THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM SOUTH CAROLINA
SC Workers' Compensation Commission
Appellate Panel

Appellate Case No.: 2018-001237

Kenneth L. Barr, Claimant, ... Appellant,

v.

Darlington County School District, Employer,
and SC School Boards Insurance Trust,
Carrier, ...Respondents.

RECORD ON APPEAL
VOLUME III OF IV

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INDEX

I. ORDERS

Administrative Order, dated November 23, 2015 5

Temporary Restraining Order,
filed December 16, 2015 6

Administrative Order, dated December 23, 2015 10

Form 4 Order, dated December 28, 2015 12

Decision and Order, dated September 20, 2017 13

Final Decision and Order, dated June 5, 2018 61

II. PLEADINGS/FORMS

Form 50 (Filing a Claim), dated June 17, 2015 91

Form 27 (Subpoena) to Larry Stegner,
dated July 27, 2015 93

Form 50 (Request for Hearing),
dated September 29, 2015 94

Form 51, dated October 28, 2015 96

Motion to Compel, dated November 6, 2015 97

Reply to Motion to Compel,
dated November 13, 2015 101

Notice of Motion and Motion Pursuant to SCRCP,
Rule 65(f)(1), Summons and Complaint for Writs of
Prohibition and Mandamus, dated December 9, 2015 112

Motion for Dissolution of Temporary Restraining
Order, dated December 21, 2015 197

Motion for Reconsideration,
dated December 22, 2015 201

Motion to Compel, dated January 27, 2016 208

Reply to Motion to Compel, dated January 27, 2016 215

Form 27 (Subpoena) to Dr. Paul Pritchard and
Notice of Taking Deposition, dated February 17, 2016 .. 217

Form 58 Pre-Hearing Brief/APA Notice,
dated February 12, 2016 219

Form 58 Pre-Hearing Brief/APA Notice,
dated February 13, 2016 227

APA Notice, dated February 15, 2016 239

Memorandum of Objections to Specific Evidence
Sought to Be Introduced by Defendants at Hearing,
dated February 19, 2016 244

Motion to Compel, dated April 13, 2016 262

Form 50 (Requesting a Hearing), dated April 29, 2016 .. 266

Form 58 Amended Pre-Hearing Brief/APA Notice,
dated August 16, 2016 268

Form 58 Pre-Hearing Brief/APA Notice,
dated August 22, 2016 529

Form 30 (Request for Commission Review),
dated October 2, 2017 789

Appellant's Brief to the Full Commission,
dated November 10, 2017 800

Brief of Respondents, dated November 22, 2017 850

III. TRANSCRIPTS

Deposition Transcript of Marshall Alleyn
White, MD, dated November 23, 2015 899

Deposition Transcript of Roland L. Skinner, MD,
dated December 10, 2015 974

Deposition Transcript of Dr. Paul Pritchard,
dated March 3, 2016 1071

Deposition Transcript of Nicholas A. Lind, Ph.D.,
dated February 19, 2016 1201

Transcript of Hearing, dated August 31, 2016 1252

Deposition Transcript of R. Joseph Healy,
Jr., MD, dated September 27, 2016 1400

Full Commission Hearing Transcript,
dated February 20, 2018 1448

IV. DOCUMENTS

Letter to Commissioner Beck from Preston F.
McDaniel, dated November 24, 2015 1476

Letter to Scott Suggs, Clerk of Court,
dated December 16, 2015 1479

Letter to Preston F. McDaniel from
A. Camden Lewis, dated December 21, 2015 1480

Letter to Commissioner Beck from
Preston F. McDaniel, dated February 1, 2016 1481

Letter to Commissioner Beck from
Preston F. McDaniel, dated February 18, 2016 1483

Letter to Commissioner Beck from
Preston F. McDaniel, dated February 19, 2016 1485

Letter to Commissioner Beck from
Kirsten L. Barr, dated February 22, 2016 1488

Request for Proposed Order, dated November 17, 2016 ...1490

Letter to Commissioner Campbell from
Gerald Malloy, dated January 19, 2017 1495

Letter to Commissioner Campbell from Preston F.
McDaniel, dated September 18, 2017 1500

Email to Barbara Cheeseboro from Kirsten L. Barr, dated September 18, 2017 1507

Letter to Barbara Cheeseboro from Preston F. McDaniel, dated September 19, 2017 1508

Letter to Commissioner Campbell from Gerald Malloy, dated September 19, 2017 1511

Vote Sheets, dated February 20, 2018 1513

Letter to Commissioner Taylor from Preston F. McDaniel, dated April 10, 2018 1516

Certificate of Counsel 1519

1 Q Okay. And do you -- your opinion that
2 these were tension type headaches complicated by
3 analgesic rebound, is that opinion given to a
4 reasonable degree of medical certainty?
5 A Yes.
6 Q Okay. Did he ever come back to you
7 after November 15th, 2011?
8 A I saw him one more time. It was in
9 February of 2012.
10 Q All right.
11 MR. MCDANIEL: February?
12 THE DEPONENT: Yeah, February the 21st
13 of 2012.
14 MR. MCDANIEL: Okay.
15 THE DEPONENT: That appears to be the
16 last time I seen him.
17 MS. BARR: Okay. I'm not sure I have
18 that note. Do you mind if I -- thank you.
19 MR. MCDANIEL: Off the record.
20 (Off the record discussion.)
21 MS. BARR: We're back on the record.
22 BY MS. BARR:
23 Q You were kind enough to -- to help us
24 sort out some of the records and to get us copies
25 of your evaluation of February 21st of 2012. How

1 was Mr. Barr doing when you saw him on that date?
2 A He -- he said his headaches were
3 better, but he again, was taking narcotics for
4 another reason and I wasn't sure whether that
5 might have been the cause of his improvement.
6 Q Okay. Anything about his general
7 evaluation, examination or neurological
8 examination that revealed any objective problems
9 that -- that impacted your assessment or treatment
10 of Mr. Barr?
11 A Can you rephrase that? I'm not
12 really --
13 Q Yeah.
14 A -- sure.
15 Q Any -- did you find anything on your
16 neurological exam that was relevant?
17 A No. He -- he seemed to be about as he
18 always had been.
19 Q Okay. All right. What was your
20 assessment at that time? And I believe this was
21 your -- your last visit with Mr. Barr on February
22 21st of 2012?
23 A Well, I thought that he was stable. I
24 -- I felt like that there were psychological
25 factors that were playing a part in his headaches

1 and I recommended to him that he might want to see
2 a counselor about that. We decided to take him
3 off the Depakote at that point because we weren't
4 sure it was really doing anything. And then we
5 were going to follow him up in four months, but I
6 did not see him after that.
7 Q Okay. When you saw him on February
8 22nd of 2012, what would -- what did you believe
9 was causing his headache complaints?
10 A I -- I still thought they were tension
11 type headaches. And that there were -- he -- he
12 was -- was -- had the anxiety problems and I felt
13 like that might be playing a part in -- in his
14 headaches. And we really hadn't come up with any
15 other reasons for his headaches at that point.
16 Q Okay. Was there anything else in your
17 mind to exclude or to -- to work up or --
18 A Not at that time.
19 Q Okay. And your opinion that this was
20 a tension type headache with perhaps some
21 psychological impacts, was that your opinion, is
22 that opinion to a reasonable degree of medical
23 certainty?
24 A Yes.
25 Q Okay. Have you learned anything about

1 Mr. Barr since that time that causes you to doubt
2 or discount the opinion as stated in your February
3 21st, 2012 report?
4 A Well, I understand that he's developed
5 new and additional symptoms since that time. But
6 I -- I don't have -- I mean, I -- I don't have --
7 I have not seen him or examined him since that
8 time, so...
9 Q Okay. All right. And this maybe a
10 silly question, but what causes tension headaches?
11 A I -- I think that's one of those
12 64,000 dollar questions. I mean, it can be
13 associated with psychological or psychiatric
14 disease, such as depression and anxiety, but they
15 don't have to be associated. Stress plays a part
16 in almost all types of headaches. But in some
17 patients it just seems to be something they have
18 sort of like some people have hypertension, some
19 people have tension headaches. So, I don't know
20 that there's any one specific cause for them.
21 Q Okay. And the only thing you can do
22 is -- is to treat the symptoms?
23 A Yes.
24 Q Okay. Did you -- when you last saw or
25 at any time during your treatment of Mr. Barr, did

1 you feel like he had any evidence of physical
2 brain damage?
3 A Not at the time that I saw him.
4 Q Okay. And how -- how does a
5 neurologist go about assessing or evaluating a
6 person for suspected or alleged brain damage? Is
7 there a course of actions that you would take to
8 try to --
9 A Well, first, you would have to have a
10 presentation that suggested some particular area
11 of dysfunction. And it would depend on what that
12 was. I mean, if it was focal paralysis, I mean,
13 that would be one thing. A speech difficulty or a
14 language difficulty, that would be one thing.
15 Problems with memory, that would be one thing.
16 Q Well, what about the memory, how would
17 you -- is there a way to work up memory complaints
18 objectively?
19 A Well, you can assess memory on exam to
20 a certain extent by asking the patient to remember
21 some set of data. Usually, we use three unrelated
22 words or sometimes five unrelated words and have
23 the patient try to learn those words and repeat
24 them from memory after a period of time. But
25 there are -- sometimes when there is a suggestion

1 of a significant objective problem with memory we
2 will obtain more in-depth objective testing
3 usually by referral to a neuropsychologist or
4 someone who is trained to -- to do that specific
5 type of testing.
6 Q Okay. So, is the neuropsychological
7 testing the best way to objectively delineate
8 whether or not somebody has problems with working
9 or long term memory or --
10 A I think it is a way of sort of honing
11 down on what the problem is and where it's coming
12 from, yes.
13 Q Okay. All right. We talked a little
14 bit about serotonin syndrome and you didn't
15 believe that at least during the course of your
16 treatment with him that -- that he had evidence of
17 serotonin syndrome, but --
18 A There was never any evidence.
19 Q Okay. What -- what are the -- what
20 are the features or -- or symptoms of -- of
21 serotonin syndrome?
22 A Well, they can be -- there can be a
23 lot of things. But the common things are abnormal
24 movements, abnormal involuntary movements, changes
25 in orientation, sweating. There can be dizziness.

1 Sort of a combination of things and it usually
2 occurs acutely.
3 Q Okay. And something that if you took
4 certain medications or certain combinations of
5 medications that -- that you might be at risk for,
6 is that --
7 A Yes.
8 Q -- how it works?
9 A If you took a high amount of
10 medications that were stimulating the serotonin or
11 increased serotonin levels in the nervous system,
12 that would be --
13 Q Okay. Can I ask, if you had a patient
14 present and report that they were taking
15 Tizanidine, Tramadol, Prozac, Klonopin, Aspirin,
16 Lorcet, and Adderall, would you have any concerns
17 about potential side effects of those medications?
18 A List those again.
19 Q Yeah. Tizanidine or Zanaflex,
20 Tramadol, Prozac, Klonopin, Lorcet, and Adderall?
21 A You know, I mean, the only -- the only
22 two of those that are really serotonin specific
23 are -- are the Tramadol and Prozac. And I think
24 in usual doses you would not be that concerned
25 about serotonin syndrome with --

1 Q Okay.
2 A -- with that -- with those two drugs
3 used in combination. Now, if you were taking --
4 over taking the Tramadol or the Prozac, you know,
5 that would be another thing. But generally
6 speaking and the doses we usually use although we
7 do take -- you know, we are cautious about that or
8 -- and have that in mind, I think it's -- I think
9 it's unusual for them to produce serotonin
10 syndrome unless there be -- there not be useful of
11 it.
12 Q Okay. Are there other potential side
13 effects of these drugs, either individually or in
14 concert, that may be significant when somebody is
15 reporting symptoms such as poor concentration,
16 headaches, fatigue, confusion, disorientation?
17 Could those potentially --
18 A Well --
19 Q -- be side effects in any of those
20 drugs?
21 A Yeah. I -- I -- I think Adderall is a
22 drug that I try not to use in patients with
23 headaches because amphetamines can cause
24 headaches. Of course, narcotics if you're taking
25 -- over taking them, I think there is a danger of

1 changes in mental status, grogginess,
2 disorientation, that sort of thing. In the doses
3 that they're usually prescribed I don't think most
4 patients get that much of that. But I mean they
5 can obviously produce euphoria as well.
6 Q All right.
7 A You know, anytime you're using a whole
8 bunch of drugs that have different modes of
9 action, the potential for interaction is there. I
10 couldn't rule that out.
11 Q Okay. I think I'm almost finished.
12 But during the course of your work and assessment
13 of Mr. Barr, at any time did he ever complain
14 about his work environment impacting his headaches
15 or his symptoms?
16 A I don't recall that.
17 Q If -- Mr. Barr worked as a painter for
18 the school district. He's testified under oath
19 that at all times while he was painting indoors at
20 the school district he was working in a ventilated
21 area and was also wearing a respirator with both a
22 particulate -- particulate and a fume filter on
23 it. Would you expect that painting in a
24 ventilated area while wearing a respirator could
25 expose him to -- to anything that -- that might be

1 relevant to his complaints of headaches or his
2 other somatic complaints?
3 A I don't really feel qualified to
4 answer that question.
5 Q Okay.
6 A I'm -- I'm not an expert in industrial
7 medicine. And I mean those sound like appropriate
8 precautions, but as far as the chances of that, I
9 -- I don't think I'm really qualified to comment
10 on it.
11 Q Certainly. If that -- those were the
12 presenting complaints of the patient, would there
13 -- is there anything appropriate that you can do
14 as a neurologist to -- to work out and either rule
15 in or out some sort of environmental exposure as
16 being a cause of -- of symptoms like headaches or
17 memory loss or fatigue?
18 A We -- we probably seldom address that
19 specifically. But it is -- it's a difficult area.
20 Now, certain -- certain environmental, you know,
21 chemicals say or -- can be measured in -- in the
22 blood, but they aren't routinely measured by a
23 neurologist.
24 Q I guess, the -- the million dollar
25 question is what would you do with one of these

1 patients? I mean, I guess we talked about the
2 neuropsychological testing to -- to determine
3 that. Is there -- is there any other further --
4 A If -- if --
5 Q -- workup?
6 A -- the patient specifically expressed
7 a concern that something that he was being exposed
8 to in his work environment was causing some of his
9 symptoms, I'd first want to know, well, what are
10 you being exposed to? And then, you know, is the
11 symptom experienced in specific relationship to
12 the activity? That would -- that would be the way
13 I would -- I would address it.
14 Q Okay. Any particular testing other
15 than the neuropsychological testing that could be
16 done?
17 A Again, I'm not really an expert in --
18 Q That's fine.
19 A -- in that particular area. And, you
20 know, my understanding from -- from what reading
21 I've done on this and it's not a whole lot, but I
22 have done some reading in the area of
23 environmental medicine as it relates to neurology
24 is that, you know, there -- for a lot of these
25 industrial exposure types of things there are ways

1 to measure levels of certain -- of the chemicals
2 in the blood or it may be in -- in -- breathed in
3 breath.
4 Q Right.
5 A Like a breathalyzer type of thing.
6 And -- and some of them there aren't. And -- and
7 so, I think it -- it's -- that has always seemed
8 to me to be somewhat of a nebulous area in trying
9 to pin down, you know, an environmental exposure.
10 But I'm sure that they do occur.
11 Q Well, is there anything about -- if a
12 patient presents to you with -- with complaints of
13 headaches, memory loss, fatigue, confusion,
14 disorientation, is there anything about those
15 complaints that makes -- suggests to you that you
16 should make the link that there's been some sort
17 of toxic exposure or brain damage? I mean, are
18 there other potential causes other than toxic
19 exposure or brain damage for -- for those
20 complaints?
21 A Well, they're -- they're very
22 non-specific complaints.
23 Q Yeah. And similar to the complaints
24 that you saw Mr. Barr for as late as 2012?
25 A I -- I didn't -- and -- I mean, he did

1 not relate to me specific concerns that he had
2 that his symptoms were coming from his work
3 environment at that time.
4 Q Okay.
5 A And so, I did not investigate that
6 particular area because it was not really in the
7 focus of what we were doing.
8 Q Okay. And independently those
9 symptoms, would they lead you to -- to speculate
10 of such an exposure or a potential cause in his
11 headache? I mean, would it have been reasonable
12 to even go there if he's not complaining about it
13 just based on the symptoms?
14 A I don't think it would have really
15 crossed my mind.
16 MS. BARR: Okay. Thank you,
17 Dr. Skinner. I appreciate your time and your
18 patience.
19 E X A M I N A T I O N
20 BY MR. MCDANIEL:
21 Q Dr. Skinner, first off, how long have
22 you been practicing? I think --
23 A About 30 years.
24 Q About 30 years. Okay. So, as I know,
25 you're probably aware we basically done away with

1 lead based paint in house painting and gone to
2 water based paints. In the course of your
3 practice though have you had occasion to see
4 anybody with a heavy chemical lead toxicity or
5 mercury toxicity in the brain? You know, heavy
6 metals causing --
7 A I have seen several patients with
8 arsenic poisoning. I have never actually had a
9 patient -- I take that back. I've had a patient
10 who was diagnosed with encephalopathy from lead.
11 I didn't -- wasn't involved and, you know, it was
12 a diagnosis made --
13 Q Right.
14 A -- prior to my -- I've never seen
15 anyone who I thought had mercury poisoning. Now,
16 we have done heavy metals screens. It's a fairly
17 frequent test that we do in patients who have
18 certain types of neuropathy --
19 Q Okay.
20 A -- dysfunction of the peripheral
21 nerves.
22 Q But you said you have had several
23 exposed to arsenic poisoning?
24 A Yes.
25 Q In reference to the arsenic is there

1 much of a differential presentation between that
2 and the presentation we've talked about if it's
3 coming from an actual physical cause of that
4 arsenic being in the blood causing the headaches
5 versus --
6 A Well, I -- I don't know that I've ever
7 had patients with arsenic poisoning that
8 specifically presented with headaches. I mean,
9 they --
10 Q Okay.
11 A -- they usually present with a whole
12 host of -- of problems that can include not only
13 neurological, but gastroenterological problems and
14 sometimes cardiac arrhythmias.
15 Q Okay.
16 A And --
17 Q I'm sorry.
18 A And -- and generally progressing
19 neuropathy.
20 Q Another generalized question, how much
21 experience do you believe you've had in reference
22 to volatile organic compounds?
23 A I've not really had experience with
24 that.
25 Q All right. Let's go back to your

1 original record when Mr. Barr first came to see
2 you, if you don't mind. On the second page of
3 that I believe, let me find my copy, and I don't
4 see this anywhere else in the records, and correct
5 me if I'm wrong, but at least at that time under
6 social history your understanding was that he was
7 a handyman for the school district and he also was
8 a painter?
9 A Yes.
10 Q So, at that point in time you did not
11 know that he was a full-time painter, that was his
12 sole job with the school?
13 MS. BARR: Objection. That's based on
14 facts not in evidence --
15 BY MR. MCDANIEL:
16 Q Assuming this --
17 MS. BARR: -- it's speculative.
18 BY MR. MCDANIEL:
19 Q Assuming that, that is in fact true,
20 you did not know at that time that he was a
21 full-time commercial painter?
22 A I don't know that.
23 Q Okay. That's what I'm saying. So, in
24 other words, your basic understanding of his job
25 or social history at that time was that he was a

1 handyman and a painter?
2 A Yes.
3 Q And you knew that he said he had been
4 having intense headaches for about five weeks?
5 A Yes.
6 Q All right. Do you have anywhere in
7 there recorded that he had gone to work for the
8 district approximately a year before that?
9 A I don't think I did, recorded that. I
10 don't --
11 Q I want to ask you to assume the fact
12 to true also and that is this that they do the
13 majority of the painting for a better term, heavy
14 painting, when the kids are not in school during
15 the summer in reference to the commercial epoxy
16 type painting. Are you --
17 MS. BARR: Ms. Barr: Objection as to
18 the form.
19 BY MR. MCDANIEL:
20 Q I'm just going to ask you --
21 MS. BARR: Based on facts not in --
22 BY MR. MCDANIEL:
23 Q -- to assume that --
24 MS. BARR: -- evidence.
25

1 BY MR. MCDANIEL:
2 Q -- assume you --
3 MS. BARR: You don't have to talk over
4 me when I'm stating an objection for the record.
5 MR. MCDANIEL: Okay. That's fine.
6 MS. BARR: So, if you'd show me that
7 courtesy, I'd appreciate it.
8 MR. MCDANIEL: Okay. I apologize.
9 All right.
10 BY MR. MCDANIEL:
11 Q Now, I'm going to ask you to assume
12 that fact to be true. Okay? Now, I want to show
13 you some --
14 MR. MCDANIEL: I want to mark some
15 exhibits.
16 BY MR. MCDANIEL:
17 Q I'm going to show you a copy of --
18 MR. MCDANIEL: And mark this as
19 exhibit, whatever, 1.
20 (Claimant's Exhibit number 1
21 marked for identification.)
22 THE DEPONENT: You want to look at it
23 first or --
24 MS. BARR: Yeah, if you don't mind.
25 Thank you.

1 BY MR. MCDANIEL:
2 Q I'd submit for the record that these
3 are all material data safety handling sheets that
4 we obtained from the district that they produced
5 for us. Now, in reference to that particular
6 material data handling sheet concerning product
7 name Anti-Graffiti coating clear. Okay? Doctor,
8 if you'd look down on routes of exposures under
9 section three, what are the two routes of
10 exposure?
11 A Inhalation and eye or skin contact.
12 Q In other words, eye or skin contact
13 with the product?
14 A With the product, yes.
15 Q Vapor or spray. Is that correct?
16 A Yes.
17 Q Okay. Now, on page two, toxicological
18 information. Under chronic health hazards, what's
19 the warning there in reference to on the second
20 reports of associated?
21 A It says reports of associated,
22 repeated, and prolonged overexposure to solvents
23 with permanent brain and nervous system damage.
24 Q Okay. And this is the warning under
25 that material data. You -- you've had a chance to

1 review this here and you're familiar with material
2 data safety handling sheets, aren't you?
3 A Not really.
4 Q Hazards --
5 A No, sir.
6 Q In reference to hazardous products?
7 A I probably have seen them before.
8 Q Okay. All right. Now, I want to show
9 you another document.
10 MR. MCDANIEL: Mark that as exhibit 2.
11 MS. BARR: May I see it?
12 MR. MCDANIEL: Sure.
13 (Claimant's Exhibit number 2
14 marked for identification.)
15 BY MR. MCDANIEL:
16 Q All right. In reference to that
17 material data safety handling sheet, would you
18 mind also in reference to routes and exposure,
19 it's inhalation from vapor or spray, mist, also
20 eye or skin contact with the product, vapor or
21 mist, spray mist?
22 A Yes.
23 Q Okay. And on page three of that
24 document under toxicological, under chronic health
25 hazards, would you mind publishing what the first

1 chronic health hazard is from that product?

2 A It says reports associated repeated

3 and due to overexposure to solvents with permanent

4 brain and nervous system damage.

5 MR. MCDANIEL: Now, I'm going to ask

6 you mark this. I'll let you just hand me that one

7 and hand it back to me.

8 (Claimant's Exhibit number 3

9 marked for identification.)

10 BY MR. MCDANIEL:

11 Q In reference to that product, again,

12 under health hazard identification, routes of

13 exposure, there again, it's both inhalation of

14 vapor or spray mist, eye or skin contact with

15 product, vapor or spray mist. Is that correct?

16 A Yes.

17 Q All right. And I'm going to ask you

18 to flip to page two and under chronic health

19 hazards, would you mind telling me what -- in

20 association to permanent brain or neurological

21 system damage?

22 A It says basically the same thing,

23 reports of associated, repeated and prolonged

24 overexposure to solvents with permanent brain and

25 nervous system damage.

1 Q All right. I'm going to show you
2 another document.
3 MR. MCDANIEL: Mark it as number 4.
4 (Claimant's Exhibit number 4
5 marked for identification.)
6 BY MR. MCDANIEL:
7 Q Doctor, if you don't mind, on page two
8 of that document under health hazard data exposure
9 may be by inhalation or skin or eye contact
10 depending on conditions of use?
11 A Yes.
12 Q All right. Now, and also under that
13 same section it says that reports with associated
14 overexposure to solvents with permanent brain and
15 neurological system damage?
16 A Yes.
17 Q I'm going to show you another
18 document.
19 (Claimant's Exhibit number 5
20 marked for identification.)
21 BY MR. MCDANIEL:
22 Q And I believe on page two you'll find
23 that routes of exposure are the same, inhalation
24 of vapor or spray mist, eye or skin contact with
25 the product, vapor or spray mist?

1 A Yes.

2 Q And on page -- that same page I

3 believe you'll find under -- actually, on pages --

4 on page three under toxicological information,

5 chronic health hazards. Again, you'll find it's

6 -- that exposure, overuse or overexposure of these

7 solvents are associated with permanent brain

8 damage and nervous system damage?

9 A Yes.

10 Q Now, Doctor, assuming --

11 MR. MCDANIEL: I'm won't move for

12 admission as part of the deposition.

13 BY MR. MCDANIEL:

14 Q The -- so, at the time you first

15 started treating him, you did not know that he was

16 a full-time painter with the district?

17 MS. BARR: Objection. Form.

18 BY MR. MCDANIEL:

19 Q Assuming that's the truth?

20 A I -- I don't know that I did or

21 didn't, but there's no record that I did.

22 Q Okay. And there -- there's no -- you

23 did not know that for -- that in reference to

24 these material data safety handling sheets that

25 these are, in fact, produced to us from the

1 district, that these are in fact, the paints and
2 solvents that he was using on a daily basis, you
3 do not know --
4 MS. BARR: Objection to the form.
5 THE DEPONENT: No, I don't.
6 BY MR. MCDANIEL:
7 Q Okay. Now, do you, on an infrequent
8 basis, or do you refer to the National Institute
9 of Health on occasion, articles from them?
10 A I probably have had occasion to. I
11 don't know -- I don't remember specifically.
12 Q Right. I mean, are they a recognized
13 group? I mean, do you --
14 A Yes.
15 Q Are they submit -- the articles and
16 publications from those, are those generally
17 accepted among the medical community and the --
18 A Yes --
19 Q -- the neurologic --
20 A -- I think so.
21 Q -- community? Now, are you familiar
22 that particularly in reference to solvent
23 neurotoxicity and particularly volatile organic
24 compounds that we're talking about here in these
25 material data safety handling sheets, that

1 particularly in the area of painting that the
2 general -- in reference to general occupational
3 exposure, that in general exposure occurs by
4 inhalation of solvent vapor?
5 MS. BARR: Objection to the form.
6 There's no basis. Facts aren't in evidence.
7 BY MR. MCDANIEL:
8 Q But that in the area of -- but in the
9 area of painting according to the National
10 Institute of Health, would you disagree or agree
11 with this -- this statement.
12 MS. BARR: Objection to form. It's
13 based on facts not in evidence.
14 MR. MCDANIEL: That's right.
15 BY MR. MCDANIEL:
16 Q Dermal exposure is important in some
17 industries such as particularly painting. Dermal
18 uptake may contribute a significant fraction of
19 the to -- the total body burden of solvents in
20 workers exposed in these sectors contributing as
21 much as 50 percent of their total body burden.
22 Would you agree or disagree with that statement?
23 A I mean, I would accept their authority
24 in that area. I have no personal knowledge.
25 Q Okay. All right. Now, I believe

1 based on your previous testimony, and I'm going to
2 ask you, that really the differential between --
3 in many regards as far as tension, this article
4 goes on to state -- and let me just state this,
5 and it says that the -- it is really in the area
6 of occupational medicine if there's a suspicion
7 that it is really basically a ruling out process
8 in reference to other potential causes. And
9 you've referred to headaches can be caused by
10 tension headaches, migraine headaches, cluster
11 headaches. Of course, headaches can be caused by
12 neurotoxicity. Is that --
13 MS. BARR: Objection to the form.
14 BY MR. MCDANIEL:
15 Q Is that correct?
16 A Yes, that's true.
17 Q Okay. And in reference to -- even in
18 your reference to your assessment of Mr. Barr over
19 the time that you saw him it was a ruling out
20 process. Would that be fair to say?
21 A Yes.
22 Q Okay. Based on the -- the few
23 patients that you've seen with -- that had
24 headaches in reference to I believe you said
25 you've had some arsenic, and of course, they had

1 other problems, my understanding of your testimony
2 was, but is there really any difference in the
3 presentation there between for example, tension
4 versus migraine versus cluster?
5 A Well, there -- there are specific
6 criteria for -- that are used that are accepted by
7 the authorities.
8 Q Okay.
9 A And headache -- you know, that
10 specializing particularly in headache for
11 neurologists that are published. I don't remember
12 it's name exactly.
13 Q What types of headaches affect
14 attention, memory, fatigue?
15 A I think any type of headache can
16 affect those.
17 Q Chronic tension headaches, and I
18 believe you referred to one thing that can cause
19 those are high blood pressure or -- is that right
20 or --
21 A No. I -- I said that some people have
22 -- I was making sort of an analogy to --
23 Q Right.
24 A -- some people have one type of
25 medical, chronic medical condition and other

1 people have another and that's -- that's -- but I
2 don't -- I don't think tension headaches
3 specifically are related to hypertension, the
4 disease hypertension.
5 Q Okay. Outside of a brain tumor or
6 something like that, let's just sort of -- if you
7 can, can you tell me, we've got tension
8 headaches --
9 A Right.
10 Q -- correct? The migraine headaches,
11 cluster headaches. What other types of headaches
12 are there?
13 A The other -- the only other types of
14 headaches are headaches related to specific
15 pathological conditions of the cranium or brain.
16 Q Can you give us an example?
17 A Like headaches related to stroke or --
18 Q Okay.
19 A -- intracranial hemorrhage or some
20 people believe in sinus headaches. I'm not a big
21 proponent of that, but --
22 Q Right.
23 A Because I think they produce more of a
24 facial pain than real headache. But that's the
25 kind of --

1 Q And -- and basically in reference to
2 the types of headaches Mr. Barr was having and --
3 and -- and were chronic, they weren't like just
4 centralized to the sinus area or something?
5 A No.
6 Q Okay. In that first report he had,
7 had the M.R.I. and it showed micro vascular
8 ischemic changes. You -- you qualified that a
9 little bit when I say that you said they were in a
10 specific area?
11 A Well, they were --
12 Q Was I right on that?
13 A They were mostly in the frontal white
14 matter.
15 Q Okay. Does that tell you anything?
16 A Not really. I mean, they were so
17 non-specific in appearance. But no.
18 Q Based on your reading in the area and
19 your knowledge in the area of neurology, is those
20 white matter lesions or changes in reference to --
21 and I believe ischemia, doesn't that like mean a
22 slowing down of the blood flow?
23 A Yes.
24 Q Okay, in that area. And do you know
25 whether or not that organic -- volatile organic

1 compounds and/or encephalopathy caused by heavy
2 metals or that type of item, one reason they
3 attack the brain is that they increase the free
4 radicals and -- and the brain ischemia, in other
5 words, reduced oxygen and blood supply is caused
6 by those -- those chemicals?
7 MS. BARR: Objection to the form.
8 It's based on facts not in evidence and otherwise,
9 has no foundation.
10 BY MR. MCDANIEL:
11 Q I'm asking you --
12 A I -- I -- I don't know --
13 Q Okay.
14 A -- specifically on that.
15 Q Have -- did you know that the
16 existence of that type of damage being done to the
17 brain stems from, or one of the purposes of an
18 M.R.I. is to establish whether or not there are
19 such white matter lesions --
20 MS. BARR: Objection to the form.
21 BY MR. MCDANIEL:
22 Q -- ischemic -- ischemic changes?
23 MS. BARR: It's based on facts not in
24 evidence, calls for speculation.
25 THE DEPONENT: I -- I don't know. I'm

1 -- I don't --

2 MR. MCDANIEL: Okay.

3 THE DEPONENT: -- have expertise in

4 that particular...

5 BY MR. MCDANIEL:

6 Q In reference to -- we're talking about

7 chronic -- let me go ahead and ask you a few more

8 questions about your records, if we can. Let's

9 flip to -- you did say that on September 23rd, he

10 also said he was -- he had some difficulty with

11 work?

12 A Yes.

13 Q Do you have any idea what he was

14 talking about?

15 A I -- I do not remember --

16 Q Okay.

17 A -- looking at the documents.

18 Q He was reporting I believe at that

19 time memory loss and he was reporting fatigue and

20 dizziness. Is that correct?

21 A Yes.

22 Q All right. Now, let's flip over to --

23 and all of these records will be put into

24 evidence. He's also having problems with

25 concentration. How -- how much of a problem is

1 concentration in reference to tension headaches?
2 A Again, I think any sort of chronic
3 pain may affect one's ability to attend to details
4 of things, concentrate on tasks, sort of
5 non-specific symptom.
6 Q Flipping up to December 20th, he had a
7 C.T. scan, which really confirmed your previous
8 suspicions, there were no paraspinal, sinuses were
9 normal?
10 A Yes.
11 Q So, that would further indicate that
12 it wasn't caused from some kind of a sinus
13 problem?
14 A I never thought that had anything to
15 do with it.
16 Q Okay. Again, I see no additional
17 social history, is that correct, as far as like
18 further delineation of what he was doing or
19 anything like that?
20 A No.
21 Q Now, let's flip up to the record of
22 February 22nd. He -- he gives reporting of
23 feelings of confusion, disorientation and
24 forgetfulness?
25 A Yes.

1 Q Tell me in reference to sinus
2 headaches.
3 A I -- I -- again, I -- I never thought
4 his headaches were sinus headaches.
5 Q Oh, I'm sorry.
6 A But --
7 Q I --
8 A But from the standpoint of tension
9 headaches, I mean I would not have expected a lot
10 of disorientation with that, but I wasn't sure.
11 He was -- he was using the Nucynta. He also was
12 on the Nortriptyline. I didn't know whether
13 medications were playing a part in it. There were
14 -- there were a lot of different possibilities,
15 again, some -- somewhat of the non-specific type
16 symptom could go along with a lot of --
17 Q And again, really --
18 A -- possibilities.
19 Q Again, in fairness to everybody, we're
20 really talking about a ruling out process or
21 trying to find out what his -- really the cause.
22 Is that a fair statement?
23 A Yes.
24 Q I want to -- we didn't go over this
25 note and I have a handwritten note and I assume

1 it's probably from your staff of April 18th, 2011.
2 Your next visit is May 18th, but I have this
3 record too of April 18th.
4 A Okay. All right. I -- I have it.
5 Q I'm sorry?
6 A I'm sure you're going to ask me --
7 Q Well, the -- the reason I -- I -- I --
8 I remember in your testimony that in May you --
9 you testified -- you testified that you had
10 obviously increased his Nortriptyline from -- to
11 100 milligrams. I have a prescription back on
12 February 22nd for 50 milligrams. Would it be
13 reasonable that the increase came about at the
14 time of the April 18th note?
15 A I -- I don't know specifically whether
16 that is the case or not. It's possible. It's
17 possible.
18 Q The only reason I'm really asking that
19 is because in -- of course, he gave the report of
20 the problems he was having. He was continuing to
21 have a problem with headaches and he was also
22 having problems with confusion and disorientation
23 and forgetfulness.
24 A Actually, it looks like I increased
25 his Nortriptyline to 100 on February the 22nd.

1 Q Okay.
2 A It's -- it's -- it's right at the end
3 of my February 22nd note. It says in the
4 meantime --
5 Q Okay.
6 A -- I'm going to get an A.N.A., sed
7 rate, C.R.P. and thyroid functions. We will
8 increase his Nortriptyline to 100 milligrams a
9 day.
10 Q It's just funny how records just lead
11 to other questions. Could you -- here's -- here's
12 the prescription that he got on February -- that
13 came from your office?
14 A Yes. And he was get -- he was taking
15 two.
16 Q Oh, I see.
17 A It says two Q.H.S. That means two.
18 Q There we go. Now, I got it.
19 A That's -- that's --
20 Q Okay. So -- so, basically -- now --
21 but as of April -- in that April note you would
22 agree with me that headaches getting worse again?
23 A That's what he said, yes.
24 Q Okay. And then there was also some
25 question about whether or not there was any

1 reference to work. Obviously, having to go home
2 from work at that time --
3 A Yes.
4 Q -- he was reporting that? So, what
5 does that lead you to believe in reference to his
6 headaches were getting worse and he was having to
7 go home from work? When was that getting worse
8 occurring?
9 A Well, I don't -- I -- I don't know for
10 sure. I mean, his headaches -- he apparently --
11 his headaches were apparently affecting his
12 ability to -- to be at work. Whether they were
13 getting worse at work or whether they were just
14 worse in general, I don't think that's possible --
15 Q Really on May 18th I don't have any
16 really additional questions. You've pretty much
17 gone over that. And going forward to August 11th
18 -- 18th, he was beginning to have headaches almost
19 on a daily basis. And this is in spite of all the
20 medications that you prescribed him or the help
21 you were trying to provide for him?
22 A Yes.
23 Q By the way, we talked about
24 analgesics. Why was he taking those analgesics?
25 A Because he was having pain fairly

1 constantly.
2 Q Headaches?
3 A Yes.
4 Q Going forward to November 15th, 2011,
5 in reference to that, in reference to the history,
6 you specifically recorded that changes in
7 temperature, changes in atmospheric pressure and
8 certain smells will trigger the headaches?
9 A Yes.
10 Q Do you know whether or not these
11 paints smell?
12 MS. BARR: Objection.
13 BY MR. MCDANIEL:
14 Q Do you know that?
15 A I think they do.
16 Q Okay.
17 MS. BARR: Should we go into a list of
18 all things that smell?
19 MR. MCDANIEL: Well, you know, I think
20 I just want to go into right now what we've
21 established under the M.S.D.A. sheets.
22 BY MR. MCDANIEL:
23 Q Okay. Now -- and then of course,
24 throughout that you continue to believe -- but you
25 didn't have -- throughout the time that you had

1 this -- your diagnosis of tension headaches and
2 over this almost two year period, you didn't have
3 the information that he was a full-time commercial
4 painter?
5 A It wasn't in my focus, no.
6 Q By the way, I want to also --
7 A I did not know what he did --
8 Q Right. And --
9 A -- specifically --
10 Q -- you weren't --
11 A -- on a regular basis.
12 Q -- aware that on a regular basis he
13 was being exposed to these chemicals?
14 MS. BARR: Objection to the form based
15 on facts not in evidence.
16 THE DEPONENT: No.
17 BY MR. MCDANIEL:
18 Q Well, assuming that my client
19 testifies and I put in facts to establish that,
20 that these are the paints that he as using --
21 MS. BARR: Same objection.
22 BY MR. MCDANIEL:
23 Q -- you didn't know -- you didn't know
24 that at the time?
25 A No.

1 Q Okay. Now -- and you haven't seen him
2 since 2012?
3 A That's correct.
4 Q Would those facts have been important
5 to know at the end, after two years?
6 A Well, I'm not sure that I can
7 speculate that. I mean, he -- I mean, he had
8 headaches that were -- I mean, they certainly -- I
9 can't say that they couldn't have been related to
10 what he was being exposed to in his environment.
11 But it would have been -- there wasn't anything
12 specific about what he told me that would have led
13 me to believe that, that was causing the problem.
14 Q All right. Or that idea -- at that
15 time that he had any idea that, that would be what
16 was causing the problem?
17 A That's correct. He -- he did not
18 relate to me that he thought that was --
19 Q Okay.
20 A -- the cause of his problem. I don't
21 know that we specifically got into which smells,
22 what particular smells might have been -- you
23 know, and smells are -- strong odors of any type
24 are not uncommon triggers for headaches in
25 patients who have chronic headaches, so...

1 Q If subsequent to your treatment, about
2 a year later, somebody went in depth with that
3 with him, a doctor, and he then -- Mr. Barr was
4 taken -- was taken out of those -- those volatile
5 organic compounds, those paints that we referred
6 to, what would it tell you if his condition
7 improved?
8 A I -- I think one could --
9 MS. BARR: Objection to the form.
10 THE DEPONENT: -- assume it possibly
11 could have had something to do with his symptoms.
12 MR. MCDANIEL: Okay.
13 THE DEPONENT: Particularly in the
14 absence of any other reason for him to have
15 improvement.
16 BY MR. MCDANIEL:
17 Q And am I -- am I wrong that from the
18 beginning throughout at least a year or so there
19 was -- there was nothing specific as a cause of
20 his tension headaches --
21 A That's correct.
22 Q -- that you were able to identify?
23 A That's correct.
24 Q Would you defer to the opinions of
25 physicians that have continued to see him and know

1 his condition at this time --
2 MS. BARR: Objection. Calls for --
3 BY MR. MCDANIEL:
4 Q -- in expressing an opinion --
5 MS. BARR: -- speculation.
6 BY MR. MCDANIEL:
7 Q -- as to -- as to cause?
8 MR. MCDANIEL: I'm sorry.
9 MS. BARR: That's right. Objection.
10 It calls for speculation.
11 THE DEPONENT: I'm -- I wouldn't --
12 having not seen him or known his course since then
13 I wouldn't -- you know I wouldn't want to
14 speculate as to causes.
15 BY MR. MCDANIEL:
16 Q Okay. Let me see. I think I've
17 already asked this, but I want to make sure.
18 Ms. Barr asked you questions about his ventilate
19 -- that he used a ventilator inside. Did she say
20 anything or do you remember anything being said
21 about his exposure in reference to being exposed
22 to the mist, to his eyes, his skin being exposed
23 to these chemicals that we refer to?
24 A I don't recall a discussion about
25 that.

1 Q Okay. Any type of protective
2 clothing, any type of gloves, that type of thing?
3 A No.
4 Q And I believe your opinion was -- is
5 that at least during the course of your treatment
6 you didn't see any serotonin toxicity?
7 A No, I did not.
8 Q And stress on the body that you said
9 can aggravate and make it -- can cause headaches
10 and cause them to be worse both, I believe you
11 said that -- that stress on the body can cause
12 that. And that can be either physical or
13 emotional. Is that correct?
14 A Yes.
15 MR. MCDANIEL: Nothing further.
16 MS. BARR: Just briefly in follow-up.
17 FURTHER EXAMINATION
18 BY MS. BARR:
19 Q And, again, thank you for your
20 patience with us. When a patient comes to you and
21 says they have headaches, can you verify that, or
22 do you have to just take the patient at his word?
23 A I take the patient at his word.
24 Q In assessing a patient, do you have to
25 then -- are you ever concerned that maybe a

1 patient is complaining of -- of pain in an effort
2 to seek pain medications?
3 A I'm sure that occurs, yes.
4 Q Okay. And I guess there's really no
5 way to -- to rule that out as a possibility for
6 somebody who reports no improvement with any
7 medications?
8 A Beyond -- I mean, an intuition or, you
9 know, if there's demonstrable evidence that
10 they're getting drugs from a number of other
11 doctors or other sources or doing a toxicology
12 screen and finding that they're on some things you
13 don't expect on there, no.
14 Q Okay. Is that something that could be
15 addressed? You had suggested a psychological
16 evaluation for the psychogenic component of his
17 headaches. Is that right?
18 A Yes.
19 Q Could that also, a psychological
20 evaluation rule out any sort of secondary gain or
21 drug seeking behaviors that could be factoring
22 into this?
23 A I -- I don't -- I guess I don't know
24 how to answer that. I -- I think secondary gain
25 certainly would be addressed by psychological

1 profile of -- of a patient. Drug seeking itself,
2 I don't know. I'm --
3 Q Okay.
4 A -- I'm not a psychologist, so I'm not
5 really sure how they would determine that. Maybe
6 they could. I don't know.
7 Q Okay. Validity, secondary gain, and
8 even maybe somatic form disorder could be
9 addressed with the neuropsychological testing that
10 we discussed?
11 A Yes.
12 Q Okay. Is somatoform disorder
13 potentially a play here with Mr. Barr's case?
14 A I think so. It's possible.
15 Q Okay. And that's based on the
16 complaints he made to you about spinal tumors and
17 things like that?
18 A Well, yes. I mean, he was focused on
19 somatic symptoms. That doesn't necessarily make a
20 diagnosis of somatoform disorder, but it could be
21 a consideration. There again, that's really a
22 psychological diagnosis and I'm not an expert.
23 Q Okay. So, you -- you would consult
24 with a psychiatrist --
25 A Yes.

1 Q -- or a neuropsychologist to -- to
2 evaluate some of those?
3 A Or a general psychologist.
4 Q Okay.
5 A Yes.
6 Q And is that regular in your -- your
7 practice in -- in working out these types of cases
8 to -- to rely on psychologists and
9 neuropsychologists?
10 A In certain situations, yes.
11 Q Okay. You were asked repeatedly if
12 you knew like how frequently Mr. Barr painted. If
13 you knew he was less of a handyman and more of a
14 full-time painter, would it have changed your
15 evaluation or your treatment or your diagnosis of
16 Mr. Barr in the years you saw him?
17 A I don't think so. I -- in that -- in
18 the e--- in the absence of some specific evidence
19 to -- to suggest otherwise, I -- I mean, I know
20 that there are particular standards that are
21 supposed to be met when handling, you know,
22 dangerous things in a work environment. Having
23 worked in a paper mill in my past, I'm really
24 aware of that. So, I don't know that, that would
25 have necessarily changed what I did. I -- I was

1 trying to rule out the obvious neurological
2 contributors that seemed evident at the time.
3 Q Okay. And at any part during your
4 evaluation of Mr. Barr, did you see any signs of
5 encephalopathy?
6 A I did not, no.
7 Q Okay. How would you diagnose
8 encephalopathy?
9 A Well, encephalopathy, it means that
10 there is abnormal mental or cognitive functioning.
11 And they can be acute or chronic. When they
12 become chronic they are pretty much felt to
13 indicate dementia. When they're acute they are
14 somewhat more obvious and the patient becomes
15 acutely confused, disoriented, unable to function
16 in his environment on an acute basis. You know
17 when Mr. Barr saw me he was alert. He was
18 conversant. He was not -- did not appear to be
19 confused. He did not -- you know, his -- his
20 general conversation with me was appropriate and
21 -- and never really suggestive. Even though he
22 said that he had episodically some feelings of
23 being disoriented and that sort of thing, he did
24 not evidence that in my one to one communication
25 with him.

1 Q If -- say if, for example, he were to
2 come back to you and say I think I have toxic
3 encephalopathy, what would you do? What steps
4 would you take to either rule that in or out as a
5 potential cause of --
6 A Well --
7 Q -- his subjective symptoms?
8 A Well, I mean we -- well, first, I'd
9 have to know what toxins he was being --
10 Q Right.
11 A -- exposed to. And -- and --
12 Q And I guess --
13 A -- I mean, in general --
14 Q -- duration and --
15 A -- evaluation we -- I would want to
16 question him about -- in regard to his
17 orientation. I probably would be more specific
18 about that in -- in that generally speaking when I
19 assess someone's mental status, I do it as much by
20 how they answer the questions that I ask them and
21 that sort of thing as opposed to saying, okay,
22 what day is it? I might do that in certain
23 situations, but generally speaking I feel that I
24 can tell when I patient is, you know, alert and
25 appropriate cognitively as opposed to -- to not

1 being. So, if someone came to me and said I --
2 I'm -- I'm having, you know, trouble with my
3 memory, I can't remember things and that sort of
4 thing, I would probably, you know, have them try
5 to recall some words and that sort of thing. And
6 if it was a recurrent -- you know, a repeated
7 complaint then neuropsychological testing would be
8 the most appropriate way. Formal
9 neuropsychological testing would be the most
10 appropriate way.
11 Q Is there -- would it be appropriate to
12 even diagnose or describe encephalopathy as the --
13 the cause of collection of symptoms without that
14 formal neuropsychological testing? I mean, could
15 you do that with any degree of certainty?
16 A I don't think I would depend on what I
17 could do just on a -- on a visit basis. I think I
18 would -- I would want some objective -- objective
19 backing.
20 Q Okay. Do neurologists ever perform
21 neuro psych testing or do you leave that to the
22 neuropsychologist?
23 A They're -- they're generally -- it's
24 generally done by a neuropsychologist. I mean, I
25 have some little sort of brief tests that I can do

1 in my office, but they're -- they're pretty
2 rudimentary. And if they indicate a problem then
3 I would refer on to a psychologist.
4 MS. BARR: Perfect. Thank you so
5 much. Thank you, Dr. Skinner.
6 F U R T H E R E X A M I N A T I O N
7 BY MR. MCDANIEL:
8 Q I've got one question based on -- do
9 you know Dr. Avie Rainwater?
10 A Yes.
11 Q Who do you use locally for
12 neuropsychological testing? Who do you normally
13 use?
14 A I usually use Dora Windsorova. I have
15 used Avie's group. They don't do, in my
16 experience, quite as in depth of testing as
17 Dr. Windsorova does. But -- but I am familiar
18 with him.
19 Q But you have the upmost confidence in
20 either one of them?
21 A I -- I do. Avie is a very intelligent
22 and well trained and experienced clinician.
23 Q So, they're at least several
24 psychologists clinical -- I actually, believe all
25 of these people, we're talking about clinical

1 psychologist. Is that pretty much --
2 A Yes.
3 MS. BARR: Objection. Two is -- I
4 don't think you've identified a third.
5 MR. MCDANIEL: These people -- oh,
6 okay. I'm sorry.
7 MS. BARR: Several usually denotes
8 three.
9 BY MR. MCDANIEL:
10 Q The several -- the two people that you
11 referred to are -- are -- they're actually
12 clinical psychologists? And actually I believe
13 the term that generally the people that do
14 neuropsychologic testing are clinical
15 psychologists. Is that correct?
16 A Yes.
17 Q All right.
18 F U R T H E R E X A M I N A T I O N
19 BY MS. BARR:
20 Q Dr. Skinner, do you have any problems
21 with the M.U.S.C. Department of Neuropsychology or
22 testing done there?
23 A No.
24 MS. BARR: Thank you.
25 MR. MCDANIEL: Thank you, Doctor.

1 (Deponent excused.)
2 (Whereupon, at 4:44 p.m., the
3 taking of the foregoing
4 deposition was concluded.)
5
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1 CERTIFICATE OF REPORTER

2 State of South Carolina

3 County of Florence

4

5 I, Roger R. Williamson, Court Reporter and

6 Notary Public for the State of South Carolina, do

7 hereby certify that the deponent in the foregoing

8 deposition was, by me, first duly sworn to testify

9 to the truth, the whole truth and nothing but the

10 truth; that said deposition transcript was taken

11 via stenomask with backup; that the foregoing

12 transcript contains a true record of the

13 deposition of said deponent.

14 I further certify that I am neither attorney

15 nor counsel for, nor related to or employed by any

16 of the parties connected to the action, nor am I

17 financially interested in the action.

18 Witness my hand at Florence, South Carolina,

19 this the 20th day of December, 2015.

20

21 ______________________

22 Roger R. Williamson

23

24 Notary Public for South Carolina

25 My Commission Expires: March 18, 2022

MATERIAL SAFETY DATA SHEET

B97C150
06 00

DATE OF PREPARATION
Jul 19, 2014

SECTION 1 — PRODUCT AND COMPANY IDENTIFICATION

PRODUCT NUMBER
B97C150
PRODUCT NAME
Anti-Graffiti Coating, Clear
MANUFACTURER'S NAME
THE SHERWIN-WILLIAMS COMPANY
101 Prospect Avenue N.W.
Cleveland, OH 44115

CLAIMANT'S EXHIBIT
1

Telephone Numbers and Websites

Product Information	(800) 524-5979 www.sherwin-williams.com
Regulatory Information	(216) 566-2902 www.paintdocs.com
Medical Emergency	(216) 566-2917
Transportation Emergency*	(800) 424-9300
*for Chemical Emergency ONLY (spill, leak, fire, exposure, or accident)	

SECTION 2 — COMPOSITION/INFORMATION ON INGREDIENTS

% by Weight	CAS Number	Ingredient	Units	Vapor Pressure
18	64742-88-7	Med. Aliphatic Hydrocarbon Solvent		
		ACGIH TLV	100 PPM	1.27 mm
		OSHA PEL	100 PPM	

SECTION 3 — HAZARDS IDENTIFICATION

HMIS Codes	
Health	2
Flammability	2
Reactivity	0

ROUTES OF EXPOSURE
INHALATION of vapor or spray mist.
EYE or SKIN contact with the product, vapor or spray mist.
EFFECTS OF OVEREXPOSURE
EYES: Irritation.
SKIN: Prolonged or repeated exposure may cause irritation.
INHALATION: Irritation of the upper respiratory system.

