIFICALLY SUBPOENAED "ANY AND ALL INVESTIGATIVE REPORTS, FILES, STATEMENTS OR OTHER MATERIALS CONCERNING THIS CLAIM, INCLUDING BUT NOT LIMITED TO, ANY INSURANCE INVESTIGATION" AND WHERE NONE WAS PRODUCED, THE COMMISSIONER ERRED BY GIVING WEIGHT TO THE DEPOSITION TESTIMONY OF JOSHIA FLUDD

A Form 12a was placed in the record, wherein the employer and its insurance carrier represented to the Commission that the claimant was walking back to his truck when he tripped and fell, causing him to hit his head and being unconscious. That statement gave the name of a witness, John, who made this report and gave his telephone number.

A witness for the employer at the hearing, testified that he thought John to be Josiah Fludd. Mr. Fludd at his deposition, to which an objection was made as to leading, was presented with

an Affidavit and then was lead through that Affidavit, which was signed by Mr. Fludd, over 3 months after this accident. An inquiry was made by the claimant's counsel as to who took the Affidavit, to which Mr. Fludd could not give an answer. He made no statement in reference to being contacted within four days after the day of the accident, by anyone or giving any statement to the employer and/or its insurance carrier or any of its agents or representatives. In addition, contrary to the prepared Affidavit, which used the word, "collapsed," Mr. Fludd said that he had told the person that Mr. Dillon, "fell". He reiterated under oath, that he saw Mr. Dillon, "fall".

There is no question that claimant's counsel had forwarded a subpoena requiring the production of:

"Any and all investigative reports, files, statements, or other materials concerning this claim, including but not limited to, any insurance investigation. Please provide a witness list with contact information for each witness."

No investigative report was provided to the claimant, nor was one available or referred to, nor was the name given at the deposition of Mr. Fludd as to who the investigator was or how the person took this information or what was the source of the information that was set forth in the Affidavit, which Mr. Fludd signed.

Mr. Fludd made it very clear in his deposition that the deposition was disruptive to his work and that he was only at the deposition because he was subpoenaed, or in other words, was

forced to be there, and did not want to be there. There is no evidence in the Record, other than claimant's counsel cross-examination, as to whether or not the witness, "John" whose telephone number appeared on the Form 12A, was ever contacted or sought to be contacted by the employer and its insurance carrier.

Based on the submission of the subpoena and the failure of the defendant's to produce any investigative information, the decision should be reversed and at a minimum remanded for a De Novo hearing.

VI. THE COMMISSIONER ERRED AS A MATTER OF LAW BY CONSIDERING THE TESTIMONIAL EVIDENCE OF MR. JOSHIA FLUDD IN HIS DEPOSITION WHERE HIS TESTIMONY AND HIS ANSWERS, AS REFLECTED IN THE FINDINGS OF FACT OF THE COMMISSIONER WERE ELICITED BASED ON LEADING QUESTIONS.

In the deposition, Mr. Fludd was shown the prepared Affidavit, which was prepared and submitted to him for signature, and instead of asking, (as claimant's counsel did), for Mr. Fludd's recollection of what occurred, defense counsel after handing the Affidavit to Mr. Fludd, elicited answers based specifically from that Affidavit by the use of leading questions. Claimant's counsel objected to those questions, which were clearly leading in nature and which should have been excluded by the Hearing Commissioner.

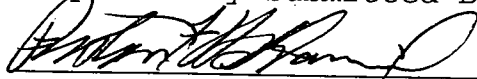
If, those questions and answers are excluded, there is no basis in evidence, as they should have been, lawfully admitted, to support the commissioner's findings. Based on this error of

law and submission of this evidence, which was highly prejudicial to the claimant, this matter should be reversed.

CONCLUSION

For all of the foregoing reasons, this matter should be reversed based on the uncontradicted testimony and evidence from the claimant as to the fact that he tripped and fell and benefits should be awarded to his widow; At the bare minimum, based on the errors of law; errors of the application of the law; and errors of fact and law, this matter should be remanded for a De Novo hearing before a hearing commissioner and the defendant's should be instructed to produce all investigative reports and records in reference to the investigation of this claim, which were not produced in reference to the subpoena that was issued.

Respectfully Submitted By:



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And

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ATTORNEYS FOR THE CLAIMANT

CERTIFICATE OF SERVICE

Edmund Dillon (deceased) v. Fleet Pridge

WCC File No. 1501382

I HEREBY CERTIFY that on this date:

I mailed a copy of the CLAIMANT/APPELLANT'S BRIEF TO THE FULL COMMISSION to:

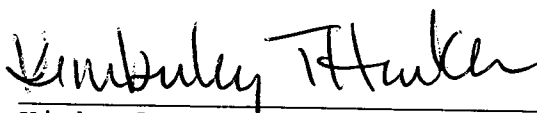
VIA eCASE UPLOAD

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

And I mailed a copy of the CLAIMANT/APPELLANT'S BRIEF TO THE FULL COMMISSION to:

VIA FIRST CLASS MAIL ONLY

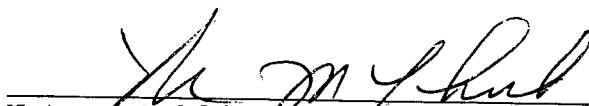
Cynthia C. Dooley, Attorney
Turner Padgett
Post Office Box 1473
Columbia, SC 29202



Kimberley T. Hinkle, Paralegal

SWORN TO BEFORE ME this

17 day of APRIL, 2017.



Notary Public for South Carolina (L.S.)

My Commission Expires: 2/4/24

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1501382

Edmund Dillon, Dec'd,

Employee,

Claimant,

vs.

Raffles (FleetPride),

Employer,

AND

Gallagher Bassett as TPA for American
Zurich Insurance Company,

Carrier,

Defendants.

**RESPONDENTS' BRIEF TO THE
FULL COMMISSION**

STATEMENT OF THE CASE

The Appellant, April Dillon, as representative for the deceased, Edmond Dillon, filed a Form 52 requesting a hearing alleging Respondents, FleetPride and Gallagher Bassett as TPA for American Zurich Insurance Company, owe benefits resulting from a collapse at work. Respondents filed a Form 53 denying that Appellant was entitled to any benefits under the Act as the fall did not arise out of and in the course of his employment.

The hearing was conducted before Commissioner Gene McCaskill on August 30, 2016. After hearing testimony and reviewing the record, the Commissioner ruled that Appellant failed to meet her burden of establishing a compensable claim by a preponderance of the evidence, determining instead that Decedent simply collapsed.

Appellant initiated this review of the Single Commissioner's Order with a Form 30, Request for Commission Review, on February 15, 2016.

FACTS

The Decedent was an employee for FleetPride. He worked behind the counter as a parts salesman. The Decedent was at work on the morning of February 23, 2015. While at work, he was observed by the sole eye witness, Josiah Fludd, to collapse outside the front of the building. He was observed to have fallen while standing idle without any attempt to stop himself or break his fall. Decedent hit his head on the concrete and lost consciousness. Fred Mogridge was the first one outside from the employer after the fall. He called EMS to the scene.

EMS arrived, and the Decedent was taken to the hospital. While at the hospital, his condition deteriorated rapidly. The records show that the Decedent suffered from many conditions, including Anemia, Thrombocytopenia (low platelet count), Hypokalemia (low potassium), Hyponatremia, Liver Disease, and severe dehydration. The Decedent's medical history, as provided by the Decedent and family members, show that the Decedent had a known history of alcohol abuse. In addition, he had been suffering from bouts of diarrhea, nausea and vomiting in the weeks leading up to the fall. Finally, the Decedent had been observed to be jaundiced, frail, and weak.

At the hearing, fellow employee Fred Mogridge testified the Decedent had some health issues in the months prior to the fall. (Hr'g Tr. 29) Further, Mr. Mogridge testified he noticed the Decedent's color had changed and that he was losing weight. (Hr'g Tr. 29) In addition, he testified the Decedent was slow moving and had some problems with his body control, particularly his bowel control. (Hr'g Tr. 30)

Gene Lane, the Decedent's supervisor, testified as well. Mr. Lane testified he had noticed the Decedent's health rapidly deteriorating over the months leading up to the accident. (Hr'g Tr. 41-42) He further testified to the fact that the Decedent had lost a significant amount of weight and became slow moving. (Hr'g Tr. 42) Mr. Lane was not on location on the date of the fall. Decedent died as a result of his injuries on February 27, 2016.

QUESTIONS PRESENTED

- I. Whether The Commissioner Properly Denied Benefits After He Reviewed The Record As A Whole And Properly Applied The Facts To The Applicable Case Law Regarding Idiopathic Falls?**
- II. Whether The Hearing Commissioner Properly Excluded Certain Evidence As Matter Of Law And Fact And Whether The Single Commissioner Properly Weighed The Admissible Evidence?**

ARGUMENTS

- I. The Single Commissioner Properly Applied The Applicable Law To The Facts And Correctly Determined That Benefits Should Be Denied As The Appellant Failed To Meet Her Burden Of Proving Decedent Sustained A Compensable Injury.**

Respondents contend the facts surrounding the Decedent's fall are contradicted. The Decedent did not merely sustain a trip and fall, he suffered from an idiopathic fall. The proper case law when dealing with idiopathic falls is *Bagwell v. Ernest Burnwell Inc.* and related cases. Therefore, the Single Commissioner properly applied the facts to the law in his Order and Decision.

- a. The Commissioner properly applied the established law, *Bagwell v. Ernest Burnwell Inc.* as distinguished from *Nicholson* and *Barnes* and correctly determined by the preponderance of the evidence that benefits should be denied as the Appellant failed to meet her burden of proving a compensable death by accident.**

While Appellant contends the facts are not disputed, the basic facts surrounding the fall are in dispute and are the crux of this appeal. Respondents assert the Single Commissioner was

correct in applying the law from *Bagwell v. Ernest Burnwell Inc.* 227 S.C. 444, 88 S.E.2d 611 (1955) and related cases.

Respondents admit the Decedent stated to EMS and the Emergency Room doctor that he slipped and fell. However, his recollection of facts is inherently unreliable due to the traumatic brain injury he suffered. Appellant's own expert, Dr. Sribnick, admitted the Decedent suffered a traumatic brain injury (Def. APA p. 886). Respondent's expert, Dr. Vandersteenhoven, noted that in instances of traumatic brain injury often times a Decedent may have some short-term memory loss regarding the events surrounding the injury. (DEF APA 993) Therefore, while the Decedent stated he slipped and fell, his recitation of the facts may not have been accurate. The Decedent may have believed he tripped and fell, but as Respondent's medical expert noted, the potential retrograde or anterograde amnesia could have caused confusion regarding the facts of the fall. Respondents contend the Decedent likely was suffering from some of these effects. In support of that contention, the Decedent denied loss of consciousness. In contrast, Fred Mogride, noted in his testimony the Decedent was unconsciousness and that it took up to a minute to revive him. (Hrg. Tr. p. 31) Further, Josiah Fludd also testified the Decedent was unconscious after the fall. (Claimant APA Ex. p. 39)

Thus, Respondents assert the Decedent's statements are unreliable, especially when the sole eyewitness testified to facts in direct contrast to the Decedent's statement. As noted, Josiah Fludd testified he witnessed the fall. (Claimant APA Ex. p. 31) He testified he saw the beginning, middle and end of the sequence of events and that the Decedent collapsed and failed to break his fall. (Claimant APA Ex. p. 45) Therefore, since the Decedent's account of the facts is unreliable, this case is very similar to *Bagwell*. In *Bagwell*, there was only one eye-witness who testified the claimant in the case collapsed at work, which led to a head injury and

subsequent death. The eye-witness stated he did not see the entire incident but noticed the claimant as he was falling ridged towards the ground. He noted the claimant did not attempt to break his fall.

Bagwell is very similar to the case at hand. While in that case, the decedent died prior to giving a statement, the eye-witness was able to testify as to events surrounding the fall. Based on the witness and the rest of the record, it was determined the decedent suffered an idiopathic fall and that there was no causal connection to the employment. Here, Josiah Fludd was able to provide testimony to the facts surrounding the fall. While the Appellant tries to inflate the issue that Mr. Fludd's view of the Decedent was not completely unimpeded, the witness in *Bagwell* did not witness all the facts surrounding the fall in that case. Here, Josiah Fludd testified he saw the Decedent standing still from the thighs down, saw him begin to collapse, and saw him fall to the ground without attempting to break his fall. Respondents contend the Decedent had extensive medical issues, and the Single Commissioner properly concluded this fall was idiopathic and, therefore, had no relation to work.

b. The Commissioner properly distinguished *Bagwell v. Ernest Burnwell Inc.* from *Nicholson and Barnes* and properly applied *Bagwell* to the facts of this case.

Respondents take the position that *Bagwell v. Ernest Burnwell Inc.* is still good law, with regard to idiopathic falls. The Single Commissioner was correct in his reliance on this case and not relying on the cases Appellant relied on, *Nicholson* and *Barnes*. Those two cases are not precedential for idiopathic fall cases. In *Nicholson*, "the question in [the] case is whether a woman who sustains a non-idiopathic fall at her place of employment while performing a job function" has sustained a compensable injury. 411 S.C. at 383, 769 S.E.2d at 2. In that case, the claimant merely tripped and fell on the carpet on her way to a meeting. *Id.* The Court held this was a compensable claim since she was performing a job function. *Id.* at 390, 769 S.E.2d at 5.