May cause nervous system depression. Extreme overexposure may result in unconsciousness and possibly death.
SIGNS AND SYMPTOMS OF OVEREXPOSURE
Headache, dizziness, nausea, and loss of coordination are indications of excessive exposure to vapors or spray mists.
Redness and itching or burning sensation may indicate eye or excessive skin exposure.
MEDICAL CONDITIONS AGGRAVATED BY EXPOSURE
May cause allergic skin reaction in susceptible persons or skin sensitization.
CANCER INFORMATION
For complete discussion of toxicology data refer to Section 11.

SECTION 4 — FIRST AID MEASURES

EYES: Flush eyes with large amounts of water for 15 minutes. Get medical attention.
SKIN: Wash affected area thoroughly with soap and water.
If irritation persists or occurs later, get medical attention.
Remove contaminated clothing and launder before re-use.
INHALATION: If affected, remove from exposure. Restore breathing. Keep warm and quiet.
INGESTION: Do not induce vomiting. Get medical attention immediately.

SECTION 5 — FIRE FIGHTING MEASURES

1.44 lb/gal 173 g/l Emitted VOC

SECTION 10 — STABILITY AND REACTIVITY

STABILITY — Stable
CONDITIONS TO AVOID
None known.
INCOMPATIBILITY
None known.
HAZARDOUS DECOMPOSITION PRODUCTS
By fire: Carbon Dioxide, Carbon Monoxide
HAZARDOUS POLYMERIZATION
Will not occur

SECTION 11 — TOXICOLOGICAL INFORMATION

CHRONIC HEALTH HAZARDS
No ingredient in this product is an IARC, NTP or OSHA listed carcinogen.
Reports have associated repeated and prolonged overexposure to solvents with permanent brain and nervous system damage.
TOXICOLOGY DATA

CAS No.	Ingredient Name			
64742-88-7	Med. Aliphatic Hydrocarbon Solvent			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available

SECTION 12 — ECOLOGICAL INFORMATION

ECOTOXICOLOGICAL INFORMATION
No data available.

SECTION 13 — DISPOSAL CONSIDERATIONS

WASTE DISPOSAL METHOD
Waste from this product may be hazardous as defined under the Resource Conservation and Recovery Act (RCRA) 40 CFR 261.
Waste must be tested for ignitability to determine the applicable EPA hazardous waste numbers.
Incinerate in approved facility. Do not incinerate closed container. Dispose of in accordance with Federal, State/Provincial, and Local regulations regarding pollution.

SECTION 14 — TRANSPORT INFORMATION

Multi-modal shipping descriptions are provided for informational purposes and do not consider container sizes. The presence of a shipping description for a particular mode of transport (ocean, air, etc.), does not indicate that the product is packaged suitably for that mode of transport. All packaging must be reviewed for suitability prior to shipment, and compliance with the applicable regulations is the sole responsibility of the person offering the product for transport.

US Ground (DOT)
May be Classed as a Combustible Liquid for U.S. Ground.
UN1263, PAINT, 3, PG III, (ERG#128)
Bulk Containers may be Shipped as:
UN1263, PAINT, COMBUSTIBLE LIQUID, PG III, (ERG#128)
Canada (TDG)
May be Classed as a Combustible Liquid for Canadian Ground.
UN1263, PAINT, CLASS 3, PG III, (ERG#128)
IMO
5 Liters (1.3 Gallons) and Less may be Shipped as Limited Quantity.
UN1263, PAINT, CLASS 3, PG III, (41 C c.c.), EmS F-E, S-E
IATA/ICAO
UN1263, PAINT, 3, PG III

SECTION 15 — REGULATORY INFORMATION

SARA 313 *(40 CFR 372.65C)* SUPPLIER NOTIFICATION

CAS No.	CHEMICAL/COMPOUND	% by WT	% Element

No ingredients in this product are subject to SARA 313 (40 CFR 372.65C) Supplier Notification.
TSCA CERTIFICATION
All chemicals in this product are listed, or are exempt from listing, on the TSCA Inventory.

SECTION 16 — OTHER INFORMATION

This product has been classified in accordance with the hazard criteria of the Canadian Controlled Products Regulations (CPR) and the MSDS contains all of the information required by the CPR.

The above information pertains to this product as currently formulated, and is based on the information available at this time. Addition of reducers or other additives to this product may substantially alter the composition and hazards of the product. Since conditions of use are outside our control, we make no warranties, express or implied, and assume no liability in connection with any use of this information.

MATERIAL SAFETY DATA SHEET

B54W101
47 00

DATE OF PREPARATION
Mar 5, 2015

SECTION 1 — PRODUCT AND COMPANY IDENTIFICATION

PRODUCT NUMBER
B54W101
PRODUCT NAME
Industrial Enamel, Pure White
MANUFACTURER'S NAME
THE SHERWIN-WILLIAMS COMPANY
101 Prospect Avenue N.W.
Cleveland, OH 44115

CLAIMANT'S EXHIBIT
2

Telephone Numbers and Websites

Product Information	(800) 524-5979 www.sherwin-williams.com
Regulatory Information	(216) 566-2902 www.paintdocs.com
Medical Emergency	(216) 566-2917
Transportation Emergency*	(800) 424-9300
*for Chemical Emergency ONLY (spill, leak, fire, exposure, or accident)	

SECTION 2 — COMPOSITION/INFORMATION ON INGREDIENTS

% by Weight	CAS Number	Ingredient	Units	Vapor Pressure
40	64742-88-7	Med. Aliphatic Hydrocarbon Solvent		
		ACGIH TLV	100 PPM	1.27 mm
		OSHA PEL	100 PPM	
0.1	100-41-4	Ethylbenzene		
		ACGIH TLV	20 PPM	7.1 mm
		OSHA PEL	100 PPM	
		OSHA PEL	125 PPM STEL	
6	14807-96-6	Talc		
		ACGIH TLV	2 mg/m3 as Resp. Dust	
		OSHA PEL	2 mg/m3 as Resp. Dust	
14	13463-67-7	Titanium Dioxide		
		ACGIH TLV	10 mg/m3 as Dust	
		OSHA PEL	10 mg/m3 Total Dust	
		OSHA PEL	5 mg/m3 Respirable Fraction	

SECTION 3 — HAZARDS IDENTIFICATION

ROUTES OF EXPOSURE
INHALATION of vapor or spray mist.
EYE or SKIN contact with the product, vapor or spray mist.

HMIS Codes	
Health	2*
Flammability	2
Reactivity	0

EFFECTS OF OVEREXPOSURE
EYES: Irritation.
SKIN: Prolonged or repeated exposure may cause irritation.
INHALATION: Irritation of the upper respiratory system.

May cause nervous system depression. Extreme overexposure may result in unconsciousness and possibly death.
SIGNS AND SYMPTOMS OF OVEREXPOSURE
Headache, dizziness, nausea, and loss of coordination are indications of excessive exposure to vapors or spray mists.
Redness and itching or burning sensation may indicate eye or excessive skin exposure.
MEDICAL CONDITIONS AGGRAVATED BY EXPOSURE
None generally recognized.
CANCER INFORMATION
For complete discussion of toxicology data refer to Section 11.

SECTION 4 — FIRST AID MEASURES

EYES: Flush eyes with large amounts of water for 15 minutes. Get medical attention.
SKIN: Wash affected area thoroughly with soap and water.
Remove contaminated clothing and launder before re-use.
INHALATION: If affected, remove from exposure. Restore breathing. Keep warm and quiet.
INGESTION: Do not induce vomiting. Get medical attention immediately.

SECTION 5 — FIRE FIGHTING MEASURES

FLASH POINT	LEL	UEL	FLAMMABILITY CLASSIFICATION
101 °F PMCC	1.0	6.0	Combustible, Flash above 99 and below 200 °F

EXTINGUISHING MEDIA
Carbon Dioxide, Dry Chemical, Foam
UNUSUAL FIRE AND EXPLOSION HAZARDS
Closed containers may explode when exposed to extreme heat.
Application to hot surfaces requires special precautions.
During emergency conditions overexposure to decomposition products may cause a health hazard. Symptoms may not be immediately apparent. Obtain medical attention.
SPECIAL FIRE FIGHTING PROCEDURES
Full protective equipment including self-contained breathing apparatus should be used.
Water spray may be ineffective. If water is used, fog nozzles are preferable. Water may be used to cool closed containers to prevent pressure build-up and possible autoignition or explosion when exposed to extreme heat.

SECTION 6 — ACCIDENTAL RELEASE MEASURES

STEPS TO BE TAKEN IN CASE MATERIAL IS RELEASED OR SPILLED
Remove all sources of ignition. Ventilate the area.
Remove with inert absorbent.

SECTION 7 — HANDLING AND STORAGE

STORAGE CATEGORY
DOL Storage Class II
PRECAUTIONS TO BE TAKEN IN HANDLING AND STORAGE
Contents are COMBUSTIBLE. Keep away from heat and open flame.
Consult NFPA Code. Use approved Bonding and Grounding procedures.
Keep container closed when not in use. Transfer only to approved containers with complete and appropriate labeling. Do not take internally. Keep out of the reach of children.

SECTION 8 — EXPOSURE CONTROLS/PERSONAL PROTECTION

PRECAUTIONS TO BE TAKEN IN USE
Use only with adequate ventilation.
Avoid contact with skin and eyes. Avoid breathing vapor and spray mist.
Wash hands after using.
This coating may contain materials classified as nuisance particulates (listed "as Dust" in Section 2) which may be present at hazardous levels only during sanding or abrading of the dried film. If no specific dusts are listed in Section 2, the applicable limits for nuisance dusts are ACGIH TLV 10 mg/m3 (total dust), 3 mg/m3 (respirable fraction), OSHA PEL 15 mg/m3 (total dust), 5 mg/m3 (respirable fraction).
VENTILATION
Local exhaust preferable. General exhaust acceptable if the exposure to materials in Section 2 is maintained below applicable exposure limits. Refer to OSHA Standards 1910.94, 1910.107, 1910.108.
RESPIRATORY PROTECTION
If personal exposure cannot be controlled below applicable limits by ventilation, wear a properly fitted organic vapor/particulate respirator approved by NIOSH/MSHA for protection against materials in Section 2.
When sanding or abrading the dried film, wear a dust/mist respirator approved by NIOSH/MSHA for dust which may be generated from this product, underlying paint, or the abrasive.
PROTECTIVE GLOVES
Wear gloves which are recommended by glove supplier for protection against materials in Section 2.
EYE PROTECTION
Wear safety spectacles with unperforated sideshields.
OTHER PRECAUTIONS
Intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal.

SECTION 9 — PHYSICAL AND CHEMICAL PROPERTIES

PRODUCT WEIGHT	8.78 lb/gal	1051 g/l
SPECIFIC GRAVITY	1.06	
BOILING POINT	300 - 395 °F	148 - 201 °C
MELTING POINT	Not Available	
VOLATILE VOLUME	57%	
EVAPORATION RATE	Slower than ether	
VAPOR DENSITY	Heavier than air	
SOLUBILITY IN WATER	Not Available	

VOLATILE ORGANIC COMPOUNDS (VOC Theoretical - As Packaged)

3.68 lb/gal	441 g/l	Less Water and Federally Exempt Solvents
3.68 lb/gal	441 g/l	Emitted VOC

SECTION 10 — STABILITY AND REACTIVITY

STABILITY — Stable

CONDITIONS TO AVOID
None known.

INCOMPATIBILITY
None known.

HAZARDOUS DECOMPOSITION PRODUCTS
By fire: Carbon Dioxide, Carbon Monoxide

HAZARDOUS POLYMERIZATION
Will not occur

SECTION 11 — TOXICOLOGICAL INFORMATION

CHRONIC HEALTH HAZARDS

Reports have associated repeated and prolonged overexposure to solvents with permanent brain and nervous system damage.

Ethylbenzene is classified by IARC as possibly carcinogenic to humans (2B) based on inadequate evidence in humans and sufficient evidence in laboratory animals. Lifetime inhalation exposure of rats and mice to high ethylbenzene concentrations resulted in increases in certain types of cancer, including kidney tumors in rats and lung and liver tumors in mice. These effects were not observed in animals exposed to lower concentrations. There is no evidence that ethylbenzene causes cancer in humans.

IARC's Monograph No. 93 reports there is sufficient evidence of carcinogenicity in experimental rats exposed to titanium dioxide but inadequate evidence for carcinogenicity in humans and has assigned a Group 2B rating. In addition, the IARC summary concludes, "No significant exposure to titanium dioxide is thought to occur during the use of products in which titanium is bound to other materials, such as paint."

TOXICOLOGY DATA

CAS No.	Ingredient Name			
64742-88-7	Med. Aliphatic Hydrocarbon Solvent			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
100-41-4	Ethylbenzene			
		LC50 RAT	4HR	Not Available
		LD50 RAT		3500 mg/kg
14807-96-6	Talc			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
13463-67-7	Titanium Dioxide			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available

SECTION 12 — ECOLOGICAL INFORMATION

ECOTOXICOLOGICAL INFORMATION
No data available.

SECTION 13 — DISPOSAL CONSIDERATIONS

WASTE DISPOSAL METHOD

Waste from this product may be hazardous as defined under the Resource Conservation and Recovery Act (RCRA) 40 CFR 261.

Waste must be tested for ignitability to determine the applicable EPA hazardous waste numbers.

Incinerate in approved facility. Do not incinerate closed container. Dispose of in accordance with Federal, State/Provincial, and Local regulations regarding pollution.

SECTION 14 — TRANSPORT INFORMATION

Multi-modal shipping descriptions are provided for informational purposes and do not consider container sizes. The presence of a shipping description for a particular mode of transport (ocean, air, etc.), does not indicate that the product is packaged suitably for that mode of transport. All packaging must be reviewed for suitability prior to shipment, and compliance with the applicable regulations is the sole responsibility of the person offering the product for transport.

US Ground (DOT)
May be Classed as a Combustible Liquid for U.S. Ground.
UN1263, PAINT, 3, PG III, (ERG#128)

DOT (Dept of Transportation) Hazardous Substances & Reportable Quantities
Xylenes (isomers and mixture) 100 lb RQ

Bulk Containers may be Shipped as (check reportable quantities):
UN1263, PAINT, COMBUSTIBLE LIQUID, PG III, (ERG#128)

Canada (TDG)
May be Classed as a Combustible Liquid for Canadian Ground.
UN1263, PAINT, CLASS 3, PG III, (ERG#128)

IMO
5 Liters (1.3 Gallons) and Less may be Shipped as Limited Quantity.
UN1263, PAINT, CLASS 3, PG III, (38 C c.c.), EmS F-E, S-E

IMO
5 Liters (1.3 Gallons) and Less may be Shipped as Limited Quantity.
UN1263, PAINT, CLASS 3, PG III, (38 C c.c.), EmS F-E, S-E

IATA/ICAO
UN1263, PAINT, 3, PG III

SECTION 15 — REGULATORY INFORMATION

SARA 313 *(40 CFR 372.65C)* **SUPPLIER NOTIFICATION**

CAS No.	CHEMICAL/COMPOUND	% by WT	% Element
100-41-4	Ethylbenzene	0.1	

CALIFORNIA PROPOSITION 65
WARNING: This product contains chemicals known to the State of California to cause cancer and birth defects or other reproductive harm.

TSCA CERTIFICATION
All chemicals in this product are listed, or are exempt from listing, on the TSCA Inventory.

SECTION 16 — OTHER INFORMATION

This product has been classified in accordance with the hazard criteria of the Canadian Controlled Products Regulations (CPR) and the MSDS contains all of the information required by the CPR.

The above information pertains to this product as currently formulated, and is based on the information available at this time. Addition of reducers or other additives to this product may substantially alter the composition and hazards of the product. Since conditions of use are outside our control, we make no warranties, express or implied, and assume no liability in connection with any use of this information.

MATERIAL SAFETY DATA SHEET

475
05 00

DATE OF PREPARATION
Jul 19, 2014

SECTION 1 — PRODUCT AND COMPANY IDENTIFICATION

PRODUCT NUMBER
475
PRODUCT NAME
MINWAX® POLYSHADES® Interior Stain & Polyurethane Gloss Finish, American Chestnut
MANUFACTURER'S NAME
MINWAX Company
10 Mountainview Road
Upper Saddle River, NJ 07458

CLAIMANT'S EXHIBIT
3

Telephone Numbers and Websites

Product Information	(800) 523-9299 www.minwax.com
Regulatory Information	(216) 566-2902 www.paintdocs.com
Medical Emergency	(216) 566-2917
Transportation Emergency*	(800) 424-9300
*for Chemical Emergency ONLY (spill, leak, fire, exposure, or accident)	

SECTION 2 — COMPOSITION/INFORMATION ON INGREDIENTS

% by Weight	CAS Number	Ingredient	Units	Vapor Pressure
15	64742-88-7	Med. Aliphatic Hydrocarbon Solvent		1.27 mm
		ACGIH TLV	100 PPM	
		OSHA PEL	100 PPM	
29	64741-65-7	Mineral Spirits (Odorless)		1 mm
		ACGIH TLV	100 PPM	
		OSHA PEL	100 PPM	
3	64742-47-8	Aliphatic Solvent		0.1 mm
		ACGIH TLV	Not Available	
		OSHA PEL	Not Available	
0.1	136-52-7	Cobalt 2-Ethylhexanoate		
		ACGIH TLV	Not Available	
		OSHA PEL	Not Available	
0.2	61789-51-3	Cobalt Naphthenate		
		ACGIH TLV	Not Available	
		OSHA PEL	Not Available	

SECTION 3 — HAZARDS IDENTIFICATION

HMIS Codes	
Health	2*
Flammability	2
Reactivity	0

ROUTES OF EXPOSURE
INHALATION of vapor or spray mist.
EYE or SKIN contact with the product, vapor or spray mist.
EFFECTS OF OVEREXPOSURE
EYES: Irritation.
SKIN: Prolonged or repeated exposure may cause irritation.
INHALATION: Irritation of the upper respiratory system.

May cause nervous system depression. Extreme overexposure may result in unconsciousness and possibly death.
SIGNS AND SYMPTOMS OF OVEREXPOSURE
Headache, dizziness, nausea, and loss of coordination are indications of excessive exposure to vapors or spray mists.
Redness and itching or burning sensation may indicate eye or excessive skin exposure.
MEDICAL CONDITIONS AGGRAVATED BY EXPOSURE
None generally recognized.
CANCER INFORMATION
For complete discussion of toxicology data refer to Section 11.

OTHER PRECAUTIONS

Intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal.

SECTION 9 — PHYSICAL AND CHEMICAL PROPERTIES

PRODUCT WEIGHT	7.65 lb/gal	916 g/l
SPECIFIC GRAVITY	0.92	
BOILING POINT	300 - 495 °F	148 - 257 °C
MELTING POINT	Not Available	
VOLATILE VOLUME	56%	
EVAPORATION RATE	Slower than ether	
VAPOR DENSITY	Heavier than air	
SOLUBILITY IN WATER	Not Available	

VOLATILE ORGANIC COMPOUNDS (VOC Theoretical - As Packaged)

3.63 lb/gal	435 g/l	Less Water and Federally Exempt Solvents
3.63 lb/gal	435 g/l	Emitted VOC

SECTION 10 — STABILITY AND REACTIVITY

STABILITY — Stable

CONDITIONS TO AVOID

None known.

INCOMPATIBILITY

None known.

HAZARDOUS DECOMPOSITION PRODUCTS

By fire: Carbon Dioxide, Carbon Monoxide

HAZARDOUS POLYMERIZATION

Will not occur

SECTION 11 — TOXICOLOGICAL INFORMATION

CHRONIC HEALTH HAZARDS

Reports have associated repeated and prolonged overexposure to solvents with permanent brain and nervous system damage.

Cobalt and cobalt compounds are classified by IARC as possibly carcinogenic to humans (group 2B) based on experimental animal data, however, there is inadequate evidence in humans for its carcinogenicity.

TOXICOLOGY DATA

CAS No.	Ingredient Name			
64742-88-7	Med. Aliphatic Hydrocarbon Solvent			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
64741-65-7	Mineral Spirits (Odorless)			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
64742-47-8	Aliphatic Solvent			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
136-52-7	Cobalt 2-Ethylhexanoate			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
61789-51-3	Cobalt Naphthenate			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available

SECTION 12 — ECOLOGICAL INFORMATION

ECOTOXICOLOGICAL INFORMATION

No data available.

SECTION 13 — DISPOSAL CONSIDERATIONS

WASTE DISPOSAL METHOD

Waste from this product may be hazardous as defined under the Resource Conservation and Recovery Act (RCRA) 40 CFR 261.

Waste must be tested for ignitability to determine the applicable EPA hazardous waste numbers.

Incinerate in approved facility. Do not incinerate closed container. Dispose of in accordance with Federal, State/Provincial, and Local regulations regarding pollution.

SECTION 14 — TRANSPORT INFORMATION

Multi-modal shipping descriptions are provided for informational purposes and do not consider container sizes. The presence of a shipping description for a particular mode of transport (ocean, air, etc.), does not indicate that the product is packaged suitably for that mode of transport. All packaging must be reviewed for suitability prior to shipment, and compliance with the applicable regulations is the sole responsibility of the person offering the product for transport.

US Ground (DOT)
May be Classed as a Combustible Liquid for U.S. Ground.
UN1263, PAINT, 3, PG III, (ERG#128)

Bulk Containers may be Shipped as:
UN1263, PAINT, COMBUSTIBLE LIQUID, PG III, (ERG#128)

Canada (TDG)
May be Classed as a Combustible Liquid for Canadian Ground.
UN1263, PAINT, CLASS 3, PG III, (ERG#128)

IMO
5 Liters (1.3 Gallons) and Less may be Shipped as Limited Quantity.
UN1263, PAINT, CLASS 3, PG III, (41 C c.c.), EmS F-E, S-E

IATA/ICAO
UN1263, PAINT, 3, PG III

SECTION 15 — REGULATORY INFORMATION

SARA 313 ***(40 CFR 372.65C)*** **SUPPLIER NOTIFICATION**

CAS No.	CHEMICAL/COMPOUND	% by WT	% Element
	Cobalt Compound	0.3	0.02

CALIFORNIA PROPOSITION 65
WARNING: This product contains chemicals known to the State of California to cause cancer and birth defects or other reproductive harm.

TSCA CERTIFICATION
All chemicals in this product are listed, or are exempt from listing, on the TSCA Inventory.

SECTION 16 — OTHER INFORMATION

This product has been classified in accordance with the hazard criteria of the Canadian Controlled Products Regulations (CPR) and the MSDS contains all of the information required by the CPR.

The above information pertains to this product as currently formulated, and is based on the information available at this time. Addition of reducers or other additives to this product may substantially alter the composition and hazards of the product. Since conditions of use are outside our control, we make no warranties, express or implied, and assume no liability in connection with any use of this information.

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— Section 1 —
Product Identification

Material Safety Data Sheet

The Sherwin-Williams Company
Krylon Products Group
101 Prospect Avenue N.W.
Cleveland, OH 44115

Emergency telephone numbers (216) 566-2917 United States

Information telephone number (800) 251-2486
July 24, 2000

©2000, The Sherwin-Williams Co.

KRYLON® PAINT ALL® Fast Dry Enamel - 1

PAINTALL1/KRI

CAS No.	— Section 2 — Hazardous Ingredients (percent by weight)	ACGIH TLV <STEL>	OSHA PEL <STEL>	Units	Vapor Pressure (mm Hg)	S04101 Flat White	S04102 Flat Black	S04103 Red	S04104 Yellow	S04105 Blue	S04106 Green	S04107 Orange	S04108 Brown
74-98-6	Propane	2500	1000	PPM	760.0	14	14	14	14	14	14	14	14
106-97-8	Butane	800	800	PPM	760.0	13	13	13	13	13	13	13	13
100-41-4 §	Ethylbenzene	100 <125>	100 <125>	PPM	7.1	3	2	3	3	4	3	3	3
1330-20-7 §	Xylene.	100 <150>	100 <150>	PPM	5.9	15	13	18	19	23	18	18	18
67-64-1	Acetone.	500 <750>	1000	PPM	180.0	42	47	38	37	28	39	39	39
14807-96-6	Talc	2	2	Mg/M3	as Resp. Dust	4	4						
471-34-1	Calcium Carbonate.	10	15[5]	Mg/M3 [Resp.	as Dust Fraction]		1						
13463-67-7	Titanium Dioxide.	10	10[5]	Mg/M3 [Resp.	as Dust Fraction]	3			2	3			
1333-86-4	Carbon Black.	3.5	3.5	Mg/M3			0.2						0.2
	Weight per Gallon (lbs.)					6.33	6.17	6.13	6.22	6.38	6.16	6.11	6.16
	VOC Less Federally Exempt Solvents - (percent by weight)					44.4	43.2	49.1	49.6	54.8	48.7	48.6	48.8
	Flash Point (°F)					< 0	< 0	< 0	< 0	< 0	< 0	< 0	< 0
	HMIS (NFPA) Rating (health - flammability - reactivity)					2 - 4 - 0	2* - 4 - 0	2 - 4 - 0	2 - 4 - 0	2 - 4 - 0	2 - 4 - 0	2 - 4 - 0	2* - 4 - 0

% BY WEIGHT

§ Ingredient subject to the reporting requirements of the Superfund Amendments and Reauthorization Act (SARA) Section 313, 40 CFR 372.65 C

P1063

CLAIMANT'S EXHIBIT
4

→→→ MSDS Text Page Follows →→→

Section 3 — Physical Data

PRODUCT WEIGHT	See TABLE	*EVAPORATION RATE*	Faster than Ether
SPECIFIC GRAVITY	0.73-0.79	*VAPOR DENSITY*	Heavier than Air
BOILING RANGE	<0 - 395 °F	*MELTING POINT*	N.A.
VOLATILE VOLUME	87-95 %	*SOLUBILITY IN WATER*	N.A.

Section 4 — Fire And Explosion Hazard Data

FLASH POINT
See TABLE

LEL 1.0 *UEL* 12.8

EXTINGUISHING MEDIA
Carbon Dioxide, Dry Chemical, Foam

UNUSUAL FIRE AND EXPLOSION HAZARDS
Isolate from heat, electrical equipment, sparks, and open flame. Closed containers may explode when exposed to extreme heat. Application to hot surfaces requires special precautions. During emergency conditions overexposure to decomposition products may cause a health hazard. Symptoms may not be immediately apparent. Obtain medical attention.

SPECIAL FIRE FIGHTING PROCEDURES
Full protective equipment including self-contained breathing apparatus should be used. Water spray may be ineffective. If water is used, fog nozzles are preferable. Water may be used to cool closed containers to prevent pressure build-up and possible autoignition or explosion when exposed to extreme heat.

Section 5 — Health Hazard Data

ROUTES OF EXPOSURE
Exposure may be by INHALATION and/or SKIN or EYE contact, depending on conditions of use. To minimize exposure, follow recommendations for proper use, ventilation, and personal protective equipment.

ACUTE Health Hazards

EFFECTS OF OVEREXPOSURE
Irritation of eyes, skin and respiratory system. May cause nervous system depression. Extreme overexposure may result in unconsciousness and possibly death.

SIGNS AND SYMPTOMS OF OVEREXPOSURE
Headache, dizziness, nausea, and loss of coordination are indications of excessive exposure to vapors or spray mists.
Redness and itching or burning sensation may indicate eye or excessive skin exposure.

MEDICAL CONDITIONS AGGRAVATED BY EXPOSURE
None generally recognized.

EMERGENCY AND FIRST AID PROCEDURES
If INHALED: If affected, remove from exposure. Restore breathing. Keep warm and quiet.
If on SKIN: Wash affected area thoroughly with soap and water. Remove contaminated clothing and launder before re-use.
If in EYES: Flush eyes with large amounts of water for 15 minutes. Get medical attention.
If SWALLOWED: Never give anything by mouth to an unconscious person. DO NOT INDUCE VOMITING. Give conscious patient several glasses of water. Seek medical attention.

CHRONIC Health Hazards
Carbon Black is classified by IARC as possibly carcinogenic to humans (Group 2B) based on experimental animals data, however, there is inadequate evidence in humans for its carcinogenicity.
Prolonged overexposure to solvent ingredients in Section 2 may cause adverse effects to the liver, urinary, cardiovascular and reproductive systems.
Rats exposed to titanium dioxide dust at 250 mg./m3 developed lung cancer, however, such exposure levels are not attainable in the workplace.
Reports have associated repeated and prolonged overexposure to solvents with permanent brain and nervous system damage.

Section 6 — Reactivity Data

STABILITY — Stable
CONDITIONS TO AVOID — None known.
INCOMPATIBILITY — None known.
HAZARDOUS DECOMPOSITION PRODUCTS — By fire: Carbon Dioxide, Carbon Monoxide, Oxides of Metals in Section 2
HAZARDOUS POLYMERIZATION — Will Not Occur

Section 7 — Spill Or Leak Procedures

STEPS TO BE TAKEN IN CASE MATERIAL IS RELEASED OR SPILLED
Remove all sources of ignition. Ventilate and remove with inert absorbent.

WASTE DISPOSAL METHOD
Waste from these products may be hazardous as defined under the Resource Conservation and Recovery Act (RCRA) 40 CFR 261. Waste must be tested for ignitability to determine the applicable EPA hazardous waste numbers. Waste from products containing Barium must also be tested for extractability.
Do not incinerate. Depressurize container. Dispose of in accordance with Federal, State, and Local regulations regarding pollution.

Section 8 — Protection Information

PRECAUTIONS TO BE TAKEN IN USE
Use only with adequate ventilation. Avoid breathing vapor and spray mist. Avoid contact with skin and eyes. Wash hands after using.
These products may contain materials classified as nuisance particulates (listed "as Dust" in Section 2) which may be present at hazardous levels only during sanding or abrading of the dried film. If no specific dusts are listed in Section 2, the applicable limits for nuisance dusts are ACGIH TLV 10 mg./m3 (total dust), 3 mg./m3 (respirable fraction), OSHA PEL 15 mg./m3 (total dust), 5 mg./m3 (respirable fraction).

VENTILATION
Local exhaust preferable. General exhaust acceptable if the exposure to materials in Section 2 is maintained below applicable exposure limits. Refer to OSHA Standards 1910.94, 1910.107, 1910.108.

RESPIRATORY PROTECTION
If personal exposure cannot be controlled below applicable limits by ventilation, wear a properly fitted organic vapor/particulate respirator approved by NIOSH/MSHA for protection against materials in Section 2.
When sanding or abrading the dried film, wear a dust/mist respirator approved by NIOSH/MSHA for dust which may be generated from this product, underlying paint, or the abrasive.

PROTECTIVE GLOVES
None required for normal application of aerosol products where minimal skin contact is expected. For long or repeated contact, wear chemical resistant gloves.

EYE PROTECTION
Wear safety spectacles with unperforated sideshields.

Section 9 — Precautions

DOL STORAGE CATEGORY — 1A

PRECAUTIONS TO BE TAKEN IN HANDLING AND STORING
Keep away from heat, sparks, and open flame. Vapors will accumulate readily and may ignite explosively.
During use and until all vapors are gone: Keep area ventilated - Do not smoke - Extinguish all flames, pilot lights, and heaters - Turn off stoves, electric tools and appliances, and any other sources of ignition.
Consult NFPA Code. Use approved Bonding and Grounding procedures.
Contents under pressure. Do not puncture, incinerate, or expose to temperature above 120F. Heat from sunlight, radiators, stoves, hot water, and other heat sources could cause container to burst. Do not take internally. Keep out of the reach of children.

OTHER PRECAUTIONS
Intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal.

Section 10 — Other Regulatory Information

CALIFORNIA PROPOSITION 65
WARNING: These products contain chemicals known to the State of California to cause cancer and birth defects or other reproductive harm.

TSCA CERTIFICATION
All chemicals in these products are listed, or are exempt from listing, on the TSCA Inventory.

The above information pertains to these products as currently formulated, and is based on the information available at this time. Addition of reducers or other additives to these products may substantially alter the composition and hazards of the product. Since conditions of use are outside our control, we make no warranties, express or implied, and assume no liability in connection with any use of this information.

P1064

00 — Section 1 —
Product Identification

Material Safety Data Sheet

The Sherwin-Williams Company
Krylon Products Group
101 Prospect Avenue N.W.
Cleveland, OH 44115

Emergency telephone numbers (216) 566-2917 United States

Information telephone number (800) 251-2486
July 24, 2000
©2000, The Sherwin-Williams Co.

KRYLON® PAINT ALL® Fast Dry Enamel - 2

PAINTALL2/KRI

P1065

— Section 2 —

CAS No.	Hazardous Ingredients (percent by weight)	ACGIH TLV <STEL>	OSHA PEL <STEL>	Units	Vapor Pressure (mm Hg)	S04109 Pink	S04110 Chrome Aluminum	S04113 Gloss White	S04114 Gloss Black	S04115 Gray	S04116 Cherry Red	S04120 Red Oxide Primer
74-98-6	Propane	2500	1000	PPM	760.0	14	16	14	14	14	14	14
106-97-8	Butane	800	800	PPM	760.0	13	16	13	13	13	13	13
64742-88-7	Mineral Spirits.	100	100	PPM	2.0		1					2
108-88-3 §	Toluene.	50	100 <150>	PPM (Skin)	22.0	3	37					
100-41-4 §	Ethylbenzene	100 <125>	100 <125>	PPM	7.1	3		3	3	3	3	3
1330-20-7 §	Xylene.	100 <150>	100 <150>	PPM	5.9	20	4	16	15	16	19	18
67-64-1	Acetone.	500 <750>	1000	PPM	180.0	27	5	39	47	42	39	30
14807-96-6	Talc	2	2	Mg/M3	as Resp. Dust							3
7727-43-7	Barium Sulfate.	10	10[5]	Mg/M3 [Resp.	as Dust Fraction]							5
13463-67-7	Titanium Dioxide.	10	10[5]	Mg/M3 [Resp.	as Dust Fraction]	5		6		3		
1333-86-4	Carbon Black.	3.5	3.5	Mg/M3					0.3			
	[% Barium]											[3.0]
	Weight per Gallon (lbs.)					6.44	6.25	6.34	6.03	6.19	6.12	6.59
	VOC Less Federally Exempt Solvents - (percent by weight)					53.6	75.3	45.8	44.7	46.5	49.9	50.5
	Flash Point (°F)					< 0	< 0	< 0	< 0	< 0	< 0	< 0
	HMIS (NFPA) Rating (health - flammability - reactivity)					2 - 4 - 0	2 - 4 - 1	2 - 4 - 0	2* - 4 - 0	2 - 4 - 0	2 - 4 - 0	2 - 4 - 0

PERCENT BY WEIGHT

§ Ingredient subject to the reporting requirements of the Superfund Amendments and Reauthorization Act (SARA) Section 313, 40 CFR 372.65 C

→→→ MSDS Text ‾ge Follows →→→

Section 3 — Physical Data

PRODUCT WEIGHT	See TABLE	EVAPORATION RATE	Faster than Ether
SPECIFIC GRAVITY	0.73-0.79	VAPOR DENSITY	Heavier than Air
BOILING RANGE	<0 - 395 °F	MELTING POINT	N.A.
VOLATILE VOLUME	87-95 %	SOLUBILITY IN WATER	N.A.

Section 4 — Fire And Explosion Hazard Data

FLASH POINT
See TABLE

EXTINGUISHING MEDIA LEL 1.0 UEL 12.8
Carbon Dioxide, Dry Chemical, Foam

UNUSUAL FIRE AND EXPLOSION HAZARDS
Isolate from heat, electrical equipment, sparks, and open flame. Closed containers may explode when exposed to extreme heat. Application to hot surfaces requires special precautions. During emergency conditions overexposure to decomposition products may cause a health hazard. Symptoms may not be immediately apparent. Obtain medical attention.

SPECIAL FIRE FIGHTING PROCEDURES
Full protective equipment including self-contained breathing apparatus should be used. Water spray may be ineffective. If water is used, fog nozzles are preferable. Water may be used to cool closed containers to prevent pressure build-up and possible autoignition or explosion when exposed to extreme heat.

Section 5 — Health Hazard Data

ROUTES OF EXPOSURE
Exposure may be by INHALATION and/or SKIN or EYE contact, depending on conditions of use. To minimize exposure, follow recommendations for proper use, ventilation, and personal protective equipment.

ACUTE Health Hazards

EFFECTS OF OVEREXPOSURE
Irritation of eyes, skin and respiratory system. May cause nervous system depression. Extreme overexposure may result in unconsciousness and possibly death.

SIGNS AND SYMPTOMS OF OVEREXPOSURE
Headache, dizziness, nausea, and loss of coordination are indications of excessive exposure to vapors or spray mists.
Redness and itching or burning sensation may indicate eye or excessive skin exposure.

MEDICAL CONDITIONS AGGRAVATED BY EXPOSURE
None generally recognized.

EMERGENCY AND FIRST AID PROCEDURES
If INHALED: If affected, remove from exposure. Restore breathing. Keep warm and quiet.
If on SKIN: Wash affected area thoroughly with soap and water. Remove contaminated clothing and launder before re-use.
If in EYES: Flush eyes with large amounts of water for 15 minutes. Get medical attention.
If SWALLOWED: Never give anything by mouth to an unconscious person. DO NOT INDUCE VOMITING. Give conscious patient several glasses of water. Seek medical attention.

CHRONIC Health Hazards
Carbon Black is classified by IARC as possibly carcinogenic to humans (Group 2B) based on experimental animals data, however, there is inadequate evidence in humans for its carcinogenicity.
Prolonged overexposure to solvent ingredients in Section 2 may cause adverse effects to the liver, urinary, cardiovascular and reproductive systems.
Rats exposed to titanium dioxide dust at 250 mg./m3 developed lung cancer, however, such exposure levels are not attainable in the workplace.
Reports have associated repeated and prolonged overexposure to solvents with permanent brain and nervous system damage.

Section 6 — Reactivity Data

STABILITY — Stable
CONDITIONS TO AVOID — None known.
INCOMPATIBILITY — None known.
HAZARDOUS DECOMPOSITION PRODUCTS — By fire: Carbon Dioxide, Carbon Monoxide, Oxides of Metals in Section 2
HAZARDOUS POLYMERIZATION — Will Not Occur

Section 7 — Spill Or Leak Procedures

STEPS TO BE TAKEN IN CASE MATERIAL IS RELEASED OR SPILLED
Remove all sources of ignition. Ventilate and remove with inert absorbent.

WASTE DISPOSAL METHOD
Waste from these products may be hazardous as defined under the Resource Conservation and Recovery Act (RCRA) 40 CFR 261. Waste must be tested for ignitability to determine the applicable EPA hazardous waste numbers. Waste from products containing Barium must also be tested for extractability.
Do not incinerate. Depressurize container. Dispose of in accordance with Federal, State, and Local regulations regarding pollution.

Section 8 — Protection Information

PRECAUTIONS TO BE TAKEN IN USE
Use only with adequate ventilation. Avoid breathing vapor and spray mist. Avoid contact with skin and eyes. Wash hands after using.
These products may contain materials classified as nuisance particulates (listed "as Dust" in Section 2) which may be present at hazardous levels only during sanding or abrading of the dried film. If no specific dusts are listed in Section 2, the applicable limits for nuisance dusts are ACGIH TLV 10 mg./m3 (total dust), 3 mg./m3 (respirable fraction), OSHA PEL 15 mg./m3 (total dust), 5 mg./m3 (respirable fraction).

VENTILATION
Local exhaust preferable. General exhaust acceptable if the exposure to materials in Section 2 is maintained below applicable exposure limits. Refer to OSHA Standards 1910.94, 1910.107, 1910.108.

RESPIRATORY PROTECTION
If personal exposure cannot be controlled below applicable limits by ventilation, wear a properly fitted organic vapor/particulate respirator approved by NIOSH/MSHA for protection against materials in Section 2.
When sanding or abrading the dried film, wear a dust/mist respirator approved by NIOSH/MSHA for dust which may be generated from this product, underlying paint, or the abrasive.

PROTECTIVE GLOVES
None required for normal application of aerosol products where minimal skin contact is expected. For long or repeated contact, wear chemical resistant gloves.

EYE PROTECTION
Wear safety spectacles with unperforated sideshields.

Section 9 — Precautions

DOL STORAGE CATEGORY — 1A

PRECAUTIONS TO BE TAKEN IN HANDLING AND STORING
Keep away from heat, sparks, and open flame. Vapors will accumulate readily and may ignite explosively.
During use and until all vapors are gone: Keep area ventilated - Do not smoke - Extinguish all flames, pilot lights, and heaters - Turn off stoves, electric tools and appliances, and any other sources of ignition.
Consult NFPA Code. Use approved Bonding and Grounding procedures.
Contents under pressure. Do not puncture, incinerate, or expose to temperature above 120F. Heat from sunlight, radiators, stoves, hot water, and other heat sources could cause container to burst. Do not take internally. Keep out of the reach of children.

OTHER PRECAUTIONS
Intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal.

Section 10 — Other Regulatory Information

CALIFORNIA PROPOSITION 65
WARNING: These products contain chemicals known to the State of California to cause cancer and birth defects or other reproductive harm.

TSCA CERTIFICATION
All chemicals in these products are listed, or are exempt from listing, on the TSCA Inventory.

The above information pertains to these products as currently formulated, and is based on the information available at this time. Addition of reducers or other additives to these products may substantially alter the composition and hazards of the product. Since conditions of use are outside our control, we make no warranties, express or implied, and assume no liability in connection with any use of this information.

P1066

CLAIMANT'S EXHIBIT 5

HMIS Codes	
Health	2*
Flammability	2
Reactivity	1

ROUTES OF EXPOSURE

INHALATION of vapor or spray mist.

EYE or SKIN contact with the product, vapor or spray mist.

EFFECTS OF OVEREXPOSURE

EYES: Irritation.

SKIN: Prolonged or repeated exposure may cause irritation.

INHALATION: Irritation of the upper respiratory system.

May cause nervous system depression. Extreme overexposure may result in unconsciousness and possibly death.

Prolonged overexposure to hazardous ingredients in Section 2 may cause adverse chronic effects to the following organs or systems:

- the liver
- the urinary system
- the hematopoietic (blood-forming) system
- the reproductive system

SIGNS AND SYMPTOMS OF OVEREXPOSURE

Headache, dizziness, nausea, and loss of coordination are indications of excessive exposure to vapors or spray mists.

Redness and itching or burning sensation may indicate eye or excessive skin exposure.

MEDICAL CONDITIONS AGGRAVATED BY EXPOSURE

May cause allergic respiratory and/or skin reaction in susceptible persons or sensitization. This effect may be delayed several hours after exposure.

Persons sensitive to isocyanates will experience increased allergic reaction on repeated exposure.

CANCER INFORMATION

For complete discussion of toxicology data refer to Section 11.

SECTION 4 — FIRST AID MEASURES

EYES: Flush eyes with large amounts of water for 15 minutes. Get medical attention.

SKIN: Wash affected area thoroughly with soap and water.
Remove contaminated clothing and launder before re-use.

INHALATION: If any breathing problems occur during use, **LEAVE THE AREA** and get fresh air. If problems remain or occur later, **IMMEDIATELY** get medical attention.

INGESTION: Do not induce vomiting. Get medical attention immediately.

SECTION 5 — FIRE FIGHTING MEASURES

FLASH POINT	LEL	UEL	FLAMMABILITY CLASSIFICATION
109 °F PMCC	0.7	7.9	Combustible, Flash above 99 and below 200 °F

EXTINGUISHING MEDIA

Carbon Dioxide, Dry Chemical, Foam

UNUSUAL FIRE AND EXPLOSION HAZARDS

Closed containers may explode when exposed to extreme heat.

Application to hot surfaces requires special precautions.

During emergency conditions overexposure to decomposition products may cause a health hazard. Symptoms may not be immediately apparent. Obtain medical attention.

SPECIAL FIRE FIGHTING PROCEDURES

Full protective equipment including self-contained breathing apparatus should be used.

Water spray may be ineffective. If water is used, fog nozzles are preferable. Water may be used to cool closed containers to prevent pressure build-up and possible autoignition or explosion when exposed to extreme heat.

SECTION 6 — ACCIDENTAL RELEASE MEASURES

STEPS TO BE TAKEN IN CASE MATERIAL IS RELEASED OR SPILLED

Remove all sources of ignition. Ventilate the area.

All personnel in the area should be protected as in Section 8.

Cover spill with absorbent material. Deactivate spilled material with a 10% ammonium hydroxide solution (household ammonia). After 10 minutes, collect in open containers and add more ammonia. Cover loosely. Wash spill area with soap and water.

SECTION 7 — HANDLING AND STORAGE

STORAGE CATEGORY

DOL Storage Class II

PRECAUTIONS TO BE TAKEN IN HANDLING AND STORAGE

Contents are COMBUSTIBLE. Keep away from heat and open flame.

Consult NFPA Code. Use approved Bonding and Grounding procedures.

Keep container closed when not in use. Transfer only to approved containers with complete and appropriate labeling. Do not take internally. Keep out of the reach of children.

SECTION 8 — EXPOSURE CONTROLS/PERSONAL PROTECTION

PRECAUTIONS TO BE TAKEN IN USE

NO PERSON SHOULD USE THIS PRODUCT, OR BE IN THE AREA WHERE IT IS BEING USED, IF THEY HAVE CHRONIC (LONG-TERM) LUNG OR BREATHING PROBLEMS OR IF THEY EVER HAD A REACTION TO ISOCYANATES.

Use only with adequate ventilation.

Avoid contact with skin and eyes. Avoid breathing vapor and spray mist.

Wash hands after using.

This coating may contain materials classified as nuisance particulates (listed "as Dust" in Section 2) which may be present at hazardous levels only during sanding or abrading of the dried film. If no specific dusts are listed in Section 2, the applicable limits for nuisance dusts are ACGIH TLV 10 mg/m3 (total dust), 3 mg/m3 (respirable fraction), OSHA PEL 15 mg/m3 (total dust), 5 mg/m3 (respirable fraction).

VENTILATION

Local exhaust preferable. General exhaust acceptable if the exposure to materials in Section 2 is maintained below applicable exposure limits. Refer to OSHA Standards 1910.94, 1910.107, 1910.108.

RESPIRATORY PROTECTION

Where overspray is present, a positive pressure air supplied respirator (TC19C NIOSH/MSHA approved) should be worn. If unavailable, a properly fitted organic vapor/particulate respirator approved by NIOSH/MSHA for protection against materials in Section 2 may be effective. Follow respirator manufacturers directions for use. Wear the respirator for the whole time of spraying and until all vapors and mists are gone. **NO PERSONS SHOULD BE ALLOWED IN THE AREA WHERE THIS PRODUCT IS BEING USED UNLESS EQUIPPED WITH THE SAME RESPIRATOR PROTECTION RECOMMENDED FOR THE PAINTERS.**

When sanding or abrading the dried film, wear a dust/mist respirator approved by NIOSH/MSHA for dust which may be generated from this product, underlying paint, or the abrasive.

PROTECTIVE GLOVES

To prevent skin contact, wear gloves which are recommended by glove supplier for protection against materials in Section 2.

EYE PROTECTION

Wear safety spectacles with unperforated sideshields.

OTHER PROTECTIVE EQUIPMENT

Use barrier cream on exposed skin.

OTHER PRECAUTIONS

Intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal.

SECTION 9 — PHYSICAL AND CHEMICAL PROPERTIES

PRODUCT WEIGHT	8.88 lb/gal	1064 g/l
SPECIFIC GRAVITY	1.07	
BOILING POINT	255 - 360 °F	123 - 182 °C
MELTING POINT	Not Available	
VOLATILE VOLUME	31%	
EVAPORATION RATE	Slower than ether	
VAPOR DENSITY	Heavier than air	
SOLUBILITY IN WATER	Not Available	

VOLATILE ORGANIC COMPOUNDS (VOC Theoretical - As Packaged)

2.26 lb/gal	271 g/l	Less Water and Federally Exempt Solvents
2.26 lb/gal	271 g/l	Emitted VOC

SECTION 10 — STABILITY AND REACTIVITY

STABILITY — Stable

CONDITIONS TO AVOID

None known.

INCOMPATIBILITY

Contamination with Water, Alcohols, Amines and other compounds which react with Isocyanates, may result in dangerous pressure in, and possible bursting of, closed containers.

HAZARDOUS DECOMPOSITION PRODUCTS

By fire: Carbon Dioxide, Carbon Monoxide

HAZARDOUS POLYMERIZATION

Will not occur

SECTION 11 — TOXICOLOGICAL INFORMATION

CHRONIC HEALTH HAZARDS

Reports have associated repeated and prolonged overexposure to solvents with permanent brain and nervous system damage.

Ethylbenzene is classified by IARC as possibly carcinogenic to humans (2B) based on inadequate evidence in humans and sufficient evidence in laboratory animals. Lifetime inhalation exposure of rats and mice to high ethylbenzene concentrations resulted in increases in certain types of cancer, including kidney tumors in rats and lung and liver tumors in mice. These effects were not observed in animals exposed to lower concentrations. There is no evidence that ethylbenzene causes cancer in humans.

TOXICOLOGY DATA

CAS No.	Ingredient Name			
100-41-4	Ethylbenzene			
		LC50 RAT	4HR	Not Available
		LD50 RAT		3500 mg/kg
1330-20-7	Xylene			
		LC50 RAT	4HR	5000 ppm
		LD50 RAT		4300 mg/kg
64742-95-6	Light Aromatic Hydrocarbons			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
95-63-6	1,2,4-Trimethylbenzene			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
110-43-0	Methyl n-Amyl Ketone			
		LC50 RAT	4HR	Not Available
		LD50 RAT		1670 mg/kg
763-69-9	Ethyl 3-Ethoxypropionate			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available
123-86-4	n-Butyl Acetate			
		LC50 RAT	4HR	2000 ppm
		LD50 RAT		13100 mg/kg
822-06-0	Hexamethylene Diisocyanate (max.)			
		LC50 RAT	4HR	Not Available
		LD50 RAT		738 mg/kg
28182-81-2	Hexamethylene Diisocyanate Polymer			
		LC50 RAT	4HR	Not Available
		LD50 RAT		Not Available

SECTION 12 — ECOLOGICAL INFORMATION

ECOTOXICOLOGICAL INFORMATION

No data available.

SECTION 13 — DISPOSAL CONSIDERATIONS

WASTE DISPOSAL METHOD

Waste from this product may be hazardous as defined under the Resource Conservation and Recovery Act (RCRA) 40 CFR 261.
Waste must be tested for ignitability to determine the applicable EPA hazardous waste numbers.
Incinerate in approved facility. Do not incinerate closed container. Dispose of in accordance with Federal, State/Provincial, and Local regulations regarding pollution.

SECTION 14 — TRANSPORT INFORMATION

Multi-modal shipping descriptions are provided for informational purposes and do not consider container sizes. The presence of a shipping description for a particular mode of transport (ocean, air, etc.), does not indicate that the product is packaged suitably for that mode of transport. All packaging must be reviewed for suitability prior to shipment, and compliance with the applicable regulations is the sole responsibility of the person offering the product for transport.

US Ground (DOT)

May be Classed as a Combustible Liquid for U.S. Ground.
UN1263, PAINT, 3, PG III, (ERG#128)

DOT (Dept of Transportation) Hazardous Substances & Reportable Quantities

Xylenes (isomers and mixture) 100 lb RQ

Bulk Containers may be Shipped as (check reportable quantities):

RQ, UN1263, PAINT, 3, PG III, (XYLENES (ISOMERS AND MIXTURE)), (ERG#128)

Canada (TDG)

May be Classed as a Combustible Liquid for Canadian Ground.
UN1263, PAINT, CLASS 3, PG III, (ERG#128)

IMO

5 Liters (1.3 Gallons) and Less may be Shipped as Limited Quantity.
UN1263, PAINT, CLASS 3, PG III, (43 C c.c.), EmS F-E, S-E

IATA/ICAO

UN1263, PAINT, 3, PG III

MATERIAL SAFETY DATA SHEET

B65C60
11 00

DATE OF PREPARATION
Aug 13, 2014

SECTION 1 — PRODUCT AND COMPANY IDENTIFICATION

PRODUCT NUMBER
B65C60
PRODUCT NAME
ARMORSEAL® REXTHANE™ I Urethane Floor Coating, Clear
MANUFACTURER'S NAME
THE SHERWIN-WILLIAMS COMPANY
101 Prospect Avenue N.W.
Cleveland, OH 44115

Telephone Numbers and Websites

Product Information	(800) 524-5979 www.sherwin-williams.com
Regulatory Information	(216) 566-2902 www.paintdocs.com
Medical Emergency	(216) 566-2917
Transportation Emergency*	(800) 424-9300
*for Chemical Emergency ONLY (spill, leak, fire, exposure, or accident)	

SECTION 2 — COMPOSITION/INFORMATION ON INGREDIENTS

% by Weight	CAS Number	Ingredient	Units	Vapor Pressure
1	100-41-4	Ethylbenzene		
		ACGIH TLV	20 PPM	7.1 mm
		OSHA PEL	100 PPM	
		OSHA PEL	125 PPM STEL	
6	1330-20-7	Xylene		
		ACGIH TLV	100 PPM	5.9 mm
		ACGIH TLV	150 PPM STEL	
		OSHA PEL	100 PPM	
		OSHA PEL	150 PPM STEL	
1	64742-95-6	Light Aromatic Hydrocarbons		
		ACGIH TLV	Not Available	3.8 mm
		OSHA PEL	Not Available	
2	95-63-6	1,2,4-Trimethylbenzene		
		ACGIH TLV	25 PPM	2.03 mm
		OSHA PEL	25 PPM	
8	110-43-0	Methyl n-Amyl Ketone		
		ACGIH TLV	50 PPM	3.855 mm
		OSHA PEL	100 PPM	
2	763-69-9	Ethyl 3-Ethoxypropionate		
		ACGIH TLV	Not Available	1.11 mm
		OSHA PEL	Not Available	
4	123-86-4	n-Butyl Acetate		
		ACGIH TLV	150 PPM	10 mm
		ACGIH TLV	200 PPM STEL	
		OSHA PEL	150 PPM	
		OSHA PEL	200 PPM STEL	
0.1	822-06-0	Hexamethylene Diisocyanate (max.)		
		ACGIH TLV	0.005 PPM	0.05 mm
		OSHA PEL	Not Available	
72	28182-81-2	Hexamethylene Diisocyanate Polymer		
		ACGIH TLV	Not Available	
		OSHA PEL	Not Available	

SECTION 3 — HAZARDS IDENTIFICATION

STATE OF SOUTH CAROLINA

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

COPY

KENNETH L. BARR, Employee/Claimant, vs. DARLINGTON COUNTY SCHOOL DISTRICT, Employer, through SC SCHOOL BOARDS INSURANCE TRUST, Carrier/Defendants.	)	WCC NO: 1507304 DEPOSITION OF: Dr. Paul Pritchard

DATE: Thursday, March 3, 2016

TIME: 2:03 p.m.

REPORTER: Holly Hiott O'Quinn, RPR

LOCATION: Department of Neurosciences
96 Jonathan Lucas Street, CSB 424
Charleston, SC 29401

HOLLY HIOTT O'QUINN, RPR
Independent Contractor working in association with

Milligan Court Reporting
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Email: Milligansc@comcast.net

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5

6 A P P E A R A N C E S

7 For Plaintiff: Preston F. McDaniel, Esquire
8 1315 Elmwood Avenue
Columbia, SC 29201
9 (803) 771-7211

10

11

12 For Defendant: Trask and Howell, LLC
By: Kirsten L. Barr, Esquire
13 763 Johnnie Dodds Boulevard
Post Office Box 2167
14 Mount Pleasant, SC 29465
(843) 881-4228

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1 INDEX

2 WITNESS PAGE

3 DR. PAUL PRITCHARD

4 By Mrs. Barr: 4

5 By Mr. McDaniel: 27

6 By Mrs. Barr .105

7 By Mr. McDaniel: 106

8 By Mrs. Barr: .107

9

10

11 **DEFENDANT EXHIBITS**

NO	DESCRIPTION	ID
1	Summary of evaluation	4
2	CV of Dr. Pritchard	5

(Line numbers 12–14 precede the exhibit table rows; lines 15–25 are blank.)

1 P R O C E E D I N G S

2 Thereupon, Dr. Paul Pritchard, The Witness, was

3 called for examination by Counsel for the

4 Defendant.

5 (WHEREUPON, Defendant's Exhibit No. 1 was marked

6 for identification only.)

7 DR. PAUL PRITCHARD,

8 being first duly sworn, testified as follows:

9 EXAMINATION

10 BY MRS. BARR:

11 Q Thank you, Dr. Pritchard. We met briefly

12 before we went on the record. But again, I'm

13 Kirsten Barr, and I represent the Darlington County

14 School District in a workers' compensation claim filed

15 by Mr. Kenneth Barr, no relation that we know of,

16 though our names do sound a lot alike.

17 The purpose of our deposition today is to

18 just ask some questions about your examination and

19 evaluation of Mr. Barr. In lieu of your live testimony

20 before the Workers' Compensation Commission, like any

21 deposition, I intend that my questions are

22 straightforward. But if they're not, please ask me to

23 repeat or rephrase them and I will be happy to do so.

24 And otherwise, we'll start with your full

25 name for the record.

1 A It is Paul Baker, B-A-K-E-R, Pritchard,
2 P-R-I-T-C-H-A-R-D, III. I was going to give you a CV,
3 if it helps you spell.
4 Q Yes, that sounds great.
5 A If that helps you. And if you --
6 MRS. BARR: Do you want to mark that as
7 Defense Exhibit 1?
8 THE WITNESS: Would you like one too? Or
9 maybe you already have one.
10 THE REPORTER: We've marked 1.
11 MRS. BARR: Okay. Well, yes.
12 (WHEREUPON, Defendant's Exhibit No. 2 was marked
13 for identification only.)
14 MR. MCDANIEL: Has that changed any since
15 you were, I believe, elevated to the appointment of a
16 new program director for neurology back on
17 February 19, 2014? Are there any additions to that?
18 THE WITNESS: Unfortunately, there's a
19 couple of new publications but not a bunch. Hardly
20 any, really. I wish I could say it changed a lot but
21 it hasn't.
22 BY MRS. BARR:
23 Q All right. So, Dr. Pritchard, you've given
24 us your CV, and I think that suffices in letting us
25 know more about your medical education and training.

1 But suffice it to say, you're a practicing neurologist
2 and professor of neurology here at the Medical
3 University of South Carolina; is that correct?
4 A That is correct.
5 Q All right. And you're board certified?
6 A I am.
7 Q And what is your certification in?
8 A I have two board certifications. One of them
9 is in neurology; and the other one is in clinical
10 neurophysiology, N-E-U-R-O-P-H-Y-S-I-O-L-O-G-Y.
11 Q Okay. And it was in your practice here at
12 MUSC that you came to evaluate Mr. Barr on
13 February 2nd of 2016; is that right?
14 A That's correct.
15 Q And you've been kind enough to provide us a
16 copy of your report of that date. And I've got an
17 extra copy, if that will help you. Is this a copy of
18 your report of February 2, 2016, regarding Mr. Barr?
19 A Let me just be sure you got everything.
20 Q Okay.
21 A It is.
22 Q Okay. And do you need a copy or do you have
23 one?
24 A I actually printed one off a short while ago.
25 Q And we have marked this as Defendant's

1 Exhibit 1. Is that how you marked it, or is it 2 now?
2 THE REPORTER: It's 1.
3 MRS. BARR: So it's marked as Defendant's
4 Exhibit 1.
5 BY MRS. BARR:
6 Q And this is a summary of your review of the
7 records and your evaluation and opinions regarding
8 Mr. Barr; is that correct?
9 A Correct.
10 Q All right. It appears that --
11 MR. MCDANIEL: I'll say that I was going to
12 note an objection, not really to the deposition. But
13 I was going to note an objection, but I'll just save
14 that for when I begin cross-examination in reference
15 to this report. Not the report itself but just the
16 submission of it versus your testimony -- in addition
17 to your testimony, I should say.
18 THE WITNESS: Okay.
19 BY MRS. BARR:
20 Q Mr. Barr appeared for the independent medical
21 evaluation accompanied by his wife; is that correct?
22 A Correct.
23 Q And he also conveyed some documents to you
24 that he had prepared?
25 A Well, I don't know if he prepared them or

1 somebody just relayed them to him. It was probably the
2 latter.
3 Q Okay. You had an opportunity to review the
4 documents he brought you?
5 A I did. And for the sake of reminding myself,
6 he sent me what I think was a partial report from the
7 neuropsychologist. I have the full report, courtesy, I
8 think, of both of you. I know I got it from you, and I
9 think I got it from you as well. And then he also
10 brought me some MSDS materials -- safety data sheets --
11 and I listed A through H here.
12 Q Okay. And it looks like he also had CDs
13 containing the actual CT and brain MRI films, various
14 dates; is that right?
15 A That is correct.
16 Q And you were able to actually look at those
17 films yourself?
18 A And with them, with the gentleman and his
19 wife.
20 Q Okay. Any significant findings on either of
21 the two CT -- or there was a CT -- an MRI and a CT
22 angiogram; is that right?
23 A Correct.
24 Q And any significant findings from your -- in
25 your opinion, on those exams?

1 A Well, they are. I scanned -- this is from
2 January 9, 2014. Showed what the radiologists often
3 call UBOs, unidentified bright objects. And these are
4 little specs of change in light matter that are seen
5 really as a norm in a person my age -- which he is not,
6 he's much younger -- are seen in people who have
7 chronic migraine, who have diabetes, who have
8 hypertension. And they're nonspecific changes that
9 relate to small vessels. They're not aneurysms.
10 Q Okay. Would this be -- do know we what
11 causes these small vessel changes?
12 A Well, they have the correlates were the four
13 things I mentioned: diabetes, hypertension, migraine
14 and being over 60 years old. I qualify for three of
15 those.
16 Q Okay. Would they have significance in
17 evaluating a patient who's complaining of cognitive
18 changes?
19 A Not likely. And here's why. Because in
20 general, cognitive abnormalities are seen in relation
21 to changes in the cerebral cortex, unless you have a
22 disease like Parkinson's disease, multiple sclerosis,
23 Huntington's disease that are more subcortical
24 pathology as well. But neither of those really applies
25 to this situation.

1 Q Okay. And then you also summarized the
2 records that my office had provided to you and you had
3 an opportunity to review those records as listed 1
4 through 12; is that right?
5 A I think that's right. That is correct, yeah.
6 Q Okay. And in addition to your review of the
7 medical records provided to you by Mr. Barr and by my
8 office, your note indicates that you had a face-to-face
9 evaluation with Mr. Barr that lasted approximately two
10 hours?
11 A It did.
12 Q Okay. And following that interview, you also
13 did a physical examination of Mr. Barr?
14 A Correct.
15 Q Anything -- any significant findings on your
16 physical examination?
17 A Okay. Let me just glance over it quickly, if
18 I may.
19 Q Yes, sir.
20 A You know, there were several. First of all,
21 this is not a finding except that he told me that he
22 had a headache rated seven of a ten in intensity. In
23 terms of the exam itself, he had some flexion deformity
24 in the fourth and fifth fingers of his right hand. And
25 he explained to me that he had injured some tendons

1 with a laceration unrelated to this action, I believe.
2 Q All right.
3 A And he had some scars from the surgery that
4 had been done there as well.
5 MR. MCDANIEL: No objection, but would you
6 mind referring to the page of your report.
7 THE WITNESS: Oh, I'm sorry. You know --
8 MR. MCDANIEL: I have it but --
9 MRS. BARR: I have a copy that's in the
10 same format that we are.
11 THE WITNESS: Yeah, I have a different
12 format here, so I -- this will help me a lot,
13 actually. It would be page --
14 BY MRS. BARR:
15 Q Top of five?
16 A Four, I believe.
17 Q Four into five, I believe.
18 A That is correct, yeah. So the physical exam
19 actually begins the bottom of page 4 and goes through
20 page 5 and a half.
21 MR. MCDANIEL: Okay.
22 THE WITNESS: And so in the very first
23 paragraph, I mentioned some operative scars in his
24 right hand, the flexion deformity of the fourth and
25 fifth fingers.

1 BY MRS. BARR:

2 Q Now, you went on to perform a neurological

3 examination; is that right?

4 A I did.

5 Q Okay. What does your neurological

6 examination -- or at least with respect to Mr. Barr's

7 case, what does that consist of? Help us understand

8 what you did and what you found.

9 A Sure. First of all, you look at the level of

10 consciousness. You examine various aspects of

11 cognitive function such as memory, language function,

12 ability to calculate and that sort of thing. In

13 conjunction with that, I did something that's called a

14 MoCA, M-O-C-A, which actually stands for Montreal

15 Cognitive -- C-O-G-N-I-T-I-V-E -- Assessment exam. And

16 he had normal comprehension, naming, fluency. All

17 components of his language were normal as were

18 calculations and, in fact, memory. We tested that as

19 well.

20 So he actually made a perfect score on the

21 Montreal Cognitive Assessment exam. This is not a

22 neuropsychological full evaluation, obviously. It's

23 the kind of thing that a neurologist does to survey for

24 language and memory and so forth.

25 Q Now, you mentioned the neuropsychological

1 testing. Is that something that you would use or rely
2 upon in your practice as a neurologist on a regular
3 basis?
4 A Often so, yeah. If somebody complains of
5 memory, in particular, that would be one thing we'd
6 like to have.
7 Q What can the neuropsychological testing
8 elucidate that maybe you can't do in a neurological
9 examination in your office?
10 A Well, it just really looks to things in
11 greater detail. That's one thing. And they have
12 certain standardized tests. For example, one of the
13 things that -- and I'm sorry, I don't remember the
14 neuropsychologist's name. But one of the things that
15 they did was a test called the Wechsler --
16 W-E-C-H-S-L-E-R -- Memory Scale, or WMS for short.
17 And so I don't think I mentioned that in
18 here, but he did have that test. And it actually
19 was -- that score was normal.
20 Q Okay. So was that consistent with your
21 neurological examination and the MoCA exam you did here
22 at MUSC?
23 A It was. The other thing I should mention
24 about a neuropsychological evaluation is they have
25 built in some tests that look at validity. In other

1 words, if somebody, quote, tries to pull a fast one on
2 it, they have tests that will often reveal a lack of
3 effort or inconsistent reporting and that kind of
4 thing. And I don't do those tests.
5 Q Okay. Do you ever work with Dr. Mark Wagner
6 or Dr. Randy Waid for neuropsychological testing in
7 conjunction with your treatment and evaluation of
8 patients?
9 A Well, I've actually worked with both of them;
10 more frequently Dr. Wagner, because he happens to have
11 an office about three doors down from mine.
12 Q Okay. This may seem like a silly question.
13 But if somebody performs well or has a perfect score on
14 the MoCA exam or a normal score on the Wechsler, is it
15 possible to have a false positive or to kind of out
16 perform your actual memory abilities?
17 A Well, I don't know why that would be the
18 case. There's sort of nothing in it for him to
19 over-perform. I just think it says he was doing his
20 best, as far as I could tell.
21 Q All right. And you don't see anything -- is
22 there anything unreliable about your testing of memory
23 or the neuropsychological testing regarding his actual
24 working memory?
25 A I don't think so. And I just have to say

1 that's on the basis of my feeling that he gave full
2 effort and was being straightforward. That's all I can
3 say. I didn't do those tests that I mentioned.
4 There's tests like the TOMM, which is Test of Malignant
5 [sic] --
6 Q Memory Malingering?
7 A Yeah. I could never remember what it stands
8 for. But that's one of the tests the neuropsychologist
9 did and that his neuropsychologist did.
10 Q All right. Now, after the neurological
11 examination section of your report -- or I should ask
12 you, anything abnormal about your neurological
13 examination or any findings that were abnormal?
14 A No. Beyond what we've talked about so far, I
15 did test cranial nerves, motor examination, including
16 cerebellar testing, sensory exam and reflexes. And
17 they were all okay.
18 Q Okay. And then the next section is your
19 assessment, correct?
20 A Correct.
21 Q All right. On bullet point marked Number 1,
22 you indicate that you felt his headaches were
23 consistent with chronic daily headache; is that right?
24 A Right. Just because he has them every day.
25 It's nothing more complicated than that.

1 Q All right. Well, is that a specific term,
2 chronic daily headache, or is that just a description
3 of his subjective complaints?
4 A It's a description.
5 Q Okay.
6 A You know, to reiterate or to go into it a
7 little more depth. Sometimes people have migraine
8 that's episodic. I know that from my own personal
9 experience. And sometimes, particularly if they don't
10 get the kind of treatment they may require, they will
11 evolve into a chronic daily headache. And some people,
12 from sort of the word go, have chronic so-called muscle
13 tension or muscle contraction headaches that are a
14 chronic daily headache. So it's a description.
15 Q Okay. Dr. Skinner, whose records I believe
16 you had an opportunity to review, had termed his
17 headaches in the past as tension headaches. Is that
18 significantly different than the description of chronic
19 daily headache?
20 A Well, tension headache is one cause of
21 chronic daily headache.
22 Q Okay. Analgesic rebound has also been
23 mentioned as a potential factor in the headaches that
24 Mr. Barr complains of. Is that a possible cause, or
25 can analgesic rebound play a role in his headaches?

1 A It could, although I can't validate that he
2 overdid pain medicine. I just don't know that to be
3 true.
4 Q At one point in his deposition, he had
5 indicated that he was taking up to three Goody's
6 Powders a day, and he's also known to drink a lot of
7 caffeinated drinks. Can those things, if you were
8 taking things like Goody's Powders or Tylenol, Advil,
9 Excedrin on a daily basis, could that be part of an
10 analgesic rebound effect?
11 A Not usually Tylenol, but Goody's Powders and
12 some of the other headache combinations that you can
13 just get over the counter. Then, of course, stronger
14 things could do it as well. I certainly don't recall
15 that he ever had any abuse of, you know, big-time
16 painkillers. It's not in any of the records that I saw
17 that I recall.
18 Q But something like a Goody's Powder if you
19 were taking those on a regular basis or frequently on a
20 daily basis, could that impact your headache syndrome?
21 A Well, it can cause rebound headaches,
22 absolutely.
23 Q Could caffeine -- you've seen those drinks.
24 I don't drink coffee, so it's all alarming to me. But
25 the Red Bulls and highly caffeinated drinks, can those

1 play a role in somebody with headaches, and can
2 caffeine --
3 A Caffeine is a two-edged sword. Because on
4 the one hand, caffeine, particularly when it's taken
5 with a simple pain medicine like Aspirin or Tylenol,
6 that sort of thing, can relieve headache whether it's
7 muscle tension headache or migraine. It's how I often
8 treated my migraine if they didn't get bad.
9 On the other hand, overuse of caffeine -- and
10 how much is overuse, that's hard to say. Overuse of
11 caffeine can also cause headache.
12 Q Okay. So if you were to treat a patient with
13 chronic daily headaches, would you have -- would you
14 caution them about the use of analgesics like Goody's
15 Powders or highly caffeinated drinks like Red Bull?
16 A I would.
17 Q Okay. Cigarette smoking. We know that
18 Mr. Barr is a cigarette smoker. Does smoking
19 cigarettes play a role in headaches, in your opinion?
20 A Well, the way it works is that you know that
21 there are changes in the small blood vessels in your
22 scalp and in the brain during a migraine attack. And,
23 of course, cigarettes -- nicotine, specifically --
24 triggers changes in small blood vessels and it can
25 complicate the treatment of migraine. Did it

1 complicate his treatment? I'm not sure about that.
2 But he is a smoker.
3 Q Okay. And patients that you've seen for
4 chronic headaches, do you have a recommendation
5 regarding smoking cessation?
6 A Yeah. I tell them it's a really bad thing to
7 do for that and a lot of other reasons.
8 Q Okay. So could the cigarettes potentially be
9 playing a role in the headaches that Mr. Barr described
10 to you?
11 A It's possible.
12 Q Okay. Regarding the headaches generally, can
13 you state to a reasonable degree of medical certainty
14 whether the headaches which Mr. Barr reports were
15 caused by his alleged exposure to volatile organic
16 compounds at the Darlington County School District?
17 A Well, I can't be sure. Let me explain a
18 little bit, because I want to be sure that it's fair to
19 everybody concerned, especially Mr. Barr. Exposure to
20 these volatile compounds, these volatile organic
21 compounds, most definitely can cause headache. But to
22 say a little bit more about volatile organic
23 compounds -- VOC, as they like to call them -- there's
24 several things to talk about. One is that not only can
25 they acutely cause headache, they can acutely cause

1 encephalopathy.

2 What's encephalopathy? Encephalopathy means
3 something is wrong with the brain. But it's a
4 transient thing. And if you stop taking the drugs, the
5 symptoms go away.

6 It also can cause some chronic changes. And
7 the best documented and the ones I think nobody would
8 dispute are the effects of, oh, compounds like
9 N-Hexane -- that's N, dash, H-E-X-A-N-E -- most
10 definitely could cause chronic neuropathy, irreversible
11 neuropathy, as can some other compounds. And I can't
12 list them for you because I don't know them all.

13 What about chronic encephalopathy? That's
14 harder. And it is, a matter of fact, some of the
15 information -- which your colleague was good enough to
16 send me -- actually speaks to that controversy a little
17 bit. And I also read about it -- I don't know when it
18 was, a few years back when I had a similar case. It
19 doesn't come up very often, at least with me, about the
20 question of chronic encephalopathy associated with
21 volatile organic compounds. And it kind of got started
22 with a graduate student in Denmark -- and I might have
23 talked about that.

24 MR. MCDANIEL: You did.

25 MRS. BARR: I think you did mention it.

1 THE WITNESS: Did I? Okay. Well, maybe I
2 could explain what I was getting at. She was working
3 on her doctoral thesis and she tackled that issue to
4 chronic exposure to volatile organic compounds cause
5 chronic encephalopathy, irreversible encephalopathy.
6 And she specifically looked at painters because of
7 their occupational exposure to -- in oil-based paint
8 and thinners and other things they may work with.
9 And she came to the conclusion that they did cause
10 chronic irreversible encephalopathy. And as a result
11 of that, as I understand the story, the workmen's
12 comp folks -- or whatever they call workmen's comp in
13 Danish, I don't speak Danish -- adopted that as a
14 cause for, you know, work-based injury and
15 disability.
16 Well, a few years later, some people in her
17 department -- and I'm sorry, I don't recall any of
18 their names. I read her paper and I read the other
19 papers several years ago. They looked at her data
20 and they said we disagree. And why do they disagree?
21 They disagree because they said she didn't have
22 appropriate controls and because they disputed some
23 of her statistics. I can't cite chapter and verse.
24 I'm just telling you what they said.
25 And as I understand it again -- and I'm

1 sorry that I can't quote chapter and verse -- Denmark
2 was sort of left, more or less, alone upon European
3 nations as one where they regularly award
4 vocationally based disability for this diagnosis,
5 which is irreversible encephalopathy associated with
6 volatile organic compounds. That's a mouthful.
7 So I'm just saying they seem -- maybe
8 they're correct, but they're out of step with the
9 other nations. And that's the story behind it, as I
10 understand it.
11 BY MRS. BARR:
12 Q Okay.
13 A I have no personal knowledge or expertise
14 beyond that, as far as toxicology is concerned. As a
15 matter of fact, you may notice that I said maybe a
16 toxicologist should address this situation and give a
17 better answer.
18 Q Certainly. You spoke to this a moment ago,
19 but that VOC exposure could cause an acute headache.
20 A Sure.
21 Q Would you expect there to be a strong
22 temporal correlation between the alleged exposure and
23 the development of the headache?
24 A Oh, yeah, for sure.
25 Q Okay. So -- just for the record, it's

1 page 342 of the HPAs. But if the record reveals that
2 Mr. Barr had sought treatment, actual treatment with a
3 pain management specialist for severe headaches in
4 May 2012, which was a period where he had been
5 completely out of work for approximately five months
6 because of that hand injury you discussed, would that
7 tell you anything about the temporal relationship
8 between his alleged exposure to VOCs and the headaches
9 which he complained of?
10 A Well, it would tell me there was a lag
11 between his exposure and his treatment. What I can't
12 tell you -- I don't have in my mind from the records
13 the time line of the onset of his symptoms of headache.
14 As I mentioned to you, based on what most neurologists
15 understand in this country, encephalopathy associated
16 with these volatile compounds is acute transient and it
17 goes away. That's what transient means. And there's a
18 lot of controversy as to whether there's any
19 irreversible aspect to it. In fact, even the MSDS
20 speaks to the controversy surrounding the chronic
21 aspect.
22 Q Well, one way -- in getting back, I guess, to
23 your assessment regarding the encephalopathy,
24 particularly -- Charlie Banov used to tell me,
25 Dr. Banov used to say you don't need to know the

1 constituents of gunpowder to determine if somebody has
2 a bullet wound -- well, for the bullet wound. And I
3 guess the bullet wound we'd be looking for here in this
4 case would be evidence of encephalopathy of brain
5 damage. So my question to you is, did you find any?
6 A I didn't.
7 Q Okay.
8 A Within the limits of what a neurological exam
9 shows -- and, again, it's not the same as a
10 neuropsychological exam -- his neurological exam was
11 normal.
12 Q All right. And encephalopathy, I mean, could
13 you state to a reasonable degree of medical certainty
14 that he even has encephalopathy?
15 A Well, not at least based on the neurological
16 exam; which is the tool I have.
17 Q Correct. I mean, would there be any other
18 way to diagnose encephalopathy?
19 A Sometimes an EEG will be abnormal and give
20 you a clue.
21 Q All right. But you haven't seen an abnormal
22 EEG in his case?
23 A I am not 100 percent sure that he ever had
24 one.
25 Q Okay.

1 A I don't remember one. But if he did, I'd
2 certainly be glad to look at the report.
3 Q Okay. And you've had an opportunity to
4 review Dr. Lind -- he's the neuropsychologist in
5 Columbia who did that testing. You've reviewed his
6 testing. Have you also seen the reports of Dr. Wagner
7 and Dr. Waid? If you don't remember, that's fine.
8 A You know, I didn't list them, so I'm guessing
9 that I haven't.
10 Q Okay. Well, with respect to Dr. Lind's
11 report, you did --
12 A So you're saying that Dr. Wagner saw him?
13 MR. MCDANIEL: No.
14 MRS. BARR: No. He refused to see
15 Dr. Wagner. But Dr. Wagner generated a report
16 based on the test data generated by Dr. Lind.
17 THE WITNESS: I haven't seen that.
18 THE REPORTER: I'm sorry, test data --
19 MRS. BARR: Yes. Generated by Dr. Lind.
20 THE WITNESS: I'm sorry, I haven't seen
21 that.
22 BY MRS. BARR:
23 Q Oh, that's fine.
24 A I now remember this gentleman's letter where
25 some of this was in dispute. But I'll leave that to

1 you guys as to who did what, when. I don't know.

2 Q But you did review the neuropsychological

3 testing by Dr. Lind?

4 A That one I did.

5 Q Okay. So anything about the

6 neuropsychological testing which would lead you to

7 believe that he has encephalopathy?

8 A No.

9 Q Okay.

10 A I mean, the thing that stood out the most is

11 the memory testing. I mean, that's one of his biggest

12 complaints other than the headache and some changes in

13 mood and so forth. And I just didn't see anything that

14 substantiated that particular claim.

15 Q Okay. And encephalopathy, that's just a

16 general term?

17 A It is.

18 Q More specifically, did you see any evidence

19 of neurological impairment or injury in Mr. Barr's

20 case?

21 A You mean from the neurological exam?

22 Q Yes, sir.

23 A No. It's a normal exam.

24 Q Okay.

25 MRS. BARR: Just give me one moment.

1 BY MRS. BARR:

2 Q From a neurological perspective, is there any

3 reason why Mr. Barr could not work in some capacity?

4 A Well, not based on my exam. I'm trying to

5 separate his concerns, which I hope I've faithfully

6 listed from what I saw at an objective level on exam.

7 And based on my objective findings, I don't see any.

8 Q Okay. This is one of those legal questions.

9 And I hope I'm almost finished here. But could you

10 state to a reasonable degree of medical certainty

11 whether or not Mr. Barr has physical brain damage as a

12 result of his alleged exposure to volatile organic

13 compounds at the school district?

14 A Well, based on my exam, I would say he does

15 not.

16 MRS. BARR: Thank you, Dr. Pritchard.

17 THE WITNESS: You're welcome.

18 EXAMINATION

19 BY MR. MCDANIEL:

20 Q Dr. Pritchard, I had a full system of things

21 I was going to ask you, but let's sort of cut back to

22 this. Let's talk about encephalopathy.

23 A Sure.

24 Q Well, actually, let's don't yet. Let's first

25 talk about types of headaches. You're board certified

1 in neurology by the American Academy of Neurology,
2 correct?
3 A Correct.
4 Q All right. And Mrs. Barr bounced around some
5 various names of headaches. But would you mind telling
6 me -- I believe the American Academy has broken them
7 down basically into four categories. And correct me if
8 I'm wrong. Basically, those are in reference to -- let
9 me find my notes. Where did I put those -- vascular --
10 A Uh-huh.
11 Q -- muscular constriction or referred to as
12 tension headaches?
13 A Right.
14 Q Traction and inflammatory?
15 A Right.
16 Q Okay. Now, vascular includes such headaches
17 as cluster type?
18 A Right.
19 Q Episodes of intense pain. Okay. And toxic
20 fever, that type of thing?
21 A Right.
22 Q Can cause them?
23 A Sure.
24 Q Muscular contraction include tightening and
25 tensing of the face and neck muscles, usually. In

1 reference to muscular contraction involved tightening
2 and tensing of the face and neck muscles; is that true?
3 A That's all true.
4 Q Now, out of those four categories in
5 reference to Mr. Barr's type of problem, his headaches,
6 which ones of those do we start out with? Or is there
7 any of those that we can exclude: The traction,
8 inflammatory, muscular contraction or vascular? Are
9 there any of those we can exclude?
10 A Well, so it's worth talking about each of
11 those a little bit, if that's okay.
12 Q Okay. I agree.
13 A So, you know, ones that have a headache,
14 well, some pain-sensitive structure has to be effected.
15 And those possibilities -- and it has to be something
16 above from the head up -- those structures include
17 muscles around the head and blood vessels inside and
18 outside the head and the covering of the brain, which
19 are the meninges, and large to medium size blood
20 vessels with the arteries and veins inside and outside
21 the head.
22 Q Okay.
23 A Actually, not the brain itself, for the most
24 part. You could open up a little trap door and punch
25 somebody on the brain and they might say stop that, but

1 it wouldn't hurt them. It wouldn't be painful is what
2 I'm saying.
3 So he has components -- and I'm just looking
4 at his description here -- some of which sound vascular
5 like migraine and cluster, and some of which -- some of
6 which sound muscle tension. And that's not uncommon,
7 actually. I mean, as a migraine sufferer, I can tell
8 you firsthand it's common for people with migraine to
9 also have muscle contraction headache.
10 So let me look at what he says here. He says
11 that his headaches are daily. They became more
12 frequent and more severe and now they're daily. He
13 says they involve his whole head and that they're both
14 steady on the one hand. That sounds like muscle
15 contraction. And throbbing on another. That sounds
16 like vascular headache; migraine, cluster, those kinds
17 of things.
18 Sometimes they're associated with nausea,
19 which is a little more typical for vascular headache,
20 especially migraine.
21 And that's really about it. And he went on
22 to tell me about all the medications he takes. So why
23 not inflammatory? Well, nobody has done a -- has
24 anybody done a spinal tap? No, not as far as I know.
25 So if you've got meningitis, you can have a very severe

1 headache. But then meningitis doesn't go on for years
2 either. So the odds of finding that are really very
3 small. Traction --
4 Q Along with encephalitis?
5 A Yeah, encephalitis, brain abscess, any kind
6 of infection or inflammation.
7 Q But that can result in permanent neuron
8 damage?
9 A Oh, yeah, all of those can, absolutely. As
10 far as vascular component, if a vessel stretches, it
11 dilates. That can hurt. If something is pulling on
12 it, that hurts. If something -- you mention traction.
13 If there's traction on the meninges -- that's the cover
14 of the brain -- that produces pain.
15 Q Okay.
16 A So we've talked about vascular. We talked
17 about inflammation. We talked about the muscle tension
18 part. It seems like there was one other thing. I
19 think I left one out. I'm sorry.
20 Q Traction and inflammatory, muscle contraction
21 and vascular.
22 A I think we covered them.
23 Q Okay. So basically, the two we're looking
24 at, vascular and tension?
25 A Right.

1 Q Okay. Components of those two. All right.
2 And along with that, we don't have any evidence of any
3 others like -- item like you were talking about like a
4 tumor or anything like that; is that correct?
5 A No. I just say that based on the scans and
6 the exams. None of that would make you think of that.
7 Q I want to go through the MSDS sheets with
8 you.
9 A Sure.
10 Q But one of the acute and chronic problems
11 associated with those MSDS sheets -- I think you'll
12 probably agree with me -- but in other words, if you
13 don't, please explain. But in other words, one of the
14 acute symptoms of a problem being associated with
15 exposure to VOCs or some type of neurotoxin, what we're
16 talking about in VOCs is neurotoxin; is that correct?
17 A Correct.
18 Q Okay. And when we're talking about that,
19 what we're talking about is one of those, at least, is
20 like dizziness and the other one is headaches?
21 MRS. BARR: I'm going to object for the
22 form of the records. The MSDS sheets speak for
23 themselves and talk about overexposure. And there's
24 certainly no evidence of overexposure in this case.
25 MR. MCDANIEL: Thank you for your

1 objection.

2 BY MR. MCDANIEL:

3 Q Okay. Do you agree that one of the acute

4 signs is headaches in reference to exposure to VOCs or

5 neurotoxins?

6 A Well, not to quibble with terms, but I would

7 say symptoms. Just because a sign is something you

8 could see, and a symptom is something people report.

9 So I'm not trying to be difficult.

10 Q No, I understand. I understand.

11 A But, yeah, that's a symptom, for sure.

12 Q And so tell me -- let's talk about that just

13 a second, the difference between sign and symptoms, so

14 I can make sure I try to phrase my questions correctly.

15 A Right.

16 Q Sign and symptom. What's the difference, in

17 your -- from your standpoint?

18 A Sure. Well, a sign is something that you can

19 see, hear, feel, taste -- I don't usually taste stuff

20 very much. But an objective change. So a good example

21 of that would be a reflex change. That the reflexes

22 are more brisk on one side of the body than on the

23 other side. That would be an example.

24 Q Okay.

25 A Or looking at the pupils, that the pupils are

1 unequal in size. That's a sign. Or the pupils don't
2 react normally to shining a light in them. That's a
3 sign. Whereas some things would be things that the
4 patient reports to you, not any less valid but just not
5 the same. And so a symptom would be headache,
6 tingling, changes in feeling, and that kind of thing.
7 Q Dizziness?
8 A Dizziness.
9 Q Fatigue?
10 A Fatigue. Nausea.
11 Q Pain?
12 A Pain, yeah. All of those.
13 Q All right. Now, let's talk a little bit
14 about encephalopathy.
15 A Uh-huh.
16 Q Well, before we do that. In reference to
17 headache and neurotoxins and -- when we're talking
18 about neurotoxins and neurotoxins' effect on the brain,
19 are we talking on a visual level or a microscopic level
20 when we're talking about damage to the neurons?
21 A Well, I guess I want to be sure I understand
22 the question. If you're talking about the effects,
23 say, of toluene, which is a volatile organic compound
24 on the nervous system, it may produce changes in
25 peripheral nerves, and that change would generally be

1 microscopic. Does that answer your question?
2 Q Yes. In part, yes. So in other words, when
3 we're talking about exposure to neurotoxins such as
4 chemicals -- or a lot of times in reference to
5 psychological problems, I imagine in your practice, do
6 you see a good number of people who have had a
7 drug-drug interaction resulting in encephalopathy of
8 the brain --
9 A Oh, sure.
10 Q -- which is actually a swelling of the brain?
11 A Well, not necessarily a swelling of the
12 brain.
13 Q Well, okay.
14 A It could be a swelling of the brain. But, I
15 mean, encephalopathy just means for whatever reason,
16 the brain isn't performing correctly. And it can be
17 from hitting a wall at 800 miles an hour. It can be
18 trauma, in other words. It can be from infection. It
19 can be from degenerative brain diseases like
20 Alzheimer's disease, which is way too common. It can
21 be from chemicals. Lots of possibility. Could be the
22 medications we give people, all of those.
23 Q Heavy metals?
24 A Heavy metals, certainly.
25 Q Anoxia?

1 A Anoxia, absolutely.

2 Q Of course, anoxia means basically the lack of
3 oxygen to the brain.

4 A Correct.

5 Q Okay. And that can occur from like being
6 knocked unconscious or something like that or your
7 heart stopping, for example?

8 A Well, for sure a heart stopping. Being
9 knocked unconscious, if you were put in a position
10 where you couldn't get a breath, that could do it,
11 yeah.

12 Q And, of course, it can also be caused by
13 simply lack of blood flow to the brain?

14 A That's definitely true.

15 Q And in other words, anoxia, that's what
16 results in it. But in other words, like, for example,
17 during cardiovascular or any type of major surgery,
18 anesthesiology where there may be a lack of blood flow
19 to the brain during the procedure or whatever.

20 A Well, again, not to nitpick -- and I sort of
21 didn't explain myself really well. Anoxia means you're
22 not getting enough blood to the brain -- not enough
23 oxygen to the brain, excuse me. Where you're not
24 getting enough blood to the brain is ischemia. But, of
25 course, how does oxygen get into the brain? Through

1 the blood. So, you know, they may be part and parcel
2 the same thing.
3 MRS. BARR: I'm going to object to this
4 line of questioning as being irrelevant.
5 BY MR. MCDANIEL:
6 Q Well, in reference to all these types of
7 damage to the brain, what level are we talking about?
8 When I say level, are we talking about something that
9 would be visual for sure on an MRI?
10 A In which case of all of these things we've
11 been talking about?
12 Q Okay. Let's say, for example, heavy metal
13 poisoning, lead.
14 A Well --
15 MRS. BARR: Again, object to the relevance.
16 THE WITNESS: Well, heavy metal poisoning
17 may cause things at the microscopic level. And
18 sometimes it may cause brain shrinkage too.
19 Actually, I have several patients like that who have
20 epilepsy as a result of lead poisoning in childhood.
21 BY MR. MCDANIEL:
22 Q Did you have any --
23 A And they've got visual things you could see
24 on the scan.
25 Q Trust me, I didn't mean to cut you off. Have

1 you had any involvement, say, for example, like any of
2 the Exide battery cases, Exide battery plant cases or
3 any of the local cases involving exposure to toxic
4 substances and to heavy metals -- and/or heavy metal?
5 MRS. BARR: Again, I'm going to object to
6 the relevancy of this entire line of questioning.
7 THE WITNESS: Well, may I just ask you
8 this? I don't know for sure if I was an expert or an
9 informal consultant. But the answer is yes, one
10 time.
11 BY MR. MCDANIEL:
12 Q Okay. Could you tell me about which type of
13 case that was?
14 MRS. BARR: Objection to the relevancy.
15 THE WITNESS: It involved a gentleman who
16 worked in a battery plant.
17 BY MRS. BARR:
18 Q Okay.
19 A And what complicated things a bit -- and I'm
20 not casting aspersions, at all -- was that he also was
21 kind of fond of moonshine, which is another source of
22 lead.
23 Q Lead.
24 A But he most definitely was exposed to lead on
25 the job. No question about it.

1 Q Okay.

2 A I haven't heard anything about that in a long
3 time, so I guess they all went away and made an
4 agreement.

5 Q Well, the reason I was asking you, in
6 particular, was in the course of reference to -- we're
7 talking about the same type of effect in reference to
8 volatile organic compounds as we're talking about in
9 reference to heavy metals, as far as -- we're talking
10 about microscopic damage to the brain; are we not?

11 A Well, it could be microscopic. If severe
12 enough, it might also cause shrinkage of the tissue.

13 Q I understand. So we can talk about -- I know
14 you said that you recommended -- I believe you actually
15 recommended that he be seeing an occupational medicine
16 and toxicological expert and that, I believe, was your
17 recommendation.

18 A I guess I was kind of assuming it might be
19 the same person. But I don't know who has those
20 credentials. I just don't know.

21 Q I was just trying to look back and see. I
22 don't want to misstate anything.

23 A Yeah, I think it's in the very last paragraph
24 on page 5, maybe.

25 Q Occupational medicine physician who has

1 training and experience in toxicology.

2 A Oh, yeah, there it is. Yeah, I'm just

3 acknowledging what I don't know. That's all.

4 Q Oh, I understand. No -- and I appreciate

5 that recommendation. Okay. Now, let's talk about in

6 reference to encephalopathy, just so the commissioner

7 can understand this and so I can better understand it.

8 You know, what we talk about is -- again, referring to

9 the American Academy of Neurology concerning prognosis,

10 it says that it depends on the treatment, it depends on

11 the type and severity of encephalopathy.

12 A Sure.

13 Q Okay. So when we talk about -- can you tell

14 me what we mean by type and severity of the

15 encephalopathy. Particularly of the type.

16 A Well, it's just some of the things that I

17 mentioned. That type can be physical trauma. It can

18 be chemical trauma. It can be not enough oxygen, not

19 enough blood flow, infection. You can go on down the

20 list.

21 Q Okay.

22 A And so that's the type part.

23 Q Okay. So if I use the term toxic

24 encephalopathy, tell me what in your reference -- frame

25 of reference what that means.

1 A When we say toxic encephalopathy, we almost
2 always mean some foreign substance that's injurious
3 that causes injury.
4 Q Okay.
5 A And so it can be everything from the doctor's
6 well medication to chemical compound encountered when
7 you're, you know, sprinkling your lawn against pests
8 and stuff, weeds, to a chemical you picked up at work,
9 et cetera --
10 Q Okay.
11 A -- to a toxin you picked up when you were in
12 the jungles of Vietnam and Agent Orange got sprayed all
13 over the place. All of those are toxins.
14 Q And then we say causing injury. What does it
15 cause injury to?
16 A Well, different organs. It depends. Agent
17 Orange, for example, put people at increased risk for
18 developing lymphoma, among other things.
19 Q Well, encephalopathy, what -- when we talk
20 about toxic encephalopathy --
21 A Oh, encephalopathy, yeah. Agent Orange
22 didn't really do that.
23 Q Well, what are we talking about when we talk
24 about toxic encephalopathy? What does it do injury to?
25 A To the brain.

1 Q To the brain. So, all right, now, if you
2 have a drug-drug interaction, one-time occasion, where
3 let's say you're hospitalized -- I'm used to seeing --
4 pardon me, Doctor, but like I'm used to seeing people
5 being admitted for drug-drug interaction like here at
6 MUSC and up in Columbia at Richland Memorial where
7 they've had a reaction, a lot of times in reference to
8 treatment for psychological conditions and they had
9 some kind of reaction and they're put in and they talk
10 about swelling of the brain and, of course, everything
11 that goes along with encephalopathy -- acute
12 encephalopathy, for a better term.
13 MRS. BARR: Objection to relevancy.
14 BY MR. MCDANIEL:
15 Q I mean, in reference to that kind of thing,
16 does -- you can have permanent damage from a one-time
17 drug-drug interaction; is that correct?
18 A That's correct.
19 Q You can have -- you can have permanent damage
20 to the brain from a one-time exposure to any type of a
21 toxin?
22 A Depends on the toxin.
23 Q Well, okay. It does depend on the toxin; I
24 agree.
25 A For example, you can -- there are huffers out

1 there. That's a street term you probably heard. Kids
2 who sniff glue. And that causes an acute
3 encephalopathy and sometimes leads to their death. But
4 most of the time, it's a temporary proposition. It's
5 transient. And that's generally typical of the
6 volatile organic compounds.
7 Q Okay. Going back to -- back when I was a
8 little kid, sniffing glue by accident, you know,
9 building those models -- I don't know if you did that
10 or not.
11 A I didn't sniff any glue, but I wasn't very
12 good at the models. They had a way of falling apart.
13 (There was a brief interruption.)
14 (Off the record 2:53 p.m.)
15 (On the record 2:53 p.m.)
16 BY MR. MCDANIEL:
17 Q I was using the term -- in other words, I
18 never sniffed glue intentionally.
19 A Okay.
20 Q But in other words -- you know, for example,
21 just using that glue in those models, that type of
22 thing. Any type of exposure to a toxin if you are
23 repeatedly exposed to it? The more you're exposed to
24 it, the more likelihood -- if it is the type of a toxin
25 that can cause organic brain damage or can cause damage

1 to the neurological system, the more likelihood that
2 you are to have a reaction or to have a -- develop a
3 permanent condition?
4 A That's probably true for some things.
5 Q Okay.
6 A What I don't know and just can't say is
7 whether it's true for the volatile organic compounds to
8 which he was apparently exposed.
9 Q Okay.
10 A I'm just acknowledging that I don't know
11 that.
12 Q I understand.
13 A But in general, the story is what I related
14 to you about the Denmark studies, as far as --
15 Q Of course, that was years ago.
16 A It's been awhile.
17 Q Yeah. And --
18 A But the ones that -- the studies that refuted
19 her stuff were, I don't know, probably about ten years
20 ago, something like that.
21 Q Okay.
22 A I can't cite chapter and verse.
23 Q Well, do you have any reason to doubt the
24 National Institute of Health and/or the MSDS sheets
25 approved by the Occupational Safety and Health Act

1 Administration in reference to that these organic
2 compounds can cause permanent physical brain damage?
3 Is that based on that --
4 MRS. BARR: Objection. It misstates his
5 actual records and --
6 BY MR. MCDANIEL:
7 Q Is that based on that study?
8 MRS. BARR: And it's not based on facts in
9 evidence. They speak of chronic overexposure.
10 There's no indication of exposure whatsoever in this
11 claim.
12 THE WITNESS: I guess I'd want to see the
13 specific thing you're referring to. But in general,
14 the MSDS sheets acknowledge the controversy
15 surrounding chronic encephalopathy from these
16 compounds. I said it was a controversial topic.
17 BY MR. MCDANIEL:
18 Q Okay. All right. Well, let's just go over
19 the MSDS sheets.
20 A Sure.
21 MRS. BARR: He doesn't have encephalopathy,
22 so it doesn't matter.
23 MR. MCDANIEL: I don't know that --
24 THE WITNESS: I think I have them with your
25 letter here. Actually --

1 BY MR. MCDANIEL:
2 Q Actually, I brought you a copy that I'm going
3 to give to the commissioner.
4 A Maybe I got it with the notes that he gave
5 me. In fact I know I've got them somewhere.
6 Q I tell you what. Let's see. Well, let me
7 march on down that road before we go to the next road.
8 A Sorry, I don't mean to mix your stuff up
9 there. Yeah, I do have his MSDS sheets right here.
10 Q Okay. I think maybe that -- before we go to
11 that, let's talk a little bit more about
12 encephalopathy.
13 A Sure.
14 Q In other words, you can have acute
15 encephalopathy. When you're referring to this term
16 where you're talking about chronic -- excuse me --
17 toxic encephalopathy. It's actually referring to, you
18 know, just damage has been done to the brain on a
19 microscopic level. Am I not correct on that? It's
20 basically just the name of the condition?
21 A Toxic encephalopathy means that something has
22 temporarily interrupted the normal function of the
23 brain. And I know this doesn't apply to anybody in
24 this room. But if a person drank a 12-pack of beer,
25 odds are they would have toxic encephalopathy. And the

1 great majority of the time it's temporary. You know,
2 the headache the next morning -- so I've heard -- and
3 then you get better and you get back to your baseline.
4 Q I'm never going to let you cross-examine me,
5 Doctor, in that regard.
6 A I wouldn't --
7 Q I'm Irish.
8 A I'm not up to the task.
9 Q Okay. And then this is going along with what
10 I'm trying to get at. In other words, this reference
11 to that condition -- I mean, it's really a -- toxic
12 encephalopathy is not really -- well, help me -- break
13 this out for me. Because I'm trying to just make sure
14 I understand this. Like, the various symptoms you can
15 have from where there is a disease or an alteration of
16 the brain function or structure, you can have various
17 types of symptoms or -- not symptoms but signs or --
18 well, symptoms from that.
19 A That's true.
20 Q And you don't have to have all of those?
21 A That's also true.
22 Q By the way, I mention that -- do you remember
23 seeing a gentleman by the name of Mr. Mundy who
24 suffered a severe electrocution injury?
25 MRS. BARR: Objection to the relevance.

1 THE WITNESS: First of all, I don't
2 remember it. It makes me uneasy just because I want
3 to be sure I don't violate any HIPAA things.
4 BY MR. MCDANIEL:
5 Q Well, that's fine.
6 A Maybe this was in litigation and maybe it's
7 okay to talk about it. I just don't recall.
8 Q It's ended. But the reason I was --
9 MRS. BARR: It's not relevant. Objection.
10 BY MR. MCDANIEL:
11 Q Let me ask you, going back to the gentleman,
12 without mentioning names, he had -- he was alleging
13 that the brain -- that the lead had caused permanent
14 brain damage. Am I right on that? Is that what --
15 A I mean, I don't remember what he alleged --
16 Q Okay.
17 A -- or if I saw him.
18 Q Oh, okay.
19 A But if you say so, maybe it happened. I just
20 don't remember.
21 Q What I'm trying to get at is I don't want to
22 get hung up on the term encephalopathy.
23 A Okay.
24 Q Okay. You can have various types of damage
25 to the brain. In other words, toxins -- does every

1 toxic permanent or chronic change in the brain
2 indicate -- or equal an encephalopathy or not?
3 A Well, encephalopathy in its broadest sense
4 just means that something is wrong with the brain. It
5 can be temporary. It can be permanent. It can be
6 caused by all of those things we mentioned.
7 Q Okay.
8 A Just take trauma, for example, physical
9 trauma. As I said, if you run into a brick wall at 800
10 miles an hour, fair chance you may have permanent brain
11 injury. If a fellow Boy Scout delivers an uppercut to
12 your chin at the National Jamboree in Colorado Springs,
13 as he did to me -- I was knocked out -- that's
14 encephalopathy. But fortunately I woke up. And would
15 I have been better if he hadn't hit me and had won the
16 Nobel Prize in spite of it, probably not. So it was
17 temporary.
18 Q What I -- here again, what I'm trying to get
19 at is we can -- encephalopathy is really a sort of a
20 term that's used all over the place. For example, in
21 reference to this toxic encephalopathy term, add the
22 word toxic and it's generally referred to where there's
23 been chronic damage done to the function or structure
24 of the brain?
25 MRS. BARR: Objection. Asked and answered.

1 THE WITNESS: It can be acute or chronic.
2 BY MR. MCDANIEL:
3 Q I agree.
4 A Right.
5 Q So it can be acute or chronic. But in other
6 words, something has done -- so in other words, you can
7 have an encephalopathy that does acute damage, like you
8 had in that event where you got knocked unconscious.
9 That's an acute encephalopathy.
10 A It is.
11 Q And as far as you know, you didn't have any
12 permanent brain damage, although you haven't won a
13 Nobel Peace Prize yet, as far as I know.
14 MRS. BARR: He graduated from Harvard, for
15 goodness sakes.
16 MR. MCDANIEL: I'm not...
17 THE WITNESS: Don't put too much stock in
18 that.
19 BY MR. MCDANIEL:
20 Q I actually thought you did a fellowship at
21 Harvard.
22 A That's exactly right.
23 Q And you did a year as an instructor at
24 Harvard?
25 A That's right. It was a social experiment,

1 I'm sure, jut to see how we work out with a South
2 Carolinian.
3 Q Trust me, I'm the least qualified of any
4 individual in this room. But I'm just wanting to make
5 sure I understand.
6 A Sure.
7 Q In other words, we don't get hung up on the
8 term encephalopathy. Is there a term that you would
9 use instead in referring to a condition of a brain
10 that's affected the structure and function of the brain
11 to refer to an encephalopathy-type condition or a -- or
12 what term would you use if you found physical brain
13 damage or you believe that there's been damage to the
14 structure and function of the brain but other than
15 encephalopathy?
16 A Yeah. You can use encephalopathy in tons of
17 neurological patients.
18 Q Okay.
19 A Suppose they've had strokes. Well, that's
20 encephalopathy. Something is wrong with the brain.
21 It's a natural disease process, not poisoning. But
22 that's a form of encephalopathy. Probably one I didn't
23 mention.
24 Q And that's what -- I mean, I want to make
25 sure that neither the commissioner nor we get hung up

1 in this. And what we're talking about -- as a matter
2 of fact, the word encephalopathy -- I know you reviewed
3 those MSDS sheets. It's not referred to, it just says
4 permanent neurological and/or damage to the brain; is
5 that --
6 MRS. BARR: Objection. Misstates the
7 record.
8 THE WITNESS: That's -- I --
9 BY MR. MCDANIEL:
10 Q I'm not trying to misstate the record. I'm
11 just trying to --
12 A I want to be sure I don't mislead you. And
13 maybe you could refer me to some specific spot or
14 something. Because I haven't committed these to
15 memory. I did faithfully read them, though.
16 BY MR. MCDANIEL:
17 Q Reports of associated repeated and
18 prolonged -- I'll just give you my -- let me give you
19 this one. This is mine.
20 MRS. BARR: Do you want to cite a page
21 number?
22 MR. MCDANIEL: Page 49. It's one of the
23 MSDS sheets. And I've got mine highlighted.
24 THE WITNESS: You're talking about the
25 signs and symptoms of overexposure?