The Court disagreed with the argument that the fall could have occurred anywhere, and therefore found the claim compensable. *Id.* However, in *Nicholson* there was no indication of an idiopathic fall, which distinguishes it from the case on hand.

Similarly in *Barnes*, the claimant merely tripped from an otherwise unexplained fall. The court distinguished this claim from an idiopathic fall claim. 411 S.C. 391, 768 S.E.2d 651 (2015). The court found there was no internal breakdown and, therefore, the claim was compensable as the fall arose out of the claimant's work. *Id.* at 393, 768 S.E.2D at 652. The court reiterated that "the idiopathic fall doctrine is based on the notion that an idiopathic injury does not stem from an accident, but is brought on by a condition peculiar to the employee that could have manifested itself anywhere." *Id.* at 396, 768 S.E.2D at 653. Since there was no evidence of an internal breakdown, other than the failed argument that the claimant was clumsy, the court distinguished this claim from the idiopathic falls cases decided earlier.

In our case, there clearly is evidence supporting the fact that this was an idiopathic fall. Numerous witnesses testified to the Decedent's poor health leading up to the date of the fall, the medical records corroborate the Decedent's condition, and the sole eye-witness testified the Decedent was standing still, collapsed, and failed to break his fall. Further, Respondents' medical expert stated to a reasonable degree of medical certainty that the fall was idiopathic in nature. (DEF APA p. 798)

II. The Commissioner Properly Excluded Certain Evidence From The Record While Correctly Weighing The Admitted Evidence.

Respondents assert the Appellant appeals numerous issues that were not timely objected to, including failing to respond to a subpoena and Josiah Fludd's deposition. Further, Respondents assert that all the medical evidence was weighed properly and that Nurse Crider's

report was properly excluded. Respondents contend many of these arguments are merely red herrings to distract from the crux of this appeal and were not properly appealed on the Form 30 pursuant to Regulation 67-701.

a. The Commissioner properly excluded Appellant's retained legal nurse due to her admission that she was not an expert in the area of causation.

Respondents contend that pursuant to Regulation 67-701, the Appellant is required in the Form 30 to specifically and concisely state the grounds for appeal. The Appellant's Form 30 failed to properly raise this issue. Therefore, Respondents request that the Full Commission not consider this appellate issue.

If the Full Commission decides to hear this issue, Respondents contend the Single Commissioner was correct in excluding the "expert" report. Appellant included two reports regarding causation in her APA evidentiary submissions. One was from Dr. Michael Sribnick, and Respondents did not object to that report becoming part of the evidence. The other report was from RN Donna Crider. However, Respondents did object to Nurse Donna Crider's report regarding causation from becoming part of the record.

Respondents submit the Single Commissioner made the proper determination to exclude the report based on Nurse Crider's own admission regarding her lack of qualifications rendering causation opinions.

In the course of discovery, Respondents noticed the deposition of Donna Crider. In response, she sent a letter to Attorney Dumas in which she stated:

My role in the Edmond Dillon [case] was that of a legal nurse consultant and not that of a testifying expert. My position is and has been to defer to treating physicians or medical doctors to make the determination of issues concerning causation. (Def. APA p. 0963)

That letter was submitted into evidence in the Respondent's APAs. Respondents argued to the Single Commissioner that Nurse Crider was not qualified to serve as an expert on causation and relied on her own letter regarding her qualifications to prove that point. After hearing both sides, Commissioner McCaskill excluded the evidence from the record; however, the Commissioner did allow the report to be proffered for review. Therefore, Respondents contend that this report was properly excluded as a matter of fact.

- b. The Commissioner did not err by failing to weigh the Appellant's medical expert, as the Commissioner considered the record as a whole and determined that the Appellant failed to meet the burden for a compensable claim.**

Respondents assert the Single Commissioner properly reviewed the record and determined that the preponderance of the evidence showed the Decedent did not suffer a compensable fall. Both medical expert's reports and depositions were submitted and properly included in the record.

Pursuant to Findings of Fact No. 24, the Single Commissioner reviewed the entire record. Therefore, it stands to reason that he reviewed both expert's opinions and depositions. In reviewing Appellant's medical expert's deposition, Dr. Sribnick agreed the Decedent suffered from liver disease, jaundice, Hyperbilirubinemia, Hypokalemia, Hypotrameia, severe dehydration, and anemia. (Def. APA p. 894-896) Further, throughout the deposition, Appellant's medical expert agreed that these conditions could result in confusion, vomiting, diarrhea, jaundice, dizziness, lightheadedness, and possible syncope.

In fact, both experts agree the Decedent was suffering from these conditions. (DEF APA p. 796-798) However, the only contradiction between the two experts is their final conclusion. Respondent's expert stated to a reasonable degree of medical certainty that the Decedent was suffering from these issues and that the Decedent had underlying issues that could lead to a

syncopal episode. (DEF APA p. 893-894). Appellant's expert stated in his report and reiterated in his deposition that the Decedent did not have any underlying conditions that would lead to a syncopal episode, despite admitting to all the noted conditions. (Claimant APA. p. 58)

Further, Appellant's expert relied on the Decedent's statements to the medical providers regarding his fall. (Def. APA p. 885) He relied on this despite the fact that the Decedent suffered a traumatic brain injury. Dr. Sribnick relied on the Glasgow Coma Scale to reiterate that the Decedent was in a state of mind to accurately relay what had occurred. (Def APA p. 890-892) However, as noted by Dr. Vandersteenhoven in his deposition, the Glasgow Coma Scale is not a test of memory; it is merely a test of consciousness. (DEF APA p. 995) Respondent's expert, Dr. Vandersteenhoven, also noted that often in cases of traumatic brain injury cases, the individual can suffer from anterograde or retrograde amnesia. (DEF APA p. 993-994) This means the individual who suffered from a traumatic brain injury may not be able to accurately remember what had occurred. They may believe they know what happened, but they likely may be incorrect.

Respondents argued the Decedent was not in a position to give reliable information after suffering from a traumatic brain injury. While he may have stated he tripped and fell, the Decedent also stated he did not lose consciousness. However, witnesses stated the Decedent did lose consciousness. The Single Commissioner relied on all medical evidence, including the expert reports and depositions, and properly determined by a preponderance of the evidence that the Decedent merely collapsed.

- c. The Commissioner did not err in giving weight to the deposition testimony of Josiah Fludd because the Respondents did not fail to produce documents pursuant to a subpoena.**

As with the arguments above, Respondents contend Regulation 67-701 requires the Appellant to state the grounds for appeal in detail in the Form 30. The Appellant's Form 30

failed to properly raise this issue. Therefore, Respondents request that the Full Commission not consider this appellate issue.

If in the alternative the Full Commission agrees to rule on the issue, Respondents contend that the Single Commissioner properly considered Josiah Fludd deposition. Appellant's contention regarding the subpoena brings in evidence outside the record. Based on the record, there is no evidence supporting the contention. In addition, Appellant has not provided the date or other relevant information to properly identify said subpoena.

If Respondents were to go outside the record as well, Respondents drafted a letter providing information in compliance with Appellant's subpoena dated July 21, 2015. In this response, Respondent's acknowledge that an investigative report was completed at that time, but refused to turn over the document due to its privileged nature.

Respondents present that they never received any correspondence from the Appellant regarding the omission of the investigative report in response to the subpoena; nor did the Appellant file any motion to compel. Further, Appellant failed to timely raise this issue in front of the Single Commissioner. Respondents assert that Appellant failed to timely correct any of these alleged issues. At the deposition of Josiah Fludd, Appellant failed to ask any questions to address their questions surrounding the investigation.

In addition, the Appellant not only failed to object to the inclusion of Josiah Fludd's deposition into the record, the Appellant, in fact, included the deposition transcript as part of their evidentiary submissions to the Single Commissioner, effectively waiving any right to review of this now-challenged evidence. (Claimant's APA Ex. P. 24-53)

For the forgoing reasons, the Respondents assert that the Single Commissioner properly considered and weighed the evidence in determining that the Decedent merely collapsed based on the single eye witness.

d. The Commissioner correctly considered the testimonial evidence of Josiah Fludd based on the proper nature of the deposition questions and the lack of a timely objection.

Similarly, the Respondents contend that pursuant to Regulation 67-701, the Appellant is required to state the grounds for appeal in detail in the Form 30. The Appellant's Form 30 failed to properly raise this issue. Therefore, Respondents request that the Full Commission not consider this appellate issue.

If the Full Commission agrees to hear this issue, Respondents assert that while conducting a thorough investigation, Respondents noticed the deposition of Josiah Fludd. The deposition was taken October 15, 2016. Mr. Fludd initially was questioned by Respondents, who asked the witness questions regarding the collapse on the date in question. This line of questioning was done prior to Fludd's own Affidavit being shown to the witness. While the attorney for the Appellant did object one time for a leading question, the attorney for the Respondents did rephrase.

In this line of questioning, without any objection, the witness testified the Decedent was merely standing still prior to his collapse and that he did not attempt to break his fall. The witness denied seeing the Decedent slip or trip. At this point, Fludd's prior Affidavit was shown to the witness. He testified that the Affidavit properly reflected his observations. Throughout this line of questioning, the attorney for the Appellant failed to object a single time.

Despite the contention that the substantive testimony was elicited pursuant to leading questions that were objected to, the number of objections throughout the deposition totaled one:

Q. Was he standing motionless before he collapsed? Standing Idle?

A. He was standing –

Mr. Dumas: Objection as to leading.

Mr. Cook: Okay. I'll rephrase.

Q: What was Mr. Dillon's physical movements at the time you saw him.

A. He was standing, just standing.

(Deposition continues without objection)

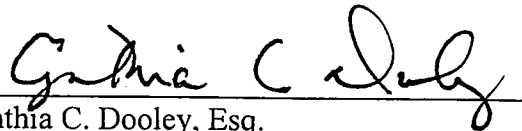
There were no other objections made regarding leading questions. Further, this issue was not raised to the Single Commissioner. Respondents contend the proper time to raise these objections was at the time of the deposition and the single commissioner level hearing. Respondents further contend the Commissioner properly considered the testimony of the only eye witness to the collapse of the Decedent as he made the determination to deny benefits.

CONCLUSION

The Single Commissioner in considering the record as a whole properly applied the evidence and the law in determining the Decedent merely collapsed at work as the result of conditions peculiar to him and, therefore, did not suffer a compensable injury.

For the foregoing reasons, Respondents respectfully request the Full Commission affirm the Single Commissioner's ruling below.

Respectfully submitted,



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May 1, 2017
Columbia, South Carolina

PROOF OF SERVICE

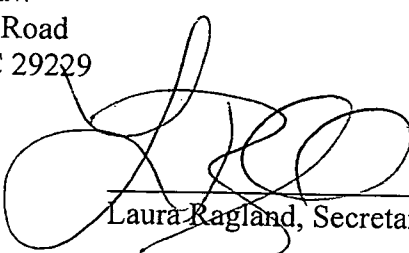
The undersigned certifies that she is an employee at TURNER, PADGET, GRAHAM & LANEY, P.A., and that the attached Respondents' Brief to the Full Commission were served upon Preston F. McDaniel, Esquire, and Brian Dumas, Esquire the attorney for the claimant, this 2nd day of May, 2017, in accordance with Regulations 67-210, 67-211, 67-213, 67-214, and 67-215 and such other law as may be applicable, by depositing a copy of same in the United States Mail, postage prepaid, addressed to:

Via E-Case Upload

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Laura Ragland, Secretary to Cynthia C. Dooley

BEFORE THE
 SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
 WCC FILE NO. 1501382

Edmund Dillon, Deceased,)
)
 Claimant,)
)
 vs.)
 FleetPride, Employer,)
)
 and)
)
 American Zurich Insurance)
 Company, Carrier,)
)
 Defendants.)

TRANSCRIPT OF PROCEEDINGS

August 30, 2016

This hearing was held before
 Commissioner Gene McCaskill, reported by Kimberly T.
 Power, Court Reporter and Notary Public in and for
 the State of South Carolina; said proceedings were
 held at the South Carolina Workers' Compensation
 Commission, 1333 Main Street, Columbia, South
 Carolina, on August 30, 2016.

KIMBERLY T. POWER, CCR (803) 622-9057

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1	CONTENTS	
2		PAGE
3	WITNESS: APRIL PATRICIA DILLON	
4	Direct Examination by Mr. Dumas	17
5	Cross-Examination by Ms. Dooley	23
6		
7	WITNESS: FREDRICK ALLEN MOGRIDGE	
8	Direct Examination by Mr. Priddy	27
9	Cross-Examination by Mr. Dumas	34
10	Redirect Examination by Mr. Priddy	39
11		
12	WITNESS: EUGENE GREGORY LANE	
13	Direct Examination by Mr. Priddy	40
14	Cross-Examination by Mr. Dumas	44
15	Redirect Examination by Mr. Priddy	52
16		
17	Certificate of Reporter	54
18		
19		
20		
21		
22		
23		
24		
25		

1 THE COURT: Today's date is
2 August 30, 2016. This is Workers' Compensation
3 Commission File Number 1501382. This is the case of
4 Edmund Dillon, Deceased vs. FleetPride. The carrier
5 is American Zurich Insurance Company. The claimant
6 is represented today by Brian Dumas and the
7 employer/carrier are represented by Cynthia C. Dooley
8 and Samuel Priddy, IV.

9 All right. The date of accident is
10 February 23, 2015. The claimant has an average
11 weekly wage of \$1,263.35, corresponding compensation
12 rate, which I believe is the max rate --

13 MS. DOOLEY: Yes, Your Honor.

14 THE COURT: -- for 2015 is \$766.05.
15 I am reading that from Ms. Dooley's pre-hearing
16 brief, Mr. Dumas. Would you stipulate that that is
17 correct?

18 MR. DUMAS: That is correct, Your
19 Honor.

20 THE COURT: Thank you very much. All
21 right. Are there any objections to jurisdiction,
22 venue, APA submissions, or any other item?

23 MS. DOOLEY: No, Your Honor.

24 MR. DUMAS: None, Your Honor.

25 THE COURT: In the pre-hearing

1 conference, there was an objection from Ms. Dooley as
2 to Pages 48 to 57 of claimant's APAs and it was --
3 and we did not go into it, but I think a correct
4 characterization would be a report from Donna Crider
5 who is an RN and I ruled that I was going to exclude
6 that from the APAs, but offered Mr. Dumas the
7 opportunity to proffer that and he is going to do so.
8 So we will consider that proffered.

9 Any other objections?

10 MR. DUMAS: No objections, Your
11 Honor.

12 THE COURT: All right. Very good.
13 The Commission file becomes a part of the record with
14 the exception of self-serving declarations and
15 unstipulated medical reports.

16 We are here today, Mr. Dumas,
17 pursuant to a Form 52 that you filed on behalf of
18 your client. If you would, please, sir, place your
19 client's position on the record.

20 MR. DUMAS: Certainly. My client's
21 position is this was a work-related injury that
22 resulted in his death which is fully compensable. I
23 believe the evidence both from the medical records
24 that existed, the EMS records that existed concerning
25 his transport after the injury, and the statements of

1 the injured employee himself who ultimately died,
2 ultimately should be given the greatest weight by the
3 Commission and should result in a finding of
4 compensability for the full amount, including the
5 medical bills attributed to his treatment and
6 associated with his death, along with the final
7 expenses. Those two items were not submitted at this
8 point in time because the issue at this point is
9 compensability.

10 THE COURT: So what you are seeking
11 today is a determination as to compensability?

12 MR. DUMAS: Yes, sir, Your Honor.

13 THE COURT: Very well. Ms. Dooley.

14 MS. DOOLEY: Thank you, Your Honor.

15 As we stated prior to the beginning of the hearing,
16 we really do understand that this is a very, very
17 unfortunate situation. Mr. Dillon was a friend,
18 co-worker that is greatly missed and we are truly
19 sorry for Ms. Dillon's loss and his family's loss
20 from an accident that occurred, unfortunately, while
21 he was at work, but that's where we have differing
22 opinions as to the facts of this case, Your Honor.

23 We contend that Mr. Dillon was an
24 extremely sick individual and he continued to work
25 through his sickness. The records will show that he,

1 unfortunately, was an alcoholic, that he was anemic,
2 that he had low platelet count. And I will butcher
3 the name of this, thrombocythemia, hypokalemia (low
4 potassium), hypernatremia (low sodium), liver
5 disease, and severe dehydration. All of these, Your
6 Honor, are found on Page 18 of the claimant's
7 submissions. The claimant's own expert admitted in
8 his deposition, beginning on Page D874, that this
9 gentleman did have these internal issues.

10 The witnesses from FleetPride, Gene
11 Lane and Fred Mogridge, will be here today to testify
12 before you that they noticed for some period of time
13 that Mr. Dillon was jaundice, that he was very slow
14 moving, and that he had difficulty standing from a
15 seated position, and that he was suffering from
16 vomiting and he had soiled himself from diarrhea.
17 They even asked him on numerous occasions if he
18 needed to seek medical attention, but Mr. Dillon,
19 being an extremely private individual, told them that
20 they weren't his mother and to mind their own
21 business.

22 Again, Your Honor, the records will
23 show, D54, that he did have a drinking problem and
24 that he was classified as an alcoholic. He actually
25 went to Providence Hospital, Providence PCP, for

1 treatment of that one year prior to this
2 February 2014.

3 When this accident -- when this fall
4 occurred, the claimant was on a smoke break and he
5 was in front of the company's premises and he
6 suddenly collapsed. According to the only
7 eyewitness, Josiah Flood, he was standing idle when
8 he suddenly fell backwards without breaking his fall.

9 Unfortunately, I've suffered several
10 of those type accidents myself. I know for a fact
11 that when I was falling backwards, I put my hand out
12 and broke my left wrist and the second time it
13 happened, I broke my right wrist and it happens, but
14 it's human nature to break your fall unless you are
15 unconscious or passed out or, for some other reason,
16 you're suffering some other internal issues.

17 And that is exactly what we're saying
18 that by human nature had he been walking forward and
19 tripped, then the forward motion would have impelled
20 him in that direction, a forward motion, and that he
21 would have tried to break his fall. But in this
22 incident, he fell backwards without trying to break
23 his fall. The records show that he had no abrasion
24 to his arm or elbow or anywhere else to show that
25 that's what happened. Our expert, Your Honor, feels

KIMBERLY T. POWER, CCR (803) 622-9057

1 that he had a syncopal episode and that's what
2 happened.

3 After he fell, he was unconscious as
4 evidenced by Josiah Flood, the only eyewitness, and
5 then also by our witness, Fred Mogridge, who will be
6 here to testify before you, Your Honor. He was then
7 transported to Richland Memorial Hospital where his
8 health declined rapidly. And due to his compromised
9 medical condition, he died on February 27, 2015.

10 THE COURT: 27th?

11 MS. DOOLEY: 27th. Yes, Your Honor.

12 THE COURT: Thank you.

13 MS. DOOLEY: Our expert,
14 Dr. Vandersteenhoven, has years of experience, since
15 1992, of doing exactly what we asked for him to do in
16 this case, which was to take the medical records and
17 do a forensic pathology analysis. He's worked with
18 Richland County Coroner's Office, Lexington County
19 Coroner's Office and does this extensively. And you
20 will see his report, Your Honor, on Page 796 where he
21 draws the conclusion that, unfortunately, the
22 underlying condition is what caused Mr. Dillon to
23 collapse and eventually then his death.

24 Your Honor, we would argue that the
25 Bagwell case is right on point as far as our case is

1 concerned. In that case the evidence presented
2 showed through an eyewitness that the employee was
3 standing at a counter when he suddenly fell backwards
4 without attempting to catch himself and the Court
5 held that that was a non-compensable accident. And
6 that is what we are asking today, is that this is a
7 non-compensable accident, again, unfortunate.

8 You will hear, again, the claimant's
9 attorney discuss issues such as a ladder and other
10 comments that the claimant may have made to EMS, to
11 the hospital staff, but our expert also goes into
12 explaining that when somebody does have a traumatic
13 brain injury, that they can have amnesia of events
14 shortly before the accident and shortly after the
15 accident. And to show you how this is played out, is
16 that he was unconscious by two witnesses and he
17 denies that he was unconscious. So we say that that
18 should play into your understanding of what he told
19 the staff there.

20 Again, Your Honor, we feel that it is
21 an unfortunate situation, but we do not feel that
22 this is a compensable claim. Thank you.

23 THE COURT: Mr. Dumas, anything else?

24 MR. DUMAS: Just very briefly. The
25 bottom line, Your Honor, is this: I believe the more

1 recent cases which would come to the effect in terms
2 of applying the new test which is set up by
3 Nicholson/Barnes and Thomas vs. 5 Star would be the
4 cases that have both recently been heard by this
5 Commission in interpreting the situation as to falls.
6 And, in particular, Your Honor, those cases would be,
7 as I have attached my memorandum, Reames vs. QVC
8 which was an October 22, 2015 case interpreting those
9 actions having to do with an employee going up and
10 down steps to get to a work area where she slipped on
11 the stairs, jammed her right knee, compensability was
12 found. Another case working at the Richland County
13 Coroner's Office fell, injured shoulder and right
14 ankle. Both the appellate panel and the Commissioner
15 found compensability despite a seizure prior to the
16 fall and the Commission finding that the injuries to
17 the left shoulder would not have occurred without the
18 presence of just standard office furniture.

19 And, again, what you're going to find
20 in the APA record of this case, Your Honor, is very
21 simply, it was during late morning, there was rain,
22 which is within the record there was rain outside.
23 The one witness who was there, Mr. Flood, who they
24 continue to talk about and while they make a lot of
25 claims about Mr. Flood -- and there's a lot of back

1 and forth about Mr. Flood. When you actually get to
2 what Mr. Flood said, I call to the Court's attention
3 specifically Mr. Flood's testimony.

4 THE COURT: Is his deposition in the
5 record?

6 MR. DUMAS: It's in the record in our
7 APA, Exhibit 6, Pages 21 through 27 specifically, and
8 I call reference to it in a memo. When it's all said
9 and done, he was looking in the man's general
10 direction while filling out forms trying to keep the
11 water off of his pad as he's filling out the forms
12 with a partially obstructed view because of the
13 tailgate of his truck. He saw the man fall only
14 because he knew Ed because he had been buying parts
15 there for a while.

16 The fall -- the motion of the fall is
17 what drew his attention. Ed was just in his general
18 vision. No particular reason to watch him. He
19 admits that the fall drew his attention, watched him
20 fall. He rushes to give some assistance and then
21 things progressed from that point. He ultimately
22 admits -- and this is a lot of back and forth with
23 this man. All he knows is he saw him fall. He
24 doesn't know why. In the face of that, in the face
25 of Dr. Sribnick's information which is in our APA --

1 THE COURT: Who is this doctor?

2 MR. DUMAS: This is our expert
3 witness who we put in at medical evidence Exhibit 5,
4 Michael Sribnick, who reviewed the medical records of
5 the decedent who came to the conclusion and his
6 report is in at 58 through 63 of our APA and he comes
7 to the conclusion that there is nothing in the
8 medical records that suggests a fainting spell that
9 caused this fall. And, in fact, he grants great
10 credibility to those statements of the deceased
11 witness as reported in the medical records repeatedly
12 where he told the EMS -- where the decedent told EMS,
13 told the treating nurse, and the treating physician
14 at the ER, "I slipped and fell." Again, I think
15 we're, perhaps, belaboring the point. We need to, I
16 guess, just present our case, Your Honor.

17 THE COURT: Answer me two questions.

18 MR. DUMAS: Certainly, sir.

19 THE COURT: Am I going to hear about
20 a ladder? I've heard a couple of references to a
21 ladder.

22 MR. DUMAS: No, sir. You will not
23 hear about a ladder other than the purpose -- and the
24 reason I even bring it up is this: Generally there's
25 a fair amount of unreliability as to eyewitness

1 testimony. If I may point out, originally a report
2 was made that somehow got -- that got to the coroner
3 claiming that Mr. Dillon was on a ladder when he
4 fell, hitting his head, which then led to going off
5 to the hospital and dying. Ultimately that got
6 changed in the death certificate and that's in -- if
7 you look at the death certificate on Page 1 --

8 THE COURT: That's my next question.
9 The death certificate is in there?

10 MR. DUMAS: Yes. And the amended
11 which removes the reference to the ladder. That
12 simply is to point out the unreliability of
13 eyewitness testimony because what you also have, Your
14 Honor, is if you look at in our APA Item 13 at
15 claimant's Page 93 in our APA, what you find is very
16 simply there was a witness, John, who called in and
17 said that Mr. Dillon was walking back from his car,
18 slipped and fell, and there's a phone number. This
19 was reported on the 27th in their EDI reports. Well,
20 that witness said he saw him slip and fall. Now, the
21 phone number that's given doesn't trace back to any
22 numbers. It was a report that was apparently made to
23 the employer, for whatever reason was never followed
24 up at that point in time. And by the time I got
25 involved in the case, it was a dead number, unable to

KIMBERLY T. POWER, CCR (803) 622-9057

1 be traced, allocated, or identified with any single
2 person. But the person was named John and that's in
3 our APA at 93, the Exhibit No. 13.

4 THE COURT: What does the death
5 certificate list as the cause of death?

6 MS. DOOLEY: Subdural hematoma.

7 THE COURT: Subdural hematoma. Okay.
8 What else, sir?

9 MR. DUMAS: I believe that would be
10 it, sir.

11 THE COURT: Ms. Dooley, anything
12 else?

13 MS. DOOLEY: Just briefly, Your
14 Honor. The cases that claimant's attorney mentioned
15 had no internal breakdown, Nicholson/Barnes. The
16 only other case that he talked about, Thomas, that
17 the claimant hit furniture on the way down. So we
18 feel that those definitely are different from our
19 case. And we will have witnesses here, Your Honor,
20 to explain --

21 THE COURT: Hold on a second. My
22 screen just went blank. And your witnesses, you were
23 about to say?

24 MS. DOOLEY: Yes, Your Honor. The
25 12A that was originally reported with John, the

1 witness, we will have witnesses that will explain
2 that there was no John. That was misreported.
3 Again, these are just red herrings, Your Honor, to
4 keep you from the central facts of what we're talking
5 about here today.