1 BY MR. MCDANIEL:

2 Q Uh-huh.

3 A And this is in specific reference to Krylon,

4 K-R-Y-L-O-N, Paint All Fast-Dry Enamel.

5 Q Okay.

6 A So, sure.

7 Q And that's what I'm getting back to is even

8 this doesn't refer to -- it says reports of associated

9 repeated and prolonged overexposure to solvents with

10 permanent brain and nervous system damage. I mean, so

11 we don't use the term encephalopathy there.

12 A We don't. But that's a term that you could

13 use. It would fit.

14 Q Okay.

15 A If there were brain injury from exposure to

16 this, you would call it encephalopathy.

17 Q All right. And am I correct that -- okay.

18 And you can have -- in any encephaloptic-type

19 condition, you can have some or all of the symptoms,

20 but you don't have to have all of them?

21 A That's true.

22 Q Okay. And would you agree that the signs or

23 symptoms of encephalopathy are -- include, you know,

24 inability to concentrate, memory loss --

25 A Correct.

1 Q Fatigue?

2 A Possibly.

3 Q Headaches?

4 A True.

5 Q And then there's a lot of others here.
6 Neurological symptoms, such as cognitive ability,
7 subtle personality changes.

8 A All of those are possible.

9 Q Okay. And you can have -- you've seen a lot
10 of patients with physical brain injury --

11 A I have.

12 Q -- caused by either one of these types of
13 conditions. And not all of them have all of those
14 problems; do they?

15 A That's correct.

16 Q And so -- and many times there is one more
17 prominent than the other?

18 A True.

19 Q Okay. Now, I think I want to -- at this
20 point, I want to go back -- and I want to be fair to
21 you. One thing I'm hearing you saying throughout your
22 testimony so far is that, that -- well, let me stop
23 right there and let me go back and do something else.

24 Is there any question in your mind that the
25 problem -- medical problem for which Mr. Barr has

1 sought treatment ever since 2010 and through the very
2 day is what?
3 A Well, I don't recall precisely when he sought
4 treatment. You said 2010?
5 Q Uh-huh. Well, let me --
6 MRS. BARR: The man's had four surgeries
7 since 2010, Preston.
8 MR. MCDANIEL: First and most respectfully,
9 if it's not an objection --
10 MRS. BARR: I've been very indulgent with
11 repeated irrelevant questions, Preston.
12 MR. MCDANIEL: You go ahead and be very
13 indulgent.
14 MRS. BARR: I just would hope that we could
15 get to the point.
16 MR. MCDANIEL: Yeah. The issue of this is
17 whether or not this man's got permanent brain damage.
18 MRS. BARR: And that's been asked and
19 answered.
20 MR. MCDANIEL: No, it has not.
21 THE WITNESS: It says here on page 3 of --
22 I'm sorry, I didn't mean to cut you off. But on page
23 3 of the -- of my IME, that his primary care
24 physician evaluated him for headaches September 2010,
25 and he referred Dr. Barr [sic] to Dr. Roland Skinner,

1 a neurologist in Florence, for an evaluation. So
2 that's the date I have.
3 BY MR. MCDANIEL:
4 Q Okay. I want to hand you a copy of
5 Commissioner Beck's copy of the APA submissions that
6 we're going to submit in there to him. I'm going to
7 begin at page 170.
8 So you have no report of chronic -- treatment
9 for chronic severe headaches or that being the major
10 focus of it before 2010, according to what you have in
11 your records and your report by your patient that you
12 evaluated Mr. Barr and that; is that correct?
13 A Well, that's my understanding. It is just
14 reflected in his primary care physician's notes. I
15 didn't know him then, but...
16 Q Right. Well, I understand. I'm going to
17 hand you Commissioner Beck's copy of what will be our
18 APA submissions. And if could ask you to just look on
19 June 15th of 2010 --
20 A I see it.
21 Q -- under chief complaint. What was the
22 reason he was seeking treatment at that time?
23 A It says CO -- which is complaint of -- HA --
24 which is headache -- off, slash, on, times two to three
25 weeks. So presumably based on this, his headaches

1 began late in May 2010 or early in June 2010.

2 Q And so the reason he was there for treatment,

3 according to this, would be what?

4 A Headache.

5 Q All right. Now --

6 A Also he mentioned fatigue.

7 Q I was going to ask you about that. Okay.

8 Now, let's flip over to page 169, back one. Oldest to

9 newest is the way I put these in.

10 A Okay.

11 Q All right. What was he -- what was the

12 reason he was there seeing the doctor then?

13 MRS. BARR: Objection. It's calling for

14 speculation. The medical records speak for

15 themselves. Dr. Pritchard has no personal knowledge

16 of why he saw his family doctor in September of 2010.

17 THE WITNESS: I do now, because I just

18 looked at the page.

19 BY MR. MCDANIEL:

20 Q Well, Dr. Pritchard -- hold on one minute.

21 In reference to counsel's objection, did she not send

22 you all these records?

23 A I don't know specifically about this page.

24 But I --

25 MRS. BARR: You're asking about the

1 claimant's personal motivations for seeing his family
2 doctor. It just seems awfully redundant.
3 BY MR. MCDANIEL:
4 Q I'm not asking about what his report -- in
5 reference to your review of the records that Mrs. Barr
6 sent you a month before I even knew that she was
7 sending any records to you, she included the records
8 from Dr. Chapman, she included the records from
9 Dr. Skinner, and she included the records from
10 Dr. White; did she not?
11 A I believe so.
12 Q All right. And so the purpose and the reason
13 this man was seeing his family doctor at that time was
14 for what problem?
15 A Well, on 9/1/10 -- and this is headed The
16 Medical Group, which is where his primary care doctor
17 was.
18 BY MR. MCDANIEL:
19 Q Right.
20 A It just says at the top he's there to discuss
21 results of a CT scan and management of persistent
22 headache with occasional classical migraine symptoms
23 and nausea. GI discomfort in photophobia.
24 THE REPORTER: I'm sorry, what was the
25 last --

1 THE WITNESS: Oh, I'm sorry, photophobia,
2 P-H-O-T-O-P-H-O-B-I-A. Means the light hurts your
3 eyes.
4 BY MR. MCDANIEL:
5 Q Okay.
6 A And CT head: normal. That's what it says.
7 Q Okay. Flip over to 167.
8 A So it looks like this is 9/13/2010.
9 Q Okay. What was his chief complaint, the
10 reason he was seeing the doctor that day?
11 A Chief complaint is a headache. That's
12 line -- sentence 2.
13 Q And he stated -- how long have the headaches
14 being going on?
15 A He states the headaches started about four
16 weeks ago, which I guess would have made it mid August.
17 Actually, I thought it was a little earlier than that
18 based on the previous note.
19 Q Well, then he -- all right. Never mind.
20 Let me stop you right there. I understand
21 you said you've got migraine headaches?
22 A I do. Well, I grew out of them. Got too
23 old.
24 Q Tell me about this. Just help me understand
25 this. Between tension and migraine, aren't there some

1 characteristics of migraine versus tension that help
2 you separate them out?
3 A Sure. They're actually criteria for making
4 the diagnosis by an organization called the
5 International Headache Society. I think it's called
6 IHS.
7 Q Right.
8 A And migraines typically have a throbbing
9 quality. They often have symptoms associated that
10 include photophobia -- P-H-O-T-O-P-H-O-B-I-A -- nausea,
11 vomiting. They are severe enough that they make you
12 stop your regular activity. And they may be preceded
13 by other symptoms that we call an aura, A-U-R-A.
14 Q Aura?
15 A That's just a little summary.
16 Q Yeah. And migraines, a lot of times, are
17 generally on one side of the other of the head?
18 A They are often hemicranial on one side, but
19 may be both sides at the same time. Either way works.
20 Q What does the effect of rest have on those?
21 A Usually helps you, especially if you can go
22 to sleep.
23 Q Okay. If you can get to sleep, then sleep --
24 it helps with the headaches?
25 A Often you hope you'll wake up without it.

1 Doesn't always happen.

2 Q But generally, do you wake up without it?

3 What is the effect of it?

4 A It almost always helps, but not always.

5 Q All right. In reference to tension

6 headaches, all right, where are they located from --

7 when patients describe, how do they describe them and

8 where are they located in --

9 A Well, they tend to describe a tightness or a

10 pressure-type thing as opposed to a throbbing. They're

11 usually on both sides, but they can be on one side.

12 That happens too. They're often up here or in the

13 back. In other words, in the front or the back. But

14 often all over. And they -- one really telling

15 characteristic is they're prone to occur as the day

16 wears on. You can sort of think of it as the day's

17 burdens mount, the headache shows up. That's just a

18 characteristic.

19 Q All right. Looking at page 167.

20 A Okay.

21 Q It said he's had a headache started about

22 four weeks ago. He was given a prescription for Lorcet

23 and states he is taking these. Unfortunately, the

24 headache has persisted. I don't know where that was

25 at. It might be 916.

1 Tell me about the -- he also reported in
2 reference to his headaches that he had been released
3 from the school district because he was having certain
4 other features. What were those problems or symptoms
5 he was having?
6 A Well, this is in the --
7 Q Subjective?
8 A This is the fifth sentence in the first
9 paragraph. And it says: Was released from work with
10 the school district because of dizziness, fatigue and
11 balance issues.
12 Q The other thing -- in the last sentence of
13 that objective, it says what? It says it persists
14 throughout the day. Do you see that?
15 A Oh, that's the second paragraph. I do see
16 that.
17 Q Okay. So he's having them all day from the
18 beginning of the day on, according to that?
19 A That's what it seems to say.
20 Q Now, in reference to tension headaches, you
21 wake up, and I believe you testified earlier that
22 they'll get worse as the day goes along.
23 A In general. Nothing is 100 percent.
24 Q I understand. You reviewed the medical
25 records, and I don't want to take too long with this.

1 We're going to go through some of Dr. Skinner's
2 records. But actually Dr. Skinner, shortly after this,
3 started seeing this man, and he treated him for two
4 years for headaches.
5 A Somewhere thereabouts.
6 Q All right. And then because he wasn't
7 getting any relief, he saw Dr. Marshal White sometime
8 in 2012?
9 A Correct.
10 Q Now, I want to just ask you a few questions
11 about Dr. Skinner. And I'll let you look at these for
12 him also, because these are records that were all
13 provided to you already by Mrs. Barr.
14 A I have Dr. White's records right here, I
15 believe.
16 Q Actually, what I want to talk to you about is
17 Dr. Skinner to start with.
18 A Okay.
19 Q And I'm going to just hand this back to you.
20 If you want to take it, it might be a little bit
21 easier.
22 A Sure.
23 Q Because Mrs. Barr also has these numbered as
24 well. Of course, he was referred there to Dr. Skinner
25 for headaches. And I believe as Dr. Skinner describes

1 them on that first page -- page 171, Kirsten -- the
2 patient states that he has had severe headaches for
3 last five weeks. Prior to that, he stated that he
4 would have an occasional headache, and usually
5 over-the-counter analgesics would take and get rid of
6 them.
7 All right. Now, he said it never lets up.
8 A Uh-huh.
9 MRS. BARR: Is that a question?
10 BY MR. MCDANIEL:
11 Q Well, my question is, is then also down
12 there, he says that he's reporting problems with
13 dizziness. Do you see that?
14 A I do.
15 Q He is reporting problems with lack of energy.
16 Do you see that?
17 A I do.
18 Q And he was having problems with
19 concentrating?
20 MRS. BARR: Is that a question?
21 BY MR. MCDANIEL:
22 Q Do you see that?
23 A Oh, I do see that. Sorry, I didn't know -- I
24 thought you were just telling me.
25 Q And you see that he was having interference

1 with work?

2 A Correct.

3 Q Now, tell me, in reference to migraines and

4 tension headaches, does any of that tell you anything

5 different? Do you normally have dizziness with tension

6 headaches?

7 A No. But I will say that Dr. Skinner thought

8 he had tension headaches.

9 Q I don't disagree with you.

10 A I'm just telling you what he said.

11 Q Oh, I understand.

12 A Yeah.

13 Q Well, in that regard, let's flip to the

14 second page.

15 A Okay. 172?

16 Q Yeah.

17 A Sure.

18 Q Before I ask you a question about that page.

19 If a person came to you with severe headaches and

20 that's why they were referred to you -- I know you do

21 your neurological examination -- does that neurological

22 examination have anything to do with confirming the

23 existence of severe headaches?

24 A No. The headache is a symptom, whereas the

25 exam shows you signs.

1 Q Okay.
2 A No way to confirm or refute a headache.
3 Q That was going to be one of my questions
4 somewhere down the line. There's very little objective
5 things we can do to confirm or deny headaches; is that
6 correct?
7 A I would say --
8 Q I think that's what you just said.
9 A I wouldn't say not very few. I would say
10 none at all.
11 Q Okay. So if I -- if a patient came to you
12 and said I've had five weeks of severe headaches, I've
13 taken Goody's Powders, hadn't never really had any
14 problem. If I had a headache before, I'd take a
15 Goody's Powder, it'd work. I'd take some kind of an
16 analgesic, it would work. These are persisting all day
17 long. I have dizziness sometimes. I have sometimes
18 problems with memory. It's affecting my ability to
19 work.
20 Tell me what kind of -- tell me what all you
21 would do in reference to that, as far as what -- tell
22 me about basically your examination. I know you'd
23 perform a neurological examination, but tell me what
24 you'd be looking at.
25 A Well, you'd do things like look in their eyes

1 to see if they have evidence of increased pressure in
2 their head. Prior to that, you look at their
3 medications to see if they're taking medications that
4 could cause those symptoms. Because medication can
5 cause any or all of those. You do a neurological exam,
6 as you mentioned, to see if they have evidence of what
7 we would call focal neurological signs, like a change
8 in the visual field, change in the reflexes, change in
9 paralysis, any of those kinds of things, to see if you
10 might need to move a little higher on the list, things
11 like a brain tumor.
12 Of course, at this point, he'd already had an
13 MRI scan and that had been excluded. But, yeah, those
14 are the kinds of things you would do.
15 Q The only thing they found was some ischemic
16 change in the white matter cells; is that --
17 A Right. That's what we were talking about.
18 Q What area of the brain was that in?
19 A What area?
20 Q Yeah, do you remember?
21 A Mostly in the frontal white matter
22 bilaterally. I've just got it written down here.
23 Q Okay. If you then did all the blood work and
24 testing and all that and they still had persisting
25 headaches from the moment they got up, rest didn't

1 appear to help, have them throughout the entire day, if
2 they were on many medications, you took them off of
3 those, what would you start to look at?
4 A You know, if I don't find any cause for
5 meningitis, brain tumor, caused from medications,
6 caused from things in their environment, then you treat
7 them symptomatically.
8 Q Time out. Good word. What would you do to
9 investigate their environment?
10 A Ask them if they're exposed to things such as
11 volatile organic compounds, among other things. You'd
12 look at -- in other words -- I don't mean to be
13 flippant about it, of course -- but you look at what
14 they do. And is there something in their life or at
15 work or at home that is part of this.
16 Q Okay. And I'm not going to refer to a
17 specific page, and I'm sure Mrs. Barr will correct me
18 if I'm wrong. But I believe Dr. Skinner testified that
19 at this point in time, all he thought was is that the
20 man was a repairman for the school district.
21 MRS. BARR: Objection. States facts not in
22 the record. Don't see even the relevancy of that
23 statement anyway. It's not a question.
24 BY MR. MCDANIEL:
25 Q On page 172, he reports that, as far as

1 social, he works for the school district as a handyman
2 and painter.
3 MRS. BARR: Are you trying to pit
4 Dr. Pritchard against Dr. Skinner?
5 MR. MCDANIEL: No, I'm not trying to pit --
6 Kirsten, is that an objection?
7 MRS. BARR: There hasn't been a question.
8 I'm trying to see what you're doing here. It seems
9 like you're just talking.
10 BY MR. MCDANIEL:
11 Q I'm not -- I'm going to ask you -- and I'm
12 sure Mrs. Barr will correct me -- to assume that you're
13 not going to find one place throughout Dr. Skinner's
14 entire records where he asked this man specifically
15 what he was exposed to at work nor did he ask for any
16 MSDS sheets or anything like that.
17 MRS. BARR: Objection. Page 172 says he
18 works at the school district as a handyman and
19 painter.
20 BY MR. MCDANIEL:
21 Q Didn't I just read you that, Doctor? I think
22 right before Mrs. Barr --
23 A You did.
24 Q Okay. My point is, is that you've said that
25 if all of your tests came back negative and they

1 weren't suffering from some sign of brain tumor or
2 something like that that we can find, that you're going
3 to start looking at the man's environment; are you not?
4 A Yeah. Including his physical environment,
5 his psychological environment, all of that. It's all
6 relevant, potentially.
7 Q Okay. I agree. And of course, Dr. Skinner,
8 as you referred to, he entertained, of course, tension
9 headaches throughout this entire time, throughout his
10 entire course of treatment. But also he did at some
11 point entertain -- I believe, also Mrs. Barr will
12 probably point this out -- rebound, possibility of
13 rebound headaches?
14 A I believe so, yeah.
15 Q All right. Now, I believe you already
16 testified that you don't believe that was -- from what
17 the history you have and everything you saw, you don't
18 believe that was the cause of his headaches?
19 A Well, I'm not exactly sure that's what I
20 said. I believe she asked me if, for example, Goody's
21 Powders could cause rebound headache.
22 Q Yeah, I agree.
23 A And I said yes.
24 Q Taken in sufficient quantity. Let's talk
25 about rebound headaches in reference to -- would you

1 agree that normally you've got to have quite a
2 substantial use of those, and if you remove them, they
3 generally improve?
4 A What typically -- it's hard to know how much
5 it takes and for how long it takes.
6 Q Right.
7 A But if you remove them, what typically
8 happens is that initially the headaches gets much
9 worse, and you have to tell them that. And then you
10 have to say but it will be worth it, because if that's
11 what the problem is, you will then get much, much
12 better.
13 Q Correct me if I'm wrong, but I don't see
14 any -- I believe you were referring to your review of
15 the records earlier, and I don't see any consistent
16 analgesic use, you know, that would equate to this man
17 having headaches from 2010 through 2016 and continuing.
18 A I can't be sure about that. I do know that
19 sort of the parting shot from Dr. Skinner on
20 November 15, 2011, is, I think, a good bit of this --
21 I'm sorry, that's page 191.
22 Q That's fine.
23 A I think a good bit of his problem may be
24 analgesic rebound. He needs to completely stop
25 intermittent Tylenol, ibuprofen, Goody's Powders. I'm

1 just quoting him.

2 Q I understand. And I appreciate that and

3 that's appropriate.

4 Now, did you know that when Dr. Marshal White

5 saw him, that since he hadn't gotten any relief for

6 almost two years that the first thing he did was he

7 asked specifically what the man did for a living?

8 A I don't remember that specific point. I

9 could look and see, though.

10 MRS. BARR: Object to the relevance.

11 BY MR. MCDANIEL:

12 Q Did you know that he took him out of work for

13 a period of 30 days from exposure to the VOCs, volatile

14 organic compounds?

15 A Could you tell me the date that it -- was it

16 11/28/12 or is this backwards?

17 Q That would be the first time I believe

18 Dr. White saw him.

19 A He -- no, I'm sorry, this is -- excuse me.

20 This is a six-week follow-up. It says still having

21 headaches. I may have skipped past the first one. I

22 beg your pardon. It's 10/17/12 was the first visit. I

23 had my hand in the wrong spot. That is the first time

24 he was seen, according to this, by Dr. White.

25 And, you know, at the bottom, it says

1 headache. And the area around plan is blank. Maybe
2 there's another note.
3 Q I don't know specifically if Dr. White took
4 him out at that time.
5 A He didn't -- he then -- but he did,
6 however -- excuse me -- write the same day a
7 prescription and says no exposure to volatile organic
8 compounds including paint fumes. So that was the same
9 day. I didn't see that at first.
10 Q I appreciate you finding that for me. What
11 would it tell you if after that time that he had some
12 improvement in his headaches?
13 MRS. BARR: Objection, based on facts not
14 in evidence.
15 BY MR. MCDANIEL:
16 Q Well, assuming that's, in fact, true.
17 A Well, it would suggest that exposure to those
18 compounds, volatile organic compounds, may have played
19 a role in his headaches.
20 Q Based on your review of the records -- I'm
21 not going to try to go too much longer through those.
22 But I do want to go through now, if we can, if we can
23 go through some of those MSDS sheets. But I want to
24 ask you one question about what was your understanding
25 of his job and exposure -- or his job. Tell me what's

1 your understanding of his job.

2 A I understand he basically was a painter that

3 sometimes did other things. I think he mainly did the

4 other things later on when they tried to get him into a

5 different situation at work.

6 Q Right.

7 A And I thought he was, you know, a maintenance

8 guy then, but I don't know specifically.

9 Q Well, you're basically correct. In other

10 words, Mr. Stagner wrote a memo about what had happened

11 back when he was Mr. Kenneth Barr's boss.

12 A I saw his deposition.

13 Q And they actually -- you know, Dr. White

14 prescribed him to be away from the organic compounds.

15 And then on another occasion, they took out -- the

16 school district took him out again out of the organic

17 compounds and it improved. At that point in time,

18 everybody thought that they were possibly just

19 aggravating his symptoms. It wasn't until later --

20 MRS. BARR: Objection for the facts not in

21 evidence and just the soliloquy from counsel.

22 MR. MCDANIEL: Well, the record will speak

23 for itself that's been submitted to the commissioner

24 in reference to Mr. Stagner's report of, I believe,

25 May 8th of 2015.

1 BY MR. MCDANIEL:
2 Q Now, let's --
3 A Do you want this back?
4 Q No, keep it for a second. We're going to
5 go -- I still want to go through those MSDS sheets with
6 you a little bit.
7 A Okay.
8 Q And then I guess -- of course, this really
9 turns on, you know, to a large extent on his exposure
10 levels. Mrs. Barr's and their position, he didn't have
11 any. And to a large degree, it's whether or not he had
12 some kind of a physical brain injury and/or if his
13 problems were -- headache problems being caused by his
14 exposure to volatile organic compounds, whether or not
15 he was exposed to them; is that a fair statement?
16 MRS. BARR: Objection. Calls for -- you're
17 asking him a legal question on what his claim turns
18 on?
19 THE WITNESS: Yeah. Well, I can't testify.
20 I see these MSDS sheets, and I didn't read them.
21 What I don't know is exactly what paint or thinner he
22 was exposed to and when and for how long. And I
23 don't know any of that.
24 BY MR. MCDANIEL:
25 Q And that was one reason I wanted to ask. I

1 know Mr. Barr and his wife, they've been seeking an
2 answer to his headaches for years. And they've just
3 gotten worse, and as you record in your records.
4 Eventually, Dr. White took him out of work. However,
5 my -- you know, did you understand that during the
6 summers he worked four 10s -- eight hours -- I mean ten
7 hours a day, all he does for the school district during
8 this time was paint.
9 A I don't recall that. I don't know.
10 MRS. BARR: Objection. Calls for facts not
11 in evidence.
12 BY MR. MCDANIEL:
13 Q Did you understand that during the school
14 year that he was a painter and that he -- during the
15 school year, they would do five 8s?
16 A I don't know that.
17 Q All right. I see reference in there to the
18 fact that he did use a respirator when he was in
19 enclosed areas.
20 A In reference -- you see that where?
21 Q In your report.
22 A Mine?
23 MRS. BARR: Actually, I think he denied it
24 to Dr. Pritchard.
25 THE WITNESS: I think he told me that

1 wasn't true. And, of course, I don't know one way or
2 the other. I just know what he told me. Let me just
3 look and see here.
4 MRS. BARR: It's page 3, Doctor.
5 THE WITNESS: Yeah. I think he and his
6 wife -- matter of fact, about the only time his wife
7 said anything was when she shook her head yes,
8 meaning --
9 BY MR. MCDANIEL:
10 Q Confirming what he was telling you?
11 A Confirming what he was saying, right.
12 Yeah, this is page 3, as she said,
13 paragraph 2, the last sentence. Quote: He also
14 contends that he was not informed that he should wear
15 personal protective devices or that such devices were
16 provided to him. And again, this is all I know based
17 on what he told me. I have no knowledge one way or the
18 other.
19 BY MR. MCDANIEL:
20 Q So we're not misstating my client or anybody
21 else. In other words, like what you recorded is that
22 he said he contends he was not informed that he should
23 wear protective -- personal protective devices?
24 A That's what he told me.
25 Q Or that such devices were provided to him.

1 So you're -- okay.

2 All right. So let's go to the MSDS sheets.

3 A Okay.

4 Q That's fine. I just want to confirm a few

5 things as I did with Dr. -- I believe those are on --

6 well, you've got your own separate copy. And I don't

7 know which order they're in.

8 A This is -- yeah, this -- it's just a series

9 of things stapled together, and they run anywhere from

10 one to four or five pages each. I listed all of them,

11 actually, in the IME.

12 Q Okay. And at least four or five of those

13 under -- that the method or routes of exposure were

14 from either inhalation and/or eye and skin contact.

15 A That's my recollection.

16 Q Okay. And under the safety equipment, you

17 don't know anything about -- in other words -- so in

18 other words, you can get through absorption -- in other

19 words, through skin and eye contact versus with contact

20 or inhalation?

21 A That's, in general, what I see here, yeah.

22 Q In reference to painters under the National

23 Institute of Health and the NIOSH report that I

24 provided you and which has been put into evidence,

25 there are certain occupations that over 50 percent of

1 the body burden is thought to come from absorption
2 through the hands and through the skin.
3 A I mean, I saw that. I don't have personal
4 knowledge or expertise that would let me know that.
5 Q So you reviewed his deposition. In his
6 deposition, he told -- I mean, did you address this
7 with him? If it was your understanding from him that
8 he didn't wear any protective -- I mean, respirator at
9 all, did you review with him the fact that he's always
10 said that he wore a respirator in enclosed -- where he
11 wasn't able to get adequate ventilation?
12 A I didn't discuss that with him.
13 Q Okay.
14 A I mean, I read this. But as I told him, my
15 opinion that I would offer that day would essentially
16 be based on what we did that day. And these records
17 would stand on their own two feet.
18 Q Okay. Well --
19 A And that I wouldn't try to get into a battle
20 with any other experts or his treating physicians. I'm
21 just expressing an opinion based on what the two of us
22 did that day.
23 Q Right. Okay. And so that just -- so we can
24 cut this a little bit. In other words, so you wouldn't
25 disagree that the two methods is inhalation and/or

1 absorption?

2 MRS. BARR: Two methods of what?

3 BY MR. MCDANIEL:

4 Q These organic -- as far as exposure, what

5 you're supposed to try to limit under the MSDS sheets

6 to these specific chemicals is you're supposed to try

7 to limit exposure. And the two routes of the way you

8 can get these chemicals into your body is through

9 either absorption or through inhalation?

10 A Well, that's what I got from reading the MSDS

11 sheets, not based on any personal expertise. That's

12 why I mentioned a toxicologist.

13 Q Right.

14 A It's important to know what you don't know

15 and to admit it.

16 Q All right. Now, we've referred to the

17 references by Dr. Chapman and Dr. Skinner --

18 A Right.

19 Q -- to the symptoms that he was relaying to

20 them. And without going through every record, I would

21 submit to you that that has been a consistent report of

22 symptoms; and that is dizziness, fatigue, confusion at

23 times and severe headaches. In reference to those and

24 in reference to migraines versus tension headaches

25 versus something being caused by a toxic injury to the

1 brain -- I'm going to use toxic injury to the brain --
2 correct me if you would like to use a different type of
3 word. Are any of those not -- let's say atypical
4 normally not found in reference to migraine headaches
5 or tension headaches?
6 A Actually, most of those things can be seen
7 with either one.
8 Q Dizziness?
9 A Sure. More with migraine than with tension.
10 Q Okay. But if he is waking up with migraines
11 or waking up with headaches, having headaches
12 throughout the entire day, that's not a typical
13 presentation of a migraine?
14 A Well, the thing that's atypical, it's a
15 little atypical for a muscle tension headache since
16 they tend to get worse as the day goes on. But
17 migraine can be there first thing in the morning.
18 Q Can be. But isn't rest normally -- if you
19 can get to sleep -- good for a migraine headache?
20 A Well, I'm talking about when it starts, not
21 when it stops.
22 Q Right. But when you wake up, is it normally
23 there or does it begin after you're awake?
24 A Oh, it most definitely can be the first thing
25 when you open your eyelids. That can happen.

1 Q Okay.
2 A It happens at different times.
3 Q Okay. All right. No question, though, in
4 your mind -- by the way, I believe you said you
5 referred to Dr. Lind's report, and you found Mr. Barr
6 to be credible and giving valid responses and fully
7 participating in your evaluation.
8 A He seemed to be cooperative and forthcoming,
9 as far as I could tell.
10 Q Okay. You refer to validity testing. Did
11 you see that, according to Dr. Lind's validity testing,
12 he was being forthright and validity test was perfect?
13 A I did see that.
14 Q Okay. So based on your evaluation, do you --
15 and what you see in these medical records where we've
16 had treatment from 2010 through 2016 for severe
17 headaches, in your opinion does he have a chronic
18 headache problem?
19 A He does.
20 Q Okay. Now --
21 A But I base that based on what -- I base that
22 from what he tells me, but nothing else.
23 Q In reference to our other conversation about
24 headaches, there's not really anything more than that
25 than we can do -- or you can do to actually verify that

1 one way or the other. Is that pretty well true?
2 A That's accurate.
3 Q Okay. There is one test I wanted to ask you.
4 I ran across at one point in time in another case, and
5 that was a use of a Holter?
6 A Say that again. I'm sorry.
7 Q Some type of use of a Holter where they --
8 sort of like an EEG except where they actually wore it
9 for like 72 hours.
10 A Oh, a Holter monitor. Oh, I'm sorry, I
11 thought you were talking about a halter like you put on
12 a horse.
13 Q I probably said it like that from -- I'm from
14 the country.
15 A A Holter monitor is just this portable device
16 you wear, usually wear a little sling over your neck,
17 and it records your heartbeats continuously day and
18 night. And sometimes they'll do it for several days.
19 Sometimes they will do it for even longer than that
20 just to monitor the heart rhythm. That's all.
21 Q But we've agreed he has a chronic pain. Is
22 it -- and we can't -- there's nothing out there we can
23 really prove or disprove whether or not that is coming
24 from, you know, what is the cause of the chronic pain
25 headache. Is that fair to say to both Mr. Barr and to

1 you?

2 A That's fair to say, but that's almost always

3 the way. Because, you know, the number one reason to

4 go see a doctor in the United States year after year

5 after year is headache. And thank goodness, most of

6 them don't have a brain tumor, don't have a stroke,

7 don't have meningitis.

8 But one of your main jobs when you're seeing

9 them is to try to be sure those things aren't true and

10 to try to be sure that any casual factor can be

11 eliminated to the extent possible. And that, if you

12 can, help them find relief. I mean, that's what it's

13 all about. And that you exclude serious underlying

14 disease to the extent possible. That's basically your

15 mission.

16 Q And in reference to heavy metals and in

17 reference to VOC exposure -- volatile organic compound

18 exposure is done on a microscopic level, and there's

19 very little objective testing to confirm that one way

20 or the other; is that correct?

21 A Confirm what?

22 Q Confirm that microscopic level, damage.

23 A I need to be sure I understand what you're

24 asking me. You're asking me to assume that volatile

25 organic compounds can cause permanent brain injury.

1 Q Right.

2 A And I've said to you earlier that that's very
3 much open to question and is highly controversial. And
4 while the acute encephalopathy --

5 Q In your opinion.

6 A In my opinion, just based on my education,
7 training and experience and the reading of the
8 literature I've done over the years, that acute
9 encephalopathy from those compounds is very well
10 documented and widely accepted. And chronic
11 encephalopathy is highly controversial. Doesn't mean
12 it can't happen, but it is highly controversial and one
13 that -- at least from my exam, I didn't see any signs
14 of encephalopathy.

15 Q Okay. Now, but what about physical brain
16 damage?

17 A Well --

18 Q Because I want to make sure we're talking
19 about the same thing there.

20 A Well, me too. But physical brain damage,
21 which caused encephalopathy, as far as I'm concerned,
22 he didn't have encephalopathy. His neurological exam
23 was normal. His memory was normal. His language, his
24 calculation, all the things we do on a neurological
25 exam were normal. So if I saw him, I wouldn't -- I

1 would certainly look at things that aggravated his
2 symptoms, but I wouldn't go into an extensive
3 evaluation for encephalopathy because, in my view,
4 there isn't any.
5 Q Okay.
6 A Not any objective evidence of an
7 encephalopathy.
8 Q Well, and here again, I'm trying to go back
9 to -- in reference to encephalopathy, I have seen that
10 term used and I've not seen that term used in reference
11 to the chronic change in the brain that there's
12 permanent brain damage from the -- for example, the
13 heavy metals, you know, and from -- I mean, there's no
14 question about lead causing -- and that you cannot do
15 it unless you document it, unless you do a biopsy of
16 the brain.
17 A That's not necessarily true. Sometimes it
18 causes shrinkage of the brain. All the patients that I
19 have who -- which is not many, less than five -- had
20 lead intoxication that was well documented by looking
21 at their blood and their urine, and they have shrinkage
22 of their brain. And, unfortunately, they have -- they
23 have cognitive impairment. They have epilepsy. They
24 have abnormal neurological signs.
25 Q Well, okay. You know, and I think you said

1 it's five or less in reference to that.

2 A Oh, I have very limited experience with lead
3 encephalopathy. But it is what we call -- that is
4 encephalopathy. That's what -- that's one cause of
5 encephalopathy.

6 Q And so is mercury beryllium, a lot of the
7 heavy metals?

8 A That's correct. I'm not sure about
9 beryllium. I'd have to look that up.

10 Q And so there's no question about -- you don't
11 disagree there's no question about volatile organic
12 compounds causing acute encephalopathy -- or acute
13 encephalopathy or injury to the brain?

14 A Acute encephalopathy, yeah.

15 Q Okay. All right. Would you agree that toxic
16 encephalopathy is a progressive condition?

17 A Well, it depends on the toxin. I mean,
18 ordinarily, let's suppose you -- let's suppose you're
19 exposed to a high level of lead. That might cause
20 permanent damage that doesn't change. Would it be
21 progressive? No, not really, unless you would continue
22 to be exposed to it, and then you might have more and
23 more damage.

24 Q All right. Now, would you agree with me,
25 that in reference to these signs and symptoms of

1 chronic -- I don't want to use the word encephalopathy
2 because it seems like it's such a mixed bag. It can be
3 used in such a broad term. But in other words, let's
4 just say physical injury to the brain structure or
5 function. You know, you've agreed with me previously
6 that you can have one or all of these signs or symptoms
7 but not without the others, or there can be one that
8 can be more major than the others.
9 A Different people have different signs and
10 symptoms for all kinds of things.
11 Q And that one of the signs and symptoms this
12 man has -- or one of the problems he has, the medical
13 problem he has is severe headaches.
14 A That's exactly what he tells us. Whether it
15 relates to exposure to volatile organic compounds, I
16 have no clue. But I doubt it if he's no longer exposed
17 to them. And I believe he isn't because he isn't
18 working now.
19 Q Right. I agree with that. But by the same
20 token, if -- in reference to heavy metals, the cases
21 that you've had, is it -- do you concur that that --
22 that it can cause physical brain damage to the
23 structure of the brain and then that that progresses?
24 A Not unless they continue to be exposed. It's
25 just permanent.

1 Q They're permanent --

2 A But I've followed some of these people for

3 ten, 15 years, they haven't progressed. They just

4 haven't gotten better. It's a permanent injury to

5 their brain caused by that exposure to lead way back

6 when they were kids.

7 Q All right. Are you aware of all the studies

8 in Japan that were done on those? The five-, ten-,

9 15-year studies?

10 A I'm not sure what you're referring to. There

11 were studies from Japan that had to do with mercury

12 exposure, if that's what you mean.

13 Q Let me see if I can find it.

14 A Of course, we aren't talking about heavy

15 metals here.

16 Q No. But my point of my question was, is that

17 in reference to toxic encephalopathy, that it

18 progresses. It can progress.

19 MRS. BARR: Objection. Asked and answered.

20 THE WITNESS: Again, I would say under what

21 circumstances, and I would want to make a distinction

22 between evolves and progresses. You know, after

23 you have a -- let's suppose, God forbid, a vessel in

24 your brain ruptures and you have bleeding into your

25 brain.

1 BY MR. MCDANIEL:

2 Q Right.

3 A And let's hope that you survive and improve.
4 Your condition evolves, but it doesn't progress from
5 that single thing, unless you also had epilepsy and
6 that might cause it to progress.

7 But, no, unless you continued to be exposed
8 to the toxin, I wouldn't expect it to progress. It
9 might evolve so that it looks different; that's all.

10 Q Okay. So I think I hear you saying -- would
11 you mind just explaining again evolution in reference
12 to if you had -- like, for example, like the cases
13 where you said that you've had some cases where they
14 had that the condition of the lead poisoning or lead
15 encephalopathy or injury to the structure, the physical
16 structure of the brain has progressed -- or not
17 progressed. You said evolved. Tell me what you mean
18 by that.

19 A Well, what I mean is that my patients,
20 unfortunately, they see me because they have seizures.
21 And the repeated seizures themselves have caused it
22 to change, have caused their situation to change. It's
23 not that -- because they're not exposed to lead
24 anymore. In fact, they don't even have abnormal levels
25 of lead in their body anymore. But they had damage

1 years and years ago.

2 Q Right.

3 A But I don't think that's got anything to do

4 with this, though, actually.

5 Q Well, I'm interested in particularly because

6 in reference to toxic exposure and physical injury to

7 the brain, Dr. Lind referenced a series of studies and

8 gave us a brochure on it, effects of lead on the adult

9 brain, a 15-year expiration. And what it showed is

10 that -- and he recommended -- one of the things he

11 recommended was retesting of neuropsychological testing

12 again every six months to a year --

13 A Well, I --

14 Q -- and it would probably show progression.

15 MRS. BARR: Objection. Misstates facts in

16 the record.

17 THE WITNESS: Well, I don't know what it

18 would show, and I'm not going to get into a battle

19 with his treating physician or another expert. I'll

20 let it stand on its own two legs.

21 BY MR. MCDANIEL:

22 Q Yeah. I wasn't trying to get you into a

23 battle with that. I was really seeking your opinion,

24 you know, from the standpoint of -- okay. Let's go

25 back in reference to an MRI. And, of course, I believe

1 you agree also, you listed some of the things that
2 cause white matter changes --
3 A Right.
4 Q -- in the MRI. That's one thing that we can
5 visibly see. Those can occur in reference to toxic
6 encephalopathy, too, correct?
7 A It's possible. But these are basically
8 nonspecific abnormalities that can be caused -- most of
9 the time we don't know what causes them. Most of the
10 time we don't. We most often -- when we have a pretty
11 secure basis for thinking we know, it's those four
12 things that I mentioned: age, migraine, diabetes,
13 hypertension.
14 But most people who come in, you look and you
15 go, oh, there's some little white matter changes, we
16 never ever discovered what caused them. And --
17 Q Tell me in -- I'm sorry.
18 A I was just going to say we don't know most of
19 the time.
20 Q Tell me in reference to epilepsy --
21 A And it mostly isn't really very relevant to
22 anything.
23 Q Tell me in reference to epilepsy and white
24 matter change.
25 MRS. BARR: Objection to the relevance.

1 BY MR. MCDANIEL:

2 Q You said something about that you had seen

3 some people that had exposure to lead previously, maybe

4 through moonshine or whatever, and that they then --

5 that you'd see some white matter changes on the MRI.

6 A Oh, I think you might have --

7 Q Maybe I misunderstood you.

8 A You might have misunderstood me. What I hope

9 I said was that they had shrinkage in their brain

10 caused by the exposure to lead. It actually wasn't

11 from moonshine in this case as it was, unfortunately,

12 from lead-based paint, which used to be everywhere.

13 It's still on some of the old houses and especially

14 here in town and it gets in the dirt and so forth.

15 Q Okay. Then in addition to that, now, you

16 also see white matter changes in reference to dementia?

17 A I'm sorry?

18 Q Dementia. And that also involves shrinkage

19 of the brain?

20 A Well, there's a gazillion causes of dementia,

21 you know, Alzheimer's disease, et cetera.

22 Q I was really referencing MRI changes that you

23 see a lot of times with dementia and -- objective

24 findings on an MRI is what I was getting at. But in

25 encephalopathy-type cases, do you see that a lot of

1 times, shrinkage of the brain?
2 A Depends on the cause of the encephalopathy
3 and how severe it was.
4 Q Okay. Okay. There we go with that word
5 severe again.
6 A Yeah.
7 Q All right.
8 A But I don't think he has encephalopathy based
9 on my exam and interview of him.
10 Q But he does have severe headaches?
11 A I'm going to accept that at his word.
12 Q If there is anything disabling him in your
13 opinion, it would be his headaches if there was
14 anything causing him to be disabled from -- you know,
15 in other words, based on what he was telling you about
16 how severe his headaches is, would that be the cause of
17 any disability or inability to work would be his
18 headaches?
19 A Well, that's not usually a sufficient cause.
20 This is the first mention we've had of disability. And
21 I've not addressed disability in my IME.
22 Q Well, you know, as a matter of fact, I'd like
23 your opinion on this. Do you think he's at maximum
24 medical improvement, or do you think there's some
25 treatment out there that can help this man?

1 A It seems as though he's at a plateau despite
2 a variety of treatments. And I suspect he is at
3 maximum medical improvement. I don't think anybody
4 asked me that question until just now. But I think he
5 likely is. Could he profit by seeing a neurologist who
6 would try to deal with his headaches? Probably so. I
7 don't know if he's still seeing Dr. White or not.
8 Q Okay. In reference to determining causation,
9 in your opinion, is it better to see a person over a
10 period of time, or are you better capable of judging
11 that on a one-time glimpse on an IME?
12 A Well, there's pros and cons. The pros about
13 seeing somebody on an IME is that you often have more
14 complete records than the treating physician does. I
15 venture to say that -- well, I don't know what records
16 Dr. White has. And I don't know what records
17 Dr. Skinner had. And I don't know what records his
18 primary care doctor has. Probably none of them has
19 better access than this. But I don't know.
20 So that's an advantage. It's an advantage.
21 I have the advantage of stepping back from the
22 situation and spending a couple hours with him and
23 spending several hours with the records and a good bit
24 of time afterwards to think about it. Those are all
25 things that help. Does it help to see somebody over

1 the course of months and years? Yeah, that helps too.
2 So I think there are advantages and
3 disadvances either way. And that's a question I've
4 been asked a lot of times. I try really hard not to
5 take -- not to trumpet somebody's position and not to
6 take a partisan stance. And I actually hope that I
7 just educate people. That really is my goal. And I
8 don't have any financial stake in what happens. I just
9 hope it works out for the best and that, as you say,
10 justice is served, whatever that is.
11 Q Yeah. I'm actually sorry I had to be
12 involved in this case. Don't know that I needed to.
13 But anyway. Let me ask you -- I'm just about finished,
14 Dr. Pritchard. According to what I have --
15 A I still have this, by the way. I don't mean
16 to steal it away from you. And I don't know if that's
17 yours. I have a copy of it, I think, so I don't mean
18 to steal it away.
19 Q Which one is it?
20 A MSDS.
21 Q I don't know if that was yours or not.
22 A I have the ones that he gave me in here, so I
23 don't want to take yours away.
24 Q Trust me, you don't -- you can keep that if
25 you want to.

1 A Thank you.

2 Q And, of course, I know you probably don't

3 want any more paper. Let's see. Okay. After request,

4 I received a copy of all the materials that had been

5 provided you. And I show that there was a

6 correspondence with you on December 8, 2015, and at

7 which time they wanted to schedule an independent

8 medical evaluation.

9 A Yeah, I think I may be missing that. I've

10 got -- that must have been the first one. And then the

11 next one I've got is January 29, where I think they

12 were trying to schedule it.

13 Q Deposition -- I've got this one dated the

14 19th.

15 A Oh. Well, I got the 29 one. I got this one

16 here, which is December 8. I'm just a poor record

17 shuffler, obviously.

18 Q Okay. I notice that --

19 A And I've got this one right here, which is

20 January 15th. Is that a duplicate? So December 8,

21 January 15, and there's one more, I think. And

22 January 29. That's the three I can see off the top of

23 my head.

24 Q Okay. Everything I've gotten, except for

25 this December 8th letter, was to your address here at

1 MUSC. This one is to an address at 939 Scotland Drive,
2 Mount Pleasant, South Carolina.
3 A That's where I live.
4 Q Okay. So the first communication -- now,
5 outside of this letter and the letter on January 19th,
6 have you had any other communications with defense
7 counsel?
8 A We may have spoken about the case before I
9 got involved. We haven't spoken about the case since I
10 saw the gentleman, because I think that's against the
11 rules.
12 Q Okay.
13 A And people strictly do that, as far as I can
14 tell.
15 Q And your report indicates this. We had gone
16 over this earlier. But in your report, you said
17 that -- your last recommendation was that he be seen by
18 an occupational medicine specialist with a specialty
19 in --
20 A Toxicology.
21 Q Yeah. Occupational medical physician who has
22 training and experience in toxicology.
23 A Right.
24 Q All right. And --
25 A Just because I thought they could shed more

1 light on the toxicologic components than I could.

2 Q It goes along with what -- Mr. and Mrs. Barr

3 told me that after the evaluation with you that they

4 reported to me that you had said -- you told them that

5 you thought you needed to get that kind of person

6 involved and that that's what you'd told the defense

7 lawyer already.

8 A I don't think so.

9 MRS. BARR: Objection. We've had no

10 conversations, Preston.

11 MR. MCDANIEL: Kirsten -- okay. Fine.

12 Thank you.

13 MRS. BARR: I mean, it's hearsay, Preston,

14 and it didn't happen.

15 BY MR. MCDANIEL:

16 Q So why did Mrs. Barr choose to send this to

17 you at your home address versus here, out of curiosity?

18 A I don't know that, except that I keep records

19 I review at home.

20 Q I agree. I understand.

21 A And I do exams here.

22 Q Okay.

23 A And exams are charged by MUSC, not by me.

24 Q Okay. I think I saw the arrangements that

25 physicians have with the various medical schools -- you

1 know, not always in treating. But in other words, I
2 noticed that. So in other words, you make, you know,
3 outside expertise money that you obtain, you know?
4 A Right. So the record review I do at nights
5 and on the weekends, that type of stuff.
6 Q Okay. If a person has a chronic headache
7 condition -- let me strike that.
8 You conducted your evaluation on
9 February 2nd?
10 A I believe so, yeah.
11 Q The first notice I got of request for your
12 deposition was February 17th. The hearing was set for
13 the 24th. When's the first time that you are aware
14 that they were requesting to take your deposition?
15 A I don't -- I actually don't know. I can look
16 at these pieces of paper.
17 Q Does somebody else do that for you, I mean,
18 some of your staff?
19 A Oh, yeah, yeah. Ms. Williams schedules the
20 depositions because they're here.
21 Q Okay.
22 A Just as she scheduled the IME, because it's
23 here.
24 MRS. BARR: Preston, we scheduled it at
25 your request, as you know.

1 MR. MCDANIEL: I'm going to get that as a
2 final thing after we finish the deposition.
3 BY MR. MCDANIEL:
4 Q Dr. Pritchard, do you have any idea of the
5 breakdown of how many cases you see in workers' comp in
6 reference to defense counsel versus plaintiff's
7 counsel?
8 A I don't keep records like that. But what I
9 can tell you, if you'll accept an estimate, is the bulk
10 of them are done at request of the defense.
11 Q Okay. I would accept that.
12 A Yeah. And if you ask me why, I don't know
13 why. It isn't because I have, you know, a
14 philosophical bent or because I haven't advertised --
15 because I don't advertise -- tilt in any direction.
16 It's just they ask me.
17 Q Okay.
18 A Somebody from plaintiff's Bar asked me to do
19 one yesterday, and I did.
20 Q All right.
21 A I'm just making you aware of that.
22 Q Well, and quite honestly, Dr. Pritchard, I've
23 asked you to do them in the past; haven't I?
24 A I think so.
25 Q Years ago, back particularly when you were up

1 in Orangeburg.

2 A Oh, that's true. Yeah.

3 Q Okay. In reference to your CV and all of the
4 articles and your focus, your interests, it looks like
5 from everything I see that your focus is on epilepsy.

6 A That's true.

7 Q And that -- correct me if I'm wrong. I saw
8 one article in reference to -- anything in reference to
9 headaches or toxic enceph -- toxic exposure.

10 A Well, this one --

11 Q Now, there may be something new. And if
12 there is --

13 A No. It didn't have anything to do with toxic
14 exposure. It did have to do with headache and
15 something that happened after a person had a lumbar
16 puncture. But, yeah, that's the only headache
17 reference in there, as far as I know.

18 Q And did you participate in that brain injury
19 symposium that was put on by, I think, Dr. Tsai put
20 that on when she was here. Y'all were part of the same
21 department; were you not?

22 A Right. Part of the time we were. She was
23 originally in the physical medicine rehabilitation
24 department, and they dissolved that department and she
25 joined our department for a while. And then she moved

1 across the street to Roper Hospital where I guess
2 she -- I heard she wasn't there anymore, that she's now
3 training for the Olympics, that she's an archer. I
4 don't know that for sure. She's a very good archer.
5 So I wouldn't take her on an archery.
6 Q I don't want to take her on in anything else,
7 having taken her deposition.
8 A She's really physically fit, too, by the way.
9 Q Yeah. Very nice lady and an excellent
10 doctor. Did you have any discussion with Dr. Wagner?
11 A Did I?
12 Q Yes.
13 A No.
14 He did mention to me in the hall one day that
15 he reviewed records in this case. And I said, oh, are
16 you going to do an IME, and he said no. That's all I
17 know.
18 Q That's fine. I appreciate it.
19 Let's see. In reference to your findings,
20 you said that he says that he grew less able to engage
21 in the hobby of building birdhouses because he couldn't
22 remember the correct measurements needed by
23 February 2015.
24 A He did say that. Well, I mean, I put that in
25 my note, if that's what you're saying. Yeah, I did say

1 that. He told me that.

2 Q Did you review Dr. Lind's test results?

3 A Sure.

4 Q Okay. That's not really more of a memory

5 issue. Isn't that more of an executive functioning

6 issue?

7 A Well, executive function has to do with

8 planning --

9 Q Okay.

10 A -- is a good example. But, no, what he

11 specifically told me was he just couldn't remember the

12 numbers.

13 Q Okay.

14 A So I would call that a memory or inattention

15 or attention deficit situation or whatever.

16 MR. MCDANIEL: All right. I don't think I

17 have any further -- I'm going to stop.

18 MRS. BARR: Doctor --

19 MR. MCDANIEL: No further questions.

20 MRS. BARR: Dr. Pritchard, I appreciate

21 your patience. I just have a few housecleaning

22 questions, if you don't mind, if you can indulged me.

23 THE WITNESS: Like brooms and stuff?

24 MRS. BARR: Yes, getting the cobwebs out.

25 EXAMINATION

1 BY MRS. BARR:

2 Q You spoke about -- in looking at the

3 environmental factors, including the psychiatric

4 history and that sort of thing, would history of

5 generalized anxiety disorder, could that be a relevant

6 factor in Mr. Barr's chronic headaches?

7 A It could be.

8 Q Do the two go hand in hand at times?

9 A Sometimes.

10 Q Okay. The word dementia came out in your

11 cross-examination. Is there any objective evidence

12 that Mr. Barr has dementia?

13 A No.

14 Q Is that your opinion to a reasonable degree

15 of medical certainty?

16 A It is.

17 Q Is there any objective evidence that Mr. Barr

18 has any permanent impairment of his brain or

19 neurological system from any cause?

20 A Not based on my exam or in review.

21 Q And is that your opinion to a reasonable

22 degree of medical certainty?