6 THE COURT: Anything else?

7 MS. DOOLEY: No, Your Honor. Thank
8 you.

9 THE COURT: Anything else, Mr. Dumas?

10 MR. DUMAS: Nothing further, Your
11 Honor.

12 THE COURT: Call your first witness.

13 MR. DUMAS: I would call April Dillon
14 to the stand.

15 THE COURT: As you can see, there is
16 no cord. It's important that you speak up. The
17 lawyers need to hear you. This young lady is making
18 a record of the proceeding, she has to hear you. And
19 it's important that, of course, I hear you.

20 My second request, very simple. If
21 you're asked a yes or no question, please give us a
22 verbal yes or a verbal no answer. If you shake or
23 nod your head, she actually has to put that in the
24 record and then we would have to have some
25 clarification. That will just show it down and that

1 muddies the record. Yes or no keeps the record clean
2 not only for us here today, but for anyone who reads
3 it in the future. So if you could do that, I would
4 appreciate it.

5 THE WITNESS: Yes.

6 (APRIL PATRICIA DILLON, being first
7 duly sworn to tell the truth, testified as follows:)

8 THE COURT: Please state and spell
9 your full name for the record, ma'am.

10 THE WITNESS: April Patricia Dillon.
11 APRIL. P-A-T-R-I-C-I-A, P-A-T-R-I-C-I-A. Dillon,
12 D-I-L-L-O-N.

13 THE COURT: All right. Thank you,
14 Ms. Dillon. Mr. Dumas, your witness.

15 DIRECT EXAMINATION

16 BY MR. DUMAS:

17 Q. Ms. Dillon, you were married to Ed Dillon;
18 is that correct?

19 A. Yes.

20 Q. And at the time of his passing, you had
21 been married about how long?

22 A. Nine years, ten years.

23 Q. And at that point in time, did he have --
24 other than you, were there any minors living in the
25 house with you that were children of you or Ed?

1 A. No.

2 Q. So did Ed have any minor -- any dependents
3 other than you -- anyone other than you who was
4 dependent upon him for financial support?

5 A. No.

6 Q. All of his children were up and grown and
7 out of the house, correct?

8 A. Correct.

9 Q. All of your children were up and grown and
10 out of the house?

11 A. Yes.

12 Q. This was not the first marriage for either
13 of you, was it?

14 A. No.

15 Q. And at the time of Ed's passing, he had
16 been working for FleetPride or its predecessor named
17 company about how many years?

18 A. About 18 years.

19 Q. And during that time had he ever gotten,
20 to your knowledge, any unsatisfactory ratings?

21 A. No.

22 Q. Had he gotten regular raises?

23 A. Yes.

24 Q. As far as you knew, was everything fine at
25 work?

1 A. Yes.

2 Q. In the months prior to his passing, had
3 you noticed any particular changes in his behavior or
4 appearance?

5 A. No.

6 Q. At that point in time you worked -- he
7 worked as a counterman at FleetPride, correct?

8 A. Yes.

9 Q. And where were you working at that point
10 in time?

11 A. I was working at Harbor Seafood as
12 assistant manager.

13 Q. And about what were your hours at the time
14 through the months leading up to Ed's passing?

15 A. 4:00 to 10:00 or 4:00 to 11:00 p.m.

16 Q. So would it be fair to say he was on day
17 shift and you were on evening shift?

18 A. Yes.

19 Q. So tell me what happened in the, say, 30
20 days prior to February 23, 2015. Did you notice
21 anything different about Ed?

22 A. No.

23 Q. And on the 23rd, will you tell the court
24 how you became aware of a problem at work?

25 A. I got -- I got a message on my phone that

1 he was taken to the hospital.

2 Q. And you then went to the hospital?

3 A. Then I went as soon as I got the message.
4 I didn't immediately get the message. I went to the
5 hospital.

6 Q. And when you went to the hospital, will
7 you please describe for the Commissioner what you saw
8 when you were brought in to see Ed? What was Ed's
9 condition?

10 A. He was unconscious.

11 Q. Were you ever able to actually speak with
12 your husband?

13 A. No.

14 Q. And he then passed four days later; is
15 that correct?

16 A. Yes.

17 Q. And at that time and after that time,
18 without going into details, did you receive medical
19 bills associated with his treatment and care up to
20 and through his death?

21 A. I'm sorry. Can you repeat it?

22 Q. Did you get all of his medical bills?

23 A. Yes.

24 Q. And were there also funeral bills
25 associated with that?

1 A. Yes.

2 Q. Are you -- after the death, when he
3 passed, did anyone from the company ever call you to
4 speak to you about anything concerning Ed's death, to
5 explain how it may have happened or how it didn't
6 happen?

7 A. Not that I recall.

8 Q. And what, if any, calls did you get from
9 the company concerning anything?

10 A. I don't recall getting any calls.

11 THE COURT: Has anyone ever called
12 you from the company since his passing?

13 THE WITNESS: I'm trying -- I don't
14 remember anyone calling.

15 THE COURT: Any question you're
16 asked, if you don't remember, that's the answer. I
17 just don't remember. Thank you.

18 BY MR. DUMAS:

19 Q. And are you asking the Commission to find
20 this injury and his death compensable under the
21 statute?

22 A. Yes.

23 Q. And are you the sole -- his sole
24 dependent?

25 A. Yes.

1 Q. There are no children out there or adults
2 who were dependent upon him for financial support
3 other than you as his spouse, correct?

4 A. Correct.

5 MR. DUMAS: I have nothing further.

6 THE COURT: Just before I hear from
7 Ms. Dooley, just for the completeness of the record,
8 he has adult children?

9 THE WITNESS: Yes.

10 THE COURT: And how many children are
11 there?

12 THE WITNESS: Four.

13 THE COURT: Four adult children. Can
14 you tell me their names and ages to the best of your
15 knowledge?

16 THE WITNESS: Melissa is 27, Robin is
17 probably 32, and there's James and Steven. I don't
18 -- I don't know their ages. They're older than
19 robin?

20 THE COURT: They're older than Robin?

21 THE WITNESS: Yes.

22 THE COURT: And are all of them last
23 name Dillon?

24 THE WITNESS: Yes.

25 THE COURT: Thank you. All right.

1 Ms. Dooley.

2 MS. DOOLEY: Thank you, Your Honor.

3 CROSS-EXAMINATION

4 BY MS. DOOLEY:

5 Q. Ms. Dillon, as you heard me earlier, we
6 are extremely sorry that this incident did occur and
7 we truly wish that this had never occurred and I just
8 want to express our sympathy to you and your family.

9 A. Thank you.

10 Q. You testified earlier that y'all had been
11 married some, I believe you said, nine to ten years;
12 is that correct?

13 A. Yes.

14 Q. But actually y'all were married October of
15 2007; is that correct?

16 A. Yes.

17 Q. And if this accident happened in 2015,
18 y'all would have been married a little less than
19 eight years?

20 A. Sorry.

21 Q. That's okay. All right. And I believe
22 you testified that you worked in the evenings from
23 4:00 to 10:00 or 4:00 to 11:00?

24 A. Yes.

25 Q. And that your husband worked during the

1 daytime?

2 A. Yes.

3 Q. So you didn't see a lot of each other?

4 A. No.

5 Q. Is that correct?

6 A. Yes.

7 Q. And I believe when we spoke before, you
8 had not noticed that he had any jaundice color; is
9 that correct?

10 A. Not until I got to the hospital, yes.

11 Q. But do you admit that you told the folks
12 at the hospital that he was an alcoholic?

13 MS. DOOLEY: And, Your Honor, this is
14 on Page 24.

15 THE WITNESS: I don't recall saying
16 that.

17 BY MS. DOOLEY:

18 Q. But if the records reflect that you told
19 them he was an alcoholic, would you dispute that?

20 A. It's possible.

21 Q. So you do admit that he drinks?

22 A. Yes, he did.

23 Q. But you're not aware how much?

24 A. No.

25 Q. Because you were not there --

1 A. Correct.

2 Q. -- during the evenings?

3 A. Uh-huh.

4 Q. All right. And you didn't see each other
5 very much due to your work schedules; is that
6 correct?

7 A. Correct.

8 Q. And I believe you just testified that when
9 you got to the hospital, you didn't have the
10 opportunity to speak with your husband?

11 A. That's correct.

12 Q. And no one in your family actually got an
13 opportunity to speak with him; is that correct?

14 A. That's correct.

15 MS. DOOLEY: That's all I have, Your
16 Honor.

17 THE COURT: Anything else, sir?

18 MR. DUMAS: Nothing further.

19 THE COURT: All right. Other
20 witnesses, Mr. Dumas?

21 MR. DUMAS: We have no other
22 witnesses, sir. We have submitted the reports,
23 everything our APA, in addition to the testimony of
24 this witness would be our case.

25 THE COURT: All right. Ms. Dooley.

1 MS. DOOLEY: Yes, Your Honor. We
2 would call Fred Mogridge.

3 (Off the record.)

4 THE COURT: Ms. Dooley, Mr. Dumas has
5 asked about sequestering witnesses. Who is your
6 employer rep?

7 MS. DOOLEY: Gene Lane.

8 THE COURT: That's what I suspected.
9 And, of course, he is entitled to be here.

10 MR. DUMAS: I understand.

11 THE COURT: Let me give you a couple
12 of instructions before we begin, sir. The first is I
13 need you to speak up. There's no cord on that mic
14 and it's imperative that the attorneys, this young
15 lady who is making the record, and I all hear you.
16 So if you would speak up, that would be helpful.

17 And if you are asked a yes or no
18 question, if you would answer with a verbal yes or a
19 verbal no. That's clearer for us here today and it
20 would be clear for anyone who reads the record in the
21 future. If you shake or nod your head or say uh-huh
22 or huh-uh, one of the attorneys or I will probably
23 ask you to say is that a yes or is that a no. So if
24 you could just answer with yes or no, that would be
25 helpful. All right?

1 THE WITNESS: Yes, sir.

2 (FREDRICK ALLEN MOGRIDGE, being first
3 duly sworn to tell the truth, testified as follows:)

4 THE COURT: Please state and spell
5 your full name for the record, sir.

6 THE WITNESS: Fredrick Allen
7 Mogridge. FREDRICK, ALLEN, MOGRIDGE.

8 THE COURT: Thank you, sir. Mr.
9 Priddy, your witness.

10 DIRECT EXAMINATION

11 BY MR. PRIDDY:

12 Q. Mr. Mogridge, how are you today?

13 A. Fine.

14 Q. Where do you work?

15 A. FleetPride.

16 Q. How long have you worked there?

17 A. Twenty-three years.

18 Q. And what do you do for FleetPride?

19 A. I'm a machinist. I build drive shafts.
20 Shop supervisor.

21 Q. Where else have you worked in your
22 lifetime?

23 A. I've worked -- I was a volunteer rescue
24 squad in Sevierville, Tennessee and I've worked
25 several different jobs when I was younger.

1 Q. And you said you were a volunteer
2 firefighter?

3 A. Volunteer rescue squad which means we had
4 to take the EMS and all of that.

5 Q. So you kind of knew what you were doing
6 that day when the accident happened?

7 A. Yes, sir.

8 Q. You said you've been with FleetPride for
9 18 years?

10 A. Twenty-three years.

11 Q. I'm sorry. Twenty-three years. How long
12 had you known Mr. Dillon?

13 A. I've known Ed Dillon -- I've worked with
14 him 18. I've known him probably 25 or 26 years or
15 longer.

16 Q. And what position was Mr. Dillon at
17 FleetPride?

18 A. I worked with him for 18 years.

19 Q. Who position was he?

20 A. Pardon?

21 Q. What position was Mr. Dillon at
22 FleetPride?

23 A. Yes.

24 Q. Which position?

25 A. He was counter rep. Sales representative.

1 Q. And you said you had known him for 23
2 years?

3 A. Yeah, I knew him when he worked at Truck
4 Supply.

5 Q. Could you kind of describe your
6 relationship with Mr. Dillon?

7 A. Ed Dillon and I had a good relationship.
8 We also had a personal relationship. When his
9 daughters' cars would breakdown or anything, he would
10 call me and I would help him get the cars going. Or
11 when his personal car messed up, he always called me.

12 Q. And did you work with him on a daily
13 basis?

14 A. Yes, sir.

15 Q. And could you kind of describe
16 Mr. Dillon's health in the month leading up to the
17 accident?

18 A. Ed, he was a personal person. He didn't
19 want you to get involved. But Ed had some issues and
20 every time he had health issues, his color wasn't
21 right. It was like he was losing weight and stuff.
22 But every time you would say something to him, he
23 would tell you it was none of our business, that he
24 would handle it on his own.

25 Q. Any other issues going on that you

1 noticed?

2 A. Beg your pardon?

3 Q. Any other issues going on that you
4 noticed?

5 A. Just he was real slow moving and he -- a
6 time or two he had had a problem with his body
7 controls and stuff like that.

8 Q. You mean control with his bowels?

9 A. Control of his body emotions, yes.

10 Q. Had he fallen any at work?

11 MR. DUMAS: Objection, leading.

12 THE COURT: Rephrase.

13 BY MR. PRIDY:

14 Q. Why did you know him to be frail?

15 A. Just the way he moved.

16 MR. DUMAS: Leading. It
17 presupposes -- the way he rephrased that question
18 presupposes the answer.

19 THE COURT: All right. I'll sustain
20 that. Try again.

21 BY MR. PRIDY:

22 Q. Who other physical characteristics had you
23 noticed?

24 A. Ed was slow moving. He got to where he
25 moved very slow and he acted very weak.

1 Q. And what happened on the day of the fall?

2 A. I was working in the shop and I had
3 finished a dry shaft for a customer. The customer
4 went out, took his stuff and put it in the truck.
5 Then the door opened and he said, "This guy fell out
6 here." And the guy -- the customer was a good
7 customer of mine. His name was Joe. And I went out
8 and Ed was laying on the concrete unconscious.

9 I walked up to him, I knelt down, and I
10 noticed his head had -- he was bleeding on his head
11 and I hollered his name. It took me probably 15, 20
12 seconds, maybe a minute, to get him to wake up and
13 get him to come to where he knew me. And when I
14 finally said, "Ed," and he finally recognized, you
15 know, that I was talking to him, he tried to get up
16 and I wouldn't let him get up because I said, "Ed,
17 your head is bleeding. Lay still."

18 "No, I want to get up. I'm okay. Let me
19 up." And I said, "No, Ed. You are bleeding on your
20 head. You've hit your head." And he kept insisting
21 to get up and I said, "Ed, we can't let you up." I
22 said, "You fell." I said, "I called the ambulance."
23 He said, "I don't need that." He said, "I don't need
24 to go to no hospital. I don't need no ambulance."
25 He said, "I'll be all right." And I said, "Ed, no.

1 You've got to go to the ambulance -- go to the
2 hospital."

3 Well, when Candy called 911, he objected,
4 but he finally laid still. I never did let him get
5 up. And then when the ambulance driver got there, he
6 told the ambulance driver, he said, "I don't need
7 you. I don't need to go to the hospital."

8 Well the ambulance driver, he looked at me
9 and he said, "Are you his boss?" I said, "At the
10 immediate time, yes, sir, I'm his supervisor." He
11 said, "What do you want?" I said, "He needs to go to
12 the hospital." And they put him in the ambulance and
13 they took him to the hospital and I followed them.

14 Q. Were there any other witnesses to the
15 fall?

16 A. No, no.

17 Q. So you mentioned John. Do you --

18 A. Joe.

19 Q. -- know who that would be?

20 A. Joe.

21 Q. Josiah Flood; is that correct?

22 A. Pardon?

23 Q. Josiah Flood?

24 A. Josiah was the one that saw him fall.

25 Q. And you're not aware of any other

1 witnesses?

2 A. No, sir.

3 Q. And you didn't witness the fall, did you?

4 A. Pardon?

5 Q. You didn't witness the fall?

6 A. No, sir.

7 Q. And you said that his head was bleeding.

8 What part of his head was bleeding?

9 A. He was bleeding on the backside of his
10 head.

11 Q. The backside?

12 A. Yes, sir, right above his ear.

13 MR. PRIDDY: I have no further
14 questions. Thank you.

15 THE COURT: Let me ask you one
16 question before Mr. Dumas. When you came out -- when
17 you saw him, tell me how he was laying.

18 THE WITNESS: He was laying on his
19 side.

20 THE COURT: On which side?

21 THE WITNESS: On his right side on
22 the ground.

23 THE COURT: In A fetal position or
24 was he --

25 THE WITNESS: No, not hardly in the

1 fetal position, but his legs were curled and he was
2 laying up like that and he was unconscious.

3 THE COURT: And was his head bleeding
4 on that side?

5 THE WITNESS: On the side that hit.
6 I figured that's the side that hit. That's the side
7 that was bleeding.

8 THE COURT: But it was on that side
9 that he was laying on?

10 THE WITNESS: Yes.

11 THE COURT: Very good. Mr. Dumas.

12 MR. DUMAS: Thank you.

13 CROSS-EXAMINATION

14 BY MR. DUMAS:

15 Q. On that day it was raining, correct, sir?

16 A. The day -- when he fell, it wasn't
17 raining. It had clouded up, but it hadn't rained
18 yet.

19 Q. So you're saying it wasn't raining at or
20 about the time that he fell?

21 A. No, sir. It was cool out, but it wasn't
22 raining.

23 Q. So if Mr. Flood's testimony is it was
24 raining and that's why he was protecting his
25 paperwork, as he testified in his deposition, is he

1 in error or could you have, perhaps, made a mistake?

2 A. You need to ask that again.

3 Q. I guess my question is this --

4 A. What paperwork?

5 Q. Well, what was -- who was the man who came
6 in to tell you that Ed Dillon had fallen?

7 A. Josiah.

8 Q. Josiah who?

9 A. Josiah. That's how I've known him for
10 years, sir.

11 Q. How do you know it was Josiah -- and bear
12 with me just a moment, sir. How did you know it was
13 Josiah? Let me rephrase. What had Josiah been doing
14 just prior to coming in to tell you Ed had fallen?

15 A. He was putting his product that I had
16 prepared for him in his truck.

17 Q. And so, just hypothetically, if Josiah
18 says it was raining and he was protecting his
19 paperwork, did you just miss that it was raining at
20 the time?

21 A. If it was raining, it wasn't raining hard,
22 sir. It might have been sprinkling, but it wasn't
23 raining, raining. When you say raining, I think
24 rain.

25 Q. So you don't consider a sprinkle to be

1 rain?

2 A. If you say so.

3 Q. Well, sir, I'm just asking.

4 A. Okay. It was raining.

5 Q. All I'm interested in is what you
6 remember, sir, and that's really all I'm looking for.
7 This is not a battle here. I just want to know,
8 according to your recollection, was it raining?

9 A. It was not raining hard. If it was
10 raining, it was sprinkling.

11 Q. Would it be fair, then, to say you don't
12 remember whether it was raining or not?

13 A. Yes, sir.

14 Q. Okay. And if the weather report on that
15 day said it had been raining at about that time, you
16 wouldn't dispute that, would you?

17 A. I wouldn't object, no.

18 Q. Okay. And you wouldn't dispute that the
19 sidewalk outside on which you found Mr. Dillon was,
20 in fact, wet?

21 A. It wasn't that wet.

22 Q. Well, was it wet or not?

23 A. What do you call them wet, like the water
24 standing on it? Damp? What are you calling wet?

25 Q. Anything other than dry?

1 A. It was damp outside, so the sidewalk could
2 have been damp. There was no water standing on it.

3 Q. But it wasn't dry, correct?

4 A. Okay.

5 Q. In your experience are wet sidewalks more
6 slippery than dry ones?

7 A. The sidewalk was not slippery, sir.

8 Q. Well, that wasn't my question, sir. In
9 your experience in life, are wet sidewalks easier to
10 fall on than dry ones?

11 A. Yes.

12 Q. Thank you. And when you said you were his
13 supervisor --

14 A. I did not say I was his supervisor.

15 Q. Let me finish my question. Perhaps it
16 will help you. I believe what you said was, in
17 response to the EMS, you said at the time right now,
18 I guess I am the supervisor because the other
19 gentleman who is sitting over here with the lawyers
20 was, in fact, the supervisor, but he was gone from
21 the premises. So you were an acting supervisor,
22 correct?

23 A. Yes.

24 Q. Okay. And I just wanted to get that
25 clear. Okay. FleetPride, any of your supervisors or

1 if you're supervising an employee and you think they
2 are too sick to work or they are a danger to
3 themselves or others, you have the full authority to
4 send them home or to a doctor, don't you?

5 A. If they would go.

6 Q. So you mean to say that if you instructed
7 an employee to go home or go to a doctor and they
8 wouldn't go, you would leave them on the job?

9 A. Sir, if it were in my position and I
10 was -- it was an employee under me, I would insist
11 they go home. At this point in time, I didn't -- I
12 didn't suggest that because every time you mentioned
13 to Ed about being sick, he said, "Leave me home.
14 I'll handle it myself."

15 Q. And I guess my question to you, sir, is
16 you generally were not Ed's direct supervisor,
17 correct?

18 A. I told you that to start with. No, sir.

19 Q. But you did have employees under you at
20 FleetPride, correct?

21 A. Yes.

22 Q. And you had the full authority if you
23 thought they were a danger to themselves or others by
24 continuing to work because they were too sick or too
25 ill, you had the authority to send them home, didn't

1 you?

2 A. I had the authority to send them to my
3 supervisor and let him make that decision. Yes, sir.

4 Q. And on that day prior to the fall of Ed,
5 no one ever did that to Ed, correct?

6 A. Well, no, sir.

7 Q. No one sent him home or to an upper level
8 supervisor saying, "Ed, you're just too weak and
9 you're just too ill. Go home. Go to a doctor," did
10 they?

11 A. No, sir.

12 MR. DUMAS: Okay. I have nothing
13 further of this witness.

14 THE COURT: All right. Mr. Priddy.

15 REDIRECT EXAMINATION

16 BY MR. PRIDDY:

17 Q. I believe you told Mr. Dumas that you were
18 friends and mentioned that he should get some help;
19 is that correct?

20 A. Yes, sir.

21 Q. But what was his response to you?

22 A. Ed's response to me was he was a grown man
23 and I wasn't his mother and I didn't need to tell him
24 what to do.

25 Q. And you weren't going to force a friend of

1 yours to do something he didn't want to do?

2 MR. DUMAS: Objection. Leading.

3 MR. PRIDDY: Nothing further.

4 THE COURT: Anything else, Mr. Dumas?

5 MR. DUMAS: Nothing further, sir.

6 THE COURT: All right. Thank you,
7 sir. You may step down. Other witnesses, Mr.
8 Priddy?

9 MR. PRIDDY: We call Mr. Gene Lane.

10 THE COURT: You were present for
11 speak up and answer with yes or no, so I don't think
12 we need to go over that again. If you would do those
13 things, it would be appreciable.

14 THE WITNESS: Yes, sir.

15 (EUGENE GREGORY LANE, being first
16 duly sworn to tell the truth, testified as follows:)

17 THE COURT: Please state and spell
18 your full name for the record, sir.

19 THE WITNESS: Eugene Gregory Lane.
20 It's E-U-G-E-N-E, G-R-E-G-O-R-Y, L-A-N-E.

21 THE COURT: Thank you, Mr. Lane.
22 Mr. Priddy, your witness.

23 DIRECT EXAMINATION

24 BY MR. PRIDDY:

25 Q. Mr. Lane, where do you work?

1 A. FleetPride.

2 Q. And what position are you at FleetPride?

3 A. At the current time, I'm assistant
4 manager.

5 Q. Did Ed work for you?

6 A. He did.

7 Q. And how long have you worked at
8 FleetPride?

9 A. Thirty-two years.

10 Q. And how long have you known Mr. Dillon?

11 A. Probably 25, 30 years. Long time.

12 Q. And how many of those years had you worked
13 with him?

14 A. Eighteen or so.

15 Q. Did you work with him on a daily basis?

16 A. Yes, sir.

17 Q. Could you describe your relationship with
18 Mr. Dillon?

19 A. Well, we had a working relationship.
20 Aside from that, not very much.

21 Q. Did you ever do anything outside of work?

22 A. I did. I was in his wedding. And other
23 than that, I can't think of hardly any other
24 activities away from working.

25 Q. You said you saw him on a daily basis.

1 Could you describe his health leading up to the
2 accident?

3 A. Well, Ed had lost a lot of weight. He had
4 become fairly slow moving. He was still Ed, but his
5 weight loss, to me, was noticeable. He -- I didn't
6 notice the particular jaundice, but I knew that Ed
7 had a problem. Something was just not right with Ed,
8 but he wouldn't share with us what that problem was.
9 When we tried to encourage him to do something about
10 it, it was always I'll take care of it type thing.

11 THE COURT: Was that his general
12 personality or specific to his health?

13 THE WITNESS: No, that was pretty
14 much Ed's personality. It's not that he wouldn't ask
15 you for help, but it was very close-knit. He didn't
16 allow a lot of his personal side at work. I'd say
17 fairly -- I won't say business like. Everybody has
18 problems, but he never would talk about any problems
19 that he had. In prior years, he was very happy to
20 get married, you know. For me the noticeability was
21 the fact that his health had declined. He had lost a
22 lot of weight from when he first got married. He was
23 really a robust, vibrant person. But towards the
24 end, he had lost a lot of weight, was the big
25 noticeable thing to me. His jeans were new and they

1 just didn't fit. They were too big. Things like
2 that were noticeable to me, but I still didn't think
3 that it was as serious as what it actually turned out
4 to be.