23 A It is.

24 Q All right. Mr. Barr's subjective complaints

25 of headaches at the time you saw him in February of

1 2016, do you have an opinion as to whether or not his
2 current complaints of headaches have any causal
3 relationship to his employment at the school district
4 which ended last May?
5 A Well, since I've expressed the opinion I have
6 about volatile organic compounds, I don't think so.
7 Q All right. Is that your opinion to a
8 reasonable degree of medical certainty?
9 A It is.
10 MRS. BARR: Thank you, Dr. Pritchard.
11 That's all the questions I have.
12 EXAMINATION
13 BY MR. MCDANIEL:
14 Q I think you said you did not have enough
15 information about his exposures.
16 A I'm sorry?
17 Q Did you not testify that you did not have
18 enough information about his exposures?
19 A What I believe I said was that I'm not
20 knowledgeable about how much he had when and I'm not a
21 toxicologist. I don't want to overstate my
22 qualifications.
23 MR. MCDANIEL: No further questions.
24 THE WITNESS: Thank you.
25 EXAMINATION

1 BY MRS. BARR:

2 Q Dr. Pritchard, is there any toxicology report

3 that you could review that would change the opinions,

4 based on your neurological evaluation, as to the

5 presence of a neurological injury?

6 A No, no, not for the way things are now, no.

7 MRS. BARR: Thank you.

8 MR. MCDANIEL: I want to put this on the

9 record. Reference had been made -- at the hearing, I

10 objected to Dr. Pritchard's report coming in and

11 wanted to preserve my right to cross-examination.

12 And I had previously written the commissioner with a

13 copy to Mrs. Barr. Mrs. Barr made a reference that

14 the deposition was scheduled at my request.

15 Actually, what I requested was, is that --

16 and I'm going to quote for the record, this is part

17 of the commission record, that since Dr. Pritchard

18 being outside of the Florence area is not subject to

19 subpoena to preserve our constitutional rights of due

20 process of law, I expect my right to

21 cross-examination at the expense of the defendants

22 will be preserved under the Administrative Procedures

23 Act as is required by both the United States Supreme

24 Court decisions and the Administrative Procedures

25 Act.

1 And I note that because -- and that was
2 sent on February 1st. As noted previously, this
3 hearing was set for February 24th. I made that
4 request in hopes that we could have a deposition
5 prior to the hearing. I did not receive a request
6 for the deposition until February 17th. I just want
7 to note that for the record.
8 All right. Nothing further.
9 MRS. BARR: Since you've now had the
10 opportunity to cross-examine Dr. Pritchard as
11 requested, seems silly; doesn't it?
12 (WHEREUPON, the deposition concluded at
13 4:22 p.m., and the deponent waived signature.)
14
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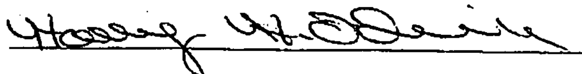
25

1 STATE OF SOUTH CAROLINA)
)C E R T I F I C A T E
2 COUNTY OF CHARLESTON)

3

4 I, Holly Hiott O'Quinn, Independent Court Reporter
5 and Notary Public for the State of South Carolina,
6 certify that I did have Dr. Paul Pritchard to appear
7 before me at 2:03 p.m. on March 3, 2016, in the Offices
8 of Medical University of South Carolina, 96 Jonathan
9 Lucas Street, CSB 424, Charleston, South Carolina; that
10 the witness was duly sworn and cautioned to tell the
11 truth, the whole truth and nothing but the truth; that
12 the foregoing pages constitute a true and accurate
13 transcript of testimony given at the time and place.
14 I do further certify that I am not of counsel or
15 kin to any of the parties to this cause of action, nor
16 am I interested in any manner of its outcome.
17 IN THE WITNESS WHEREOF I have hereunto set my
18 hand and seal this the 16th day of March, 2016.
19
20 COPY
21 
22 Notary Public for South Carolina
My Commission Expires March 21, 2016
23
24
25

Progress Notes Kenneth Barr (MR# 001789557)

Progress Notes by Paul B. Pritchard, MD signed at 2/2/2016 8:28 PM

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Kenneth Barr,
MRN 1789557
Date of birth: 8/17/1969

By request of Ms. Kirsten L. Barr of Trask & Howell, L.L.C., Mount Pleasant, SC

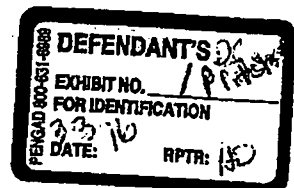
Re: Kenneth L. Barr v Darlington County School District and SC School Boards Insurance Trust
W.C.C. File No.: 1507304
Carrier File No.: WC016314
Date of Acident: May 21, 2015

Credentials of the examiner:

Education:
A.B. (chemistry), Duke University
M.D., Medical University of South Carolina

Training:
Internship, internal medicine, University of Virginia
Residency, neurology, University of Virginia
Fellowship, clinical neurophysiology, Harvard Medical School

Medical licensure:
South Carolina # 5721



Board certification:
Neurology (American Board of Psychiatry and Neurology)
Clinical Neurophysiology (American Board of Clinical Neurophysiology)

Current employment:
Professor of Neurology, Medical University of South Carolina

This is the first office visit for this 46 year old right-handed man who was accompanied by his wife. I explained that he is here for an IME by request of Ms. Kirsten Barr of Trask & Howell, L.L.C., and I reviewed the list of documents which Ms. Barr furnished to me in

advance of the appointment today. I further explained that I will not participate in his medical care and that the IME is for evaluation purposes only. I told him that he may obtain a copy of my report through his attorney.

Mr. Barr conveyed the following documents to me, which I reviewed with him:

1. A three page "summary of scores," marked as pages 6-8, which he said represents results of a neuropsychology evaluation. The document was not otherwise identified, and it appears to represent a portion of a larger report.
2. Material Safety Data Sheets, including the following products:
   a. Armorseal Resthane/urethane floor coating, clear (Sherwin-Williams)
   b. Minwax Polyshades Interior stain & polyurethane gloss finish (American Chestnut)
   c. Industrial enamel, pure white (Sherwin-Williams)
   d. DTM acrylic primer/finish, white (Sherwin-Williams)
   e. Krylon Pain All fast dry enamel (Sherwin-Williams)
   f. Pro-Industrial multi-surface acrylic coating, extra white (Sherwin-Williams)
   g. DTM Acrylic semigloss acrylic coating, extra white (Sherwin-Williams)
   h. Pro Industrial pre-catalyzed waterbased semi-gloss epoxy, extra white (Sherwin Williams)

   Note: Section 11 for these products indicates that exposure to several of them may cause neurological injury and that several of them may be carcinogenic, at least in laboratory animals.
3. Radiology reports as follows:
   a. CT brain, 3/16/2015, Carolina Pines Regional Medical Center
   b. MRI brain, 11/1/2015, Carolina Pines Regional Medical Center
   c. Two EKG reports, one from Carolina Pines and one from Hartsville Medical Group.
4. CDs which I reviewed with the patient and his wife, as follows:
   a. CT brain of 4/22/2015: normal to my view.
   b. MRI brain of 1/9/2014: scattered T2 hyperintensities in white matter.
   c. CT angiogram of brain of 9/29/2010 and 9/23/2011: no aneurysms confirmed.

Ms. Barr furnished the following records, which I enumerated to Mr. Barr as follows:

1. Laboratory report (serum drug levels) ordered by Marshall White, MD for drugs of abuse, all negative.
2. Deposition of Kenneth L Barr done September 9, 2015.
3. Deposition of Larry Stegner done September 9, 2015.
4. Sumter Neurology & Pain Management, Marshall A White, MD, 10-17-12 through 7-16-15.
5. McLeod Neurological Associates, Dr. Roland Skinner, III, MD, 9-23-2010 through 10-16-15.
6. The Medical Group, 4-20-05 through 4-7-15.
7. Florence Neurosurgery & Spine 10-18-10.
8. McLeod Urgent Care, Darlington 6-9-11 through 11-20-11.
9. Camden Orthopedics 5-2-12 through 9-12-12.
10. Thomas Brandt, MD 5-9-12 through 5-24-12.
11. Kershaw Health Medical Center 5-11-12.

12. Transcript of Mr. Barr's school records.

Otherwise, the IME is based upon the interview and examination of Mr. Barr. Our face to face evaluation consumed a full two hours which does not take into account the time for review of medical records and the time required to prepare this report.

The essence of Mr. Barr's concern is that he contends that he was exposed to a variety of painting and other materials in the course of his employment by the Darlington County School District. Mr. Barr further contends that the products to which he was exposed produce a high volume of volatile organic compounds (VOC). He also contends that he was not informed that he should wear personal protective devices or that such devices were provided to him.

Although I reviewed the Material Safety Data Sheets (MSDS) which he provided today, I cannot say to which of these products he may have been exposed. The patient's wife came with him, but she did not contribute to the information gathered today, apart from expressing her assent from time to time.

Mr. Barr reported that he has suffered from headaches for a number of years which he says began when he started to work for the Darlington County Schools. The records show that his primary care physician evaluated him for headaches in September 2010 and that he referred Mr. Barr to Dr. Roland Skinner, a neurologist in Florence, for further evaluation. He was later evaluated by Dr. Marshall White in Sumter. His wife interjected that the headaches became prominent in 2011, approximately two years after he started the job. As his symptoms became evident, he sought alternative duties on the job so that he could continue to work, but he reports that he was released from the job in 2015. At this time he says that he does not receive compensation.

He went on to provide the following summary of symptoms which he attributes to exposure to chemicals for which he submitted MSDS sheets:

1. By January 2015 his attention span had decreased, and his concentration was impaired.
2. Around the same time his memory became "terrible," although he believes that it may have started to decline in 2014. He says that he grew less able to engage in his hobby of building bird houses because he couldn't remember the correct measurements he needed by February 2015.
3. Because of progressive fatigue, he was unable to spend an appropriate amount of time with his family. He grew briefly tearful on sharing this information.
4. He described an episode of disorientation in March 2015 during a trip to Lowe's to get school supplies.
5. Headaches became more frequent and more severe, progressing to daily headaches of moderately severe intensity at this point. They represent daily holocranial pain which includes steady, throbbing, and pressure components. Sometimes they are associated with nausea. When they become severe he ceases his activities and lies down. Occasionally they wake him from sleep. Currently he takes valproate, 250 mg daily as prophylaxis, but this is not helpful. Previous, unhelpful approaches have included topiramate, Tramadol, and Goody powders. He uses Tylenol and Naproxen with little benefit. Other medications include

clonazepam for anxiety and Prozac. He started Prozac well before his employment by the school system.

Past medical history: Previous surgeries include repair of carpal tunnel syndrome, ankle surgery X 2, appendectomy during childhood, endoscopic knee surgery, and repair of tendons in his right wrist and hand.

Allergies: no known drug allergies.

Current medications:
Naproxen, 500 mg BID
Prozac, 50 mg daily
Nexium, 50 mg daily
Valproate, 250 mg HS
Clonazepam, 0.5 mg BID
Aspirin, 81 mg daily.

Review of systems: a general review of systems was otherwise unremarkable except as outlined above except for eyeglasses to correct myopia.

Social history: native Darlington but life-long resident of Hartsville, SC except a brief period of time in Pensacola, FL. His parents were divorced when he was 8 years old. He was married in 1992, with no prior marriages. They have three children, including a daughter who is 19 years old, a son who is 13, and another daughter who is 10, all of whom live with them, in addition to one grandson. Leisure: metal detecting, building bird houses. He smokes ¾ pack of cigarettes per day, dips snuff, and takes an occasional drink of moonshine (the legal variety purchased at the liquor store). He denies use of illegal drugs.

Educational history: attended kindergarten and then enrolled in Emmanuel Baptist School, which he attended through graduation at age 17. He says that he was a strong student in math and sciences and that he was weakest in history, which he had to repeat. He was active in sports, particularly soccer.

Vocational history: he considered joining the military after he completed high school but never got around to doing so. His first job was working for his father, who was in the roofing and carpentry business. Other employment has included work in sales (mens' ware), self-employment as a painter (but he specified that he tried to use latex paint rather than oil-based paint), and working as a painter for a nuclear plant. He first began working for the school district as a painter in 2009. He said that Dr. Marshall White insisted that he stop his exposure to paints and other organic compounds on the basis of his diagnosis with encephalopathy which he related to paint exposure. For a period of time he was given other duties, but he was released from employment in August 2015.

Family history: father died at age 72 of metastatic carcinoma of prostate. His mother is 73 and has lupus erythematosus and rheumatoid arthritis. He has a 55 year old brother and a 52 year old sister, both in good health.

Physical examination: BP 120/75, pulse 57 and regular, height 5'11", weight 135 pounds. Report of headache with 7/10 intensity. He was well nourished and in no acute distress.

Normocephalic/atraumatic. Normal ocular fundi. Neck supple. No neck bruits. Chest clear. Regular cardiac rhythm without murmurs or gallop. Skin clear except for operative scars on his right hand. Extremities normal except for flexion deformity of the 4th and 5th fingers of his right hand which he attributed to previous tendon injuries from a laceration.

Neurological examination: he was alert, oriented, pleasant, and cooperative. Despite his concerns about his memory, he organized the history well and did so in detail. He scored a perfect score of 30/30 on the Montreal Cognitive Assessment (MOCA) exam. His speech was fluent and well articulated. He had normal comprehension, naming, repetition, and word finding. Pupils were 3-4 mm., equal and reactive. Eyes conjugate with full ocular movement and no nystagmus. Facial sensation and motor trigeminal function intact. No facial weakness. Hearing intact to finger rub and tuning fork. Symmetrical movement of the face, tongue, and soft palate. Gait normal, including heel, toe, and tandem gait. No titubation of head or trunk. No appendicular ataxia. Negative Romberg's sign. No abnormal movements. Sensory testing normal including light touch, pin prick, joint position, vibration, tactile localization, and stereognosis. Visual fields full without visual extinction. Deep tendon reflexes were 1-2 + and symmetrical, with flexor plantar responses.

Assessment:

1. Report of headaches and cognitive impairment following alleged exposure to VOCs (volatile organic compounds) through his job as a painter for the Darlington County School District. By history, they are consistent with chronic daily headache.
2. Although he has been diagnosed as having an encephalopathy, the neurological exam today was normal, including normal scores for orientation, memory, calculations, and language function on exam and the Montreal Cognitive Assessment. Mr. Barr did not have findings to support a diagnosis of encephalopathy on today's exam.
3. The partial neuropsychology report Mr. Barr provided me indicated generally average to low average scores and scores in the impaired range for visual scanning, letter fluency, and inhibition (Delis-Kaplan Executive Functioning System), and motor skills for the grooved pegboard test. On the other hand, he made normal to above average and even superior scores for recall on the Rey Complex Figure Test and Hopkins Verbal Learning Test. The latter do not support memory impairment, nor did the average scores on the Wechsler Memory Scale do so.
4. Mr. Barr's academic records indicated generally average work at Emmanuel Baptist School but poor performance in history, which he was compelled to repeat.
5. I cannot speak authoritatively on the potential for impairment from the various paint and other compounds to which he reports on the job exposure. The medical literature indicates that Denmark stands out as the only country in the European Union which regards paint exposure as a workers' compensation issue, based on a graduate student's paper which was re-examined and recanted by other psychologists in her department.

As I explained to Mr. Barr and his wife, I would recommend that he be evaluated by an occupational medicine physician who has training and experience in toxicology.

I offer all of the above within a reasonable degree of medical certainty.

Paul B. Pritchard, III, MD
Professor of Neurology

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Revision History

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PAUL B. PRITCHARD, III, M.D.

Suite 309, 96 Jonathan Lucas Street, Charleston, SC 29425
Department of Neurology, Medical University of South Carolina
pritchap@musc.edu
843-792-3221

FAMILY: Wife: Rebecca C. Pritchard, B.A., M.A. Ed.
Children: Nancy Pritchard Jackson, B.A., B.S., M.H.S.
Paul Baker Pritchard, IV, B.A., M.B.A.
Matthew Crawford Pritchard, B.A.

EDUCATION: Primary and secondary schools of Ware Shoals, SC. Graduate of Ware Shoals High School, Class of 1961.

A.B. (Chemistry), Duke University,1965.

M.D. (Honors), Medical University of South Carolina, 1969.

TRAINING: Research assistant in Pathology, Medical University of South Carolina, June – September 1967 and June 1968 – May 1969. Preceptor: Gordon Hennigar, M.D.

Intern in Medicine, University of Virginia Hospital, July 1, 1969 – June 30, 1970.

Assistant Resident Neurologist, University of Virginia Hospital, July 1, 1970 – June 30, 1972.
Resident Neurologist, University of Virginia Hospital, July 1, 1972 – June 30, 1973.
Mentor: T. R. Johns, MD, Chair, Department of Neurology

Fellow in Neurology (Epileptology and Clinical Neurophysiology), Seizure Unit, Children's Hospital Medical Center, Boston, July 1, 1973 – June 30, 1974.
Mentor: Cesare T. Lombroso, Chief, Seizure Unit, Children's Hospital Medical Center

Fellow in Neurology, Harvard Medical School, July 1, 1973 – June 30, 1974.

Chief of Staff Institute, Veterans Health Administration, Department of Veterans Affairs, Washington, D.C., Class of 1993.

HONORS AND AWARDS: Academic Grant, Josiah Macy Foundation, 1968-1969.

Third place award, Student Research Competition, Medical University of South Carolina, 1968.

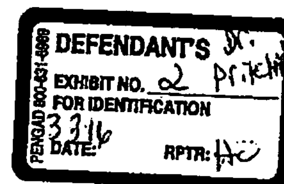
Vice President/Secretary, Class of 1969, Medical University of South Carolina.

Alpha Omega Alpha, Medical University of South Carolina, 1969.

Director's Commendation, Ralph H. Johnson Department of Veterans Affairs Medical Center, Charleston, SC, 1983, 1993.

Best Doctors in America (Woodward-White): 1997-2016

Nominee, Health Sciences Foundation Teaching Excellence Award, Educator-Mentor Category, 2000.



First MUSC recipient, Humanism in Medicine Award, Association of American Medical Colleges, 2000.

Nominee, Golden Apple Award, Medical University of South Carolina, 2000.
Nominee, Health Sciences Foundation Teaching Excellence Award, Educator-Mentor Category, 2001.

Nominee, MUSC-COM Class of 2001 Faculty Excellence Award, 2001.

Best Faculty Role Model, 2008-2009. Awarded by neurology residents, Department of Neurosciences, 2009.

MVP Faculty Award, 2009-2010. Awarded by neurology residents, Department of Neurosciences, 2010.

PROFESSIONAL ORGANIZATIONS:

American Academy of Neurology
- Active Member, 1975.
- Fellow, 1985.
- Member, Government Services Committee, 1992 – 1993.
- Mentor, Minority Scholars Program awardees:
  - Karon Hammonds (2008)
  - Rahim Wooley (2010)

American Epilepsy Society, 1975.
- Education Committee, 1977 – 1979.
- Chair, Scientific Session A, Annual Meeting, 1983.
- Continuing Education Committee, 1984 – 1992.
- Director, Continuing Medical Education, 1987 – 1992.
- Director, Annual Course, 1988.
- Corporate Advisory Committee, 2001.

Epilepsy Foundation of America
- Ad Hoc Reference Committee on Behavior, 1983 – 1984.
- Professional Advisory Board, 1987 – 1992.

Associate Examiner (Neurology), American Board of Psychiatry and Neurology
- Chicago: October 17-19, 1976.
- Washington: April 9-10, 1979.
- New Orleans: April 18-19, 1983.
- Houston: January 12-13, 1987.

American Electroencephalographic Society
- Member, 1982.
- Fellow, 1986.

Eastern Association of Electroencephalographers
- Associate Member, 1973.
- Member, 1980.

South Carolina Neurological Association
- Member, 1976.
- Secretary-Treasurer, 1982 – 1983.
- President, 1983 – 1984.

South Carolina Epilepsy Association
- Chair, Professional Advisory Board, 1978 – 1982.

South Carolina Medical Association, 1985.

American Board of Registration of Electroencephalographic And Evoked Potential Technologists, Inc. (ABRET).
- Associate Examiner, Charleston, SC: November 8-9, 2003.

Ad Hoc Reviewer: *Epilepsia, Neurology, Annals of Neurology, CNS Spectrums, Epilepsy*

and Behavior, American Journal of Medical Science, Cognitive and Behavioral Neurology, International Journal of Psychiatry in Medicine, eNeurologicalSci

American Board of Clinical Neurophysiology: examination review panel, 2010-2011.

Alpha Omega Alpha

Elected to membership, 1969

Reviewer, Carolyn L Kuckein Student Research Fellowship Awards, 2014, 2015, 2016.

LICENSURE AND BOARD CERTIFICATION:

South Carolina, July 15, 1969 (#5721).

National Board of Medical Examiners, March 1973 (#105249).

Massachusetts, July 5, 1973 (#35597) – inactive.

Certified in Neurology, American Board of Psychiatry and Neurology, May 1975 (#14076).

Certified in Clinical Neurophysiology, American Board of Clinical Neurophysiology, April 15, 1984.

APPOINTMENTS:

Harvard Medical School

Fellow in Neurology, Harvard Medical School, July 2, 1973 – June 30, 1974.

Instructor in Neurology, Harvard Medical School, July 1, 1974 – June 30, 1975.

Assistant in Neurology, Children's Hospital Medical Center, Boston, July 1, 1974 – June 30, 1975.

Assistant in Medicine (Neurology), Peter Bent Brigham Hospital, October 15, 1974 – June 10, 1975.

Medical University of South Carolina

Assistant Professor of Neurology, Medical University of South Carolina, July 1, 1975 – June 30, 1979.

Chief, Neurology Service, Veterans Administration Medical Center, Charleston, July 1, 1975 – December 31, 1984.

Acting Chief of Staff, Veterans Administration Medical Center, 1983-1984.

Associate Professor of Neurology, with tenure, Medical University of South Carolina, July 1, 1979 – December 31, 1984.

Clinical Associate Professor of Neurology, Medical University of South Carolina, January 1, 1985 – June 30, 1991.

Private practice of neurology and epileptology (Neurology Consultants), Charleston, SC, December 1984 – December 1991.

Chief of Staff, Ralph H. Johnson Department of Veterans Affairs Medical Center, Charleston, SC, January 6, 1992 – January 31, 1994.

Assistant Dean for Veterans Affairs, Medical University of South Carolina, January 6, 1992 – January 31, 1994.

Professor of Neurology, Medical University of South Carolina, March 17, 1992 – present. Awarded tenure (2nd MUSC tenure award), October 2003.

TEACHING AND COMMITTEE ASSIGNMENTS:

Medical University of South Carolina:

Member, Faculty Senate, 1982 – 1984 and 1998 – 2000.

Member, Special Investigative Committee appointed by Provost, 1998.

College of Medicine, Medical University of South Carolina:

Member, Curriculum Committee, 1977 – 1981 and 1995 – 1997.

Electives Subcommittee, 1983 – 1984.
Member, Office of Education Services Advisory Committee, 1980 – 1984.
Instructor, Physical Diagnosis Course, 1992.
Member, Graduate Medical Education Committee, 1992 – 1994 and 2002-2010.
Search Committee for Chair of Physiology, 1993 – 1994.
Search Committee for Chair of Neurosurgery, 1982 and 1996.
Member, Committee on Diversity, 2002-present.
Member, Admissions Committee, 2003-2006.
Founding Advisor, Paul Underwood chapter, Arnold Gold Humanism in Medicine, 2005-2006.
Peer Review Committee, 2007-2008.
Institutional Review Board III, 2008-2010.
Alternate reviewer, 2010-present.
Careers in Medicine advisor, 2013 - present

Department of Neurology (re-designated Department of Neurosciences 2004-2015), Medical University of South Carolina.
Course Director, Elective in Clinical Neurology (4th year medical students), 1976 – 1978.
Course Director, Neurology Section, Scientific Basis of Medicine (2nd year medical students), 1977.
Chair, Residency Committee, 1977-1984.
Course Director, Mini-Residency in Neurology (practicing physicians), 1980.
Member, Promotion Committee, 1996 – present.
Coordinator, Neurology Journal Club, 1998 – 2000.
Compliance Liaison Officer, May 1999 – 2002.
Medical Director, Clinical Neurophysiology, 2000 – 2002.
Director, Adult Epilepsy Program, May 2000 – 2004.
Coordinator, Clinical Neurophysiology Conference, July 2000 – 2002.
Director, Postgraduate Education (Neurology) and Program Director, Neurology Residency, 2002-2010.
Member, Promotion and Tenure Committee, 2004-2014
Executive Director, Charcot Society, 2007, 2008.
Coordinator, Epilepsy Journal Club, 2008-present.
Director of External Affairs, 2013-present.
Course director, *Annual Neurology Update for the Primary Care Provider* (CME course), September 7, 2013.
Director, 3rd year medical student clerkship in neurology, 2014- present.
Course Director, *Annual Neurology Update for the Primary Care Provider* (CME), March 21, 2015.
Course director, *Rock the MOC! Comprehensive Update in Clinical Neurology* (CME), November 20-22, 2015.
Course director, *Annual Neurology Update for the Primary Care Provider 2016*, April 9, 2016.

Department of Veterans Affairs Medical Center, Charleston:
Clinical Executive Board
Member, 1975 – 1983, 1984.
Chair, 1983, 1992 – 1994.
Course Director, Mini-Fellowship in Epilepsy (VA Region 3 course sponsored by VA Central Office, Washington, DC), 1981.
Dean's Committee, 1992 – 1994.

PUBLICATIONS

Original peer-reviewed papers:

Pritchard, PB, Netsky, MG: Prevalence of neoplasms and causes of death in paralysis agitans: a necropsy study. *Neurology* 23:215-222, 1973.

McIntyre, MJ, **Pritchard, PB**, Lombroso, CT: Left and right temporal lobe epileptics: a controlled investigation of some psychological differences. *Epilepsia* 17:377-386, 1976.

Pritchard, PB, Lombroso, CT, McIntyre, MJ: Psychological complications of temporal lobe epilepsy. *Neurology* 30:227-232, 1980.

Pritchard, PB: Hyposexuality: a complication of complex partial epilepsy. *Trans. Am. Neurol. Assoc.* 105:193-195, 1980.

Pritchard, PB, Wannamaker, BB, Sagel, J, DeVillier, C: Postictal hyperprolactinemia in complex partial epilepsy. *Trans. Am. Neurol. Assoc.* 106:117-118, 1981.

Pritchard, PB, Wannamaker, BB, Sagel, J, Nair, R, DeVillier, C: Endocrine function following complex partial seizures. *Ann. Neurol.* 14:27-32, 1983.

Pritchard, PB, Martinez, R, Hungerford, GD, Power, MJ, Perot, PL: Dural plasmacytoma. *Neurosurgery* 12:576-579, 1983.

Pritchard, PB, O'Neal, DB: Non-convulsive status epilepticus following metrizamide myelography. *Ann. Neurol.* 16:252-254, 1984.

Pritchard, PB, Holmstrom, VL, Roitzsch, JC: Epileptic amnestic attacks: benefit from antiepileptic drugs. *Neurology* 35:1188-1189, 1984.

Pritchard, PB, Wannamaker, BB, Sagel, J, Daniels, CM: Serum prolactin and cortisol in evaluation of pseudoepileptic seizures. *Ann. Neurol.* 18:87-89, 1985.

Pritchard, PB, Holmstrom, VL, Giacinto, J: Self-abatement of complex partial seizures. *Ann. Neurol.* 18:265-267, 1985.

Sperling, MR, **Pritchard, PB**, Engel, J, Daniel, C, Sagel, J: Prolactin in partial epilepsy: an indication of limbic seizures. *Ann. Neurol.* 20:716-722, 1986.

Pritchard, PB: The effect of seizures on hormones. *Epilepsia* 32 (Suppl. 6):S 46-50, 1991.

Pritchard, PB: Intensive neurodiagnostic monitoring, *J. S.C. Med. Assoc.* 88:226-229, 1992.

Harsha, WJ, Varon, D, **Pritchard, PB:** Recurrent bacterial meningitis: the search for a cause. *J. S.C. Med Assoc.* 98:193-195, 2002.

Varon, D, **Pritchard, PB**, Wagner, M, Topping, K: Transient Kluver-Bucy syndrome following complex partial status epilepticus. *Epilepsy & Behavior. 4:348-351, 2003.*

Wagner MT, Wymer JH, Topping KB, **Pritchard PB**: Use of the Personality Assessment Inventory as an efficacious and cost-effective diagnostic tool for nonepileptic seizures. *Epilepsy & Behavior* 7:301-304, 2005.

Halford JJ, Pressly WB, Benbadis SR, Tatum WO, Turner RP, Arain A, **Pritchard PB**, Edwards JC, Dean BC: Web-based Collection of Expert Opinion on Routine Scalp EEG: Software Development and Interrater Reliability. *J Clin Neurophys* 28:178-184, 2011.

Soper AC, Wagner MT, Edwards JC, **Pritchard PB**: Transient Epileptic Amnesia: A Neurosurgical Case Report. *Epilepsy & Behavior* 20:709-713, 2011.

Jonathan J Halford, M.D.; Robert J Schalkoff, Ph.D.; Jing Zhou, M.S.; Selim R Benbadis, M.D.; William O Tatum, M.D.; Robert P Turner, M.D.; Saurabh R Sinha, M.D. Ph.D.; Nathan B Fountain,M.D.; Amir Arain, M.D.; **Paul B Pritchard, M.D.**; Ekrem Kutluay, M.D.; Gabriel U Martz, M.D.; Jonathan C Edwards, M.D.; Chad G Waters, M.S.; Brian C Dean, Ph.D. Standardized Database Development for EEG Epileptiform Transient Detection: EEGnet Scoring System and Machine Learning Analysis *J Neuroscience Methods* *J Neurosci Methods.* Nov 19;212(2):308-316, doi:10.10.16/j.jneumeth.2012.11.005., 2012

Patel BA, Williams NR, **Pritchard PB**: Unique case of "Post-Lumbar Puncture Headache" *Headache.* doi: 10.1111/head.12005, 2013.

Koontz, EH, Hanson, J, **Pritchard, PB**: Nonepileptic events in South Carolina:outcome from two year experience in an inpatient epilepsy monitoring unit. *J S.C. Med Assoc,* 109:82-84, 2013.

Bolen BD, Koontz EH, **Pritchard PB**: Prevalence and distribution of MRI abnormalities with psychogenic non-epileptic events: providing possible clues to the pathophysiology? Submitted to *Epilepsy & Behavior,* January 17, 2016.

Chapters:

Pritchard, PB: Personality and emotional complications of epilepsy. In KM Heilman, P Satz (Eds.) *Neuropsychology of Human Emotion* New York, Guilford Press, 165-192, 1983.

Pritchard, PB: The role of prolactin in the diagnosis of non-epileptic seizures. In AJ Rowan, JR Gates (Eds.) *Non-epileptic Seizures:* Stoneham, MA: Butterworth-Heinemann, 1993:93-100.

Pritchard, PB: Hormone changes in epilepsy. In J Engel and TA Pedley (Eds.) *Epilepsy: A Comprehensive Textbook* New York, Lippincott-Raven, 1997:1997-2002.

Pritchard, PB: Seizures. In Endres, Lien,Tyor (Eds.) *Drug Therapy Pocket,* Hermosa Beach, CA, Börm Bruckmeier Publishing LLC, pp. 209-214, 2003.

Pritchard, PB: The role of serum prolactin in seizure diagnosis. In PW Kaplan, RS Fisher (Eds.) *Clinical Imitators of Epilepsy* 2nd Edition, New York: Demos Medical Publishing, 2004.

Pritchard, PB: Seizures. In Russ, Endres (Eds.) *Drug Therapy Pocket,* Hermosa Beach, CA, Börm Bruckmeier Publishing LLC, pp. 209-214, 2004.

Pritchard, PB: Seizures. In Endres, Lien, Tyor (Eds.) *Drug Therapy Pocket,* Hermosa Beach, CA, Börm Bruckmeier Publishing LLC, pp. 215-220, 2006.

Pritchard, PB: Pharmacotherapy for seizures. In Lisak, Truong, Carroll, Bhidayasiri (Eds.) *International Neurology: A Clinical Approach,* Oxford, UK, Blackwell Publishing, Ltd., 2008.

Sohn M, **Pritchard PB:** The Diagnosis of Epilepsy. In Edwards, JC, Harley, LK, Vought, EC (Eds.) *Handbook of Epilepsy: Diagnosis and Management.* Charleston, SC: University Press, pp. 47-50, 2009.

Pritchard PB, Sohn M: Status Epilepticus. In Edwards, JC, Harley, LK, Vought, EC, (Eds.) *Handbook of Epilepsy: Diagnosis and Management.* Charleston, SC: University Press, pp. 134-137, 2009.

Martz GU, **Pritchard, PB**: Epilepsy: Background and Terminology. In Edwards, JC, Harley, LK. (Eds.) *Handbook of Epilepsy: Diagnosis and Management.* Charleston, SC: University Press, pp. 9-15, 2012.

Pritchard, PB: The Diagnosis of Epilepsy. In Edwards, JC, Harley, LK. (Eds.) *Handbook of Epilepsy: Diagnosis and Management.* Charleston, SC: University Press, pp. 30-32, 2012.

Hamilton E, Kornegay A, **Pritchard PB**, Edwards JC: Non-epileptic events. In Edwards, JC, Harley, LK. (Eds.) *Handbook of Epilepsy: Diagnosis and Management.* Charleston, SC: University Press, pp. 58-59, 2012.

Pritchard PB: Status Epilepticus. In Edwards, JC, Harley, LK. (Eds.) *Handbook of Epilepsy: Diagnosis and Management.* Charleston, SC: University Press, pp. 116-118, 2012.

Pritchard PB: Neuropharmacology of antiepileptic drugs. In Lisak, Truong, Carroll, Bhidayasiri (Eds.) *International Neurology: A Clinical Approach,* Edition 2. Oxford, UK, John Wiley & Sons, Ltd., 2016.

Letters:

Pritchard, PB, Wannamaker, BB, Sagel, J, DeVillier, C: Endocrine dysfunction in temporal lobe epilepsy. *Arch. Neurol.* 39:786-787, 1982.

George, MS, Pickett, JB, Kohli, H, Allison, MA, and **Pritchard, PB**: Paroxysmal dystonic reflex choreoathetosis after minor closed head injury. *Lancet* 336 (8723):1134-1135, 1990.

Abstracts:

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Hanson J, Hamilton E, Pritchard P, Edwards J: Reasonable length of stay to make a diagnosis of psychogenic nonepileptic events. Poster, Neurosciences Research Day, Medical University of South Carolina, May 3, 2012.

Sun W, Selassie A, **Pritchard PB**: Ambulatory Health Care Visits by Patients with Parkinson's Disease in the United States, 2005-2008. Poster, National Conference on Health Statistics, Washington, DC, August 6-8, 2012.

Pritchard PB, Wagner MT, Bachman DL: Episodic autobiographical dysfunction in transient epileptic amnesia: effectiveness of antiepileptic drugs. Poster presentation, annual meeting, American Epilepsy Society, San Diego, CA, December 3, 2012.

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Pritchard, P., et al (2015). Episodic Misperception of Time Associated with Temporal Lobe Epilepsy, *Journal of the International Neuropsychological Society*, 21: Supplement s1, 194.

Koontz E, **Pritchard PB** Prospective Analysis of Depression, Quality of life, and Anxiety in patients admitted for diagnostic Video EEG monitoring. Submitted to 2015 annual meeting, American Epilepsy Society.

Bolen RD, Koontz E, **Pritchard PB**: MRI abnormalities in patients with psychogenic non-epileptic events. Submitted to 2016 annual meeting, American Clinical Neurophysiology Society

Other Extramural Presentations:

"Psychological complications of temporal lobe epilepsy." South Carolina Epilepsy Association Meeting, Columbia, SC, January 31, 1977.

"Disorders of neuromuscular transmission." Medical Grand Rounds, Spartanburg General Hospital, Spartanburg, SC, February 18, 1977.

"Diagnostic technology of epilepsy." Region 6 Epilepsy Symposium, Charleston, SC, March 1, 1978.

"Complex partial epilepsy." Medical Grand Rounds, Richland Memorial Hospital, Columbia, SC, August 4, 1978.

"All about epilepsy: proper use of medications in seizure disorder." As a part of "Epilepsy – an update, REACH-MUSC (TV presentation in collaboration with Epilepsy Branch, National Institutes of Health), December 13, 1978.

"Psychological complications of temporal lobe epilepsy." Presented with CT Lombroso in Symposium on Psychological Aspects of Epilepsy, American Epilepsy Society, annual meeting,1979.

"Current concepts about epilepsy." Medical television series via satellite. Co-moderator with Booker, HE, Brown, TR, Crandall, PH, Masland, RL, Nelson, KB, Penry, JK, Porter, RJ, Wannamaker, BB, Wilder, BJ, and Willmore, LJ. May 2, 9, 16, 23, and 30, 1979.

"Differential diagnosis of the staring spell." Joint Michigan-South Carolina Family Practice Review Course, Kiawah Island, SC, April 1, 1980.

"Comprehensive treatment of complex partial epilepsy." Medical Grand Rounds, Greenville General Hospital, Greenville, SC, August 21, 1980.

"Comprehensive treatment of complex partial epilepsy." Medical Grand Rounds, Spartanburg General Hospital, Spartanburg, SC, August 22, 1980.

"Sexual dysfunction associated with complex partial epilepsy." Neurology-Neurosurgery Grand Rounds, North Carolina Memorial Hospital, University of North Carolina – Chapel Hill, September 22, 1980.

"Utility of video-EEG in the epileptic patient." Annual meeting, South Carolina Epilepsy Association, November 1, 1980.

"Value and limitations of EEG in the management of epilepsy." And "Precipitating factors in epilepsy." Presented at VA Region 3 course co-sponsored by Neurology Service, VA Central Office, and Southeastern Regional Medical Education Center, Birmingham, AL., June 15-17, 1981.

"Intensive monitoring of paroxysmal neurological symptoms." Grand Rounds, Naval Regional Medical Center, Charleston, SC, May 18, 1983.

"Commonly encountered neurologic problems." Annual course, South Carolina Affiliate – National Kidney Foundation, Charleston, SC, September 9, 1983.

"Utility of serum prolactin in evaluating pseudoepileptic seizures." Presented with Wannamaker, BB, Sagel, J, and Daniel, DM, at 15th Epilepsy International Symposium, Washington, DC, September 28, 1983.

"Neuropsychological and personality assessment of untreated complex partial epilepsy." Co-authored with VL Holmstrom at annual meeting, American Psychological Association, Toronto, August, 25, 1984.

Visiting Professor, Saint George's University School of Medicine, Kingstown Medical College, Saint Vincent, West Indies. Presented a two week course in clinical neurology for third year medical students.

September 28 – October 9, 1985
August 25 – September 5, 1986.

"EEG Traits." Presented in annual course, "Epilepsy and Genetics," American Epilepsy Society, Baltimore, MD, December 6, 1987.

"Role of serum prolactin in the diagnosis of non-epileptic seizures." Presented in symposium "The dilemma of non-epileptic (pseudoepileptic) seizures: current concepts in causation, diagnostic classification, and treatment." Fort Lauderdale, FL, March 1, 1990.

"Effects of seizures on hormones." Annual course, American Epilepsy Society: "Endocrine and reproductive dysfunction in epilepsy," San Diego, CA, November 11, 1990.

"Medical management of epileptic seizures." Central State Hospital, Milledgeville, GA, June 19, 1991.

"Endocrine issues in epilepsy." Presented in course " Epilepsy management: current progress and new directions." Springfield, MA, June 12, 1992.

"Utility of serum prolactin in the diagnosis of epilepsy." Grand Rounds, Department of Neurology, Medical College of Pennsylvania, Philadelphia, PA, March 2, 1993.

"Male reproductive and sexual dysfunction." Presented in course "Women and Epilepsy," Charleston, SC, October 29, 1993.

"What's new in seizures?" Presented in plenary session, annual meeting of South Carolina Medical Association, Charleston, SC March 20, 1995.

"Epilepsy and sex." Presented in 4th annual "Epileptology for neurologists" course, Isle of Palms, SC, May 9, 1998.

"Parkinson's disease: variations on the theme." Grand Rounds, Gaston Memorial Hospital, Gastonia, NC, April 14, 1999.

"Endocrine and sexual dysfunction in epilepsy." Neurology Grand Rounds, New York Presbyterian Hospital – Cornell Medical Center, New York, NY, November 1, 2000.

"Pitfalls in Pediatrics." Presented at 7th annual "Epileptology for Neurologists," course, Kiawah Island, S.C., April 28, 2001.

"Problems for Men." Presented at 4th Biannual Statewide Conference, "Epilepsy: A Balancing Act for Families," Charleston, SC, November 9, 2001.

The agony of the ecstasy. Presented at Alcohol and Drug Awareness Week, Porter-Gaud School, Charleston, SC, 2001.

Women with Epilepsy. Community outreach program targeted for adolescent women with epilepsy, Charleston, SC, 2001.

Electroencephalography: clinical applications. Presented to Palmetto Professional Coders Association, 2001.

Men with Epilepsy. Community outreach program targeted for adult men with epilepsy, Charleston, SC, 2002.

The management of headache 2003. Presented at Office Practice of Primary Care Medicine 2003 (CME course), Charleston, SC 2003.

Nonepileptic seizures. Neurology Grand Rounds, University of South Carolina School of Medicine, Columbia, SC. October 28, 2004.

Amyotrophic lateral sclerosis: overview and update. Inaugural meeting, Charleston chapter of ALS Society, September 20, 2005.

Seizures: classification and treatment. Info 2006: International Neurology Forum. Ho Chi Minh City, Vietnam. November 25, 2006.

First convulsive seizure: two epileptic syndromes. Info 2006: International Neurology Forum, Ho Chi Minh City, Vietnam. November 25, 2006.

Antiepileptic drugs: how to pick 'em, when to switch 'em, and what to do when it doesn't work out Annual Meeting, South Carolina Neurological Association, Charleston, SC. October 5, 2007.

The diagnosis of epilepsy. Epilepsy Boot Camp, Charleston, SC January 8, 2010.

Status epilepticus. Epilepsy Boot Camp, Charleston, SC January 9, 2010.

Nonepileptic events. Meeting, American Association of Neurological Nurses, Low Country chapter, Charleston, SC February 18, 2010.

Status Epilepticus. Epilepsy Boot Camp, Charleston, SC: April 21, 2012.

Nonepileptic attack disorder (NEAD): recognition and management of nonepileptic seizures. National University Health System, Singapore, February 13, 2013.

All that shakes isn't epilepsy: diagnosis and management of nonepileptic attack disorder. At Annual Neurology Update for the Primary Care Provider (CME course), Charleston, SC. September 7, 2013.

Nonepileptic attack disorder (NEAD): diagnosis, pathogenesis, and management. Neurology Grand Rounds, University of Utah Health Sciences Center, Salt Lake City, UT, January 28, 2014.

Episodic Amnesia: Clinical syndromes. Annual Neurology Update for the Primary Care Provider (CME course), Charleston, SC March 21, 2015.

Directorships, Continuing Medical Education Courses:

Annual Neurology Update for the Primary Care Provider, September 7, 2013. Doubletree Hilton Hotel, Charleston, SC.

Annual Neurology Update for the Primary Care Provider 2015. March 21, 2015, Drug Discovery Building, Medical University of South Carolina, Charleston, SC.

Rock the MOC! Comprehensive Update in Clinical Neurology. November 20-22, 2015, Bioengineering Building, Medical University of South Carolina, Charleston, SC.

Annual Neurology Update for the Primary Care Provider 2016, April 9, 2016. Bioengineering Building, Medical University of South Carolina, Charleston, SC.

Videotapes for Undergraduate Medical Instruction:

"Parkinson's Disease." (1976).

"Polymyositis." (1976).

"The Neurological Examination." (1977).

"Absence Seizures." (1978).

"Internuclear Ophthalmoplegia." (1980).

"Tardive Dyskinesias." (1980).

Educational presentations to community schools:

Porter-Gaud School, Charleston, SC
Volunteer, Student Council, 1991 – 2001, 2010 – 2012.
Visiting teacher, Biology, AP Biology students, 1997 and 2000.

Visiting teacher, Human Biology students, 2011: "Sudden neurological symptoms: what is their source, and how might we control them?" November 7, 2011.
Assistant Group Leader, "Italian Serenade 2001" (2 week study trip to Italy with 21 students, sponsored by the American Council for International Studies).
Speaker, Alcohol and Drug Awareness Week, 2001.
Assistant Group Leader, ":Dynastic China", 2009 (study trip with students to China sponsored by the American Council for International Studies)
Assistant Group Leader, "Sydney and the Great Barrier Reef", 2010 (study trip with students to Australia sponsored by the American Council for International Studies)
Assistant Group Leader, "China Old and New", 2011 (study trip with students to China sponsored by the American Council for International Studies).

Ashley Hall School, Charleston, SC. Lecturer, Summer Neurosciences Institute
"Cell Communications," July 18, 2011.
"A case of epilepsy," July 18, 2011.
"Cell Communications," June 25, 2012
"A case of epilepsy," June 25, 2012
"Cell Communications," June 24, 2013
"Workshop on epilepsy," June 24, 2013
"Sudden neurological symptoms," June 11, 2015

Trident Academy, Mount Pleasant, SC Lectures: Global Explore! Program
"The brain and epilepsy," March 13, 2013
"Ways to think about the brain," March 19, 2014

Mentor, Wando High School Student Career Day, 2001, 2006, 2008.

Mentor, University School of the Low Country: 2008, 2009.

Community service/memberships:

Member, Medical Advisory Committee, Spoleto Festival – USA, 1977.

Whitesides Elementary School Parent – Teacher Association, Mount Pleasant, SC.
Co-President, 1978 – 1980.
Executive Board, 1979 – 1981.
Founder and Coordinator: Performing Arts Day, Health Sciences Day, Visual Arts Day, Field and Sports Day.
Founder and Coordinator: Community Scholars Program.
Life Member Honoree, 1979.

Pack Master, Cub Scout Pack 40, Mount Pleasant, SC, 1979 – 1980.

Charleston Civic Ballet, Charleston, SC (now Charleston Ballet Theater)
Member, Board of Directors, 1980 – 1983.
President, 1981 – 1983.

Participant, Jenkins Orphanage Career Day, 2001 (sponsored by Alpha Omega Alpha).

Volunteer, Lymphoma and Leukemia Society, 2000, 2001, 2006.

Member, Palmetto Society, Trident United Way, 1999-2014.

Member, Society of 1824, Medical University of South Carolina, 1995-2014.

Life Member, Society of 1824, Medical University of South Carolina, 2009-present.

Former Member, Washington Duke Club, Duke University.

Communicant, Grace Episcopal Church.

Member, Carolina Yacht Club.

Rev. 1/14/2016

Before the

South Carolina Workers' Compensation Commission

KENNETH L. BARR,	)	
	)	
PLAINTIFF,	)	
	)	WCC File No.:
versus	)	1507304
	)	
DARLINGTON COUNTY SCHOOL DISTRICT,	)	
	)	
EMPLOYER,	)	
	)	
SC SCHOOL BOARDS INSURANCE TRUST,	)	
	)	
CARRIER,	)	
DEFENDANTS.	)	
	)	

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The Deposition of Nicholas A. Lind, Ph.D.

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Post Trauma Resources
1709 Laurel Street
Columbia, South Carolina
February 19, 2016
9 a.m. - 10:05 a.m.

In behalf of the attorneys for the Defendants, the deposition of the above-named witness was taken before me, Judith H. Hayes, Certified Court Reporter and Notary Public in and for the State of South Carolina, pursuant to notice and/or agreement in the above-entitled cause pending in the above-named court.

Appearing for the Claimant:

McDaniel Law Firm
1315 Elmwood Avenue
Columbia, South Carolina 29201

By: Preston F. McDaniel, Esq.

Appearing for the Defendants:

Trask & Howell
P. O. Box 2167
Mount Pleasant, South Carolina 29465

By: Kirsten L. Barr, Esq.

INDEX

Examination:	Direct	Cross	Redirect
By Ms. Barr	4		49
By Mr. McDaniel		39	

(No exhibits marked.)

1 This deposition is taken pursuant to the
2 South Carolina rules of civil procedure; that all
3 objections, except as to the form of the question, are
4 reserved until time of trial.
5 It is further stipulated among counsel and
6 the witness that the witness will waive reading
7 and signing of the deposition.
8
9 THEREUPON,
10
11 Nicholas A. Lind, Ph.D.,
12 being first duly sworn to tell the truth, the whole truth,
13 and nothing but the truth, as hereinafter certified,
14 testified as follows:
15
16 **Direct Examination**
17 BY MS. BARR:
18 Q. Dr. Lind, we met briefly before we went on the
19 record. My name is Kirsten Barr, and I represent the
20 Darlington County School District in a worker's
21 compensation claim filed by Mr. Kenneth Barr. If we are
22 related, it's distant. I'm sorry for that confusion.
23 Before we went on the record you indicated
24 you only have an hour today just given your scheduling
25 requirements, so we'll try to move quickly through this.

1 If you would, state your full name for the
2 record.
3 A. Nicholas Alexander Lind.
4 Q. Dr. Lind, could you give us a brief overview of
5 medical education and training?
6 A. I received my doctorate in 2001 and licensed in
7 2003 in the State of South Carolina. I worked at Shaw Air
8 Force Base up until 2005, and then I became a civilian and
9 have been working here at Post Trauma Resources ever since.
10 Q. You are a psychologist, is that right?
11 A. Right.
12 Q. You came to see Mr. Barr on December 16, 2015, is
13 that right?
14 A. That's right.
15 Q. It looks like from the report you issued you had
16 reviewed records from Dr. White, is that right?
17 A. That's correct.
18 Q. Did you have an opportunity to review any of
19 Mr. Barr's other medical records?
20 A. I did not.
21 Q. It looks like you had an interview with Mr. Barr
22 and then administered neuropsychological testing, is that
23 correct?
24 A. That's correct.
25 Q. You were kind enough to give us a narrative

1 overview of your neuropsychological testing as well as the
2 summary of scores and maybe we can kind of go through some
3 of this quickly. It looks like from page three of your
4 report, and for the Commission's edification, that's page
5 78, of the APA's, it looks like the first measure was
6 validity measures, is that correct?
7 A. That's correct.
8 Q. Valid test results based on this validity score?
9 A. That's correct.
10 Q. The next section, Personality, what were the
11 results of the personality test?
12 A. The personality test, it's a test of effort to
13 take a look at whether or not somebody is actually trying
14 on the cognitive measures. The personality measure is
15 useful, because it takes a look at whether or not somebody
16 is over or under reporting emotional distress as well as
17 cognitive complaints, and according to the
18 MMPI-2-Restructured Format, he appeared to approach the
19 measure in an open and honest manner and his results
20 suggested that he perceived himself to currently be in a
21 crisis, be complaining of somatic complaints and
22 preoccupied with his physical health.
23 Q. So those somatic complaints, could that be
24 indicative of a potentially somatic form disorder or some
25 sort of somatic overlay here in this case?

1 A. Right.

2 Q. Help us understand what that means.

3 A. It could be due to any number of things. It
4 could be due to preexisting pain. It could be due to pain
5 consistent with their neurotoxic exposure, prior back
6 injury.

7 Q. Those somatic complaints or potentially somatic
8 form disorder component, does that impact the results of
9 neuropsychological testing?

10 A. It can.

11 Q. You have to take that into account when
12 interpreting the scores on other portions of the test?

13 A. We do.

14 Q. The next section, Mood and Emotional Symptoms,
15 this indicates severe levels of depression, is that right?

16 A. That's correct.

17 Q. Did Mr. Barr give you a history regarding his
18 depression?

19 A. He did. He gave me a brief history.

20 Q. Based on the history he had given you of
21 depression, was it your understanding that that was a
22 long-standing problem for him?