5 THE COURT: Mr. Priddy.

6 BY MR. PRIDDY:

7 Q. Do you have any sort of medical background
8 at all?

9 A. Do I have a medical background? Is that
10 what you asked?

11 Q. Yes.

12 A. I have some issues, yes.

13 Q. No, no.

14 THE COURT: Are you a medical
15 professional, is what he means?

16 THE WITNESS: Oh, no.

17 BY MR. PRIDDY:

18 Q. I meant you wouldn't know how serious it
19 was?

20 A. I could give you some recitation about my
21 side of the story, but no. To answer your question,
22 no.

23 Q. So you wouldn't be able to really tell how
24 serious it was?

25 A. No, I would not be a doctor of any kind.

1 Q. But as you said, you could just kind of
2 generally tell, though?

3 A. You asked. I'm sorry. Yes, sir.

4 Q. Were you there on the day of the accident?

5 A. No, sir.

6 Q. Did you know of any witnesses that were
7 there?

8 A. The only one that I know of was Josiah and
9 he has -- I wasn't there. So everything that I know
10 is pretty much hearsay. It's just what I was told
11 that went on. I wasn't there that day. I was stuck
12 in Charlotte in the airport.

13 MR. PRIDDY: I have no further
14 questions. Thank you.

15 THE COURT: All right. Mr. Dumas.

16 CROSS-EXAMINATION

17 BY MR. DUMAS:

18 Q. Mr. Lane, you were the -- as you say, you
19 were basically the manager or the head guy on duty at
20 FleetPride on the day of -- or when Ed passed away,
21 correct, at about that time?

22 A. Yes, sir.

23 Q. You were basically running that location;
24 fair enough?

25 A. Yes, sir.

1 Q. And I guess my question to you is this:
2 I'm going to show you this would be Exhibit 13 in
3 claimant's APA. Looking towards the bottom of that,
4 and that would be Page, I believe, 93 Your Honor.
5 Can you tell me this is dated just to make things
6 quicker it's dated February 27, 2015 and there's a
7 report here that says, "Describe employee's
8 activities when injury occurred with details of how
9 the event occurred," would you please read that
10 entire paragraph to the judge?

11 A. It says here, "Describe the employee's
12 activities when injury occurred with details of how
13 the event occurred. He was leaving his car headed
14 toward the building when he tripped and fell hitting
15 his head knocking him unconscious as witnessed by
16 customer John at (803) 272-7497."

17 Q. Now, that report would have originally
18 come through you because it's your office, correct?

19 A. No, sir.

20 Q. Did you or anyone in your office or anyone
21 from FleetPride ever follow up on this report from
22 John with that phone number at that point in time?

23 A. That I can't answer.

24 Q. Well, you never followed up on it, did
25 you?

1 A. No, sir, I didn't. Nor did I file this.

2 Q. I understand. My question, though, is:
3 How is it if you keep saying Josiah Flood is the only
4 witness, where is John and how did this get into your
5 company records for the report of the accident? Why
6 doesn't it say Josiah Flood?

7 A. You're asking me that?

8 Q. Yes, sir.

9 A. I do not know.

10 Q. Because according to the other testimony
11 that we heard from Mr. Mogridge, his customer came
12 in -- a customer came in and reported the injury,
13 correct, because you weren't on the premises, right?

14 A. Yes, sir.

15 Q. Well, then, how does John become Josiah?
16 Any idea?

17 A. Do you want me to give you my speculative
18 idea?

19 Q. No, sir. Only if you know.

20 A. I don't know how John became in your
21 report. I do know the fellow that came in and talked
22 to Fred was Josiah and the fact that I have known him
23 for -- he's been a customer of ours for a number of
24 years.

25 Q. How do you know there was no John?

1 A. I don't know there was no John, sir.

2 THE COURT: Speak up, sir.

3 THE WITNESS: I don't know.

4 BY MR. DUMAS:

5 Q. And the reason I'm asking is this is in
6 your own company's report that you sent to the
7 Workers' Compensation Commission four days after the
8 accident saying the witness' name was John who
9 reported a slip and fall, correct? And you have no
10 idea how that could have been -- gotten into your
11 company records, do you?

12 A. I do have an idea, but you're asking me to
13 be speculative about it. I don't know for sure.

14 Q. I'm not asking you to speculate. My point
15 is -- I guess my question is: Who filled out that --
16 a company report like that had to come from
17 information, ordinarily, from your branch, correct?

18 A. (Witness nods head.)

19 Q. Is that a yes?

20 A. That's a yes, sir.

21 Q. Okay. So someone from your branch, three
22 days after, and that would have only been -- could
23 have only been you or Fred Mogridge, correct?

24 A. No, sir.

25 Q. Who else could it have been?

1 A. It could have been other people.

2 Q. But according to Mr. Mogridge, Josiah came
3 in and spoke to him, correct?

4 A. That's what he said.

5 Q. So how did the injury -- where did the
6 slip and fall disappear, I guess is what I'm asking?

7 A. I don't understand what you're asking.

8 Q. I guess the response would be you wouldn't
9 have any idea how it changed, would you?

10 A. How what changed?

11 Q. Well, the company reported on February 27,
12 2015 --

13 A. On that piece of paper you just gave me?

14 Q. On the piece of paper that the company
15 reported he slipped and fell while on the job,
16 correct?

17 A. Yes, sir.

18 Q. And at some point later, many months
19 later, it became different from that somehow,
20 correct?

21 A. (Witness nods head.)

22 Q. Is that a yes?

23 A. Yes, sir.

24 Q. And that was only after Ms. Dillon -- it
25 became known that Ms. Dillon was making a workers'

1 compensation claim, correct?

2 A. I have no knowledge of whether she was or
3 wasn't.

4 Q. Well, isn't it in part of the record
5 back -- the story changed after employees started
6 discussing Ms. Dillon had made a workers' comp claim?

7 A. Can you ask me that again?

8 Q. I guess my question is: How often did
9 Josiah Flood come to the store? I guess let me
10 rephrase it that way.

11 A. Not every day, but frequently.

12 Q. And I guess my problem with the whole
13 thing, and I'm asking you this question, sir: This
14 is supposed to be a regular customer, correct?

15 A. This is a --

16 Q. Mr. Flood?

17 A. Yes, sir.

18 Q. Who comes in, reports that your 17 year
19 employee, Ed, had smacked his head on the sidewalk
20 and he's bleeding, correct?

21 A. Yes, sir.

22 Q. That's not an every day event at
23 FleetPride, is it?

24 A. No, sir.

25 Q. And Ed then dies four days later. That's

1 not an every day event at FleetPride, correct?

2 A. That's true.

3 Q. And someone at your branch made a report
4 that he slipped and fell and y'all reported it that
5 way to the workers' compensation commission
6 apparently from that document, correct?

7 A. Yes, sir.

8 Q. And it wasn't until many months later that
9 suddenly and in that report y'all called the man
10 John, correct?

11 A. Yes, sir.

12 Q. And in that report four days after the
13 death, you called it he slipped and fell while at
14 work, correct?

15 A. Yes, sir.

16 Q. And it wasn't until several months later
17 the slip and fall kind of disappeared, right?

18 A. I can't answer that for you.

19 MR. DUMAS: I have nothing further.

20 I do apologize.

21 BY MR. DUMAS:

22 Q. One other thing, sir. You had the
23 authority as the supervisor at any point in time that
24 you noticed someone's health making their continued
25 work a danger to themselves or others to order them

1 to go to a doctor or go home, couldn't you?

2 A. Yes, sir.

3 Q. You never felt that Ed's health had gotten
4 to that point, did you?

5 A. No, sir.

6 Q. Because you didn't see him as a threat to
7 his own health, did you?

8 A. No, sir.

9 Q. And that's when you saw him every day,
10 correct?

11 A. Yes, sir.

12 Q. And you didn't see him as a threat to
13 others due to any illness or ailment or health
14 condition, correct?

15 A. We had no idea it was as bad as it was.

16 Q. In other words, there was actually no
17 physical manifestation to you either that alerted you
18 to any problem or, rather, to any severe problem of
19 Ed continuing on the job, correct?

20 A. No, sir.

21 Q. Because had you thought he was a danger to
22 himself, you would have sent him home or to a doctor
23 because he was your long-time friend and employee,
24 wouldn't you?

25 A. Yes, sir.

1 MR. DUMAS: Nothing further.

2 THE COURT: Mr. Priddy.

3 REDIRECT EXAMINATION

4 BY MR. PRIDDY:

5 Q. The report that Mr. Dumas mentioned, did
6 you fill it out?

7 A. No, sir.

8 Q. Do you know who filled it out?

9 A. Not directly.

10 Q. Do you believe that there was probably
11 some discovery done after the completion of the form?

12 A. I feel sure that there was.

13 MR. PRIDDY: No further questions.

14 MR. DUMAS: I'm going to object to
15 that as being hearsay.

16 THE COURT: Objection is noted.
17 Anything else?

18 MR. PRIDDY: No, sir.

19 THE COURT: Anything else, Mr. Dumas?

20 MR. DUMAS: Nothing further.

21 THE COURT: Thank you, sir. Any
22 other witnesses, Mr. Priddy?

23 MR. PRIDDY: No, Commissioner.

24 THE COURT: That's your case?

25 MR. PRIDDY: Yes, sir.

1 THE COURT: All right. That
2 concludes this proceeding. Thank you all.

3 (The hearing was concluded.)
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CERTIFICATE OF REPORTER

I, Kimberly T. Power, Court Reporter
and Notary Public for the State of South Carolina at
Large, do hereby certify:

That the foregoing proceeding was
taken before me on the date and at the time and
location stated on Page 1 of this transcript; that
the deponent was duly sworn to testify to the truth,
the whole truth, and nothing but the truth; that the
testimony and all objections made at the time were
recorded stenographically by me and were thereafter
transcribed; that the foregoing transcript as typed
is a true, accurate, and complete record of the
testimony and of all objections made at the time of
the examination to the best of my ability.

I further certify that I am neither
related to nor counsel for any party to the cause
pending or interested in the events thereof.

Witness my hand, I have hereunto
affixed by official seal this 25th day of October,
2016, at Lexington County, South Carolina.

Kimberly T. Power, Court Reporter
Notary Public
State of South Carolina at Large
My Commission Expires: 04/24/2025

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1501382

Edmund Dillon,)
)
Claimant,)
)
v.)
)
Raffles,)
)
Employer,)
)
and)
)
American Zurich,)
)
Carrier/Defendants.)
-----)

FULL COMMISSION HEARING

Monday, May 15, 2017
2:11 p.m. - 2:30 p.m.

The Full Commission Hearing was heard before Commissioners Susan S. Barden, Aisha Taylor, and T. Scott Beck, at the Workers' Compensation Commission, 1333 Main Street, Suite 500, Columbia, South Carolina, on the 15th day of May, 2017, before Sonia D. Wallace-Sanders, Court Reporter and Notary Public in and for the State of South Carolina.



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INDEX

<u>CALL TO ORDER:</u>	<u>PAGE:</u>
COURT REPORTER.	3

<u>ARGUMENT BY:</u>	
MR. MCDANIEL.	3
MS. DOOLEY.	11

<u>REPLY BY:</u>	
MR. MCDANIEL	15
Certificate	19

EXHIBITS

(There were no exhibits marked during the hearing.)

STIPULATIONS

It is stipulated and agreed that this deposition is being taken pursuant to the Administrative Procedures Act and the South Carolina Rules of Civil Procedure.



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CALL TO ORDER:

COURT REPORTER: Today is May 15th, 2017. This is South Carolina Workers' Compensation Case Number 1501382. This is the case of Edmund Dillon, Claimant, versus Raffles, Employer, and American Zurich, Carrier. The Appellant is the Claimant/Defendant, represented by Preston F. McDaniel. The Respondent is represented by Cynthia Dooley. Each side is allowed 10 minutes for oral argument and the Appellant three minutes in reply. You are requested to argue the grounds of exception and stay within the record.

COMMISSIONER BECK: Mr. McDaniel?

ARGUMENT BY MR. MCDANIEL:

MR. MCDANIEL: All right, Commissioner. May it please the Commission, first off, I want to -- I don't know how important y'all'll would find this, but in finding of fact in the notes that Commissioner made, Commissioner McCaskill made, he makes reference to the fact that there were records put in about a prior passing out event. And in his notes, he notes that he was under the impression that the -- if you'll find in fact -- find in fact number 6, he says that the



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1 Kershaw County Medical Center records are dated
2 February 4th, 2014.

3 **COMMISSIONER BECK:** Right.

4 **MR. MCDANIEL:** And he took that in consideration in
5 reference to the problems that the claimant was
6 having at that time, in reference to what the
7 clai- -- the defendants were alleging were a
8 pre-existing condition at the time of this.
9 However, in his Order you will find under
10 finding of fact number 6, which is found at
11 page 8, that he says that that was corrected to
12 say by -- in the Order to say that the
13 claimant's medical history and medical record
14 from Kershaw County Medical Center dated
15 February 4th, 1994 reports that the claimant
16 got up to go to the bathroom. And that's --
17 that's when the report was from, 21 years
18 before this. And it was taken into
19 consideration in many regard. But I just want
20 to note that because I think that's somewhat
21 emblematic about what I'm going to argue to
22 today, because this case really turns upon and
23 is based upon the claimant lived. The claimant
24 lived long enough to tell his story. And in
25 reference to what he told EMS and in what he



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1 told the nurse at the hospital and what he told
2 the doctors, as set out in my brief and I'm
3 going to go through that. Be- -- and, also the
4 report, the 12A, which is what my co-counsel
5 had at -- going throughout this entire thing,
6 in reference to what was being reported and
7 what occurred. I mean, this looked like a
8 clearly -- a compensable death injury at the
9 time this all came about. What you'll find in
10 going through my brief, number one on page 2,
11 you're going to find the EMS wrote at 11:11,
12 neurological condition at the time, level of
13 consciousness, alert. Neurological presence,
14 normal. Everything is normal. Glasgow Coma
15 scale -- Scale, totally normal. He is -- he
16 reports that -- he reports his problems, this
17 is all taken from the claimant, as the EMS
18 report, reports, that he had -- it was a work
19 related fall. All this information was taken
20 from the claimant. They arose at a road --
21 arrived at the hospital at 11:30. At 11:35,
22 the emergency room nurse -- the triage nurse
23 recorded that the -- Mr. Dillon arrived via
24 ambulance and at 11:30 eastern standard time
25 and at 11:35 eastern standard time, a nurse



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1 watched and recorded that patient tripped and
2 fell, MD at bed side.

3 **COMMISSIONER BECK:** Per EMS?

4 **MR. MCDANIEL:** Per EMS. And, also and then again,
5 but -- she notes specifically that MD at
6 bedside after that. Then the doctor, Dr. Ford,
7 recorded from Mr. Dillon that he states -- he
8 states that he slipped and fell, hit the back
9 of his head. Today he had mechanical fall, did
10 not have syncopal symptoms, denies any
11 headache, chest pain or shortness of breath.
12 I want to specifically note to the Commission
13 and in any of those records at that time, okay,
14 and this is something that was totally ignored
15 by this expert that they hired, but in other
16 words, this is a factual case. This is a
17 factual case from the standpoint of the issue
18 is, what happened to him. And my cli- -- our
19 client lived long enough that he was -- his
20 Glasgow Coma Score, at that time, those -- at
21 the time that that doctor took all of those
22 notes, his Glasgow Coma Score and he had all
23 his recorded vital signs and all of that, at
24 that time, when they took them at the hospital,
25 were totally normal. And he ---



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1 **COMMISSIONER BECK:** How do you reconcile that, Mr.
2 McDaniel, with a witness who was able to
3 observe your claimant from his head to his
4 thighs, and said that he saw no movement what-
5 so-ever, the claimant just fell over backwards?

6 **MR. MCDANIEL:** Well, Commissioner, first off that
7 goes back and forth. But how else -- the way
8 I reconcile that is, is simply this, as
9 compared to every other case and the Supreme
10 Court has said, the idiopathic fall concept is
11 an exception and it is to be narrowly
12 construed. Also, in these kind of cases,
13 Nicholson, the Court -- the Supreme Court also
14 said, that the Commission should look at the
15 evidence in the most favorable light to the
16 claimant. Of course, the burden of proof is
17 simply this, by preponderance of the evidence
18 if it slights -- if it, if it tilts ever so
19 slightly. But in this case as compared to any
20 of the -- any death case where we've had an
21 idiopathic fall, you're not going to find one.
22 I reviewed this in my brief. You're not going
23 to find an idiopathic fall case where the
24 claimant lived -- every one of those where they
25 died, they did not live to tell their story.



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1 And, so we have direct evidence, you know,
2 remember that we all look -- know the excited
3 utter- -- utterance. This man had no reason to
4 lie. This man had no reason to do anything
5 other than tell them what happened and he told
6 the EMS. We don't know, I agree with you,
7 Commissioner, whether or not he specifically
8 told the nurse, but, however, we do know he
9 specifically told the doctor and the resident.
10 They both recorded those notes, that he slipped
11 and fell. And that's how I -- if you look at
12 the totality of Mr. Fludd's testimony, what you
13 have is, Mr. Fludd was loading product in the
14 back of his truck. And you can see in those
15 two pictures the bay doors. He was loading
16 product outside of those bay doors into his
17 truck and he was in the rain and he was
18 hurrying to put paperwork into the dash of his
19 truck. And while he's doing this, he looks up.
20 Now, he's putting the paper on -- in his truck
21 and while he's doing this, Mr. Fludd looks up
22 or he's looking up. He, Commissioner, his view
23 was not focused on Mr. -- on what happened to
24 Mr. Dillon. It was focused on putting his
25 paperwork and he sees something. That's what



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1 he saw. And he goes back and forth in his
2 testimony, as I know Your Honor's aware having
3 read it, back and forth and back and forth.
4 And this is the reality of what we're really
5 asking, the defendants asked this Commission to
6 reverse this case on or in other words, to deny
7 this widow benefits. It's on a -- it's -- I
8 actually cited out on page, it's on page 7 of
9 my brief. Okay, but you were obviously busy
10 with what you were doing, correct? Yes. Okay,
11 were you actually watching him for that full
12 minute? No. How I was putting paperwork
13 inside my truck had me looking that direction.
14 Okay. So you were just kind of looking in that
15 per- -- general direction? Yes, sir. Okay.
16 And I assume the motion is what caught your
17 eye? Yes, the motion of the fall, yes. Now,
18 I'm not going to tell -- I'm not going to sit
19 here and tell you that you can -- if you'll
20 notice, defense counsel lead leading questions
21 that were aimed at and were objected to by my
22 co-counsel, but they were always, he collapsed,
23 he collapsed, he collapsed. You're gonna find
24 that when you ever get to all the testimony and
25 evidence from anybody else, you're gonna find



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1 that from the leading questions of a collapse.
2 You're gonna find, yes, he was able to see him
3 from his waist up. But what was he doing, what
4 was he doing at the time? He wasn't looking --
5 he wasn't standing there looking at Mr. Dillon.
6 What was he doing? He was putting his
7 paperwork -- it's raining, it's raining. He's
8 putting his paperwork so it won't get wet into
9 the truck. We're going to deny this widow
10 benefits based on that? Now, in addition, four
11 days later, I think this is critically
12 important, four days later, the employer sends
13 in a 12A, and you can find that 12A listed at
14 page 4. This is what the report -- the
15 employer reports to the insurance carrier, he
16 was leaving his car, headed towards the
17 building when he tripped and fell, hitting his
18 head. Knocking him unconscious as witnessed by
19 customer John at -- and there was a telephone
20 number. That telephone number is obviously
21 wrong because supposedly, you know, well
22 anyway, this -- they never contacted him
23 anyway. Now, this couples with another thing
24 that happened in this case, okay. So here we
25 go, four days afterwards, what the carrier



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1 should be relying on -- and look at Mr. Fludd's
2 statement, it was actually a prepared
3 statement. The first time he was talked to
4 about this thing was three months later. Three
5 months later. I can't remember what color
6 socks I had on yesterday, you know. There are
7 only certain events I can remember, but,
8 however, three months later and in a prepared
9 statement admitting which he's locked into, you
10 know, he has presented that. And couple that
11 with the fact that my co-counsel subpoenaed all
12 of the their discovery records, all the
13 investigator records and none were produced.
14 Thank you, Commissioner.

15 **COMMISSIONER BECK:** Thank you, sir. Ms. Dooley?

16 **ARGUMENT BY MS. DOOLEY:**

17 **MS. DOOLEY:** Thank you, Your Honor. First we would
18 like to take up some housekeeping issues as far
19 as scrivener's errors in the Order and submit.
20 And we have received approval to submit that,
21 if that was okay?

22 **COMMISSIONER BECK:** Mr. McDaniel?

23 **MR. MCDANIEL:** No objection, I -- yeah, those are
24 without objection. Cindy and I talked about
25 that.



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1 **COMMISSIONER BECK:** Cindy, just hand those up here,
2 please. All right, Ms. Dooley?

3 **MS. DOOLEY:** Thank you. First of all, the issue
4 that appellant counsel first addressed to you
5 was not in the Form 30, it was not briefed.
6 The date, that was changed, that was -- we
7 emailed claimant's attorney before the Order
8 was drawn to admit that in the notes from the
9 Commissioner that there was an error. So we
10 would ask you to disregard that since that was
11 not briefed, that's not part of the appeal.

12 **COMMISSIONER BECK:** Okay.

13 **MS. DOOLEY:** We feel that the crux of this case
14 really boils down to whether or not the single
15 Commissioner did apply the applicable law to
16 this case. It was an idiopathic fall. We gave
17 extreme amount of evidence, we had an expert
18 that testified as to the underlining condition
19 that Mr. Dillon had going on at the time. He
20 was extremely dehydrated, jaundice, had
21 multiple other conditions. Unfortunately, at
22 the time on the day that he had his injury,
23 revealed that these culminated and caused him
24 to collapse outside of the job. The eye
25 witness testified to that as you, Your Honor,



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1 had recalled. He said he saw him from hips up.
2 He was not moving. He didn't trip, trip you
3 normally fall forward, catch yourself. When
4 you slip you fall backwards. A human, a normal
5 healthy person, breaks their fall. This
6 gentleman did neither. He literally fell like
7 a tree, no attempt to break his fall. We say
8 that that sho- -- that's undeniable that that
9 was a collapse on his part, internal breakdown.
10 Unfortunately, it did happen at work and it's
11 not related to work, it could have happened
12 anywhere. And we do feel that the line of
13 cases that follow idiopathic falls, this is
14 right on point. And unfortunately, three days
15 later he did die. He had a traumatic brain
16 injury. Appellant counsel makes a big deal of
17 his statements, unfortunately, he had suffered
18 a traumatic brain injury. Our expert also
19 points out that you have antegrade and
20 retrograde amnesia following a traumatic brain
21 injury. And that he thought, maybe he thought
22 he was remembering the facts correctly, but
23 could have been very confused. He even noted,
24 at some point, that he had not lost
25 consciousness. We have two witnesses that say

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1 he did lose consciousness. Glasgow comma -
2 Coma Scores only test people's neurological,
3 whether they're alert. It doesn't test whether
4 their memory is correct or not. So, they make
5 a big deal about the Glasgow Coma Scores, those
6 have nothing to do with the -- to indicate
7 whether or not his memory was correct at the
8 time. Our witness -- our expert witness, who
9 is board certified forensic pathologist, that
10 does this type reconstruction to figure out
11 what went on, rendered an opinion that it was
12 a combination of his internal breakdown of his
13 body that caused him to collapse on that day.
14 Unfortunate, I hate it, I don't like it. I
15 know my people don't like it either that he had
16 this happen, but our folks at work had noticed
17 him for days and months ahead that he was
18 jaundice, that he was losing weight, he lost
19 body control was soiling himself. And they
20 even questioned him about it. And he said,
21 leave me alone. So, that can go even to why he
22 told the people what he told them at the
23 emergency room because he didn't want to admit
24 that he was having something internal unto
25 himself. But we definitely feel that the



1 single Commissioner did the correct thing in
2 his decision, made the correct decision. I
3 think he weighed all of the evidence that was
4 placed before him and came up with the correct
5 decision that this was an idiopathic fall. We
6 feel that the decision of the single
7 Commissioner should be affirmed.

8 **COMMISSIONER BECK:** Thank you, very much.

9 **MS. DOOLEY:** Thank you.

10 **COMMISSIONER BECK:** All right. Mr. McDaniel?

11 **REPLY BY MR. MCDANIEL:**

12 **MR. MCDANIEL:** Commissioners, I've tried to address,
13 but didn't quite -- ran out of time but in
14 other words, also in our brief we, of course,
15 assert the Duckworth versus First National.
16 In, you know, in reference to that 12A, they
17 had every right to investigate all that. They
18 should have produced, obviously, somebody took
19 that statement from Mr. Fludd. My counsel
20 subpoenaed that, it was never produced. Now --
21 -

22 **COMMISSIONER BARDEN:** Was there any kind of Motion
23 to Compel, or?

24 **MR. MCDANIEL:** No, there was not. There was not.
25 You know, in addition to that -- and something



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1 I want to, here again, point out, the old
2 saying, would've, should've, could've and you
3 know, well that would -- that could show you
4 why. That could do this, that could explain
5 this. That's not the law. I mean,
6 unfortunately, I have to come over here all the
7 time and make sure I've got a more probable
8 than not statement, but also something that has
9 not been pointed out in reference to this fall,
10 there are two bays here, there are two bays.
11 That's (indicating) where Mr. Fludd's truck
12 was, he's loading stuff in there. Looks what
13 -- what's right there, curb cut, right where
14 Mr. -- where his body was found or where he was
15 found lying. What happens when you step off of
16 a curb? Maybe ---

17 **COMMISSIONER BECK:** Aren't you violating the very
18 the rule that you accuse Ms. Dooley of
19 violating?