23 A. Right. I believe dating back to 2006. Let me
24 make sure I've got that right though. Right. Ten years
25 ago.

1 Q. And you are aware that he had been on medications
2 for depression and anxiety for at least that amount of
3 time, is that right?
4 A. I was.
5 Q. Does that depression, especially the severe level
6 of depression, is that also another factor you need to
7 consider when interpreting your neuropsychological test
8 results?
9 A. It is.
10 Q. How does the depression, generally speaking,
11 affect the test results?
12 A. Generally speaking, both the emotional distress,
13 and when I say emotional distress, I'm talking about
14 anxiety and depression and pain impact the
15 neuropsychological test results by way of inattention, just
16 specifically your ability to divide attention, so that's
17 something we have to take into account. So the first task
18 is to see, of course, the complaints are consistent with
19 element self-testing with what they are reporting in the
20 interview and whether or not it's over or under reporting
21 and then whether or not there is valid effort, and then to
22 see if there is any kind of impairment, and then once you
23 see whether or not there's an impairment -- so if there is
24 impairment, the next question is can that be explained away
25 by anxiety, depression and physical pain. So you have to

1 factor that out and we factor that out by way of
2 inattention.
3 Q. So on each of these other subtests we are going
4 to look at, you have to factor in that pain, depression and
5 anxiety and interpreting those results if they appear
6 numerically abnormal, is that fair to say?
7 A. That's fair to say.
8 Q. Intelligence, I guess we are all somewhat
9 familiar with IQ testing. Is that what you tested here
10 under the Intelligence section?
11 A. It is.
12 Q. How did Mr. Barr perform on the intelligence
13 testing?
14 A. He performed well on the task of premorbid
15 functioning. So of course there is a difference between
16 academic achievement and intelligence we've actually
17 obtained in school, and based on the measure of estimated
18 premorbid functioning, which is the information subtask, he
19 performed in the average range. So the scores from the
20 rest of the measures are compared to that estimate of
21 premorbid functioning.
22 Q. The estimate of premorbid functioning, that's
23 just an extrapolation from this test result, is that right?
24 A. It is.
25 Q. Did you have an opportunity to look at his actual

1 academic records or standardized testing, S.A.T. scores,
2 that sort of thing that might have demonstrated actual
3 premorbid or intellectual functioning prior to his
4 employment with Darlington County School District?
5 A. I did not.
6 Q. Is there a large disconnect between what you
7 projected to be his -- we keep saying premorbid. There was
8 an insult at work, but premorbid, I suppose, I will
9 suggest, means prior to his employment with Darlington
10 County School District. Is there a huge disconnect between
11 what you suppose his prior intellectual functioning is and
12 what you tested on the Wechsler Adult Intelligence Scale?
13 A. On two measures, on two areas of concern which
14 was some of the measures of executive functioning which was
15 above and beyond any kind of possible impairment due to
16 inattention and on motor skills.
17 Q. With respect to his IQ, your measures of
18 intelligence, those weren't substantially different than
19 what you projected his prior intellectual functioning to
20 be?
21 A. Right.
22 Q. Would you agree that his actual academic records,
23 especially if they were to include standardized test
24 scores, would be a better measure of any premorbid
25 intellectual functioning than the extrapolation from your

1 test?

2 A. No. Because the academic performance has a lot
3 to do with motivation, the opportunities more synthesized
4 in the home life. In order to perform well on the
5 information subtest you have to know the information, so
6 it's something that's learned at some point in your life
7 and you retained it and you can actually demonstrate that
8 you still know it.

9 Q. You are not suggesting that his intellectual
10 functioning has changed?

11 A. Right. I am not. What I am suggesting is that
12 academic performance is not always indicative of
13 intelligence, at least I hope so with my ten-year-old son.
14 I'm holding on to that faith.

15 Q. But the academic performance could be one
16 indicator of intellectual functioning?

17 A. Right. And it could be -- and that is true with
18 the estimate of premorbid functioning, just as academic
19 achievements, somebody might not live up to the best of
20 their potential. The information subtest, too, if someone
21 doesn't want to learn anything throughout school or even
22 after school they might be very intelligent but incurious.
23 So someone could have a very low information subtest score
24 and still be intelligent, but we just can't capture that
25 estimate of premorbid functioning. If someone is curious

1 and continues to learn throughout their life, we can
2 capture that. So he was at least of average intelligence.
3 Q. The intelligence testing that you did you are not
4 suggesting that your measure of low average range of
5 intellectual functioning was caused by any alleged exposure
6 to toxic materials?
7 A. The processing speed, that is impacted by a
8 number of things: Daily stress, pain. So it's possible
9 that that brought that down lower, the general
10 intelligence. But that's not what I was suggesting in my
11 report.
12 Q. You did measure his processing speed. It was
13 still within an average range, is that correct?
14 A. Right. The simple search and coding individually
15 were in the low average range. I'm sorry. The processing
16 speed was in the low average range.
17 Q. You said that stress, pain, depression can all
18 impact processing speed?
19 A. Right.
20 Q. The next measure reported on the narrative report
21 was the testing of memory, is that right? It looks like
22 you did actually three subtests for Mr. Barr's memory
23 testing?
24 A. Right.
25 Q. Take us through those. The first one is the

1 Wechsler, is that right?

2 A. That's right.

3 Q. How did Mr. Barr perform on the Wechsler?

4 A. He performed well. On Wechsler Memory Scale, all

5 the tests of memory, there was no compromise. That

6 includes the memory for stories that are presented to you

7 verbally you have to recite back and then recall. A

8 complex figure they need to copy and then recreate after a

9 book of three and 25-minute delay and be able to recognize

10 components in that. And on word lists, they repeat it

11 three times. He was able to learn and recall those word

12 lists.

13 Q. So on this, we have the Wechsler, the Rey Complex

14 Figure Test, Hopkins Verbal Learning Test, is that right?

15 A. That's right.

16 Q. On all of those tests his scoring was average,

17 above average or on one of the subtests superior, is that

18 right?

19 A. That's right.

20 Q. When we are saying average, is that average for

21 brain damaged people or is that average for the normal

22 adult population in the United States?

23 A. Average for the normal population.

24 Q. Is there any way to have a false positive on

25 memory testing so that could he have faked his way into

1 above average test results?

2 A. He could have been a very good guesser, but no, I

3 don't think so.

4 Q. He couldn't have guessed his way through all of

5 these tests, could he?

6 A. No.

7 Q. Is there any objective evidence of any memory

8 loss or memory impairment in Mr. Barr's case?

9 A. No. Not from this testing.

10 Q. Would his memory testing be consistent with

11 dementia or severe cognitive impairment?

12 A. No.

13 Q. We have seen the word dementia used in this case,

14 but if you would, what do you take that to mean?

15 A. It's a general decline in functioning. So it's

16 most notable in depression -- I'm sorry, in memory, but you

17 see it across the board.

18 Q. And it's a severe impairment, is that right?

19 A. It's progressive and it might start with specific

20 deficits and be global and severe.

21 Q. But we're generally thinking that memory is going

22 to be a key companion of a dementia diagnosis, a dementia

23 classification?

24 A. Right. That is not what I was looking for in

25 this case. So we can put a pen in that. I know we are

1 going through one by one. The next question of whether or
2 not there's impairment, if there is impairment, where did
3 that come from, and in this specific case we were looking
4 for executive dysfunction and motor coordination. So in
5 2009, the task was different what I was called to do. I
6 don't know if you remember the Exide battery factory, but
7 we needed to determine whether or not people who were
8 exposed to toxic chemicals had any kind of impairment, and
9 that was a different case, because that was years later,
10 and what we relied on was a study, a series of studies of
11 these are very useful (producing document) because it gives
12 us something to compare an individual to.
13 And in 2009, what we were expected to do was
14 look at people who were exposed years ago and see if they
15 are consistent with the people who have impairment based on
16 these studies, so this is a series of 38 longitudinal
17 studies and the one that is concerned with former workers
18 is concerned with global impairment, and so in that study
19 what they found was people who had been exposed an average
20 of 16 years prior to the toxic chemicals were globally
21 impaired.
22 Nineteen of the 19 cognitive measures that
23 were used showed decline, and this was over a five-year
24 period so people who had been workers exposed to toxic
25 chemicals, 16 years later, they followed them for five

1 years, and found there was decline, so what the authors
2 concluded was these toxic agents enter the body causing
3 insult and then years later there is progressive decline.
4 And at a certain level of exposure that's equivalent to a
5 five-year progression and cognitive aging. That's not
6 relevant for this case because he was more recently
7 exposed.
8 Q. Let me stop you right there. On what basis do
9 you say he was exposed to anything?
10 A. Well, the assumption is. That's what we're
11 testing out, right. So what we are looking for is there
12 any kind of impairment that's consistent with people who
13 have been shown to be exposed currently. There's a study,
14 series of studies, same authors, different lead authors in
15 each study, the Korea lead exposure study is more
16 consistent because they included both former workers and
17 current workers and the longitudinal design as well.
18 Q. And these were people who were exposed to toxic
19 levels of lead?
20 A. Right.
21 Q. Which is not an allegation Mr. Barr makes?
22 A. Right. So they're trying to generalize the
23 exposure to neurotoxins in this study, because the point of
24 this study was to take a look at former and current workers
25 and expose the type of neurotoxins that the person was

1 exposed to, and as you can imagine, the impairment was
2 obvious, but there was impairment on 8 of the 19 measures,
3 most notably on executive functioning and motor
4 coordination.

5 Q. But in this case, you are only assuming for the
6 sake of argument that there may have been exposure to some
7 sort of chemical, is that right?

8 A. Right. Yes, and if you read my conclusion, if it
9 is determined that there was neurotoxic exposure, then this
10 impairment is consistent with that and we would expect it
11 to progress and generalize.

12 Q. When you say consistent you are not suggesting
13 that any abnormalities revealed on your testing were
14 actually caused by any exposure of the Darlington County
15 School District?

16 A. They would be explained by any kind of exposure.

17 Q. They could also be exposed to other things?

18 A. They could be.

19 Q. Or explained by other things?

20 A. Right.

21 Q. So you looked at his executive functioning.
22 Normal memory, basically normal on all the other
23 parameters, and you get to executive, and generally
24 speaking, executive function was not abnormal, was it?

25 A. He demonstrated inhibition and compromised verbal

1 fluency.

2 Q. He was only showing compromised verbal fluency on
3 one of the subtests, letter fluency versus category, is
4 that correct?

5 A. Right. Borderline impaired on the one and
6 impaired on the other.

7 Q. The other tests of executive functioning like the
8 Wisconsin Card Sort Test were not impaired?

9 A. Right. So executive functioning is
10 superordinate. There are several types of executive
11 functioning. So the inhibition was impaired. So on the
12 other measures of executive functioning, he was well
13 preserved.

14 Q. There was no test retest validity on the letter
15 fluency impairment. That was just a single test, it wasn't
16 validated by retest, is that correct?

17 A. That's right.

18 Q. So is it possible that that is a measure of
19 fatigue or effort or prolonged testing? It's a long day
20 for neuropsych testing, is it not?

21 A. Good point. It is. I don't see that happening
22 the way that these measures are given. That would not be
23 explained by the fatigue at that point. It wouldn't be
24 like just the exact same things that we are expecting to
25 see if there was an exposure. It just happened to be what

1 we see. Now, of course, my assumptions can be tested out,
2 because this is something that's, you know, what my
3 conclusion is, is this is the early warning signs of
4 progressive decline, of generalized decline, so he can be
5 tested like at six, twelve month increments and we can test
6 these things out as long as everybody agrees on
7 methodology.
8 Q. So you feel like it's a prognosticator of early
9 decline but not necessarily specific to any particular
10 exposure or other cause?
11 A. Well, the hypothesis is that it's due to exposure
12 and we can test that out. When you look at the studies,
13 those are just done over a five-year period, so we can
14 replicate the studies with a single-case design.
15 Q. But the hypothesis being that there was some sort
16 of exposure, it's not borne out by actual evidence, is it?
17 A. It is consistent with what was seen in the
18 research that was done on former and current workers, so
19 those exposed---
20 Q. To lead?
21 A. Right.
22 Q. But I am talking about specifically Mr. Barr's
23 case. There's no evidence of any sort of toxic exposure,
24 is there?
25 MR. MCDANIEL: Objection. Misstates the

1 evidence.

2 MS. BARR: Or lack thereof. There's no

3 misstatement.

4 A. So you're right. I need to base it on the

5 convergence of evidence, so this is one piece hopefully

6 that will be helpful to you all and to the triers of fact

7 that this is a cognitive functioning, and so this is what

8 is consistent with the studies that have been done, and

9 based on the studies that have been done we can predict

10 based on those studies, this is my prediction.

11 Q. Have you been able to rule out all the other

12 possible reasons why letter fluency may have been impaired

13 on this one set of tests of executive functioning?

14 A. Well, we can rule out the impact of anxiety,

15 depression and pain.

16 Q. What about medications such as Depacote?

17 A. We can rule that out based on his well-preserved

18 vigilance on the CPT, so when somebody has medication side

19 effects from any medication, it's vigilance that you are

20 concerned about.

21 Q. But Depacote can affect verbal fluency, correct?

22 A. It can influence attention, but you would see

23 that on the other measures of attention, so you would see

24 that across the board.

25 Q. So the verbal fluency subtest is consistent with

1 your other test results?

2 A. Right.

3 Q. But it's not inconsistent with his verbal IQ, is

4 it?

5 A. It's inconsistent with his test of premorbid

6 functioning.

7 Q. You don't know anything accurately about his

8 premorbid functioning such as his verbal IQ?

9 A. We know just what's used in best practice as an

10 estimate of premorbid functioning which is the information

11 subtest.

12 Q. Your current assessment of his verbal IQ is not

13 inconsistent with the verbal test score, is it?

14 A. Where's the verbal IQ? (Referring to document.)

15 The verbal comprehension is low average.

16 Q. Right.

17 A. Right. It is inconsistent with that.

18 Q. Do you know anything concretely or objectively

19 about his verbal skills prior to his employment with

20 Darlington County School District?

21 A. No. I just know what I have as far as the

22 measures, so the verbal IQ is in the low average range

23 which is still significantly different from the impaired

24 and borderline impaired range.

25 Q. Depression also could account for impaired letter

1 fluency, could it not?

2 A. Again, by way of inattention, but we can rule

3 that out.

4 Q. What about ischemic vascular disease or scattered

5 white matter hyper-intensities in the frontal lobe? Could

6 that account for impaired letter fluency?

7 A. It could. And again, if there is neurotoxic

8 exposure which is beyond my pay grade, that's something

9 somebody else might need to determine, but if it is found

10 that there has been neurotoxic exposure, then that would

11 aggravate that decline.

12 Q. Would aggravate what decline?

13 A. Any declining due to other dementia or any other

14 kind of insults.

15 Q. How would you know? I mean, if you don't have a

16 baseline, why would you suggest there's been an

17 aggravation? That's a lot of assumption. You're assuming

18 that there has been a decline, number one; and number two,

19 you're assuming that there has been some insult, are you

20 not?

21 A. Right. And those are symptoms that are based

22 just on the data that we have, the studies that have been

23 done.

24 Q. If Mr. Barr has vascular ischemic changes in the

25 frontal lobe that predate his employment with the

1 Darlington County School District could that not be a
2 potential explanation for impaired letter fluency on this
3 one subtest?
4 A. Right. But again, if there has been the
5 exposure, then that would progress the decline more rapid.
6 Q. Again, you don't know if there's been exposure or
7 a decline?
8 A. Right. It looks like as though there has been a
9 decline.
10 Q. Based on what?
11 A. Based on the estimates of premorbid functioning.
12 Q. You don't know that nor do you have any objective
13 evidence of a decline.
14 A. Just the best practice which is the use of the
15 standardized accepted estimate of premorbid functioning.
16 Q. Did you look at any of the serial MRI scans done
17 of Mr. Barr's brain?
18 A. No.
19 Q. If they do in fact show scattered white matter
20 hyper-intensities in the frontal lobe, that could be
21 related to the subtest score on letter fluency, correct?
22 A. Correct.
23 Q. And if those scattered white matter
24 hyper-intensities were not necessarily caused by any toxic
25 exposure, they could be accounted for by other causes, is

1 that correct?

2 A. That's correct.

3 Q. You also spoke about his inhibition or

4 disinhibition. Klonopin can certainly play a role in that,

5 can it not?

6 A. It can, but by way of inattention. Medication,

7 pain, anxiety, depression affects people's function by way

8 -- that's something very important to look at, because I

9 would say 80 percent of the time that is what we are

10 looking at is inattention, but that's not the case for him.

11 Q. And disinhibition is not something he complained

12 to you about subjectively, or his wife even, that that was

13 a problem in his daily life?

14 A. Right. You're right. It tends to be something

15 that people can't quite put a name to, so I am not sure if

16 he noticed it or didn't notice it.

17 Q. Impulse control wasn't a complaint, correct?

18 A. Right.

19 Q. Was it something you noticed on your interview,

20 because it seems that he seemed appropriate in his

21 responses and you said that his impulse control appears

22 reflective and he's able to resist urges, is that right?

23 A. Right. In the interview. On the CPT he had a

24 liberal response to style which is suggestive of speed over

25 accuracy, and that is suggestive of disinhibition.

1 Q. Disinhibition is not necessarily peculiar to
2 toxic exposure or brain damage, is it?
3 A. No.
4 Q. And white matter changes in his frontal lobe that
5 have been demonstrated by MRIs could also be responsible
6 for disinhibition or the test results suggesting
7 disinhibition that you obtained, is that right?
8 A. That's right.
9 Q. I think the next thing you were pointing to was
10 motor coordination. Like the disinhibition, would you
11 agree that impaired motor coordination is not peculiar to
12 toxic exposure or brain damage?
13 A. Right. I mean that is the lowest hanging group
14 in the study that was done in Korea. So that's what was
15 most notable in that study was motor coordination and
16 executive dysfunction such as disinhibition. So again,
17 it's not necessarily the one and only cause, but it was
18 something that was noted in that study, so if there was any
19 kind of preexisting condition, it is likely to be
20 aggravated. So this again is just what we would expect to
21 see initially, and then if there was any kind of neurotoxic
22 exposure, any kind of decline, it's expected to be more
23 global and more rapid.
24 Q. Again, impaired coordination on a group pegboard
25 test is not clear indicia of a brain injury, is it not?

1 A. Right. But it does stand out compared to his
2 other scores.
3 Q. There are multiple possible explanations for
4 impaired motor coordination, are there not?
5 A. There are.
6 Q. The Klonopin and Depacote that he takes on a
7 regular basis could be significant contributors?
8 A. I think we can rule that out because of the
9 inattention measures and how he performs throughout. I
10 think we can rule out that inattention. We can rule out
11 any kind of medication effects, because we would expect to
12 see that in the other measures, the measures that look at
13 attention.
14 Q. But isn't that attention going to be relative to
15 the length of the test and the part of the day that you
16 measure motor coordination?
17 A. We would typically see just a distinct drop. If
18 somebody is just done with testing, then after lunch, boom,
19 all the tests from there forward are impaired, bottomed
20 out. You don't see that.
21 Q. Couldn't he have bottomed out when he took the
22 group pegboard test?
23 A. Anything is possible. It's not consistent with
24 what I observed.
25 Q. The depression can also affect motor

1 coordination?

2 A. By way of inattention.

3 Q. You only did the single motor coordination test,

4 is that right?

5 A. That's correct.

6 Q. And he had no subjective complaints regarding

7 coordination, did he?

8 A. No. I don't recall. I don't think I made a note

9 of that.

10 Q. What about a hand injury, hand pain, could that

11 impact somebody's motor coordination as tested on the group

12 pegboard test?

13 A. It can.

14 Q. What do you know about his history of hand pain

15 and hand injury?

16 A. I know that he had prior pain. I don't know the

17 specifics.

18 Q. So you didn't look at any of the records from the

19 occupational therapist who treated him for his hand?

20 A. Right.

21 Q. If he has a known complex tendon laceration,

22 multiple surgeries on his dominant hand, would you expect

23 that to affect his performance?

24 A. It would. And so the performance is compared to

25 the normal population with the dominant hand as well as the

1 non-dominant hand. He performed impaired on both.

2 Q. The year prior to seeing you he was complaining

3 of left hand pain, non-dominant left hand pain to his

4 family physicians. That hand pain from whatever source

5 could account for the impaired motor coordination on the

6 group pegboard test, correct?

7 A. Right.

8 Q. Again, hand pain standing alone isn't peculiar to

9 or couldn't only be explained by some sort of brain damage,

10 is that fair to say?

11 A. That's fair to say.

12 Q. Lots of reasons people might have hand pain or

13 hand problems?

14 A. That's correct.

15 Q. After this executive function, you tested

16 language. It looks like that was above average, is that

17 right?

18 A. That's correct.

19 Q. Cancellation, the Star Cancellation Test, how did

20 he perform there?

21 A. Performed well.

22 Q. So when you get to your conclusions -- you were

23 merely asked whether or not Mr. Barr's cognitive complaints

24 were consistent with brain damage. You weren't asked

25 whether or not they were caused by brain damage, is that

1 correct?

2 A. That's correct.

3 Q. You were asked whether or not he even has brain

4 damage?

5 A. Right.

6 Q. In your summary, disinhibition and impaired

7 dexterity were the only parameters that you mentioned, is

8 that right?

9 A. That's correct.

10 Q. Those were the only parameters that you measured

11 that are even potentially consistent with some sort of

12 brain injury?

13 A. Right.

14 Q. You can't tell whether or not those things were

15 caused by brain damage generally or some alleged toxic

16 exposure specifically, can you?

17 A. No. The best we can do is take a look at the

18 convergence of evidence and rely on a variety of sources.

19 Q. Based on your neuropsychological testing, is

20 there any evidence that he is suffering from dementia?

21 A. Based on studies there's evidence that suggest

22 that he has the early warning signs of toxic exposure that

23 can be progressive and generalized.

24 Q. Why do you say early warning signs of toxic

25 exposure? Could these not be early warning signs of

1 something else or just a constellation of unrelated
2 symptoms?
3 A. They can be. We can let the evidence bear it
4 out. But it is consistent with -- you know, before we do
5 the test, you know, people who are referred to us are often
6 frustrated with us because we say beforehand we take your
7 money, we'll cash your check and then we'll see what we
8 have got. We'll look at the data---
9 Q. This might be useful ten years from now?
10 A. Well, no. It might not be useful and it might
11 hurt you. You know, it's risky. When you come to us, it's
12 risky. So we make predictions before we actually test
13 somebody, and in the previous cases, the Exide cases, there
14 were specific things we were looking at and said, okay, if
15 this person does have real impairment, this is what we
16 expect to see, and then we look at the data. We don't look
17 at the payer source. We look at the data. And in this
18 case, we looked at the data. Before I looked at the test
19 results I looked at the previous studies, and what am I
20 looking for, this is what I am looking for. So there were
21 8 of 19 measures that's consistent with neurotoxic exposure
22 and most notably was executive functioning and motor
23 dexterity, and in each of the cases that were in this group
24 as a population, you know, I'm sure there is anxiety,
25 depression, hand pain, you know, previous incidents, but as

1 a whole, those were the early warning signs.

2 Q. There were eight of them?

3 A. Right.

4 Q. So that means at least six of them weren't

5 present in Mr. Barr's case?

6 A. The authors said most notably executive

7 functioning, the most notable impairment, the most notable

8 amount of variance was due to executive functioning and

9 motor coordination.

10 Q. And generally speaking, his executive functioning

11 was intact?

12 A. Right. Generally speaking.

13 Q. In fact, intact on all but two subtests of the

14 Delis-Kaplan executive functioning test which was only one

15 of the tests of the executive functioning that you did?

16 A. Right. So we can bear out that idea with future

17 testing and see if it does generalize and see if it does

18 decline even more.

19 Q. So these other eight measures that you were

20 looking at that may be consistent with some sort of lead

21 exposure or other toxic exposure, what were the other six?

22 A. When we talk about the eight measures, it's not

23 every single person had a decline on those specific eight

24 measures.

25 Q. Right, but those were the things you were looking

1 for?

2 A. Right, but most notably was the executive

3 functioning and the motor coordination, so the authors

4 found that the current workers were experiencing declines,

5 but they're more likely to have decline in those areas, and

6 so of course there was memory, memory for things you see

7 and memory for things you hear.

8 Q. You say decline. Again, you've got a snapshot in

9 time. You don't have any evidence of decline, do you?

10 A. Right. So what I am doing is comparing him to

11 population and not to himself and he can be compared to

12 himself. You want to give -- to replicate the study you

13 want to give 12 months which is -- I personally don't have

14 patients to wait that long, but it's something that can be

15 done.

16 Q. You also gave some opinions about emotional

17 impairment that Mr. Barr has. Again, you have not reviewed

18 any records regarding his emotional impairment and I think

19 you said earlier by emotional impairment you were talking

20 about anxiety and depression, is that right?

21 A. Right.

22 Q. You haven't reviewed any records of his

23 complaints of or treatment for emotional impairment over

24 the past decade, have you?

25 A. I have not.

1 Q. Is there any evidence that you have that there's
2 been a change in his emotional impairment?
3 A. Based on what he is reporting, and I do believe
4 what he is reporting as far as his physical limitations and
5 his headaches, so based only on those two things which that
6 is due to self report, but it's not invalidated by the
7 validity measures. Any kind of physical pain causes the
8 adrenaline to rise which accounts for anxiety. And any
9 difficulty doing the things that you used to enjoy doing,
10 including gainful employment, will lead to depression.
11 Q. And that could include the neck and chronic low
12 back pain that he complained of, or the chronic arm pain?
13 A. Right.
14 Q. So that could be impacting any change in his
15 emotional impairment over the years, is that right?
16 A. That's right.
17 Q. I assume that there are many other factors that
18 could have created a change in his emotional impairment
19 over the course of his employment at the Darlington County
20 School District. Would you agree?
21 A. Right. It's difficult to tease things out, but
22 if there is any kind of physical pain, regardless of the
23 source, that does aggravate both the anxiety and
24 depression.
25 Q. But you didn't get into with Mr. Barr anything

1 like the impact of his father's death or his teen
2 daughter's pregnancy out of wedlock or anything like that
3 that could potentially impact his emotional impairment?
4 A. Right. I did not.
5 Q. And obviously this is a silly question, but
6 emotional impairment is not something that is peculiar to
7 exposure to volatile organic compounds. That's not the
8 first thing you are looking for, is it?
9 A. Right. It's consistent with the cascading
10 effects of any kind of impairment.
11 Q. Not necessarily related to VOC exposure or brain
12 damage either?
13 A. Right. It's not specific.
14 Q. Having met Mr. Barr and done your
15 neuropsychological testing, is there any evidence that he
16 has severe permanent brain damage at this time?
17 A. I know that the severe, that there is a
18 distinction between what psychologists call it and what the
19 commission calls it, but I would say at this time it is not
20 severe. So he is capable of certain types of work, but at
21 the same time, the performance on the measures is
22 consistent with the early warning signs of progressive
23 decline.
24 Q. But those two measures, that could also be
25 accounted for by depression or medication or vascular

1 ischemic changes in the frontal lobe that are unrelated to
2 toxic exposure?
3 A. Well, they're related to toxic exposure based on
4 the study that was done.
5 Q. What is related to toxic exposure?
6 A. So the specific impairment that he had is
7 consistent with the population that had been found to be
8 impaired due to neurotoxic exposure.
9 Q. It's also consistent with other things like
10 vascular ischemic changes in the frontal lobe?
11 A. Right. So it can be attributed to different
12 things. So based on -- I mean I'm not sure if he read the
13 effects of lead on the adult brain, a 15-year exploration,
14 you know, I don't know if he would know, oh, this is what I
15 am going for, you know, so I think it's odd that the very
16 specific things that are mentioned in that study that was
17 done are found in somebody who is in the exact same
18 situation that is claiming to be exposed to a neurotoxic
19 agent and claiming to have cognitive decline secondary to
20 that.
21 Q. You're talking about like his motor coordination?
22 A. His motor coordination and his executive
23 functioning.
24 Q. But you don't know anything about what might be
25 causing his problems with motor coordination such as in a

1 complex hand injury?

2 A. Right. I mean I just know what we would expect

3 to see if any kind of impairment was aggravated.

4 Q. But if he had a complex hand injury wouldn't that

5 be the more likely cause of impaired motor coordination

6 than some unknown exposure, some unquantified exposure to

7 substances?

8 MR. MCDANIEL: Objection to the question. It

9 misstates the evidence.

10 Q. I mean I can show you hundreds of pages of

11 occupational---

12 MR. MCDANIEL: Well, go ahead and show him a

13 hundred pages. Objection. No. The question is not

14 specific as to time, as to result, as to final diagnosis

15 and as to his condition after his treatment.

16 BY MS. BARR:

17 Q. What seems more likely to you to account for

18 impaired motor coordination in the hand, a complex hand

19 injury requiring multiple tendon repairs and resulting in

20 contractures of the fingers or toxic exposure?

21 A. Well, if it was specific to the one hand, if we

22 saw compromise of only one hand, then I would say it was

23 due to the injury.

24 Q. What about bilateral carpal tunnel syndrome?

25 A. Right. So that would definitely come into play.

1 Q. So impaired motor coordination is not specific to
2 brain damage generally or toxic exposure specifically?
3 A. Right.
4 Q. When we talk about, again, the executive
5 functioning, he only showed impairment on a single
6 parameter of a single subtest of a single test of executive
7 functioning, right?
8 A. Right. So when we are talking about executive
9 functioning we are talking about a number of executive
10 functions, and that is what bears out in the research that
11 was done, so we weren't looking for him to be globally
12 impaired. We were looking to see if there was any kind of
13 impairment, if so, where might it come from and it is
14 consistent with the neurotoxic exposure.
15 Q. But it could also be consistent with any other
16 number of reasons, effort, attention---
17 A. Like you said, we have a snapshot in time, and so
18 to be responsible in our statements we need to point out
19 that that is a snapshot in time. Best guess based on the
20 evidence that we have, including everything that you just
21 mentioned which I think is good to point out, and then we
22 can bear that out with evidence in the future. So I am
23 more than willing to say, hey, I'm wrong if 12 months from
24 now there is no global impairment on both valid neuropsych
25 tests.

1 Q. That gets into we spoke a little bit about the
2 test, retest reliability, is that right?
3 A. Right.
4 Q. But with neuropsych testing it's my
5 understanding, since it is such a long battery of tests,
6 doing too many tests or doing too many tests in successive
7 days without the passage of time, that could impact your
8 results, can it not? I mean affect reliability in and of
9 itself?
10 A. Right. We're getting into the responsibility
11 again. That's right. What has to be taken into account is
12 the way the tests are set up, the length of time between
13 tests, the way people are treated when they take the tests.
14 You're right. That is a very good point.
15 Q. So it's not something you or another
16 neuropsychologist could bring him back in and just do the
17 same thing all over again today. That would affect
18 reliability in and of itself?
19 A. Using the safeguards that are in place and using
20 the practices that are in place you do retests, so the
21 studies were longitudinal, so they saw the decline on these
22 measures across time and the whole point is to replicate
23 what was done in these studies.
24 Q. So over time---
25 A. Over time. So it can't be done today, right.

1 Q. So really, to have a better interpretation of
2 your neuropsychological testing, it would be better to wait
3 a year and see if it can be replicated or if there's been
4 some change? Is that fair to say?
5 A. Right. And if I'm validated I'm sure everybody
6 will come back and let me know. It always happens. And if
7 I'm wrong, if I'm wrong I know I'll be told. But I would
8 welcome to be proved right, but I am taking a chance that I
9 be proved wrong.
10 Q. You spoke to this briefly before, but based on
11 your interview of Mr. Barr and your neuropsychological
12 testing, there is no contraindication to him returning to
13 work in some capacity?
14 A. In some capacity, right. With the limitation in
15 which I think a medical doctor would be in a better place
16 to place limitations on the manual dexterity.
17 Q. But his cognitive function is not preventing him
18 from working or earning wages.
19 A. Right.
20 Q. In the interest of speed, I am ceding the floor
21 to Mr. McDaniel?
22 **Cross-Examination**
23 BY MR. MCDANIEL:
24 Q. In reference to one of the questions that says
25 testing later on, versus, would be any reputable

1 neuropsychologist testing, in other words, like if we

2 replicate these tests within a year?

3 A. Right. Anybody who agrees on the methodology I

4 would agree with, and I think we both know there are some

5 people who aren't as responsible, but I would say, with the

6 exception of just a few neuropsychologists, that I think

7 any reputable neuropsychologist.

8 Q. Explain to me if you would. You referred to in

9 reference to the Exide battery cases. Tell me what your

10 relationship was to those cases.

11 A. In 2009, it was a very tight few months. I think

12 the cases were given to me in November. I was asked to

13 review them before---

14 Q. Who asked you to review?

15 A. It was the defense asked me to review 23 cases.

16 Among those 23 cases, 13 were found to have no cognitive

17 impairment or cognitive impairment that was more consistent

18 with pain and anxiety and could not be -- that more likely

19 than not due to the neurotoxic exposure. The other ten

20 needed to be tested again and they were found not to have

21 any -- the way I remember it, they were found to actually

22 have impairment secondary to the neurotoxic exposure. And

23 that again we were looking for -- that was more global.

24 The impairment they were looking at was what you are more

25 likely to think of when you think of dementia, global

1 impairment, but then there's also physical pain and anxiety
2 and we all agreed on the methodology and said, hey, we
3 might be cutting nature at her joints, but this is what we
4 are going to decide to do.
5 Q. And so basically a defense firm hired you and
6 then would it be fair to say you were sort of like the
7 triage and then after that you decided who needed testing,
8 all that, is that correct?
9 A. Right. To triage into cases that clearly had
10 impairment, clearly didn't have impairment, and then what
11 needed further investigation.
12 Q. In addition to that you have had, would you say,
13 a fair amount of exposure with people with toxic problems
14 in reference to exposure to neurotoxins?
15 A. That was the big influx, and then I have had
16 maybe a handful, I would say probably no more than six
17 since that time.
18 Q. In reference to neuropsycholgical testing, Ms.
19 Barr asked you a good question, and I have seen this across
20 the board, but basically my understanding from your
21 testimony is your responsibility, you feel like as a
22 neuropsychologist, is to perform neuropsychological testing
23 to express to a medical provider or medical providers what
24 those results are, and then they are to use those in
25 conjunction with their treatment of the patient or

1 evaluation and examination. Is that fair?

2 MS. BARR: Objection. Leading.

3 A. Right. People use our testing as one piece of

4 data to inform either the treatment or their investigation.

5 Q. You're not a medical doctor?

6 A. Right.

7 Q. And you are not professing to express medical

8 opinions concerning whether or not what caused his actual

9 problem, is that correct?

10 A. Right. I just wanted to identify whether or not

11 there was any impairment, and if so, if that was consistent

12 with neurotoxic exposure.

13 Q. And your opinions, as expressed in this report,

14 would remain the same after this deposition?

15 A. They do.

16 Q. And that represents your opinion to a reasonable

17 degree of psychological certainty?

18 A. It does.

19 Q. I want to ask you a few more questions. You

20 really actually explained this during Ms. Barr's

21 examination, but anxiety and depression are two distinct

22 psychological conditions, is that correct?

23 A. That's correct. They often occur together a lot

24 of times, but they are distinct.

25 Q. So does a lot of time, if you have anxiety, does

1 it lead to depression or does depression lead to anxiety?
2 Which way is it?
3 A. The way I have seen it, given that this is a
4 trauma clinic, I have seen it where the anxiety leads to
5 depression, and if you're anxious and you don't have as
6 much control over things you might be depressed because of
7 that. Depression comes from a lack of predictability and
8 control and erosion of pleasure if you just can't do the
9 things that you used to enjoy.
10 Q. Anxiety, explain anxiety to me just a little
11 more.
12 A. It can come from a number of areas. It can take
13 many different forms. It can be apprehension about the
14 future. If you have physical pain, anything that drives
15 the adrenaline level up is going to make you more anxious.
16 Q. But it's not uncommon to see people with anxiety
17 or diagnosis of anxiety for a given number of years and
18 then later on they're diagnosed with depression?
19 A. Right.
20 Q. So would it be, if the record showed that Mr.
21 Barr was suffering from anxiety back in 2006 and reported
22 anxiety and was on medications, and then if later on after
23 hand surgery and an extensive period of being out of work
24 and then another period of time when he had knee surgery in
25 2012, would it be uncommon to then see an added diagnosis

1 of depression?

2 A. It would not.

3 Q. Would it be uncommon that once he returned to

4 work and was doing okay that he may continue with the

5 anxiety but the depression would not be as much of a

6 problem?

7 MS. BARR: Objection. Calls for speculation.

8 BY MR. MCDANIEL:

9 Q. Assuming that's what the records show?

10 A. Right.

11 MS. BARR: Calls for facts not in evidence.

12 MR. MCDANIEL: Okay. That's fine. We'll let the

13 record speak for itself.

14 BY MR. MCDANIEL:

15 Q. In reference to physical hand problems, and I

16 appreciate and understand what you are saying about in

17 reference to one hand versus the other. If I told you that

18 Mr. Barr had hand surgery in 2012 and I don't see any

19 reference to further treatment of the hand after 2013, and

20 that he was a full-time painter from then on, right-handed

21 painter, do you think that would affect whether or not

22 there's any actual long-term physical findings in reference

23 to the problems with his hand?

24 A. If it was expected to be one hand versus the

25 other.

1 Q. I guess really you would leave that to his
2 medical doctor, like his neurologist that saw him from 2012
3 to 2016?
4 A. Right. I would rely just on the convergence of
5 evidence, right.
6 Q. You brought up a wonderful point that I wish I
7 had had the opportunity to at one time to explain this to
8 the Supreme Court, but however, tell me about the grades in
9 reference to brain damage as you see it from a
10 psychological standpoint. I think there is a scale that
11 you all refer to. If I use the term mild, moderate and
12 severe, is that the normal scale that you use?
13 A. I have seen it used that way.
14 Q. What is your frame of reference from a
15 psychologist's standpoint?
16 A. From my perspective it has to do with the
17 impairment, so the impairment is not great right now, but
18 if his impairment is aggravated by neurotoxic exposure,
19 then we expect it, if it's in the mild range, we expect it
20 within the next five years, if it's consistent with the
21 previous study, the studies that have been done, to decline
22 progressively and you would actually see that decline
23 within that five-year period.
24 Q. If a person is suffering from whatever source,
25 headaches, severe headaches, is that going to affect

1 whether or not they're in a severe headache sequence at the
2 time as given as to their memory?
3 A. Right. So again, that's by way of attention. If
4 you can't pay attention to things, you're not going to
5 encode the information. In the first place, I'm not going
6 to be able to divide your attention because you're focused
7 on the pain.
8 Q. Just in reference to headaches in general, if
9 somebody suffers from migraine headaches, let's say
10 migraine headaches, and you test them on a day that they
11 are not having a migraine headache, and then on a day that
12 they are having a migraine headache to the standpoint of
13 like some clients have told me they have to get in a dark
14 room, they have audio/visual impairment, that kind of
15 thing, would there be a totally different result in the
16 neuropsychological testing in reference to memory?
17 A. Right. We have seen that. And again, that is by
18 way of the attention.
19 Q. Can you tell me how Mr. Barr was on the day of
20 his examination as far as his headache level? Was he on
21 medications?
22 A. I can't recall if he was on medications. They
23 were well controlled. We do keep tabs to see, if there is
24 head pain, and if it gets worse throughout the day, check
25 in to see how they're doing, make sure that they are still

1 awake, that they're not fatigued.

2 Q. I want to go over one more thing and then I am

3 finished. Under executive function on your page 8 of 8, I

4 want to make sure if I can understand. We have

5 trail-making that's impaired, correct? Or visual scanning.

6 Excuse me.

7 A. Visual scanning is impaired, right.

8 Q. Number sequencing borderline. What does that

9 mean?

10 A. What that means, those are actually the contrast

11 measures so that -- the measure that, and it does take

12 executive functioning to do the visual scanning, letter

13 sequencing, but those are lower level skills. The true

14 task, the true executive task is the number letter

15 sequencing, so in terms of visual scanning and letter

16 sequencing, any kind of impairment can be attributed to

17 inattention, and so that's why I really like this test is

18 that it does help you factor out the variables that could

19 be due to pain and anxiety so that inhibition cannot be

20 accounted for by pain and anxiety.

21 The letter fluency and category fluency

22 scores cannot be attributed to pain and anxiety. And the

23 reason that we take a look at that is that that is the most

24 important thing to look at. Like I said, 80 percent of the

25 time, any kind of cognitive impairment is not existing in a

1 vacuum. A lot of times there's the assumption that it
2 does, that it's due specifically to organic brain damage,
3 and you have to consider the context. So that is the
4 reason that we spend so much time looking at those things.
5 Q. Of course, all these tests are evaluating
6 executive function and cognitive functioning and that type
7 of thing. They really have nothing to do with severe
8 headaches?
9 A. Right. I didn't see the impact of any kind of
10 pain.
11 Q. So as in reference to his ability to work, the
12 severity of his headaches and that type thing, also
13 consideration should be made and you defer to his---
14 A. I defer to a neurologist for headaches.
15 Q. One thing in reference to the psychological, from
16 any source, assuming that if it is consistent with him
17 having been exposed, how is this condition or this lack of
18 executive functioning and cognitive function going to
19 affect his psychological makeup?
20 MS. BARR: Objection to the form of the question
21 based on facts not in evidence and it calls for
22 speculation.
23 A. He would likely be frustrated which can lead to
24 anxiety, and if he feels helpless, then that would lead to
25 depression.

1 Q. If he was in a deposition and after about an hour
2 just sort of began to break down and cry, would that be
3 indicative of -- what would that tell you about his
4 psychological condition at that time?
5 A. That he is starting to feel fatigued and which I
6 can sympathize with. I think the endurance after a certain
7 point gives out. You know, if you have a lot of stressors,
8 the more stressors over a longer period of time, your
9 endurance gives out and you have less frustration time.
10 Q. And as you were saying earlier, neuro cognitive
11 functioning is not in a vacuum and it can be caused by
12 organic or functional problems, meaning psychological
13 versus physical and that that affects both physical or
14 cognitive function such as dexterity, those types of
15 things, but it also affects the psychological makeup of a
16 person, psychology of a person, is that correct?
17 A. Right. So psychology can be both the cause and
18 effect. When it's the cause of impairment we see it
19 through inattention.
20 **Redirect Examination**
21 BY MS. BARR:
22 Q. Your testing, in your opinion, was Mr. Barr's
23 objective neuropsychological testing consistent with a
24 diagnosis of a memory deficit or memory impairment?
25 A. My test results are not consistent with that.

1 Q. Are your test results consistent or inconsistent
2 with a diagnosis of slow processing speed? His processing
3 speed was within the range of average, was it not?
4 A. Low average, right. So modestly compromised.
5 Q. And that compromise can be due to depression,
6 anxiety or medication effects?
7 A. Yes.
8 MS. BARR: Thank you so much.
9 (At 10:05 a.m., the deposition was
10 concluded.)
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CERTIFICATE OF REPORTER

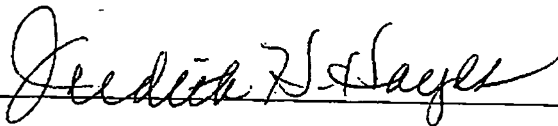
STATE OF SOUTH CAROLINA)

COUNTY OF LEXINGTON)

I, Judith H. Hayes, Certified Court Reporter and Notary Public for the State of South Carolina at large, hereby certify that I transcribed the foregoing deposition of the witness at the time and place hereinabove set forth, that the witness was duly sworn, and that the foregoing pages numbered from 4 through 50, constitute a true and correct transcription of the stenographic report of the witness.

I further certify that I am neither attorney nor counsel for, nor related to or employed by any of the parties connected to the action, nor am I financially interested in the action.

Witness my hand and seal at Lexington, South Carolina this 20th day of February, 2016.



Judith H. Hayes, Certified Court Reporter

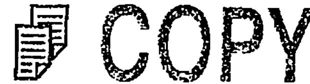
Notary Public, State of South Carolina at Large

My Commission Expires: 11/26/24.

Before the South Carolina
Worker's Compensation Commission

Kenneth L. Barr,
Claimant,
V.
WCC# 1507304

Darlington County School District,
Employer,
and
South Carolina School Board
Self-Insurers Trust Fund,
Carrier,
Defendants.



Hearing in the Above-Referenced Cause
Before Commissioner Mike Campbell

Location: City-County Complex, Room 803
180 North Irby Street
Florence, South Carolina

Date: Wednesday, August 31, 2016

Time: 10:20 a.m. - 1:02 p.m.

Court Reporter: Ashley Rogers

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7
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10 By: Kirsten L. Barr, Esq.
11
12 I N D E X
13 WITNESSES:
14 Robert Bennett
Direct Examination by Mr. McDaniel 20
15 Cross-Examination by Ms. Barr 24
Redirect Examination by Mr. McDaniel 28
16 Recross-Examination by Ms. Barr 73
Redirect Examination by Mr. McDaniel 76
17
Kenneth L. Barr
18 Direct Examination by Mr. McDaniel 79
Cross-Examination by Ms. Barr 125
19 Redirect Examination by Mr. McDaniel 144
20 E X H I B I T S
21 Pg/ln Ex. Description
Defendant's
22 Premarked 1-4 Deposition transcripts of
Dr. Paul Pritchard,
23 Nicholas A. Lind, Ph.D.,
Roland L. Skinner, III, M.D.,
24 Marshall Allyn White, M.D.
25

1 E X H I B I T S (Continued)

2 Pg/ln Ex. Description

Pg/ln	Ex.	Description
Defendant's 126/4	5	Deposition transcript of Kenneth L. Barr
Claimant's Premarked	1	Deposition transcript of Larry Stegner

7 ** uh-huh = affirmative
huh-uh = negative

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1 P R O C E E D I N G S
2 (Defendant's exhibit numbers 1-4
3 premarked for identification.)
4 (Claimant's exhibit number 1
5 premarked for identification.)
6 The Court: Today's date is August
7 31st, 2016. This is worker's compensation case
8 file number 1507304. The claimant is Kenneth
9 Barr, Kenneth L. Barr, represented by Preston
10 F. McDaniel and Gerald Malloy. The defendant is
11 Darlington County School Districts represented by
12 Kirsten L. Barr and the carrier is the South
13 Carolina School Board Self Insurers Trust Fund.
14 The average weekly wage of $611.61 with a
15 corresponding compensation rate of $407.76.
16 A.P.A.s have been submitted. Are there any
17 objections to A.P.A.s, jurisdiction or venue --
18 venue or any other items?
19 Ms. Barr: Your Honor, we had raised a
20 number of objections to the A.P.A. No objection
21 to -- to venue or -- but as to the A.P.A.s, I
22 pointed your attention to A.P.A. number one, page
23 one. It's -- it's a doctor's opinion based on
24 unfounded hypotheticals and facts not in evidence.
25 And I draw -- drew your attention to number two

1 where the doctor was asked to opine about the
2 effects of industrial spray paints and durable
3 exposure in connection with addressing causation
4 in this case.
5 There is simply no evidence that the
6 claimant used industrial spray painters whatsoever
7 in his employment with the Darlington County
8 School District. We also objected to A.P.A.
9 number seven, which is a journal article by a F.D.
10 Dick, who is apparently a resident of Aberdeen in
11 the United Kingdom. Since he's not subjected to
12 my subpoena power, I have no opportunity to cross-
13 examine Mr. Dick and therefore we believe that
14 it's filed in the -- the due process in the
15 A.P.A. for this article to be submitted and
16 further suggest inappropriately that the
17 commission may be able to draw conclusions from --
18 from documents such as this when that's best left
19 to a medical expert. No offense.
20 Again, page 219 is A.P.A. number eight
21 is another hypothetical based on unproven facts.
22 It's from a Dr. Healy. Dr. Healy first evaluated
23 the claimant on March 31st of 2016 yet when they
24 filed a Form 50 on April 29, 2016, the claimant
25 failed to notify us in the treatment he was

1 receiving from Dr. Healy despite the fact the
2 claimant now says that he should be appointed the
3 authorized treating physician. We were prejudiced
4 by his failure to disclose this information as
5 required by The Commission statutes and
6 regulations and we have asked that the record
7 remain open so that we can exercise our -- our
8 right to cross-examine Dr. Healy. It's my
9 understanding that you have granted that motion.
10 The Court: Yes.
11 Ms. Barr: And we will let Barbara know
12 once that date is confirmed. So our other
13 objections regarding propriety of Dr. Healy's
14 records are no longer germane.
15 The Court: Okay. And -- and as we
16 discussed in the prehearing conference regarding
17 the -- the two documents that -- that we discussed
18 previously, I'm -- I'm going to allow those in and
19 give them the weight that I feel that they need
20 given. Also, you're correct that -- that I -- I
21 did, as we discussed in the prehearing conference,
22 say that you could have -- leave the record open
23 so you could depose Dr. Healy. Mr. McDaniel, any
24 objections?
25 Mr. McDaniel: Your Honor, as

1 previously noted Commissioner, we had objected to
2 the submission of the reports from Dr. Wade and --
3 and I'm just noting these for the -- for the
4 record. And -- and Dr. Wagner because they have
5 never -- and also Dr. Eagerton but they have never
6 seen or evaluated nor are they here personally to
7 testify and it is in violation of our
8 constitutional right to due process by shifting
9 the burden of us to undergo the expense to
10 cross-examine these out-of-court hearsay
11 documents. And so I have originally objected and
12 I would continue to -- to make that objection to
13 the submission of those records in to -- I
14 understand the commission's ruling previously on
15 that. Commissioner Beck would admit those
16 pursuant to our regula--- current regulations,
17 which is -- that sets out the process that we're
18 to follow. I cite again at that time United
19 States Supreme Court cases to the contrary.
20 However, I understand the commission's ruling.
21 Just note that for the record.
22 The Court: Okay.
23 Mr. McDaniel: In reference to the --
24 outside of that, we don't have any objection to
25 the A.P.A. submissions. I would note in -- in

1 conference that there was reference to Mister --
2 Dr. Bennett as being not qualified because he's a
3 pharmacist and there was reference to -- and
4 correct me if I'm wrong, but that this Dr.
5 Eagerton is a professor of toxicology at Newberry
6 College. I believe it would -- does that concur
7 in your recollection that that was the -- that he
8 was noted to you as being a professor of
9 toxicology?
10 The Court: I -- I didn't remember
11 anything about Newberry College.
12 Mr. McDaniel: Well, I think it's
13 actually Presbyterian. I -- I misspoke.
14 Ms. Barr: His curriculum vitae is
15 contained in the record under A.P.A. number 21 --
16 Mr. McDaniel: Right. And I --
17 Ms. Barr: And what I referenced was
18 that he was the chief toxicologist for the South
19 Carolina Law Enforcement Division for --
20 Mr. McDaniel: Right.
21 Ms. Barr: -- from 1997 to 2009. He's
22 currently an assistant professor of pharmacology
23 at Presbyterian College --
24 Mr. McDaniel: Well, I -- that -- and
25 that's -- that was exactly the reason I wanted to

1 -- to note that for The Commission because I'm
2 getting ready to put up Dr. Bennett, but you will
3 note that Doctor -- all I wanted you to know is
4 Dr. Eagerton -- his Ph.D is in pharmacology. And
5 his background and experience is in pharmacology
6 because there is not a specific degree in
7 toxicology.
8 Ms. Barr: Right. But he was the chief
9 toxicologist for --
10 Mr. McDaniel: I understand --
11 Ms. Barr: -- SLED. And --
12 Mr. McDaniel: I -- I appreciate that
13 and I'm sure you'll review his credentials, but I
14 just wanted to note that to you in reference to
15 Dr. Bennett.
16 The Court: Okay. All right. Thank
17 you.
18 Mr. McDaniel: Commissioner, that's --
19 that's all we have except our position that -- I
20 would also like to note for the record that the
21 deposition that they requested to take of Dr.
22 Healy is without objection and I -- absolutely.
23 We just got that report. We just got his latest
24 reports and hospitalization records right before
25 the hearing and we have absolutely no objection to

1 her taking the deposition of Dr. Healy.
2 The Court: Okay. All right. Any
3 further objections? Okay. Without further
4 objection, the commission file becomes a part of
5 the record with the exception of self-serving
6 declarations and unstipulated medical reports.
7 Mr. McDaniel, we're here today, sir, on your Form
8 50, so if you would, please, put your position on
9 the record and let us know exactly what you're
10 seeking here today, sir.
11 Mr. McDaniel: Yes, Commissioner.
12 Commissioner, as we noted in the prehearing
13 conference, it's our position at -- that as a
14 result to exposure to volatile organic compounds
15 contained within the paints and other solvents and
16 chemicals with which he was working at the school
17 district that he has developed a -- problems with
18 his brain and central ser--- nervous system. We
19 are -- take the position that Dr. White says that
20 it is his -- he believes he's -- believe -- an
21 encephalopathy-type condition that would progress
22 and continue to get worse. He believes it's
23 severe at this time. He's suffering from fatigue,
24 chronic headaches, memory loss and other problems,
25 but particularly the chronic fatigue and the

1 severe headaches are, in our opinion -- are the
2 disabling factor at this time.
3 We -- we take -- plead in the
4 alternative in reference to that you can find
5 today that he is totally and permanently disabled.
6 However, Dr. Healy, who is his current treating
7 neurologist, states his opinion he's not at
8 maximum medical improvement. Doctor -- you'll
9 find from the medical records and also from the
10 records of Dr. Lind that Dr. Lind believes that he
11 needs to be retested in a year or so to establish
12 whether or not the brain injury is progressing.
13 Dr. Lind stated the opinion to a reasonable degree
14 of psychological certainty and professional
15 certainty that his -- if we establish that he was
16 exposed to V.O.C.'s on the job that his findings
17 and the neuropsychological testing confirm the
18 type of brain damage that would occur from
19 exposure to volatile organic compounds. And -- so
20 based on -- as -- as a matter of fact even their
21 doctor that they sent him to down in Charleston
22 who is a -- a noted neurologist, Dr. Pritchard --
23 Dr. Pritchard stated that all he was saying was is
24 that he did not believe that he -- when he fin---
25 read the deposition, he did not believe that he

1 found Mr. Barr to have severe brain damage at this
2 time nor did he believe that he had an
3 encephalopathy. He also stated that -- that he
4 was not commenting on the headaches.
5 In other words, everybody agrees this
6 man has severe headaches. The ques--- question
7 really -- where is the source? And whether or not
8 you believe that they're related to the exposed
9 volatile organic compounds. So on one side, you
10 can find today that he is totally permanently
11 disabled from this exposure, however, on the other
12 side, we -- we pleading that we ask for really our
13 main focus is today is to ask that he be found to
14 be compensable, that the case be found to be
15 compensable, that he be placed under care of
16 Dr. Healy, that he's not at maximum medical
17 improvement. We allow for Dr. Healy to treat this
18 man and hopefully be able to get him back to work
19 in some capacity.
20 And then in addition to that to get the
21 medical care he needs. As -- as we discussed off
22 the record that this man lost his health
23 insurance, he had no way of paying for health
24 insurance we finally were able to get him under
25 affordable care act, he -- he and his wife.