20 **COMMISSIONER BARDEN:** I ---

21 **MR. MCDANIEL:** I -- absolutely. Absolutely.
22 Circumstantial evidence, however, let's go back
23 to it and you're right. Let's go back to it.
24 What have they got other than a statement that
25 a man who is putting stuff in his truck, trying



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1 to avoid the rain, trying to prevent his
2 paperwork from getting wet. Now is that what
3 you want to rely on to establish that this
4 widow's not entitled to benefits? I mean, and
5 would we want to apply an exception to the
6 workers' compensation law, the idiopathic fall?
7 You know, we've got -- this man lived. He told
8 them he slipped and fell. Four days later,
9 they record that. They don't do anything to
10 investigate any of that. They could've taken
11 the EM doctor's deposition, they could've
12 challenged that. That is uncontested evidence
13 in the record, direct evidence from the
14 claimant, which you will not find in any other
15 idio- -- any other death case where the
16 idiopathic fall has been, has been applied.
17 You're not going to find it. I cited to you
18 the one case where, you know, there was similar
19 testimony about the guy falling and the
20 Commissioner awarded in that case because there
21 was just, you know, there was nothing to
22 countermand that, to establish. I go back to
23 this, it was at Harvard. Also the Commissioner
24 failed by excluding -- he excluded the
25 testimony of this legal nurse expert. I would



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1 ask you to reverse the decision or at least
2 grant us a new hearing.

3 COMMISSIONER BECK: Thank you, sir.

4 MR. MCDANIEL: Thank you.

5 COMMISSIONER BECK: That concludes this proceeding.

6 COMMISSIONER BARDEN: Y'all have a good rest of the
7 day.

8 COMMISSIONER BECK: Good to see everybody.

9 (There being nothing further, the hearing concluded
10 at 2:30 p.m.)
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Sabrina Kelley

From: Mediation@wcc.sc.gov
Sent: Tuesday, December 19, 2017 3:16 PM
To: MEDIATION@WCC.SC.GOV; AHAM@PFMCDLAW.COM; CRYSTAL@PFMCDLAW.COM;
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KHINKLE@SOWELLGRAY.COM; KKIBLIN@SOWELLGRAY.COM;
MROBERTSON@PFMCDLAW.COM; MWAYMER@SOWELLGRAY.COM;
PRESTON@PFMCDLAW.COM; ROSE@PFMCDLAW.COM; SABRINA@PFMCDLAW.COM;
SENLOE@SOWELLGRAY.COM
Subject: Christie Brooks v. Intertape Polymer Corp, WCC: 1419085

MEDIATION PROCEDURE

The review of the pleadings by the Judicial Department in this matter indicates this case is subject to mediation either by the order of the Commission pursuant to Reg. 67-1801, mandatory mediation pursuant to Reg. 67-1802, or by agreement of the Parties pursuant to Reg. 67-1803.

Please advise the Judicial Department at mediation@wcc.sc.gov of the name of the mediator and the date of mediation pursuant to Reg. 67-1804 within ten (10) days of receipt of this email.

Brian Dumas

From: Lindler, Kellie <klindler@wcc.sc.gov>
Sent: Tuesday, September 20, 2016 12:18 PM
To: Brian Dumas; Dooley, Cindy C.
Cc: CindyDooley-Group
Subject: Dillon Edmund - order instructions 1501382

Ms. Dooley please upload your APAs.
Mr. Dumas, we only have 158 pages of the APAs uploaded.

REQUEST FOR PROPOSED ORDER

This document is not an Order. It is a request for a proposed Order. The undersigned reserves the right to modify or delete any portion of this document.

WCC File Number: 1501382

Date of Hearing: 08/30/16

Place of Hearing: Richland County

CLAIMANT: Edmund Dillon , Deceased

EMPLOYER: Fleetpride

CARRIER: American Zurich Insurance Company

Claimant's Attorney: Brian
Dumas

Defendants' Attorney: Cynthia C. Dooley and Samuel V. Priddy IV

DOI: 02/23/15

AWW: \$1,263.35 CR: \$766.05

Court Reporter: Kimberly T. Power
PO Box 2403
Lexington, SC 29071
kimberlytpower@aol.com
803-622-9057

FINDINGS OF FACT AND DIRECTIVES

Mr. Dooley and Mr. Priddy, please draft the order consistent with the below findings and return to this office within 30 days.

1. The question at bar is whether the Claimant's death subsequent to a collapse at work arose out of his employment rendering the injury compensable?
2. The Claimant was at work on the morning of 02/23/15. While at work, he was injured when he fell and was transported by Richland County EMS to Palmetto Health Richland where he was hospitalized.
3. There is no dispute that the Claimant's death on 02/27/16 resulted from injuries he received when he hit his head in the fall on 02/23/15.
4. It is the Defendant's position that the Claimant suffered from many conditions, including Anemia, Thrombocytopenia (low platelet count), Hypokalemia (low potassium), Hyponatremia, Liver Disease, and severe dehydration.
5. The medical records indicate the Claimant has had a problem with alcohol.
6. As to medical history, a medical record from Kershaw County Medical Center dated 02/04/14 reports that the Claimant got up to go to the bathroom, had a coughing spell, felt dizzy and passed out hitting his head.
7. The medical note of Dr. Mark Jones/Dr. David T. Ford on 02/23/15 (date of injury) reports that the Claimant reported that he slipped and fell hitting the back of his head. Claimant also reported that he had not felt well for the last several days, had not been eating well and that he did notice that his skin had changed color (medical records from that day report that he was jaundice). He also reported that he had been vomiting and had diarrhea; and had not felt well that day.
8. On the day of his fall, the Claimant reported that he slipped and fell. He also reported that he did not lose consciousness.
9. The EDS report of the transport indicates that the Claimant was alert when they arrived, but that during transport his condition declined.
10. Sadly, the Claimant's physical condition deteriorated over the next four days; and on 02/27/15, the Claimant succumbed.
11. The Amended Death certificate, which is part of the record, lists the cause of death as "cardiopulmonary failure, subdural hematoma with mass effect, subarachnoid hemorrhage."

12. The question at bar – as to a determination of compensability - is whether the Claimant slipped and fell which is what he indicated to medical professionals on the day of his injury; or did he simply collapse and hit his head?
13. In either instance, that fall and the resulting head injury is the cause of death. That fact is not in dispute.
14. The Claimant was outside on break when he fell/collapsed.
15. While there was initially some confusion as to whether the Claimant was on a ladder and fell from that ladder, both parties agree that he was not on a ladder and his fall/collapse occurred while he was standing on the ground.
16. Josiah Fludd was a witness to the fall/collapse. The parties took Mr. Fludd's deposition on 10/15/15.
17. Mr. Fludd testified that, on that day, the Claimant was standing on the sidewalk beside Mr. Fludd's truck.
18. Mr. Fludd testified that he saw the Claimant collapse. He also testified that the Claimant did not try to break his fall nor did he attempt to brace himself in anyway.
19. Mr. Fludd testified that the Claimant fell backwards.
20. He further testified that the Claimant was not walking at the time; and he did not see the Claimant slip.
21. On cross-examination Mr. Fludd testified that he could not see all of the Claimant's legs; but he could see his thighs.
22. While Mr. Fludd could not testify as to whether the Claimant slipped, he did testify that the Claimant's thighs were stationary.
23. I have read the Mr. Fludd's deposition in its entirety. Mr. Fludd is simply a witness to the event. He does not stand to gain or lose based on his testimony in this case. I give his testimony great weight.
24. When I consider the record as a whole, I am not persuaded that the Claimant slipped or tripped.
25. I find that the Claimant simply collapsed. A review of the Claimant's medical history gives us insight as to why this could occur. There is medical evidence that the Claimant suffered from numerous conditions peculiar to him that could result in such an event.
26. This is a denied claim. The burden to prove there was a compensable injury rests with the Claimant. He must prove by a preponderance of the evidence that he indeed did slip and fall.
27. Here the Defendants have presented a persuasive case as to idiopathic injury which has no nexus to his work.
28. At the time of this event, the Claimant was on break outside. The Defendants have presented a witness that observes the event. While his line of sight is somewhat obstructed, he can see the Claimant from the head down to his thighs. This witness describes the event – he sees the Claimant falling backwards without any flailing or any attempt to break his fall. The witness describes an event that took place from a stationary position. He testified that the Claimant was unconscious. The Claimant stated to medical personnel that he did not lose consciousness. Candidly, whether he was conscious or unconscious is not dispositive of whether he slipped or just collapsed.
29. In this case, I am persuaded by the greater weight of the evidence that the Claimant suffered an idiopathic fall. The description of the event which the Claimant provides is given after he suffers an event so significant that it will lead to his death. It is also clear from the medical evidence that the Claimant is – prior to the fall – suffering from compromising medical conditions. The Claimant's statements at the time of his injury must be viewed through the lens of the events that day and his general physical condition on that day as well.
30. The Claimant's statement as to mechanism of injury must be viewed juxtaposed to the testimony of Mr. Fludd with consideration for the Claimant's general physical health at the time.
31. This case is distinguishable from *Nicholson and Barnes*. Here *Bagwell v. Ernest Burnwell, Inc.* is on point. The fact pattern in that case and this case are very similar. The Court stated in *Bagwell* that being at work was not enough to justify an award, but it must be shown "either that the cause of the

fall or the resulting injury bore some special relation to his work or to the conditions under which it was performed.” The Court further noted that “while the cause of [the employee’s] fall may be unexplained, the circumstances of his fall are fully covered by the testimony of eyewitnesses.”

32. Given the totality of the evidence, the Claimant has failed to meet his burden. As such, the claim is dismissed with prejudice.

INSTRUCTIONS: Please let our office know if you have difficulty obtaining a transcript or cannot complete the order within this timeframe. Draft the Order consistent with the above substance of the preceding Findings of Fact. You may also add additional Findings of Fact consistent with the above ruling. The Order should include biographical information regarding the Claimant’s work history and previous medical history, if relevant to the case.

If you need a transcript, order it **immediately** from the court reporter listed above. Provide a copy of the proposed Order to opposing counsel or *pro se* claimant before or at the same time one is submitted to the Commission.

When submitting the proposed Order to the Commission, please email only to klindler@wcc.sc.gov. The Commission no longer needs hard copies of the proposed order unless the claimant is *pro se*.

Matters to include in the Order:

1. APA Submissions
2. Stipulations
3. Statement of the Case (contentions of the parties – stated concisely)
4. Evidence of the Case (synopsis of the evidence – including testimony and medical reports)
5. Findings of Fact [numbered] (Do **not** delete any of the above findings.) The prevailing party may add to support the decision, except regarding credibility unless you have been so instructed.
6. Conclusions of Law (cite applicable statutory sections and case law)
7. Award

Do not address credibility in the Order, unless it has been addressed in the preceding Order Notes.

Commissioner Gene McCaskill
South Carolina Workers’ Compensation Commission
1333 Main Street
Columbia, South Carolina 29201

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THEIR Proposed Order due 7/13/17

Preston McDaniel

From: Hollmon, Eugenia <EHollmon@wcc.sc.gov>
Sent: Tuesday, June 13, 2017 12:05 PM
To: cdooley@turnerpadget.com; Brian Dumas (brian@briandumasattorney.com); preston@pfmcdlaw.com
Cc: cindydooley-group@turnerpadget.com; CRYSTAL@PFMCDLAW.COM
Subject: Dillon

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4#

Below is a request for a proposed decision and order.

**SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
REQUEST FOR A PROPOSED DECISION AND ORDER**

This document is not a Decision and Order. It is a request for a proposed order. The Commissioners reserve the right to modify and/or delete any or all portions of the submitted Decision and Order.

**Edmund Dillon v FleetPride
SCWCC: 1501382
Commission Panel: Barden, Taylor, Beck; Chair
Order Assigned to Commissioner: Beck
Court Reporter – Sonia Wallace – 803-252-3445**

Preston F. McDaniel
Cynthia C. Dooley

Claimant/Appellant
Defendants/Respondents

This matter was heard before the South Carolina Workers' Compensation Full Commission Appellate Panel during the last term of Review. The Commissioners considered the matter and **Affirm with Amendments** the decision and order of the Single Commissioner. On page 7 delete 1 of the Mr. Mogridge. On page 8 delete "?" in finding #1 and replace with a ".". On page 9 replace "jaundice" with "jaundiced". On page 11 finding of fact # 28 change too " While his line of sight was somewhat obstructed , he could see " On page 12 italicize "Bagwell" found in finding of fact # 31. On page 12 finding of fact # 32. Please include language that state "The parties stipulated by consent at the appellate hearing that the amended & revised order will be the language reviewed by the Panel.

Ms. Dooley please prepare a proposed order and submit to the Judicial Department within thirty (30) days of this notice. The proposed order shall be submitted in Word format to appeals@wcc.sc.gov and shared with each Party. Please make sure the Appellate Panel Decision and Order recites the specific Finds of Fact and Rulings of Law of the Single Commissioner's Decision and Order and reflects any comments requested by a Commissioner.

The signature page shall include a signature line for each Commissioner and the first signature should be the name of the Commissioner assigned the case as indicated above.

If you have any questions, please do not hesitate to email me at ehollmon@wcc.sc.gov or call at 803-737-5737

Judicial

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission
Appellate Panel

Appellate Case No. 2017-002124

Edmund Dillon, Employee, ... Appellant,

v.

FleetPride, Employer
And Gallagher Bassett as TPA for
American Zurich Insurance Co, Carrier, ... Respondents.

RECEIVED

JUN 08 2018

CERTIFICATE OF COUNSEL

SC Court of Appeals

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other materials.

Dated: June 8, 2018



Preston F. McDaniel
MCDANIEL LAW FIRM
1315 Elmwood Avenue
Columbia, SC 29201
(803) 771-7211

Attorney for Appellant