1 They're on all kinds of public assistance. His --
2 his access until he got to Dr. Healy was very
3 limited and so we just want to get the man
4 treated. We want to get him on -- on -- on
5 temporary total disability running award until
6 such time as the doctors feel like he's at maximum
7 medical improvement. And hopefully this will not
8 progress and he hasn't crossed that barrier.
9 You're going to hear testimony today about the
10 barrier. In other words, like there's a point
11 that the brain -- when you're -- these exposures
12 that it will just then continue to progress --
13 Ms. Barr: Your Honor, I'm going to
14 object to -- to facts not in evidence in -- in the
15 testimony from Mr. McDaniel --
16 Mr. McDaniel: Well, Commissioner...
17 The Court: Okay.
18 Mr. McDaniel: Of course, anything I
19 say -- I learned a long time ago, you better not
20 say something you can't back up because a -- a
21 jury, which you are the jury today, will remember
22 that. Mr. McDaniel, you told me that and you
23 didn't prove it. So, yes, absolutely, everything
24 I'm saying is subject to proving as Ms. Barr
25 knows.

1 The Court: All right.
2 Mr. McDaniel: That would be our
3 position, Commissioner. We believe it's due to
4 repetitive exposure. We believe also that it fits
5 under the occupational disease as Ms. Barr did not
6 note to you, but I would note to you that whether
7 or not something is peculiar to the industry is in
8 your decision peculiar. And what -- peculiar
9 doesn't mean it has to be peculiar to just that.
10 In other words, is he exposed to something in his
11 workplace to a greater degree than he is exposed
12 to in the -- that we are all exposed to in normal
13 life? In other words, in reference to cotton
14 mills and -- and brown lung, which being from the
15 upcountry you know a lot about, at -- you know, I
16 remember seeing a hundred -- there -- there is
17 exposure from cotton dust is in the workplace.
18 Here again, he's exposed to volatile organic
19 compounds to a large degree and a massive degree
20 in his job at the Darlington County School
21 District. Of course that's subject to your
22 determination.
23 The Court: Okay.
24 Mr. McDaniel: We believe it fits the
25 criteria that ask -- and also he, of course, had

1 the major event where he became delusional, had to
2 pull off on the side of the road. So it actually
3 fits in to a singular accident where, you know,
4 that that event aggravated the preexisting
5 condition going in at that time.
6 The Court: Okay. All right. Ms.
7 Barr, if you'll put your position on the record,
8 ma'am.
9 Ms. Barr: Thank you, Your Honor. It's
10 the position of the Darlington County School
11 Boards and the South Carolina School Boards
12 Insurance Trust that the claimant had not
13 sustained any injury by accident, repetitive
14 trauma or occupational disease. Quite simply the
15 headaches, alleged memory loss and fatigue that
16 Mr. Barr now complains of is something that he's
17 been known to have for quite some time separate
18 and apart from his employment with the school
19 district. And in his job as a painter, he was not
20 exposed to volatile organic compounds as alleged
21 because Mr. Barr has testified under oath that he
22 always wore a respirator and was in a ventilated
23 area when he painted with a brush and roller
24 applying paints which have been found to have low
25 va--- vapor pressure and not even considered

1 volatile organic compounds by some sources. So we
2 don't believe that there's been any injurious
3 exposure that could lead to either a finding under
4 the accident, the occupational disease or the
5 repetitive trauma statute.
6 Furthermore, of the -- regard to the
7 occupational disease statute, you're well familiar
8 with the -- the requirements of that statute and I
9 believe it -- it takes an additional burden of
10 expert testimony regarding those elements which we
11 don't believe that the claimant has -- has met.
12 We've noted in our prehearing brief and in our
13 prehearing conference that we do not believe that
14 the claimant has encephalopathy. That defense is
15 based on a finding by Dr. Paul Pritchard that he
16 does not think he has a normal neurological exam
17 and does not have evidence of encephalopathy.
18 Dr. White's opinion to the contrary was
19 admittedly based on subjective speculation. Page
20 32 is what I referenced in Dr. White's deposition
21 where he admitted that he based his subjective
22 opinion on his observation that Mr. Barr was
23 forgetful and that he believed him to have memory
24 deficits. Dr. White conceded that the only
25 objective way to test -- test memory deficits was

1 with neuropsychological testing. That was
2 performed after a -- a great amount of litigation
3 and the three neurologists who have evaluated this
4 claim none of them found any evidence of -- of
5 memory loss or memory deficit. In fact, Dr.
6 Wagner testified and opined that his memory
7 performance was his major area of cognitive
8 strength and greatly exceeded his I.Q.
9 Dr. Wade also found that there was
10 absolutely no evidence of any physical brain
11 injuries as a result of his employment with the
12 school district. So it was on -- on those
13 opinions of Dr. Pritchard that we deny he's
14 entitled to any benefits under the act, medical
15 compensation or otherwise. If the claim were to
16 be found compensable, we would object to the
17 appointment of Dr. Healy as his authorized
18 treating physician.
19 Dr. Healy is currently treating him for
20 severe obstructive sleep apnea. There's been no
21 claim made for severe obstructive sleep apnea.
22 But sever obstructive sleep apnea, I believe, the
23 testimony will -- will show -- can cause the same
24 subjective complaints of headaches, fatigue and
25 subjective memory loss that Mr. Barr complains of

1 now. And we don't believe that we should be
2 responsible for such treatment or any of the other
3 modalities that have been offered prior to the
4 judication of this claim.
5 The Court: Okay. All right. Thank
6 you, ma'am. Mr. McDaniel, anything more?
7 Mr. McDaniel: No. I would note to you
8 that in Dr. Pritchard's report that he recommended
9 referral to a doctor specializing in the
10 occupational exposure. I just note that to you --
11 and I -- I would leave the reading of the
12 depositions -- I'm not going to -- I think that
13 those are taken out of context. Nothing further.
14 The Court: All right. Ms. Barr,
15 anymore?
16 Ms. Barr: No, Your Honor.
17 The Court: Okay. All right. And do
18 you want to call your witness?
19 Mr. McDaniel: Yeah, we first call Dr.
20 Robert Bennett.
21 The Court: Okay. Dr. Bennett, you can
22 come sit in that end chair right there, sir. And
23 make yourself comfortable.
24 The Witness: Yes, sir.
25 The Court: Yeah, in front of that

1 microphone. And before we get -- you can have a
2 seat, make yourself comfortable. And before we
3 get started, I have a couple of quick things to
4 run through with you, sir. If you would, please,
5 speak up and speak clearly. It's important that
6 we all hear your responses to the questions, but
7 most importantly, this nice lady right here get
8 them for the record. If you're asked a yes or no
9 question, please, give us a verbal yes or no
10 answer. You can shake your head yes or no like I
11 do all the time, just make sure you accompany that
12 with a verbal yes or no answer. Try and stay away
13 from things like uh-huh and huh-uh. That's just
14 too easily misunderstood for the record, so if you
15 could help us out with that, we'd appreciate it,
16 sir.
17 The Witness: Absolutely.
18 The Court: Okay. Please raise your
19 right hand.
20 Robert Bennett,
21 being first duly sworn by The Court, as
22 hereinafter certified, testified as follows:
23 The Court: Okay. You can put your
24 hand down and, please, state and spell your name
25 for the record, sir.

1 The Witness: Robert Bennett,
2 R-O-B-E-R-T, B-E-N-N-E-T-T.
3 The Court: Okay. Thank you,
4 Mr. Bennett. Mr. McDaniel, your witness.
5 D I R E C T E X A M I N A T I O N
6 By Mr. McDaniel:
7 Q Thank you, Your Honor. Dr. Bennett,
8 you're here to testify today in reference to a
9 pharmacology and also to reference toxicology.
10 Would you mind -- would you, please, give The
11 Court the benefit of your background and
12 experience -- educational background first and
13 experience in the area of toxicology?
14 A Sure. I obtained a pharmacy degree
15 from the Medical University of South Carolina and
16 passed the state pharmacy boards and practiced as
17 a pharmacist for a number of years. Within the
18 pharmacy degree is a significant amount of
19 pharmacology. After working in the pharmaceutical
20 industry doing research and development for about
21 five years, I returned to the Medical University
22 of South Carolina and obtained my doctor degree in
23 the -- the same field in the area of
24 pharmaceutical sciences, which includes a
25 significant amount of toxicology work on a

1 graduate level. Since graduating in 1991, I have
2 been in -- employed in doing toxicology work to
3 various degrees and currently practice full time
4 as a forensic toxicologist out of Charleston,
5 South Carolina.
6 Q I noted in reference to Dr. Eagerton
7 that he has a Ph.D in pharmacology. I notice that
8 you -- your Ph.D is in pharmaceutical -- ceutical
9 sciences and you have a -- in pharmacology. Is
10 that correct?
11 Ms. Barr: Objection. It's not the
12 testimony.
13 By Mr. McDaniel:
14 Q Exact--- again, your Ph.D is in...
15 A Well, it's in pharmaceutical sciences,
16 which includes a significant amount of toxicology.
17 There -- there is --
18 The Court: I'll -- I'm sorry. I was
19 responding to that. I will allow that. Go ahead.
20 The Witness: As -- as you mentioned
21 earlier, there is no specific Ph.D degree in
22 toxicology. That's not available. However, the
23 related health sciences such as pharmaceutics and
24 pharmacology are the background that's required to
25 become an expert in toxicology, which is a

1 sub-specialty of those health sciences.
2 By Mr. McDaniel:
3 Q If you would, give me the ben--- give
4 The Commissioner the benefit of various courts in
5 which you have been qualified to te--- testify as
6 a toxicologist.
7 A I've been qualified as a toxicologist
8 and as a pharmacologist in various --
9 Ms. Barr: Objection to the relevance.
10 This is a very specific line that he's attempting
11 to introduce his testimony for. I -- I don't
12 believe that toxicology generally is -- is grounds
13 to admit his testimony.
14 The Court: Well, I'll -- I'll let you
15 respond --
16 Mr. McDaniel: This goes as background
17 experience in toxicology and expressing expert
18 opinions. I've never had -- but anyway, how --
19 The Court: I'll -- I'll allow -- go
20 ahead. To -- to establish him as an expert. Go
21 ahead.
22 By Mr. McDaniel:
23 Q Let's -- first off, have you been
24 qualified as a toxicologist in both criminal and
25 civil cases?

1 A Yes.
2 Q All right. What all courts have you
3 been qualified to testify and have you testified
4 and entered expert opinion in the area of
5 toxicology and pharmaco--- and or pharmacology in
6 -- in --
7 Ms. Barr: Objection. There's no
8 evidence that he's ever been in -- he doesn't even
9 claim to be an expert in pharmacology, Preston.
10 Mr. McDaniel: I'm submitting him as an
11 expert in pharmacology. He does claim to be an
12 expert in pharmacology.
13 By Mr. McDaniel:
14 Q Have you been admitted in the courts --
15 would you mind giving us the benefit -- if I can
16 at least hopefully get this in -- would you give
17 us the benefit of your background experience as
18 testifying in reference to specifically toxicology
19 and also pharmacology in the courts of our state?
20 A Okay. I -- I've been accepted as an
21 expert in toxicology and in pharmacology in
22 various courts including criminal court, civil
23 court, worker's compensation hearings, family
24 court and -- and this -- South Carolina and other
25 states.

1 Q Federal courts?
2 A Yes.
3 Mr. McDaniel: Commissioner, I would
4 submit him as an expert in the area of
5 pharmacology and toxicology.
6 Ms. Barr: Do I -- do I have the right
7 to cross-examine him?
8 The Court: Yes.
9 C R O S S - E X A M I N A T I O N
10 By Ms. Barr:
11 Q Thank you. Mr. Bennett, you do not
12 have a medical degree, do you?
13 A You -- do you mean do I have a M.D.
14 degree?
15 Q A medical degree. That's what I said.
16 Do you have a -- an M.D. degree?
17 A I do not have an M.D. degree.
18 Q You are not a medical doctor?
19 A I am not.
20 Q In fact, you have no professional
21 licenses whatsoever, do you?
22 A None that I -- well, I have a pharmacy
23 license that is expired because I don't practice
24 pharmacy anymore.
25 Q You do not have a pharmacy license.

1 And in fact, the department of labor has issued a
2 cease and desist order for you holding yourself
3 out as a pharmacist. Is that correct because
4 you're not licensed?
5 A Correct.
6 Q And you have no professional
7 certifications in -- in toxicology, pharmacology
8 or any other professional field, do you?
9 A I have quite a number that's listed on
10 my C.V.
11 Q We haven't ben--- benefited from your
12 C.V. I do have a copy of your website where you
13 hold yourself out as a drug and alcohol D.N.A.
14 testing expert. Is that right?
15 A I do quite a bit of that, yes.
16 Q All right. That's in fact the bulk of
17 -- of your professional work and your private
18 practice where you -- you sell your services as a
19 drug and alcohol and D.N.A. tester. Is that
20 correct?
21 A That -- that is the bulk of my work on
22 a daily basis, yes.
23 Q Have you done any professional or
24 scientific research in to paint solvents or vol---
25 volatile organic compounds?

1 A I've done quite a bit of research.
2 Q Here -- for this hearing today?
3 A No -- no, as part of my career.
4 Q All right. You've published nothing on
5 the subject, have you?
6 A No, I have not.
7 Q All right. You have no specific
8 training -- formal training on -- in those areas,
9 do you?
10 A I -- for--- formal training in the area
11 of paint solvents does not exist.
12 Q All right. But you've had none. You
13 -- you just read on the side in your -- in your
14 private time?
15 A No. Reading on the side in my private
16 time is -- is -- is not an accurate description of
17 my profession. No.
18 Q Because your profession is really about
19 drug and alcohol and D.N.A. testing. Is that
20 correct?
21 A No. My profession is forensic sciences
22 with a specialty in toxicology.
23 Q A specialty. Says who?
24 A Says me.
25 Q All right. No --

1 A And the courts --
2 Q -- professional organization has -- has
3 deemed you a specialist in toxicology nor have you
4 sought professional certification by the American
5 Boards of -- of toxicology or forensic toxicology,
6 have you?
7 A Well, there's quite a number of
8 voluntary organizations that will allow you to
9 obtain various types of certifications ranging
10 from taking a couple of hours class on the
11 internet all the way up to attending a
12 conference --
13 Q And you have none of those?
14 A -- to obtain -- no, I do not.
15 Q Okay. And what is the status of the --
16 the indictment that was brought down against you
17 in Charleston County in -- in 2015 for conspiracy?
18 A It has been summarily dismissed, unable
19 to prosecute.
20 Q All right. Thank you.
21 The Court: Okay. Is that all?
22 Ms. Barr: Yes, Your Honor.
23 The Court: Okay. And as we -- as we
24 discussed in our prehearing conference, I'm
25 obviously going to let the doctor testify and

1 we'll give his testimony the weight that I feel it
2 deserves. Okay. Mr. McDaniel, you can continue.
3 REDIRECT EXAMINATION
4 By Mr. McDaniel:
5 Q Dr. Bennett, have you testified as an
6 expert in toxicology before -- or been involved in
7 cases in reference to volatile organic compounds?
8 A I have provided my expertise in the
9 area of volatile organic compounds. When I
10 provide my expertise, it's in a variety of forms:
11 Consultation, reports, testimony, depositions.
12 And so I have done quite a bit of work in the past
13 in volatile organic compounds.
14 Q Now, if you would, give -- tell The
15 Commission the benefit of the information you
16 reviewed in reference to Mr. Barr and the M.S.D.S.
17 sheets, et-cetera. What -- what all have you
18 reviewed in reference to this case?
19 A The file that was provided by you which
20 consisted of medical records as well as material
21 safety data sheets on the compounds that the
22 claimant reportedly used as well as a toxicology
23 report from Dr. Eagerton or should I say a
24 pharmacology report.
25 Q Now, let's talk about -- first off, as

1 part of that, did you review the medical records
2 from Dr. Marshall White?
3 A Yes, I did.
4 Q Did you review the M.S.D.S. sheets
5 provided to Mr. Barr and to Dr. White by the
6 school district?
7 A Yes.
8 Q Did you review the records of Dr.
9 Nicholas Lind?
10 A Yes.
11 Q Did you review Carolina Pines Hospital,
12 Dr. Raymond Chapman, Dr. Roland Skinner -- did you
13 review all of their records?
14 Ms. Barr: Objection. This -- this is
15 speculative. All of their records? Can you be
16 specific like dates, what records he reviewed? I
17 don't know what all is.
18 The Witness: I -- I have all the
19 records that I had here with me if Counsel wishes
20 to review what I've reviewed.
21 By Mr. McDaniel:
22 Q All right. Doctor, if you would, is
23 there a document --
24 Ms. Barr: We subpoenaed those, so it
25 would -- it would have been helpful for me to have

1 what he has so I could actually know.
2 By Mr. McDaniel:
3 Q Doctor, look at --
4 The Court: What -- what -- what
5 records do you -- are these not the records that
6 are part of the A.P.A.s?
7 Mr. McDaniel: Yes.
8 By Mr. McDaniel:
9 Q As a matter of fact, I was going to ask
10 you, is there a document in there that looks like
11 this?
12 A Yes, identical.
13 Q Okay. So -- so -- in fact I believe I
14 also sent you my -- our prehearing brief that we
15 submitted to The Commissioner.
16 A Correct.
17 Q So the records would be the records
18 that I submitted to you and which were -- I
19 referred to in the tab as being A.P.A.
20 submissions?
21 A Yes.
22 Q All right. And those would be the
23 records that you reviewed in preparation for your
24 testimony today?
25 A Correct.

1 Q All right. In addition to, I believe I
2 also provided you with a copy of the report from
3 Dr. Eagerton?
4 A Correct.
5 Q Now, let's -- let's first talk about
6 exposure to V.O.C.'s. We also gave you a job
7 description and, of course, the job description
8 was contained within the -- the A.P.A. submissions
9 that we submitted to you. And you reviewed that
10 job description when in during the summers,
11 Mr. Barr --
12 Ms. Barr: Objection to the leading.
13 Mr. McDaniel: Okay.
14 The Court: Please rephrase.
15 By Mr. McDaniel:
16 Q All right. Let me -- let me ask you --
17 I'm trying to cut to the chase. But in other
18 words, did you review a history that stated that
19 -- that Mr. Barr was a commercial painter for the
20 district?
21 A Yes.
22 Q That he painted five days a week,
23 Monday through Friday, during the school year.
24 A That was in the records, yes.
25 Q And Monday through Thursday, ten hours

1 a day during the summer?
2 A That was in the records as well.
3 Q Using industrial paints including
4 pre-catalyzed epoxy and oil-based paints.
5 A Correct.
6 Ms. Barr: Objection. Facts not in
7 evidence.
8 By Mr. McDaniel:
9 Q Now --
10 The Court: Sustained.
11 By Mr. McDaniel:
12 Q And he was doing oil-based painting and
13 also conversions to pre-catalyzed epoxy are
14 usually done during the summers --
15 Ms. Barr: Objection to facts not in
16 evidence. And this does seem to be a leading
17 question --
18 Mr. McDaniel: Commissioner, this is --
19 this is -- basically the background of this is his
20 -- his understanding and what will be submitted in
21 to evidence at a later -- at -- whenever we put up
22 Mr. Barr. And it is -- as a matter of fact, this
23 is what counsel and I -- we both submitted --
24 Ms. Barr: It -- it sounds to me -- is
25 what you were telling him is his understanding,

1 which is why I objected to it to being a leading
2 question.
3 The Court: All right. Please rephrase
4 it.
5 By Mr. McDaniel:
6 Q Is it your understanding from -- in the
7 job description in rendering your opinions today,
8 did you also consider that and were told -- and --
9 sub--- considered that Mr. Barr --
10 Ms. Barr: Objection to leading. Ask
11 him what his understanding was otherwise you're
12 putting words in the gentleman's mouth.
13 By Mr. McDaniel:
14 Q Okay. Well, let's do it this way.
15 Would you mind telling The Court and The
16 Commissioner what your understanding was of Mr.
17 Barr's job?
18 A He was a commercial painter and used
19 the chemicals that are required in performing
20 those duties, which consisted of a variety of
21 formulations of paint that are both oil-based and
22 water-based.
23 Q And what type of protective gear did --
24 did he -- what type of painting did he do in
25 reference to -- what did he use to do that? Was

1 it brush and roller? Spray painting?

2 A The rec--- the records indicate that

3 the majority of the painting was with brush and

4 roller as opposed to aerosol spraying.

5 Q Was it inside or outside?

6 A Both.

7 Q Okay. What type of protective gear did

8 he wear?

9 A The records indicate that when he was

10 inside that he wore a respirator and -- and that

11 the inside was also ventilated as best it could be

12 done. When he was painting outside, the records

13 indicate that he did not use a respirator because

14 he was outside and was assuming that the outside

15 environment was -- would account for adequate

16 ventilation.

17 Q Now, also as part of your -- you

18 reviewed the M.S.D.S. sheets.

19 A Correct.

20 Q Based on your review of his job

21 description as a commercial painter for the school

22 district and based on your review of the M.S.D.S.

23 sheets, was he exposed to volatile organic

24 compounds in the workplace?

25 A In my opinion, yes.

1 Q Now, let's talk about volatile organic
2 compounds and tell me about their relationship to
3 causing brain damage.
4 Ms. Barr: Objection. The -- the
5 claimant -- the witness is not a medical doctor,
6 is not a neurologist and has no expertise in -- in
7 brain damage.
8 The Witness: I'm assuming she -- he
9 was asking a toxicological question.
10 Mr. McDaniel: I am. I --
11 Ms. Barr: I -- I would object to any
12 testimony from this witness regarding the medical
13 implications of any exposure. He's not qualified
14 to testify on the cause of brain damage.
15 Mr. McDaniel: He is qualified as a
16 toxicologist to testify.
17 The Court: Your objection is noted.
18 I'll -- I'm gonna allow him to -- to respond as --
19 as to toxicology.
20 The Witness: Thank you. Volatile
21 organic compounds are a class of chemicals that by
22 nature are lipophilic, meaning they're fat
23 soluble. A compound that is fat soluble will
24 cross the blood brain barrier, the membrane that
25 protects the brain from toxic damage. Once the

1 compounds that can cross the blood brain barrier
2 cross that barrier, then they can -- those
3 compounds can affect the brain.
4 Ms. Barr: Objection, Your Honor.
5 There -- he has no qualification to talk about
6 neurological damage or -- or -- or the brain. He
7 -- he's simply not qualified to testify about the
8 brain.
9 Mr. McDaniel: He is testifying about
10 anatomical and chemical transactions within the
11 body. He is not --
12 Ms. Barr: Which he is not qualified to
13 do --
14 Mr. McDaniel: He is not rendering a
15 medical opinion.
16 Ms. Barr: It certainly sounds that way
17 when he's saying what the --
18 The Court: And I -- I'm -- your --
19 your objection is noted and as I say I'm going to
20 give the testimony the weight that I feel it
21 deserves. Okay? Thank you.
22 Ms. Barr: Thank you.
23 By Mr. McDaniel:
24 Q Go ahead, Doctor.
25 A Once these compounds cross the blood

1 brain barrier, then if they are toxic, they can
2 exert a toxic effect on the brain structure to
3 various degrees. In the field of toxicology, the
4 most critical component as far as whether the
5 compound is toxic is the dose. A variety of
6 compounds can be non-toxic if the dose is small
7 enough. A variety of compounds that are generally
8 accepted as non-toxic can be toxic if the dose is
9 high enough. So the most important factor is what
10 quantity does get into the brain? And being that
11 volatile organic compounds are fat soluble, then a
12 relatively high amount of exposure can lead to a
13 relatively high amount of the drugs getting into
14 the brain. Now, volatile organic compounds, the
15 research has shown in well-published scientific
16 journals, they do have an effect on the -- the
17 brain and that they can cause what's called
18 macromolecular changes in cellular structure in
19 the brain --
20 Ms. Barr: Objection to any testimony
21 regarding the cellular structure of the brain,
22 which the clai--- the witness has absolutely no
23 qualification to testify about.
24 The Court: Okay. I'll sustain that
25 and can we -- can we move on past that?

1 Mr. McDaniel: Commissioner, again, I
2 -- I understand -- okay.
3 Ms. Barr: We deposed two neurologists
4 -- three neurologists in this case.
5 Mr. McDaniel: Com--- Commissioner,
6 it's different in -- in rendering a medical
7 opinion and talking about anatomical and chemical
8 effect. That's exactly what a to---
9 pharmacologist does. They develop medicines all
10 the time in reference to the biochemical aspects
11 of the body. This is not --
12 Ms. Barr: There's simply no foundation
13 for any of this. He's not evaluated the claimant.
14 He's not looked at his brain. Ag--- again,
15 there's a whole host of reasons why he should not
16 be testifying regarding the, you know, the
17 specious effects of -- of V.O.C.'s on this
18 gentleman's brain.
19 The Court: I will -- as long as we
20 stick to the records that he has reviewed, then --
21 then I'll allow testimony on that.
22 Mr. McDaniel: Commissioner, also, if
23 you look at Dr. Eagerton's -- this is exactly the
24 testimony that they're complaining about that
25 their toxicologist gives in reference to the

1 biochemical structures and -- and the general
2 toxicological effect on the body. That's why a
3 toxicology testify. I just note that to -- to
4 Your Honor, because, you know, she's not giving
5 medical opinions. However, I would note to you
6 that Dr. Eagerton actually stated a medical
7 opinion. He actually states he stated a medical
8 opinion in his records, but, however -- all right.
9 By Mr. McDaniel:
10 Q Now, you reviewed the
11 neuropsychological testing. Tell me, first off,
12 from a toxicological standpoint, what types of
13 tests are there out there now to determine --
14 right now, not back in 2010 or while he was being
15 exposed, but right now to confirm whether or not
16 there are volatile organic compounds in the body.
17 A Specifically analyzing for the
18 compounds can be done through testing of
19 biological matrixes such as blood or urine or hair
20 in looking for the presence of those compounds,
21 which would indicate recent exposure.
22 Q Okay. And you said recent exposure.
23 If there's been no exposure since 2000--- when --
24 when you refer to recent, what are you referring
25 to?

1 A Well, the compounds that are in the
2 body are rapidly excreted from the blood and it
3 takes a little bit longer to be excreted in the
4 urine and even longer to be detectable in a hair
5 specimen. But the maximum time period for
6 detection would be in a hair specimen which would
7 be at most a couple years.
8 Q All right.
9 A Blood -- blood would be a couple of
10 minutes and urine would be a couple of days.
11 Q Now, you reviewed the
12 neuropsychological testing.
13 A I did.
14 Q All right. And Dr. Lind has testified
15 that in his --
16 Ms. Barr: Objection to leading.
17 By Mr. McDaniel:
18 Q He -- in his --
19 The Court: I'll allow it. Go ahead.
20 By Mr. McDaniel:
21 Q Based on -- on the records, Dr. Lind is
22 of the opinion that his -- his brain damage is
23 mild at this point in time.
24 Ms. Barr: Objection to facts not in
25 evidence. I'm just gonna go over this for the

1 record.

2 By Mr. McDaniel:

3 Q Let me go -- let me go back to --

4 The Court: So noted.

5 By Mr. McDaniel:

6 Q Let me go back to it again. All right.

7 You testified that in your opinion based on your

8 review of the M.S.D.S. sheets and his job

9 description that he was exposed to volatile

10 organic compounds on the job and that there's a

11 cause and effect relationship between --

12 Ms. Barr: Objection. He has not -- he

13 has not testified to causation. If there's a

14 question, I -- that question has not been asked.

15 The Court: Please ask the question,

16 Mr. McDaniel.

17 By Mr. McDaniel:

18 Q All right. You testified about the

19 exposure to V.O.C.'s.

20 A Correct.

21 Q You testified about that -- that --

22 well, actually, let's go over this again just to

23 make sure. In reference to volatile organic

24 compounds, it is -- how -- is it well documented

25 -- tell me about the documentation about the cause

1 and effect relationship that can cause the brain
2 damage.
3 A There's been numerous studies over the
4 decades both here in the U.S. as well as
5 international on the effects of volatile organic
6 compounds in commercially available products such
7 as paint and the effects of exposure to those
8 substances both on a -- on acute basis as well as
9 a chronic basis. And there are voluminous
10 published scientific and medical articles
11 published on the effects of those volatile organic
12 compounds on humans.
13 Q Now, what are the routes of exposure to
14 organic compounds in -- as referenced to the
15 M.S.D.S. sheets.
16 A The main routes are what is commonly
17 seen with usage of those compounds as recommended
18 by the manufacturer and that is exposure through
19 inhalation, exposure through dermal absorption.
20 There are other routes that are less common such
21 as accidental swallowing, as far as employees, I
22 mean. But the majority of exposure is inhalation
23 and skin exposure.
24 Q And skin exposure, can that also be
25 exposure through the eyes?

1 A It can be, yes.
2 Q Not only through the nasal passages --
3 and also through the dermal?
4 A Correct, yes.
5 Q Now, you testified that Mister -- that
6 he used a respirator inside.
7 A The records indicate that he did use a
8 respirator when he painted inside.
9 Q All right. Tell me about use of a
10 respirator in reference to con--- exposure to
11 volatile organic compounds.
12 A Well, the respirator is designed to
13 prevent the volatile organic compounds from being
14 inhaled, but it does nothing to prevent the
15 absorption of these compounds through the skin or
16 -- or through the eyes unless, of course, the
17 respirator is a full-face respirator. But the
18 most common respirator just covers the nose and
19 mouth and use compounds that absorb the volatile
20 compounds before it gets absorbed into the lungs
21 as -- as the -- as the intake of the breath passes
22 through the compounds, such as activated charcoal,
23 which is a common ingredient in respirators.
24 Q The -- in reference to that, do you
25 have any record that he was provi--- provided

1 gloves or long sleeve shirts?
2 A There's no indication in the records
3 that he was provided any type of dermal
4 protection.
5 Q Okay. Is there any record that you see
6 that he was provided a full-face respirator?
7 A There was none in the records.
8 Q Tell me that -- about even using a
9 NIOSH respirator and I -- we're referring to those
10 that look like they've got two cans coming out of
11 each side. Is that basically the type of
12 respirator we're referring to?
13 A Correct. And those -- those two cans
14 you refer to are canisters that typically contain
15 activated charcoal which absorb the gases before
16 they enter the lungs. They are main--- meant to
17 be used to seal the nose and mouth from the
18 outside air in which -- when an -- an intake
19 breath occurs that all of the air passes through
20 the activated charcoal absorbing the gas before it
21 reaches the lungs. It's not 100 percent
22 effective, but it does a very good job. Also,
23 it's important to note that the seal between the
24 mask and the skin be air -- airtight as well. As
25 sometimes, you know, from a pragmatic standpoint,

1 that can be a problem. All of these allow for a
2 small amount of V.O.C.'s to enter the lung, but
3 typically the amount is below the threshold of
4 toxicity.
5 Q And we all -- I believe there's also
6 referred to by the OSHA as to the admissible
7 exposure limits?
8 A Correct. There are guidelines for
9 that.
10 Q And you're trying -- you're supposed to
11 be trying to keep that below that?
12 A Yes. Of -- of course the desirable
13 scenario is none because there's no safe level of
14 volatile organic compound exposure in my opinion.
15 But from a pragmatic standpoint, it's -- we -- we
16 do everything we can to keep the exposure to an
17 absolute minimum.
18 Q So in other words, in -- in -- industry
19 and labor got together and they -- these are what
20 we're trying to do to protect some--- but however
21 even with that --
22 Ms. Barr: Objection to the leading.
23 By Mr. McDaniel:
24 Q Can you in your opinion --
25 The Court: Sustain.

1 By Mr. McDaniel:
2 Q -- expert --
3 The Court: Phrase it as a question --
4 By Mr. McDaniel:
5 Q Can you as an expert in the area of
6 toxicology -- do you have an opinion as to if you
7 used all the protective clothing required and
8 equipment and all that, can you obtain exposure
9 from the volatile -- volatile organic compounds?
10 A In my opinion, yes, because no device
11 is perfect. It -- no -- no system is going to be
12 100 percent effective in keeping the volatile
13 organic compounds from entering the human body.
14 Q Doctor, do you mind -- tell me the
15 acute effects of exposure to volatile organic
16 compounds.
17 A The acute effects are due to --
18 Ms. Barr: And I -- note my objection
19 for the record that the witness is not qualified
20 to give an opinion regarding medical issues --
21 The Court: Okay. So noted.
22 Ms. Barr: -- such as facts of --
23 Mr. McDaniel: Commissioner --
24 The Court: Let -- let -- let her
25 finish. Okay. All right. Thank you, go ahead.

1 By Mr. McDaniel:
2 Q All right. Let's -- let's reference,
3 for example, the M.S.D.S. sheets. And -- and --
4 in your -- your opinion, what are the acute
5 effects and also you reference the M.S.D.S.
6 sheets. I believe we can find those, Doctor, at
7 page 49 of the Claimant's A.P.A. submissions.
8 A Well, the acute effects are not just my
9 opinion, but also well published in the scientific
10 literature as well as published in M.S.D.S.
11 sheets. As far as acute exposure through
12 inhalation, which results in the compound crossing
13 the blood brain barrier and getting into the brain
14 will include disorientation, dizziness, nausea,
15 sometimes vomiting. The -- the signs of
16 inebriation similar to alcohol. And that's due to
17 the fact that many of the V.O.C.'s are metabolized
18 in the body to alcohols and have a similar effect
19 as ethanol would.
20 Q Also headaches?
21 A Very much so, yes.
22 Ms. Barr: Objection to the leading. I
23 just...
24 The Court: Sustained.
25

1 By Mr. McDaniel:
2 Q In reference to the acute effects, is
3 there anything else than what you named?
4 A Well, the -- the acute effects are
5 short -- short lived. Once the person is removed
6 from that environment, the V.O.C.'s -- it -- it --
7 they leave the body through various mechanisms and
8 the -- those side effects go away and the patient
9 returns to normal. But that's strictly under
10 acute-type exposure.
11 Q Doctor, I'm going to ask you to look at
12 page of -- I -- I hope you've got these set out on
13 page 55 of the documents that I submitted to you.
14 A Are -- are you referring to page 55 of
15 the M.S.D.S. sheets or page 55 --
16 Q That would be -- that -- no, just page
17 55 -- it should be a number down -- well, let me
18 just show you my copy and see if you -- you can
19 look at that.
20 A Yes, I have it.
21 Q That's a M.S.D.S. sheet. And -- and by
22 the way, that refers to material safety data
23 handling sheets. Is that right?
24 A Correct.
25 Q And those are put out by who?

1 A Usually the manufacturer will put those
2 out as required by regulatory agencies.
3 Q Now, would you mind publishing for the
4 record -- on page 55 it says that the acute
5 effects of exposure to volatile organic compounds
6 are what? I've actually got mine highlighted,
7 Doctor.
8 A Oh. Well, you're saying it's on page
9 55. Yes. Under section three under hazards
10 identification, it lists the roots of exposure
11 that we discussed earlier mainly inhalation of
12 vapor or spray mist as well as eye or skin contact
13 with the product vapor or spray mist. And that if
14 exposed to the eyes can cause irritation. Exposed
15 to the skin that prolonged or repeated exposure
16 may cause irritation. And inhalation it states
17 that it causes irritation of the upper respiratory
18 system. And in confined area of vapors and high
19 concentration may cause headache nausea and
20 dizziness.
21 Q And, of course, you previously
22 testified to the acute effects and so would the
23 M.S.D.S. sheets correlate to your testimony?
24 A Correct.
25 Q So in other words, headaches are one of

1 the acute effects?
2 A Yeah, absolutely. It's one of the most
3 common effects of -- of all the V.O.C.'s.
4 Q All right. Now, Doctor, as -- as part
5 of this, we refer to -- you reviewed the records
6 of Dr. Chapman?
7 A Yes.
8 Q I'm gonna ask you to turn to page 167.
9 A Okay.
10 Q On -- on September 13, 2010, under
11 subjective -- and --
12 Mr. McDaniel: And this is just
13 probably for The Commissioner from -- for your
14 edification from the record, page 167.
15 The Court: Uh-huh.
16 By Mr. McDaniel:
17 Q Under subjective at the top of the
18 page, chief complaint is headache.
19 A Yes.
20 Q Do you see that? All right. And in
21 addition to that, he says that he had been working
22 with the school district. Unfortunately the
23 headaches has persisted. He returned to work on
24 9/7 and worked through Thursday and was released
25 from work by the school district that --

1 Ms. Barr: Objection to -- to leading.
2 I mean, the medical records --
3 Mr. McDaniel: Leading?
4 Ms. Barr: -- speak for themselves. I
5 mean, you're -- you're just --
6 Mr. McDaniel: Leading?
7 The Court: I'll --
8 Mr. McDaniel: This is publishing
9 evid--- I -- I'm referring to evidence.
10 Ms. Barr: Okay. It's -- it's --
11 docu--- documents are in evidence.
12 Mr. McDaniel: Okay. Well --
13 Ms. Barr: I'm waiting for a question.
14 Mr. McDaniel: -- let me -- let me
15 finish my question.
16 The Court: I'll -- in the form of
17 question, please. Go ahead.
18 By Mr. McDaniel:
19 Q All right. Doctor -- and it says there
20 that the cause of dizziness, fatigue and balance
21 issues.
22 A Correct.
23 Q Are those the acute effects of V.O.C.
24 exposure --
25 A Yes, they are.

1 Q So headaches, dizziness, fatigue and
2 balance issues are specifically in reference to
3 and correlate to your specific testimony as an
4 expert --
5 Ms. Barr: Objection to the leading --
6 By Mr. McDaniel:
7 Q -- in toxicology and according to the
8 M.S.D.S. sheets --
9 The Court: I'll -- I'll allow --
10 By Mr. McDaniel:
11 Q -- as to the acute effects. Is that
12 correct?
13 A That is correct.
14 Q Now, one thing just for clarification.
15 You said the effects are sort of like a person
16 being intoxicated. What did you mean by that?
17 A Well, we're all familiar with the
18 effects of the intoxication of alcoholic
19 beverages, namely ethanol. The volatile organic
20 compounds -- many of them are metabolized to
21 various types of alcohols that in the brain can
22 have a similar effect of ethanol. So a person can
23 have the feeling and appearance of being
24 inebriated or intoxicated from the volatile
25 organic compounds. They -- they work -- they

1 metabolize -- work the same on the brain much as
2 ethanol does causing intoxication that's short
3 lived.
4 Q Now, you reviewed the records of Dr.
5 Skinner and based on your review of the records of
6 Dr. Chapman, Dr. Skinner and Dr. Marshall White,
7 beginning in 2010 and continuing through the time
8 that he left the school district in 2015 and
9 actually at this time under the care of Dr. Healy,
10 whose, also, records you have --
11 A Yes.
12 Q Has he been under treatment for chronic
13 headaches ever since?
14 Ms. Barr: Objection to both the
15 relevance and the qualification of this -- this
16 gentleman to -- to testify as to the medical
17 treatment, which is part of the record. I -- I --
18 Mr. McDaniel: I'm just asking if he
19 concurs that based on his review that he has been
20 under treatment for severe headaches ever since
21 2010.
22 The Witness: Yes.
23 The Court: I -- based on his opinion
24 of what he's reviewed, I'll allow that. Yes.
25 Mr. McDaniel: Yeah. I -- I'm not --

1 I'm not asking for his medical opinion. I'm just
2 asking if he -- based on his review of the --
3 thank you, Commissioner.
4 By Mr. McDaniel:
5 Q All right. Now, Dr. Lind performed
6 neuropsychological testing and found him to have
7 brain injury damage consistent if it was
8 established that it's -- would be consistent with
9 exposure to volatile organic compounds if it was
10 established that he was exposed to volatile
11 organic compounds.
12 A Okay.
13 Q Do you remember reading that in Dr.
14 Lind's report?
15 A I do, yes. And that was his
16 conclusion.
17 Q All right. And what I'm trying to get
18 at from here is I would like you to explain from
19 the toxicological standpoint as to assuming that
20 someone has been exposed to volatile organic
21 compounds as to the relationship to brain damage
22 and whether or not it would progress from the
23 standpoint of toxicology --
24 Ms. Barr: Ob--- objection. This --
25 this witness has no qualified -- qualifications to

1 talk about brain damage or anything close to this.
2 Again, the neurologists have spoken on this issue
3 and I would submit to you that the neurologists
4 and the neuropsychologists are the only ones
5 qualified to do so.
6 The Court: Okay. But I'll -- I'll
7 allow him to -- to voice his opinion, but
8 obviously, we'll weigh the neurology reports as
9 well and their -- their testimony.
10 Mr. McDaniel: Commissioner, I want to
11 try to make -- again, I want to make it perfectly
12 clear. I'm not trying to ask this man, this
13 doctor -- I'm asking from a toxicological
14 standpoint. I'm not asking for a medical opinion.
15 What I'm asking is -- is based on the tox--- when
16 -- when someone is exposed, tell me about the
17 chronic effect as -- as far as --
18 Ms. Barr: The effects are the medical
19 part. Exposure is his -- is his wheelhouse,
20 Preston. And that's the nature of my -- my
21 objection.
22 The Court: And I understand. I'm --
23 and I -- like I said, I noted. I'm going -- I'm
24 going to allow it, but as I say, I'll give it the
25 -- the weight I feel it deserves.

1 By Mr. McDaniel:
2 Q Dr. Heal--- Dr. Lind has recommended
3 repeat neuropsychological testing in a year. Dr.
4 Healy has said in his opinion, this man is not at
5 maximum medical improvement. My question to you
6 is simply this, can the brain damage -- tell me
7 about in reference to the brain damage and
8 exposures as to what can happen in reference to --
9 you've talked about chelating or the chemicals
10 leaving the body, what can happen in -- over what
11 period of time would we be able to tell how much
12 damage has been done?
13 A Okay. From a strictly toxicological
14 standpoint --
15 Q Correct.
16 A -- the toxic effects of V.O.C.'s are
17 cumulative. In other words, if someone is exposed
18 to V.O.C.'s in one incident for a short time
19 period, the likelihood of any permanent brain
20 damage is near zero. However, if there is
21 repeated exposure over time, then the toxic
22 effects of the V.O.C.'s will be cumulative. And
23 the brain will reach a point where the toxicity
24 becomes permanent. So it's a dose-related
25 response, which is the hallmark of toxicology as I

1 alluded to earlier that the dose is what defines
2 what's toxic and what's not.
3 Therefore, someone exposed to V.O.C.'s
4 on a chronic basis, the damage that occurs on a
5 daily basis if that's the -- the exposure will
6 accumulate and then the brain will reach a point
7 where it's very difficult to recover. In fact,
8 there's been pa--- papers published -- I have one
9 with me that is a -- what I consider a very
10 important paper on the exposure of humans to
11 volatile organic compounds where it discusses the
12 stages of progression. And there are four major
13 stages, the last being chronic encephalopathy,
14 toxic encephalopathy. Once step four stage is
15 reached, that's usually permanent. So it's
16 important to be able to distinguish if a person
17 has reached that stage or not because if they have
18 not reached the stage of chronic, toxic
19 encephalopathy, then there is a chance for
20 recovery.
21 Therefore, it's important through
22 neuro-diagnostic imaging, such as C.T. and M.R.I.
23 scans as well as through neuropsychological
24 testing to determine what stage a person is in as
25 well as to have follow-up studies performed to see

1 if the -- the -- the condition is worsened, stay
2 the same or gotten better.
3 Q So that basically would go in line with
4 Dr. Lind has --
5 Ms. Barr: Objection to leading.
6 The Court: I'll allow that.
7 Ms. Barr: Again, now, he's pitting
8 witnesses. I think only Dr. Lind can speak for --
9 Mr. McDaniel: Well --
10 Ms. Barr: -- himself.
11 Mr. McDaniel: You know -- and -- and
12 he did.
13 The Court: And of course, I'll let Dr.
14 Lind's report speak for itself.
15 Mr. McDaniel: Exactly.
16 By Mr. McDaniel:
17 Q And that's what -- what I'm really
18 trying to get at is -- you know, we're here today
19 -- of course, we're asking for determination of
20 compensability, but also we've asked The
21 Commissioner to either decide whether or not he's
22 totally permanently disabled from the -- his
23 injury at this point or whether or not there's
24 hope for this man to be able to recover. And so
25 that -- that is the purpose of my question from a

1 toxicological standpoint. Am I correct in
2 assuming that what you're saying is that this
3 man --
4 Ms. Barr: Objection to the leading.
5 The Court: I'll let him -- let him
6 finish his question though.
7 By Mr. McDaniel:
8 Q Well, just tell me -- I -- I think
9 you've already answered it, but just go back again
10 and tell me, can he improve?
11 A Well, it's my opinion that we don't
12 know yet. It -- there has been some testing
13 that's been performed to indicate that there is a
14 strong possibility that exposure to V.O.C.'s has
15 resulted in some medical conditions that have been
16 diagnosed by his physicians that could affect his
17 quality of life. It's my opinion that we need to
18 continue with the tests, both neuro-diagnostic
19 imaging as well as neuropsychological testing to
20 determine what his progression is. I'm not sure
21 if that answered your question, but we're just not
22 there yet as far as knowing exactly what type of
23 permanent disability is -- is or is not occurring.
24 Q That did. Now, based on your review of
25 the medical records, the job description, M.S.D.S.

1 sheets, the chemicals to which he was exposed,
2 what is your opinion in reference to the cause of
3 his current medical problems, his severe headaches
4 and fatigue in reference to the -- his exposure on
5 the job?
6 Ms. Barr: Objection, Your Honor. This
7 calls for a medical opinion and a diagnosis --
8 Mr. McDaniel: From a tox---
9 Ms. Barr: -- this witness is not
10 qualified to make.
11 The Court: So noted and from --
12 from --
13 Mr. McDaniel: -- toxicological
14 standpoint.
15 The Court: Yes.
16 The Witness: Okay. Could you ask --
17 By Mr. McDaniel:
18 Q Well, tell me -- I -- I guess really --
19 tell me in your opinion based on your review of
20 all these records and job description what your
21 opinion is about the cause and effect of the -- of
22 the V.O.C.'s in reference to his condition.
23 A Well, it's my opinion in general that
24 any painter is going to be exposed to volatile
25 organic compounds if that painter is using those

1 compounds in their profession. So it's my opinion
2 based on the records that Mr. Barr did perform his
3 job satisfactorily using chemicals and paints that
4 contain volatile organic compounds that he was
5 exposed to those to some degree or extent. And
6 that subsequent to that exposure, he exhibited
7 symptoms, medical symptoms that are consistent on
8 the toxicological basis with exposure to volatile
9 organic compounds.
10 Q I want to ask you a couple more
11 questions, now, in reference to -- there's been
12 various entertaining in reference to his headaches
13 in reference to migraines versus tension headaches
14 versus rebound headaches.
15 A Correct.
16 Q From a toxicological standpoint and
17 also he was taking analgesics. And was prescribed
18 analgesics for his headaches in a large part. And
19 he's been doing -- doing those ever since 2010.
20 Tell me about rebound headaches versus migraine
21 headaches and tension headaches from a
22 toxicological standpoint in reference to the --
23 for example, the source of rebound headaches.
24 A Well, I've studied headaches and the
25 causes of headaches from a toxicological

1 standpoint and compounds that due to their
2 toxicity would cause a variety of types of
3 headaches. The most common headache is a tension
4 headache in which the muscles in the back of the
5 skull become tense and it feels like there's a
6 headache in the back of your head called the
7 occipital area. And that can be due to stress as
8 the main cause, but there -- but that -- I
9 consider that an external headache because it's
10 affecting the muscles on the outside of the skull.
11 Internal headaches in the brain itself can be due
12 to a variety of conditions, such as a clot or a
13 stroke or a swelling on the brain or toxic
14 compound that's in the brain that's causing
15 cellular changes in the brain that causes pain.
16 Typically, volatile organic compounds will get in
17 to the brain, cause cellular changes that will
18 result in pain. Now, that pain in and of itself
19 may be mild. However, that mild pain can be very
20 stressful especially if it professes itself over a
21 chronic time period. It becomes aggravating and
22 frustrating, which can lead to stress, which can
23 lead to tension headaches.
24 Ms. Barr: Objection, Your Honor. This
25 -- this witness is not qualified to -- to testify

1 about the ideology of headaches. This -- these --
2 this is -- he's giving medical opinions for which
3 he's not qualified. I would ask that his
4 testimony be stricken.
5 The Court: I'll let you respond to it.
6 Mr. McDaniel: Commissioner, here
7 again, he's testifying from a toxicological
8 standpoint as to -- and what I -- what I wanted to
9 get to is to the next question, which is from a
10 pharmaceutical standpoint -- a pharmacology
11 standpoint, what did you use to treat these
12 various types of headaches? And that's -- that --
13 Ms. Barr: Again, the -- his treatment
14 for a medical condition, a headache, has already
15 been addressed by the medical experts of which he
16 is not. And so we would object to any testimony
17 regarding the diagnosis or treatment
18 recommendations by this gentleman who's not a
19 medical doctor.
20 The Court: Okay. And that would be --
21 again, it's noted and -- and all the medical
22 records will be reviewed and will speak for
23 themselves. I'll let them speak for themselves
24 and so I'll -- and again, I'm going to give all of
25 it the -- the proper weight that I feel it --

1 Ms. Barr: Thank you, Your Honor.
2 The Court: -- it deserves. Okay?
3 Mr. McDaniel: And -- and -- and
4 Commissioner, thank you very much. And I -- I --
5 I just like to note that you're going to find when
6 you go through the medical records reference to
7 potential -- to possible diagnosis of migraines
8 and possible diagnosis of tension and possible
9 diagnosis of rebound. That's --
10 By Mr. McDaniel:
11 Q Now, tell me what -- from a
12 pharmaceutical standpoint -- from a pharmacology
13 standpoint what types of medications are used to
14 treat tension -- tension headaches?
15 A Well, they're -- depending on the type
16 of headache determines what the best treatment is.
17 Analgesics are a major class of drugs used to
18 treat pain, but their mechanism of action, which
19 is the definition of pharmacology, is -- is the
20 mech--- the mechanism of action of the drug on the
21 human body. For example, relieving a tension
22 headache might best be served with a muscle
23 relaxer since it's the muscle that's being tense.
24 Treatment of an ischemic headache might be with
25 aspirin or other blood thinners to dissolve the

1 clot that's causing the headache. If there's
2 swelling on the brain, there's other medications
3 that you use to decrease the swelling.
4 So depending on the type of headache
5 would determine which compound is going to work
6 best. But I -- I think where your question was is
7 once these medications are used and they're used
8 on a chronic basis, that some tolerance develops
9 to use of these medications and many times relief
10 is not obtained after long-term use. And more of
11 the drug is used.
12 A classic example is the opiates. They
13 are well characterized in the scientific
14 literature as tolerance developing, such as
15 hydrocodone, which Mr. Barr's reported to have
16 been taking, in which tolerance develops where
17 more of the drug is necessary to achieve pain
18 relief. But you mentioned rebound pain. Once a
19 person stops taking the medication, then the
20 beneficial effect that the medication was having
21 is removed and the head -- headache will return.
22 I'll use a colloquial term, return with vengeance
23 and it'll -- post-relief, the return of the
24 headache will have the feeling to the person
25 receiving the headache as being even more severe

1 than it was before. So I think that answered your
2 question.
3 Q It does. It does. And -- and what
4 about the treatment of migraines? You know, what
5 -- what type of pharmacology -- is there a
6 difference between those and treating tension
7 headaches?
8 A Yes, and as a pharmacist --
9 Ms. Barr: Same objection, Your Honor,
10 to the qualifications of this witness to -- to
11 recommend treatment for a medical condition.
12 The Court: So noted.
13 By Mr. McDaniel:
14 Q Not treating from a pharmacology
15 standpoint is what I was hoping to ask.
16 A Right. Being that I received a
17 pharmacy degree and practiced as a pharmacist for
18 many years, the effects of the drugs are -- are my
19 specialty.
20 Ms. Barr: Objection. As noted before,
21 there -- he has been ordered not to hold himself
22 out as a pharmacist.
23 The Witness: I said previously as a
24 pharmacist, which I was licensed for many years.
25 The Court: All right. Well, let's --

1 let's -- let's move on.

2 The Witness: A migraine has its own
3 set of drugs used for treatment that specifies the
4 type of pharmacologic action that the drug has on
5 the brain to alleviate a migraine. So it's just a
6 -- a classic example of how very specific
7 analgesics and treatments for headaches are
8 necessary to treat the specific type of headache
9 the person is experiencing.

10 By Mr. McDaniel:

11 Q Tension headaches are in reference to
12 the muscles in the back of the head. The migraine
13 headaches are...

14 A Inside the head mainly related to how
15 -- blood flow.

16 Ms. Barr: Again, objection, Your
17 Honor, to the qualification --

18 By Mr. McDaniel:

19 Q In reference --

20 Ms. Barr: -- of the witness.

21 By Mr. McDaniel:

22 Q From a -- from a toxicological
23 standpoint, the volatile organic compounds if they
24 are affecting the brain, they are affect--- is it
25 internal or external?

1 A Internal. They're crossing the blood
2 brain barrier and getting into the brain affecting
3 them -- the micro-structure, the micro-cellular
4 structure of brain cells.
5 Q Dr. Bennett, actually I have no further
6 questions except for one. In other words, are all
7 the answers that you've given today expressed to a
8 reasonable degree of toxi--- certainty as a
9 toxi--- as -- as an expert in the area of
10 toxicology and pharmacology?
11 A Yes, to a scientific and toxicological
12 degree of certainty. Yes. Not medical certainty.
13 Q And in all the questions I've
14 referenced today, you're testifying from the
15 standpoint of toxicology and pharmacology?
16 A Correct.
17 Q I do want to go over one thing with
18 you. And this really is to make sure I
19 understand. I ask -- ask you to reference
20 material data safety sheet on page 59.
21 A Okay.
22 Q Under section two, for The
23 Commissioner's benefit and -- and mine, when it
24 talks about composition, can you tell me what that
25 percent of weight -- what does that mean in

1 reference to the -- the compounds?

2 A Did -- did you say vapor pressure?

3 Q I'm sorry. Section two.

4 A Section two.

5 Q On page 59.

6 A Yes.

7 Q Okay. It says composition information

8 on ingredients.

9 A Right. That's the list of ingredients

10 that are in the product referenced by the M.S.D.S.

11 Q Okay. And when it refers to percent by

12 weight, what does that mean?

13 A That means that the amount of that

14 compound -- that it -- relative to the other

15 compounds on a percentage scale -- meaning that

16 the total percentage is 100 percent. So if

17 something is 40 percent by weight, part of the

18 entire composition, then as -- as mentioned in the

19 first compound, then 40 percent of the total

20 product contains that compound by weight rath---

21 as opposed to by volume. It takes in account the

22 differences between density and different

23 materials.

24 Q Okay. So 40 percent by weight of that

25 particular paint is -- if you -- you might be

1 better at this than I am. Where it says
2 ingredient, the first one says 40 percent by
3 weight.
4 A Correct.
5 Q And it's -- what -- what is that
6 compound?
7 A It's medium aliphatec hydrocarbon
8 solvent. That's a chemical name for a very
9 volatile organic compound.
10 Q And if you'll turn over to page 61 at
11 the top it says physical and chemical properties.
12 A Yes.
13 Q What's the -- there's a reference to
14 evaporation rate.
15 A Right.
16 Q Tell me about -- what that -- what that
17 means and what's that in reference to.
18 A Well, it states it's slower than ether
19 and ether is a volatile organic compound that
20 rapidly -- relative to other volatile organic
21 compounds, rapidly evaporates and has what we call
22 a low vapor pressure meaning that at room
23 temperature or room barometric pressure, the
24 compound will evaporate and become a gas. What
25 it's stating here is that it's slower than ether,

1 meaning that it doesn't evaporate as fast as ether
2 would. The other end of the spectrum is water.
3 If -- if a puddle of water was in the same
4 environment, it would evaporate relatively slow.
5 For example, ether would evaporate in a matter of
6 seconds, whereas the same amount of water would --
7 could take hours.
8 Q So this is slower than ether?
9 A Yes, but what that's saying is that
10 being ether is rapidly evaporating that it's
11 slower than something that rapidly evaporates.
12 And that doesn't quantify how much slower, but if
13 it's being compared to something that rapi---
14 evaporates rapidly it leaves to the assumption
15 that it also evaporates relatively rapidly.
16 Q What -- tell me about vapor density.
17 A It -- it's another relative term
18 meaning that if the gas is either heavier or
19 lighter than air -- I can best define it by giving
20 examples. For example, helium in balloons --
21 helium is lighter than air, so that causes it to
22 float upwards. Some compounds are heavier than
23 air, this specific compound in particular, meaning
24 that it sinks and settles on the lowest part of
25 the room which it's in. So depending on where a

1 person is in that room will determine whether or
2 not they're exposed to that. So if a -- a very
3 tall person will get less exposure to this
4 compound than a shorter person and an animal who
5 is like a dog or a cat who's closer to the floor
6 level would be most vulnerable to this type of
7 compound being that it's settling on the floor.
8 Q And so if -- if one were painting with
9 this compound, the baseboards versus the ceiling,
10 what would he get -- which one would get more
11 exposure?
12 A It would be dra--- dramatically
13 different exposure. If you're painting above your
14 head, then when that paint dries and being that it
15 dries relatively quickly -- the nature of paint is
16 to dry relatively quickly. It's formulated by the
17 manufacturer with volatile organic solvents with a
18 very rapid evaporation so the paint will dry.
19 That's the whole person of -- of painting is you
20 want it to dry relatively quickly and the only way
21 to do that is to formulate it with rapidly
22 evaporating volatile organic compounds to -- to
23 make sure the formulation. So if that paint is
24 applied above your head with a roller or either on
25 a short stick or a long stick, then those

1 evaporation fumes being heavier than air are going
2 to come right down on you. And you're going to be
3 breathing those as you're working unless you're
4 wearing a respirator.
5 Q And before, we talked about proper
6 fitting and all that.
7 A Correct.
8 Q But those fumes also would be coming
9 down on your eyes as well?
10 A Absolutely.
11 Q And your skin?
12 A Absolutely.
13 Q And so...
14 Ms. Barr: I'm going to object to the
15 leading and we just -- we've gotten through it and
16 I just have to object.
17 The Court: Okay. So noted.
18 Mr. McDaniel: I -- Commissioner, I
19 have no further questions. Dr. Bennett, would
20 you, please, answer any questions that Ms. Kirsten
21 Barr may have?
22 The Court: Ms. Barr?
23 R E C R O S S - E X A M I N A T I O N
24 By Ms. Barr:
25 Q Thank you. It'll be brief. Mr.

1 Bennett, my name's Kirsten Barr. And I represent
2 the Darlington County School District in this
3 claim. You testified earlier that you believe Mr.
4 Barr was exposed to volatile organic compounds to
5 some or degree -- to some degree or extent. Is
6 that correct?
7 A Correct.
8 Q You can not quantify objectively that
9 -- the degree or extent of his alleged exposure to
10 V.O.C.'s, can you?
11 A That's correct.
12 Q All right. And by the same token, can
13 you quantify with any objective -- by any
14 objective measure his degree of exposure to
15 V.O.C.'s outside of his employment with Darlington
16 County School District?
17 A That's correct. I have no records to
18 the extent of exposure or in fact that he was
19 exposed to volatile organic compounds outside of
20 his employment of the school district.
21 Q Okay. And that would be most notable
22 in his personal business as a painter?
23 A While employed with the school
24 district?
25 Q Yes.

1 A Or previous?
2 Q Both.
3 A Both, yes. The records indicate that
4 there was both.
5 Q Okay. And so I believe based on your
6 testimony that -- that painting of all stripes
7 whether it be residential or commercial has the
8 potential to expose one to volatile organic
9 compounds?
10 A Yes.
11 Q All right. But at the end of the day,
12 you said dose was most relevant and dose is what
13 we can not quantify in this case, correct?
14 A As far as the total cumulative dose as
15 well as the source of those doses.
16 Q Okay. Perfect. One other question,
17 Mr. McDaniel provided you with some records, but I
18 believe those records began in the year 2010. Is
19 that correct?
20 A Correct.
21 Q Did you have benefit of any -- of any
22 records regarding Mr. Barr prior to 2010?
23 A I did not.
24 Q Okay. So you can't speak to the
25 potential effects of volatile organic compounds on

1 Mr. Barr prior to 2010?
2 A Correct.
3 Q Or for that matter, a potential
4 relation of -- of volatile organic compounds or
5 other factors in the headaches and vertigo and
6 dizziness he experienced prior to 2010?
7 A Correct.
8 Ms. Barr: Thank you very much. I
9 appreciate your time.
10 The Court: Thank you, Ms. Barr. Mr.
11 McDaniel, anything more?
12 R E D I R E C T E X A M I N A T I O N
13 By Mr. McDaniel:
14 Q In reference to Ms. Barr's questions
15 about the symptoms and effects -- in reference to
16 the symptoms that Mr. Barr has and the effects of
17 V.O.C.'s, is that consistent with exposure to
18 V.O.C.'s?
19 A Yes.
20 Ms. Barr: Nothing further, Your Honor.
21 The Court: Okay. Mr. McDaniel?
22 By Mr. McDaniel:
23 Q In reference to my earlier questions
24 under direct examination and Ms. Barr's questions
25 to you in cross-examination, Dr. Eagerton in his

1 report states that Mr. Barr suffered no ill
2 effects that are commonly seen with acute exposure
3 to V.O.C.'s. We -- we talked about the cause and
4 effect and we talked about the effects and we went
5 over Dr. Chapman's report and what are the common
6 acute effects. Do you --
7 Ms. Barr: I would object to pitting of
8 the witnesses. It's improper.
9 By Mr. McDaniel:
10 Q My question is just simply -- okay -- I
11 believe --
12 Ms. Barr: He's pitting the witnesses.
13 By Mr. McDaniel:
14 Q -- your earlier testimony stands,
15 Doctor. Dr. Chapman's report is consistent with
16 the same acute --
17 Ms. Barr: Objection to leading.
18 The Court: Okay.
19 Mr. McDaniel: I'm just restating it,
20 you know. I can do it one of two ways.
21 By Mr. McDaniel:
22 Q Ms. Barr asked you about the effects on
23 Mr. Barr. And my question to you is --
24 Ms. Barr: No, I didn't.
25 Mr. McDaniel: I'll withdraw the

1 question.
2 The Court: Okay. Thank you. I
3 appreciate that.
4 Mr. McDaniel: I have no further.
5 The Court: Okay. Thank you. Ms.
6 Barr, any more?
7 Ms. Barr: No, Your Honor.
8 The Court: Okay. Sir, you can step
9 down and thank you for your testimony and being
10 here today. We appreciate it. Okay?
11 The Witness: Thank you.
12 Mr. McDaniel: I'm going to ask if Dr.
13 Bennett can be excused?
14 The Court: Yes, absolutely. And I'm
15 going to take a two-minute break.
16 (WHEREUPON, A BREAK WAS TAKEN
17 FROM THE PROCEEDINGS.)
18 The Court: Mr. McDaniel?
19 Mr. McDaniel: Commissioner, we call
20 Ken Barr.
21 The Court: Okay. Mr. Barr, if you'll
22 just step right up there, sir. Have a seat and
23 make yourself comfortable. And real quickly, I'll
24 -- I'll run through the instructions with you. I
25 know you already heard them, but, please, speak

1 up, speak clearly for us. If you're asked a yes
2 or no question, please, give us a verbal yes or no
3 answer and try and stay away from things like
4 uh-huh and huh-uh. That's just too easily
5 misunderstood. Okay?
6 A Yes, sir.
7 The Court: All right. Please, raise
8 your right hand.
9 Kenneth L. Barr,
10 being first duly sworn by The Court, as
11 hereinafter certified, testified as follows:
12 The Court: Okay. You can put your
13 hand down and please state and spell your name for
14 the record, sir.
15 The Witness: My name's Kenneth L.
16 Barr. It's K-E-N-N-E-T-H, L, B-A-R-R.
17 The Court: Okay. Thank you, Mr. Barr.
18 Mr. McDaniel, your witness.
19 DIRECT EXAMINATION
20 By Mr. McDaniel:
21 Q Mr. Barr, we -- if you would -- are --
22 are you married?
23 A Yes, sir.
24 Q How long have you been married?
25 A Twenty-five years.

1 Q And how many children do you have?
2 A Three.
3 Q Are those living at home with you or
4 depending upon you for support?
5 A Yes, sir.
6 Q All right. Prior to you leaving the
7 school district, who was the major breadwinner in
8 the family?
9 A Myself.
10 Q Okay. Now, let's talk about your
11 educational background. The -- what -- did you
12 finish high school?
13 A Yes, sir.
14 Q Where did you go to high school?
15 A Emmanuel Baptist School in Hartsville.
16 Q And I believe you described yourself as
17 pretty much an average middle-of-the-road guy --
18 type student?
19 A Yes, sir.
20 Q All right. Now, after you got out of
21 high school, tell me -- let's talk about your work
22 background.
23 A Okay.
24 Q All right. When you got out of high
25 school, what do you remember to be your first job?

1 A That's been many years ago.
2 Q Well, let me see if I can help you a
3 little bit --
4 A I'm sorry.
5 Q -- and see if -- if you -- if you
6 disagree with anything I say. Okay?
7 A I apologize.
8 Q Out of high school, you went to work
9 for a Hartsville Furniture Company?
10 A Yes, sir.
11 Q All right. What did you do for them?
12 A I was a delivery driver; I delivered
13 furniture.
14 Q Okay. Do you happen to know how many
15 years you did that job?
16 A I think only a cou--- two maybe.
17 Q Okay. Do you -- do you know what --
18 when you left that job, what type of work you were
19 doing after that, the next job?
20 A I believe I was in retail at B.C.
21 Moore's.
22 Q Well, was there a period of time --
23 A Or --
24 Q -- that you -- you did roofing and
25 carpenter work with your dad?

1 A Well, I helped my dad between, you know
2 -- between B.C. Moore's and Hartsville Furniture,
3 yes, sir.
4 Q All right. And then -- then you went
5 to work for B.C. Moore?
6 A Yes, sir.
7 Q And what did you do for them?
8 A I was a clothing salesman for the men's
9 department.
10 Q And do you know how -- how long did you
11 do that job?
12 A I don't think I was there but about a
13 year, year and a half maybe.
14 Q Now, where did you go from there? Does
15 Dan Atkins sound familiar?
16 A Yes, sir, a construction company. It
17 was Dan Askins Construction.
18 Q What -- what type of work did you do
19 for Dan Atkins? What did -- what did they do and
20 what did you do?
21 A Well, it was general construction work.
22 Mainly I did framing or rough -- rough carpentry.
23 Q All right. And how long did you do
24 that?
25 A I don't think that job lasted very

1 long, maybe a couple years.

2 Q And then from there, where did you go?

3 How about Williams --

4 A I believe --

5 Q -- Power Company?

6 A Yes, sir. I was gonna say I believe I

7 went to Williams Power Company up in H.B. Robinson

8 Nuclear.

9 Q Okay. Where are they out of and what

10 kind of work did you do for them?

11 A They're from Stone Mountain, Georgia

12 and I was a painter.

13 Q Okay. And you were a painter where?

14 A At the H.B. Robinson nuclear plant.

15 Q Okay. So there you were using

16 commercial paints?

17 A Yes, sir.

18 Q All right. Tell me about what type of

19 safety equipment you used when you were painting

20 for the nuclear plant.

21 A Well, for the nuclear plant, we had

22 used like rubber gloves, not latex, but rubber

23 gloves.

24 Q They would reach up the arm or how long

25 would they be?

1 A They would come almost to your elbow.
2 Long sleeve shirts always. We had a full-face
3 respirator and since I wore regular lenses, I had
4 to have my glasses -- a -- a pair of glasses that
5 would fit actually into the respirator.
6 Q Okay.
7 A A full-face respirator.
8 Q All right. And so it fit completely
9 over your eyes, face, nose, the whole -- full
10 face?
11 A Yes, sir.
12 Q All right. Was it air supplied or not?
13 A Sometimes certain areas we would have
14 to have air supplied and sometimes it was not.
15 And if it was used the -- I'm not sure what the
16 correct terminology is, but the -- the filtration
17 mask. And it was also full-face or half-face.
18 Q And you had to -- okay. All right.
19 Now, how long did you do that?
20 A I think it was three years or a little
21 over three years.
22 Q From there where -- where did you go
23 next?
24 A Well, at -- went to Suburban Propane.
25 Q And what did you do for Suburban

1 Propane?
2 A At first I delivered propane gas to
3 houses.
4 Q And then what did you do later on?
5 A Later on, I was -- we always had to
6 cross-train whether it be service or installing.
7 I eventually wound up to be chosen for lead
8 installer of gas appliances, tanks, lines and
9 et-cetera.
10 Q And about how long were you with
11 Suburban Propane?
12 A I'm not exactly sure. I'm thinking
13 about four or five years probably.
14 Q You left there and what did you start
15 doing then?
16 A I left there and started a little
17 painting company of my own.
18 Q I -- I haven't ever asked you this
19 before, but after Williams Power Company where you
20 got your training as a painter --
21 A Yes.
22 Q And you were doing commercial painting,
23 did -- did you do any painting on the side during
24 the time you worked for Suburban Propane? I --
25 I...

1 A For Suburban?
2 Q Yeah.
3 A I really didn't have time 'cause I was
4 on call a good bit.
5 Q Okay.
6 A We didn't have many people at that
7 time, so we were on a call schedule right
8 regularly then. You know, you could drive -- you
9 could call a driver to come deliver gas or if you
10 needed service work, which I wasn't a service man
11 at the time, you could call a service man and work
12 on appliance.
13 Q So then -- then after that, you opened
14 your own painting business?
15 A Yes, sir.
16 Q All right. How many people did you
17 have working for you at -- at any time?
18 A The most I've ever had is two.
19 Q You and two others?
20 A Yes, sir.
21 Q Okay. Generally was it you and one
22 other or you or...
23 A It was me and one other sometimes and
24 then I found out that it's just better just do it
25 on your own.

1 Q Okay. And so how long did you operate
2 Kenny's Painting? I believe that was the name of
3 your business.
4 A Yes, sir.
5 Q Did you operate it before -- before you
6 went -- took your next job?
7 A I'm not exactly sure of how long. I'm
8 gonna say approximately five years.
9 Q And what was your next job?
10 A Worked for Darlington County School
11 District.
12 Q Okay. How did you come to go with the
13 Darlington County School District?
14 A Well, a friend of mine that works for
15 -- that had worked with me when we had our little
16 painting business going --
17 Q What was his name?
18 A David Waters. Was a real good friend
19 of mine and he told me about a job coming up and I
20 told him I wasn't interested. I'm doing fine.
21 And he said, well, we really need a good painter.
22 He said, we -- you're a good painter and we need
23 you. And he had talked to me about it and I told
24 him I wasn't interested. And the next thing I
25 know he's bringing me a -- a file folder full of

1 information about job duties and an application
2 from the school district was sent from Mr.
3 Stegner.
4 Q I'm sorry?
5 A That was sent from Mr. Stegner.
6 Q Stegner. Okay, Mr. Stegner, who --
7 who's --
8 A Mr. Larry Stegner, yes, sir.
9 Q Okay. And so then you went to work for
10 the school district. Decided to take the job?
11 A Yes, sir. I -- I decided to take the
12 job.
13 Q And according to what I have, it looks
14 like you -- according to the school district
15 application and all that, you went to work at the
16 first of June -- end of May, first of June, 2009.
17 A That is -- yes, sir. I think it was
18 around June -- first week of June, yes, sir.
19 Q All right. Tell me -- let's -- let's
20 talk about your work schedule. What was your work
21 schedule at -- as a painter?
22 A During the school year, it was five --
23 five days a week, eight hours a day. During the
24 summer, four days a week, ten-hour days, off on
25 Fridays.

1 Q Was there any difference in the
2 painting that you did for the school district
3 during the year versus the summer?
4 A Yes, sir. We used -- we could use --
5 instead of trying to paint oil during the spring
6 or during the school year, we would hold the
7 oil-based projects off and just use pre-catalyzed
8 epoxy, which is supposed to stick to the oil-based
9 paints. And -- and the conditions were different.
10 I -- you know, you go into a room and, you know, I
11 -- you could leave the doors open because most of
12 the times people were waxing floors, the
13 custodians. And -- but the air conditioning was
14 not on in each rooms.
15 Q Now, you're talking about during the
16 summer?
17 A Yes, sir, when school was out.
18 Q Okay.
19 A So a lot of the school rooms were not
20 on or broken, but that's the difference. I mean
21 -- not much difference, but a little bit.
22 Q Talk to me about how much -- did you do
23 inside and outside painting and was -- was there
24 one that you did more of than the other?
25 A Yes, sir. I did both. My primary goal

1 was interior, but there was some exterior
2 projects.
3 Q Tell me about the safety equipment that
4 you used while -- while doing your painting.
5 A Well, we had latex gloves. We had the
6 -- whatever kind of respirator y'all call it with
7 the filters on the side. I call it a filtration
8 air filter, that we use. And I would change out
9 intermittently whether it would be a particulate
10 or a -- a fume, particle or fume.
11 Q Okay. Let's talk about -- okay. Let's
12 talk about outside painting. Did you wear any
13 protective type of equipment at all outside?
14 A No, sir.
15 Q All right. How much of the time did
16 you ever wear gloves?
17 A I tried to wear gloves regularly, but
18 sometimes you couldn't. But not very often.
19 Q Okay. So you did wear gloves a lot of
20 the time?
21 Ms. Barr: Objection. That -- that was
22 not his testimony.
23 Mr. McDaniel: Well --
24 Ms. Barr: He said regularly.
25 The Court: Sustained.

1 By Mr. McDaniel:
2 Q Tell me -- tell me again how much of
3 the time you wore gloves?
4 A I didn't wear 'em regularly. I wear --
5 wore 'em sometimes. I mean, I don't know -- I
6 mean, this week, I might not wear 'em. It depends
7 on what I'm using and wear I'm at. I mean, how
8 nasty the bathroom is, it just all depends.
9 Q All right. Now, in reference to
10 outside painting, did you wear a respirator
11 outside?
12 A No, sir.
13 Q All right. What about inside?
14 A Yes, sir. If I could not ventilate the
15 room or ventilate an area where I was at, I would
16 vent--- I would wear it. Now, if I could not
17 ventilate, open doors, windows, whatever, put fans
18 in, then I would -- I wouldn't wear it.
19 Q Okay. So if you were in a location --
20 explain that to me again. Go back over your
21 testimony.
22 A If I was in a room that was not well
23 ventilated, that I couldn't open the door that
24 goes out to the hall and ventilate through the
25 door or open the windows, then I would wear a

1 respirator. If I could ventilate well, which was
2 open the windows -- most of the time, the rooms
3 have two windows. I would open the windows, open
4 the door that I could -- sometimes you can't with
5 kids in school. I would not wear it sometimes.
6 But it depends -- more or less on how my eyes
7 would burn. Sometimes they would burn terribly.
8 I'd put it on no matter if I had the doors open,
9 the windows open or whatever. So, therefore, I
10 would wear it.
11 Q Tell me about the type of respirator
12 that you had. You referred to your eyes burning.
13 And you referred that earlier when you were at the
14 -- the plant, you had a full-face respirator.
15 What type of respirator did you have at the school
16 district?
17 A Strictly a -- it covered your mouth and
18 your nose -- the partic--- or filtered --
19 Q Two can?
20 A Two cans, right.
21 Q What type of filters did you use in
22 those cans?
23 A Two different kinds. It was a 3M
24 filter. It was 3M mask. But the one that any
25 kind of filtration that -- that particulates would

1 be flying around in the air --
2 Q Like sand -- like sand dust? Was --
3 A Sand and wire wheels, whatever. I
4 would use one that would cut out the dust
5 particles. Then once I started painting, I would
6 change it out to the fume or to reduce the fume
7 intake.
8 Q Did you ever also wear a dust mask?
9 A On occasion, but not -- not as often as
10 the respirator.
11 Q Did you -- when I say problem, did you
12 -- were you -- did you consistently have available
13 the type of filters that you needed to use the
14 respirators?
15 A I mean, I can go to Lowe's and buy 'em
16 if I needed 'em, but, of course, I'd have to ask.
17 I mean, I couldn't just go get -- I had to make
18 sure it was fine.
19 Q Now, let's -- let's go up to -- you --
20 we've established that you started in 2009 in
21 approximately June. The first record I have after
22 that of you seeing a doctor about a problem in
23 reference to headaches and why we're here today is
24 June 15th of 2010. Who was your family doctor
25 during this period of time?

1 A I believe it was Dr. Chapman.
2 Mr. McDaniel: Now, Commissioner, on
3 tab four, page 170 --
4 By Mr. McDaniel:
5 Q According to Dr. Chapman's records on
6 June 15th, 2010, you saw -- the main complaint of
7 headaches off and on for approximately two to
8 three weeks and fatigue, that you had been taking
9 Tylenol every day, but it -- it -- to -- to --
10 Ms. Barr: I'm going to object to the
11 leading.
12 Mr. McDaniel: State -- restate the
13 medical record.
14 The Court: I'll -- I'll allow it.
15 By Mr. McDaniel:
16 Q All right. Mr. Barr, when -- is that
17 the first time you remember reporting specifically
18 to Dr. Chapman --
19 Ms. Barr: Objection to the leading.
20 Is that the first time you remem--- I mean, he's
21 suggesting an answer. It's a classic --
22 Mr. McDaniel: No, it's not --
23 Ms. Barr: -- leading question.
24 Mr. McDaniel: It is not a leading
25 question simply because I'm asking for a yes or no

1 answer.
2 The Court: All right. Go ahead.
3 By Mr. McDaniel:
4 Q Mr. Barr, to your recollection, is that
5 the first time that you reported to Dr. Chapman
6 with headaches if that's according to the record?
7 A As far as --
8 Q As far as your recollection?
9 A As far as I can recall, yes, sir. I --
10 I have not prior to this.
11 Q Tell me what kind of -- what kind of
12 problems -- you know -- tell me about your
13 headaches at that time, what you remember about
14 them and what you remember about after that. The
15 next time I have you -- you seeing Dr. Chapman is
16 in September. Tell me about your headaches during
17 that time and what you remember about how it was,
18 what kind of problems you were having.
19 A They were fairly bad to where I could
20 take two Tylenol each time and I may not wait four
21 hours. I may wait three, take two more, because
22 if I -- and maybe a total of six a day or maybe
23 even eight a day. But I would most the time
24 intermittent with Tylenol or Motrin in between. I
25 remember, you know, having dizzy spells on

1 occasion. But the main thing was severe headache.
2 And some days it would go away; some days it
3 wouldn't. So -- I mean, that's all I can
4 remember.
5 Q The -- you saw him again on September
6 1st. He ordered a C.T. scan --
7 Ms. Barr: Objection. The medical
8 records speak for themselves. I'm not quite sure
9 why they're being read in to -- in to --
10 Mr. McDaniel: Well --
11 Ms. Barr: -- the record here.
12 By Mr. McDaniel:
13 Q Okay. If -- if Dr. Chapman records
14 that -- that you saw him on September 1st, 2010
15 with persistent headaches that would not stop, did
16 -- does that -- is -- is that in accordance with
17 your recollection --
18 Ms. Barr: Objection to the leading. I
19 just -- we can spoon feed like everything Preston
20 wants to say to Mr. Barr and stay here all day
21 long --
22 Mr. McDaniel: Well, we can --
23 Ms. Barr: The medical records speak
24 for themselves, but only non-leading questions, I
25 believe, are appropriate, Your Honor.

1 Mr. McDaniel: Commissioner, I am not
2 suggesting an answer. It is simply a question of
3 whether or not what this doctor recorded is in
4 accordance with my client's te--- recollection of
5 what kind of problems he was having --
6 Ms. Barr: The -- the appropriate
7 question would be what do you recollect?
8 Mr. McDaniel: No, the -- the question
9 is to ask him whether or not he agrees with that,
10 yes or no. It's not just an answer --
11 The Court: Okay. Well, let's -- let's
12 ask the question then, please.
13 By Mr. McDaniel:
14 Q Okay. Let's go -- let's go forward to
15 September 13th and this is what Dr. Chapman
16 records and I want to tell -- you to tell me what
17 you remember about this at that time. Okay. All
18 right. Now, chief complaint is headache. You
19 state the headaches started about four weeks ago.
20 You had a C.T. scan and then after that, it
21 records that -- I have given him prescription of
22 Lorcet and states he is taking these.
23 Unfortunately, the headache has persisted. All
24 right. He returned to work on September 7th and
25 worked through Thursday and was released from work

1 with the school district because of dizziness,
2 fatigue and balance issues --
3 Ms. Barr: I object to the testimony --
4 By Mr. McDaniel:
5 Q My question to you --
6 Ms. Barr: -- by Mr. McDaniel. I mean,
7 we -- we're --
8 Mr. McDaniel: That's evidence in the
9 record, Commissioner. And now I -- I --
10 Ms. Barr: But -- but it's not a
11 question.
12 Mr. McDaniel: Well, let me ask a
13 question --
14 The Court: All right. Well, let --
15 let him ask the question. I will -- I will --
16 just to help streamline things along so we can
17 kind of move along, anything that you can more --
18 be more direct on, I would appreciate it --
19 Mr. McDaniel: As -- as soon as I can
20 get to this and then one other thing, I -- I --
21 I'll try to go through it fairly quickly --
22 The Court: Okay. Okay. All right.
23 Thank you.
24 By Mr. McDaniel:
25 Q All right. Now, what do you remember

1 about your headaches at that time and the problems
2 that you were having?
3 A I do remember 'em getting progressively
4 worse and dizziness and little fatigued at the
5 time and just unbalanced, but it was vertigo. I
6 was always told vertigo.
7 Q Now, the -- all right. Right after
8 that, Dr. Chapman referred you to Dr. Skinner --
9 A Yes, sir.
10 Q -- and how long was your recollection
11 did you treat with Dr. Skinner?
12 A I don't think had been more than a
13 year, year and a half at the very, very most.
14 Q And during that year, year and a half
15 -- well, let me say stop right there. Let me ask
16 you this, from the time that you started reporting
17 headaches that were two to three weeks persistent,
18 then after that, you came back with four weeks
19 persistent headaches that could not be relieved --
20 Ms. Barr: Objection to the leading. I
21 -- I...
22 The Court: Go ahead and finish your
23 question.
24 Mr. McDaniel: Okay.
25 Ms. Barr: I mean, he's telling him --

1 By Mr. McDaniel:
2 Q From that time --
3 Ms. Barr: -- like his whole history.
4 By Mr. McDaniel:
5 Q From that time on, have you been under
6 treatment for headaches ever since 2010?
7 A I mean, I've been getting medications
8 from Dr. Chapman and I've gotten medication from
9 Dr. Skinner -- with my neurologist.
10 Q All right. So you -- okay. Now, tell
11 me about your headaches ever since the start in
12 2010?
13 A Well, it -- it started --
14 Q What's happened?
15 A It started off as a headache that I
16 could control mostly maybe one, two a week.
17 Tylenol, Advil would take care of it. Now it's to
18 the point to where there's nothing takes care of
19 it whether the neurologist prescribes it or my
20 family physician prescribes it or what.
21 Q How bad were they during the time at --
22 that you were seeing Dr. Skinner? How did it
23 change --
24 A They were getting --
25 Q -- from -- from then to 2011, 2012?

1 A They were getting severe then, but not
2 as severe as they have been in the past couple
3 years.
4 Q All right. Now -- and Dr. Skinner --
5 you've already testified to this in part, but the
6 doctor prescrib--- Dr. Skinner, what did -- what
7 kind of treatment did he provide for you?
8 A Medications.
9 Q Okay.
10 A That's it.
11 Q Do some -- did he do any testing?
12 A He -- he did like a C.T., M.R.I. And
13 was gonna follow up every six months, but that
14 never happened.
15 Q Why did you -- why did you leave Dr.
16 Skinner or why did you quit seeing him?
17 A I didn't want -- I mean, I wanted to
18 find and get a second opinion because he was not
19 doing anything.
20 Q Okay.
21 A Just to give -- feeding me medicine.
22 Q And...
23 A And I mean, there's nothing --
24 Q Who did you go to about that at that
25 time?

1 A I went to -- well, I went to Dr.
2 Chapman to give me a referral to Dr. White.
3 Q And -- and he referred you to Dr.
4 White?
5 A Yes, sir.
6 Q Okay. Where -- where was -- at --
7 during this period of time back in 2012, where was
8 Dr. White's office?
9 A He was there -- he had an office there
10 in Hartsville at the hospital.
11 Q Okay. Now, the first record I have is
12 from October 17th of 2012. Tell me about your --
13 your first evaluation of Dr. White.
14 A Well, we had talked -- he asked
15 questions of something that Dr. Skinner didn't do
16 was what was my occupation, what I did for a
17 living, what was my routine activities, what would
18 I do after work, you know. And he told me
19 automatically --
20 Ms. Barr: Objection to hearsay.
21 The Court: Yeah. You can't -- you
22 can't tell me what he told you. You can tell me
23 what your understanding about something is, but
24 don't tell me what he told you. But yeah, if he
25 referred something to you or what he did to treat

1 you, you can tell me that and what your
2 understanding, but don't tell me what he told you.
3 Okay?
4 By Mr. McDaniel:
5 Q What was your understanding?
6 A That I needed to get out of painting.
7 Q Okay. Okay. And 2012, what did he do
8 in reference to -- at that point in time?
9 A He did --
10 Ms. Barr: Objection to hearsay. The
11 medical records speak for themselves --
12 The Witness: Well, nevermind.
13 By Mr. McDaniel:
14 Q Well, let me ask you -- well, let me
15 ask you this --
16 A Nevermind.
17 Q Did -- did you -- did he give you an
18 excuse and tell you to get out of --
19 Ms. Barr: Objection to the leading.
20 The Witness: For six weeks.
21 The Court: I'll -- I'll allow that.
22 Go ahead.
23 Mr. McDaniel: We've already referred
24 to it. I -- I -- if I have to, Commissioner, I
25 can --

1 Ms. Barr: But it doesn't change it
2 from being a leading question, Preston, which was
3 my objection.
4 Mr. McDaniel: Well, Kirsten, you know,
5 of course, we disagree on leading questions,
6 however --
7 By Mr. McDaniel:
8 Q Mr. Barr, did you -- what did you do
9 with the work excuse that Mister -- that Dr.
10 Marshall White gave you?
11 A I gave it to Mr. Stegner.
12 Q All right. Did they in fact take you
13 out of painting --
14 A Yes, sir.
15 Q -- for six weeks?
16 A They accommodated me, yes, sir.
17 Q Okay. What happened with your
18 headaches during that time?
19 A They seemed to gotten better. About
20 the fourth week after -- out and fifth, sixth
21 weeks felt pretty good. And then I had to go back
22 in to painting and two or three weeks after I got
23 back in, I started feeling bad again.
24 Q Okay. And I see that you saw -- you
25 saw Dr. White -- you saw -- you saw Dr. Chapman

1 after 2012 through 2015, but you also saw Dr.
2 White every now and then. Why -- why did that
3 change? Do you remember why -- when he -- did he
4 always have an office here in Hartsville?
5 A No, sir. He closed his office in
6 Hartsville and went back to Sumter.
7 Q All right. Now, let's refer to in --
8 in 2013, 2014, 2015, tell me about how you -- how
9 your headaches -- how did they do?
10 A Progressively worse.
11 Q Okay. Did -- did it begin to affect
12 your job?
13 A Yes, sir.
14 Q All right. How did it affect your job?
15 A I was missing work. I was missing
16 work, couldn't concentrate, couldn't focus on
17 tasks that I had to do and I just wasn't a good
18 employee.
19 Q Now, let's move up to -- and Dr. White,
20 did he also prescribe medications for your
21 headache?
22 Ms. Barr: Objection --
23 The Witness: Yes, sir.
24 Ms. Barr: -- the medical records speak
25 for themselves.

1 Mr. McDaniel: Well --
2 The Court: I -- I'll -- that -- I'll
3 allow that.
4 By Mr. McDaniel:
5 Q Thank you. And was anything working?
6 A Not at the time, no, sir.
7 Q Now, let's go up and let's talk about
8 March 16th of 2015.
9 Mr. McDaniel: Commissioner, it's tab
10 three, A.P.A. admissions.
11 By Mr. McDaniel:
12 Q You went to Carolina Pines that day,
13 but tell me what happened that -- that morning,
14 where you were, what happened.
15 A That morning I reported to Carolina
16 Elementary School. Talked to Ms. Barrett, the
17 principal. And -- excuse me.
18 The Court: Take your time.
19 The Witness: She told me that -- I
20 don't remember what drill they were gonna have,
21 but there was gonna be a drill around a certain
22 time. And I said, well, that's fine, that'll give
23 me time to get my area set up and I had to go to
24 Lowe's anyway to -- to pick up supplies. And when
25 I always left -- I have to go to Lowe's from

1 Carolina or anywhere, I went down Marlboro Avenue.
2 And when I got to Marlboro Avenue, instead of
3 going toward Lowe's, I took a left and went to --
4 it's -- Carolina Avenue. And then next thing I
5 know I was sitting a block from the school behind
6 the chiropractor's office confused.
7 By Mr. McDaniel:
8 Q Mr. Barr, just prior to that in -- in
9 -- during that time frame up to March 16th, how
10 bad were your headaches? How often were you
11 having them?
12 A Every day. Every day.
13 Q All right. When this all started
14 occurring, were you having a headache?
15 A Yes, sir.
16 Q Okay. Do you remember how bad it was
17 if you compare it to other headaches?
18 A I don't remember how bad. I just got
19 disoriented and lost.
20 Q And so tell us what happened after
21 that.
22 A So I called my wife. She asked if I
23 called Mr. Larry. I just told her -- I said no,
24 'cause I knew her number. So she called him and
25 tell him what happened. And so I had to take the

1 county vehicle back to the shop, which was a few
2 miles. And then my wife picked me up and took me
3 -- I don't remember if it was Chapman's office or
4 Carolina Pines. I think it was Carolina Pines. I
5 had to go to -- to the emergency room.
6 Q And I believe they -- they did -- they
7 did tests and all that eventually --
8 A Yes, sir.
9 Q Released you and follow up back with
10 Dr. Chapman?
11 A The next day, yes, sir.
12 Q Did they actually give you some -- did
13 they give you an injection of pain kill--- there?
14 A Yes, sir. They give me a couple of
15 pain -- couple of injections. I don't know what
16 they were, but I know one was pain medication.
17 Q And then after that, you followed up
18 with Dr. Chapman?
19 A Yes, sir.
20 Q All right. Then according to the
21 records I have, you then -- let me go back to that
22 day. Do you remember at the hospital what you
23 told them about your headaches?
24 A I don't remember what I told 'em.
25 Q Do you remember -- do you remember

1 telling anybody that the worst headache of my
2 life --
3 Ms. Barr: Objection, Your Honor. It
4 -- the question's been asked and answered and this
5 is now a leading question trying to suggest a
6 different answer.
7 Mr. McDaniel: On page 85, the records
8 speak for themselves.
9 The Court: Okay. Thank you.
10 By Mr. McDaniel:
11 Q Now, I then have you seeing Dr. White
12 and also we know that on the -- Mr. Stegner --
13 Mr. McDaniel: Commissioner, refer to
14 page 199 of Claimant's A.P.A. submissions.
15 By Mr. McDaniel:
16 Q Let me first say this, Mr. Stegner,
17 from 2010 all the way through this time, has he
18 been your supervisor throughout --
19 A Yes, sir.
20 Q Okay. And I believe actually when you
21 actually went in the school district, this other
22 gentleman referred you, but who did you actually
23 interview and who actually hired you?
24 A Mr. Stegner.
25 Q Mr. Stegner a good man?

1 A Yes, sir.
2 Q All right. Now, he records that after
3 this incident on March 16th, that you and he met
4 on March 28th. And then I have you seeing Dr.
5 White in April. Tell me what you were discussing
6 -- tell me what Doctor -- when you went to Dr.
7 White, basically, what was your understanding at
8 that time?
9 A When I went to Dr. White?
10 Q When you -- when you went to Dr. White.
11 A That I needed to get out of paint fumes
12 now. I needed to get out of that occupation.
13 Q Okay.
14 A Period. No if, ands or buts, just get
15 out of it. You got to get out of it.
16 Q All right. Had you obtained the
17 M.S.D.S. sheets for Dr. White from the school
18 district?
19 A At that time, no, sir.
20 Q Okay. When did you get those forms?
21 A One of the trips that when we went to
22 Sumter to see him. I don't even remember when it
23 was.
24 Q Okay. All right. Now, so tell me
25 about the discussions -- Mr. Stegner's been nice

1 enough to document this, but tell me, basically,
2 your discussions in March and April with the --
3 with Mr. Stegner and what -- what were you trying
4 to do.
5 A Well, since Dr. White was wanting me to
6 get out of the occupation, I went to Mr. Stegner
7 and see what other jobs I could do. And every one
8 that he had mentioned was a pretty heavy cut in
9 pay. I know I couldn't afford five or six bucks a
10 hour, not with my wife working two little
11 temporary jobs or part-time jobs. I mean, there's
12 no way.
13 Q And did y'all discuss also the
14 possibility of retiring from the school district?
15 A I --
16 Q Do you remember --
17 A I don't remember retiring -- talking
18 about retirement.
19 Q Okay. All right. Now, you again saw
20 -- now, in April -- and Mr. Stegner says you had
21 another meeting on May 7th. Now, we know you went
22 back to Dr. White on May 21st. Did you have an
23 attorney in April?
24 A No, sir.
25 Q All right. Was it before or after the

1 visit on -- with May 7th when you talked to Mr.
2 Stegner that you went to see Mr. Malloy?
3 A I think it was some time in June or
4 Aug--- or July. I don't -- I don't recall Ma---
5 May.
6 Q Okay. All right. When you went to see
7 Dr. White on May 21st, and you were still working
8 as a painter with the district up until that time.
9 A Yes, sir.
10 Q How was your condition, Mr. Barr, at
11 that time?
12 A Typical everyday headache, every day,
13 hard. It wasn't a secluded area of my head. It
14 was my entire head like it always is. And it's --
15 I mean, I don't -- I mean, nothing -- nothing
16 really changed.
17 Mr. McDaniel: Commissioner, page seven
18 of Claimant's A.P.A. submissions.
19 By Mr. McDaniel:
20 Q When you went to see Dr. White on May
21 21st -- I want to show you two documents and ask
22 you if you can identify those?
23 A Yes.
24 Q All right. And what were -- what was
25 Dr. Mar--- Mar--- Dr. White's opinion as to what

1 was causing your headaches at that time?
2 Ms. Barr: Objection. The medical
3 records speak for --
4 The Witness: It says --
5 Ms. Barr: -- themselves.
6 The Witness: It says right there --
7 The Court: I'll let him answer --
8 By Mr. McDaniel:
9 Q What was your understanding?
10 A What I understood him saying was the
11 paint fumes were the cause of it. Period.
12 Ms. Barr: That's hearsay and I ask
13 that it be stricken. What I heard him say.
14 The Court: Well, he -- he can tell me
15 what -- he said that was his understanding, so I
16 -- I'll allow --
17 Ms. Barr: So it's hearsay. It's based
18 on hearsay.
19 Mr. McDaniel: Well, as a matter of
20 fact, all these written reports we -- I'll always
21 argue that to The Commissioner all the time.
22 The Court: Yeah.
23 By Mr. McDaniel:
24 Q However -- okay. Now, also --
25 Ms. Barr: I'm just trying to speed us

1 along.
2 By Mr. McDaniel:
3 Q What did he do as far as work at that
4 time?
5 A He gave me a work excuse for one and he
6 gave me the other --
7 Q Okay.
8 A -- to take me out of work.
9 Q Okay. And what did you do with these?
10 A I gave 'em to Mr. Stegner.
11 Q Okay. All right. Now, have you been
12 out of work ever since then?
13 A Since May 20 -- whatever it was, yeah.
14 Q Now, I've got another one -- another --
15 Mr. McDaniel: Page eight,
16 Commissioner, and page nine.
17 By Mr. McDaniel:
18 Q I'm going to show you these two. And
19 let's look at -- first, the one at page nine,
20 prescription by Dr. White. And it looks like he
21 saw you in September -- or July on that one. When
22 -- did he give you another work excuse to be out
23 of work?
24 A Yes, sir, to give to 'em.
25 Q Okay. And what did you do with that

1 one?
2 A Gave it to Mr. Stegner.
3 Q Okay. And there's another one here in
4 September 15th.
5 A I always give 'em to Mr. Stegner.
6 Q All right. Now, is that the last time
7 you -- you saw Mister -- Dr. White or do you
8 remember the last time you saw him?
9 A I don't remember the exact day that I
10 did see Mr. White, but it wasn't very long after.
11 Q When you first started treating with
12 Dr. White way back in 2012, how were you paying
13 for those back in 2012 when you first started
14 seeing him?
15 A I had --
16 Q Was he accepting your insurance?
17 A I had insurance, yes, sir.
18 Q Okay. When you returned to see him in
19 2015, did he take your insurance?
20 A No, sir.
21 Q Okay. So how -- how were those visits
22 paid for?
23 A It was out-of-pocket expense. I had to
24 borrow the money if I didn't have it.
25 Q Okay. So -- and -- and -- and when you

1 saw him in July and the September...
2 Ms. Barr: Objection. Facts not in
3 evidence. The last record for Dr. White for an
4 office visit was May 21, 2015, which was in
5 accordance with Dr. White's deposition testimony
6 that he has not seen him since May 21st of 2015.
7 The Court: Okay.
8 Mr. McDaniel: Commissioner, page 13.
9 Ms. Barr: All right, excuse me. July
10 16th, 2015.
11 Mr. McDaniel: Oh, I -- I -- I'm --
12 Ms. Barr: He did not see him in
13 August. Is there an August report you want to
14 point to, Preston? I'm sorry. I missed that one.
15 Mr. McDaniel: First one, I said
16 September.
17 Ms. Barr: Okay. So there's a
18 September office visit? Because that's not in
19 here.
20 By Mr. McDaniel:
21 Q Did Dr. White on September 15th give
22 you an out-of-work statement?
23 Ms. Barr: He testified he doesn't
24 remember when he last saw Doctor -- Dr. White.
25 Mr. McDaniel: Again, Commissioner, I'd

1 appreciate it if she would address -- I -- I --
2 last time I checked --
3 Ms. Barr: Again, it was --
4 Mr. McDaniel: I'm not --
5 Ms. Barr: This was the same
6 objection --
7 Mr. McDaniel: I'm not The
8 Commissioner.
9 Ms. Barr: -- that these were facts not
10 -- not in evidence.
11 The Court: Okay.
12 Ms. Barr: And -- and there's no office
13 note from September. And it's contrary to
14 testimony of -- of Dr. White and the claimant
15 testified he doesn't remember when he last saw
16 him, so I would object to questions that are
17 suggesting that he saw him another time as both
18 leading and improper without a foundation.
19 Mr. McDaniel: Well, until we stipulate
20 he saw him July 16, 2015.
21 Ms. Barr: The medical records speak
22 for themselves, Preston.
23 Mr. McDaniel: That's a good idea.
24 Thank you.
25

1 By Mr. McDaniel:
2 Q All right. Now, when you went out of
3 work with the school district, did you get your --
4 tell me what happened to your insurance.
5 A Well, I had insurance for a couple
6 months, but it was dropped because I couldn't pay
7 for it.
8 Q Okay. Back in the spring, how -- and
9 tell me about your ability to get any kind of
10 medical care between, let's say July and through
11 the spring of this year.
12 A Well, I mean, I have to pay for my
13 medic--- medical care. But I had to go down there
14 to that -- I call it the Obama care act. I don't
15 know what it's called, but I've had to go through
16 them to get insurance.
17 Q And you now have an insurance policy.
18 And who's treating you now?
19 A My family physician or my neurologist.
20 Q So you've got two doctors. Who are
21 those?
22 A Jennifer Lynch at CareSouth, she's my
23 medical doctor.
24 Q Okay.
25 A And Dr. Healy, my neurologist.

1 Mr. McDaniel: I want to refer to some
2 records, Commissioner, just for purposes of
3 medications. Let me refer to page --
4 Ms. Barr: Your Honor --
5 Mr. McDaniel: -- tab nine.
6 The Court: I'm -- I'm --
7 Ms. Barr: The -- this reference to
8 this Dr. Lynch who's treating him, Dr. Lynch like
9 Dr. Healy was not disclosed on their Form 50. So
10 we're going to ask to leave the record open so
11 that we can obtain those records since that
12 information was withheld from us. We ask that the
13 record remain open for the same.
14 Mr. McDaniel: Well, I object to the
15 fact that they're saying we're holding rec---
16 withholding records.
17 Ms. Barr: Well, you withheld the
18 information that was to be disclosed on the Form
19 50, na--- namely who's treating him.
20 Mr. McDaniel: Commissioner -- okay.
21 The Court: I'll -- I'll leave -- I'll
22 leave the record open --
23 Mr. McDaniel: We didn't list --
24 The Court: -- so you can --
25 Ms. Barr: Thank you, Your Honor.

1 The Court: Okay. That's fine.

2 Mr. McDaniel: And that -- that's fine.

3 If she wants to take his deposition -- or her

4 deposition that's fine.

5 Ms. Barr: No, I -- I want to subpoena

6 her records.

7 The Court: Okay.

8 Mr. McDaniel: All right. Now,

9 Commissioner, under nine, I simply want to -- in

10 -- in reference to the Carolina hospital records

11 where he was seen in July, I simply want to go

12 over the list of medications, a couple of these,

13 and just ask him --

14 By Mr. McDaniel:

15 Q In -- in reference to your medications

16 there at the hospital, you record as--- they

17 record aspirin, lisinopril, Lorcet. Who's

18 prescribing that and what was that for?

19 A The -- which one?

20 Q The Lorcet.

21 A The Lorcet, Lynch.

22 Q And what's she prescribing it for?

23 Ms. Barr: Objection.

24 The Witness: For pain.

25 Ms. Barr: It's hearsay.

1 The Witness: It's not hearsay.
2 Ms. Barr: We don't even have these
3 records.
4 By Mr. McDaniel:
5 Q What's your understanding --
6 The Court: All right. Sustained.
7 Mr. McDaniel: Well, you have these
8 records.
9 Ms. Barr: Of Dr. Lynch?
10 Mr. McDaniel: The got -- these records
11 here. They're from the hospital. I'm just trying
12 to establish --
13 Ms. Barr: He's talking about what Dr.
14 Lynch is prescribing.
15 By Mr. McDaniel:
16 Q Okay. I'm just -- I'm just trying to
17 establish what medications you're currently
18 taking. Are you taking methazopril (ph)? Okay.
19 The Court Reporter: Was that a no? I
20 didn't...
21 By Mr. McDaniel:
22 Q Okay. Well, let me --
23 A What is that?
24 Q -- spell that,
25 M-E-T-H-I-M-A-Z-O-L-E.

1 A Yes.
2 Q Okay. Nexium?
3 A Yes.
4 Q All right. And you're taking Prozac?
5 A Yes.
6 Q And you're taking Valium?
7 A Yes.
8 Q Okay. And aspirin?
9 A Yes.
10 Q And lisinopril?
11 A Yes.
12 Q Is that pretty much the medications
13 you're on now?
14 A Yes, sir.
15 Q Okay. Now -- okay. Mr. Barr, have you
16 worked anywhere since May 2015?
17 A No, sir.
18 Q What -- tell The Commissioner what your
19 days are like, what kind of problems you're having
20 in reference to your headaches and the other
21 problems you're having.
22 A Well, I mean, I -- I get disoriented.
23 I get confused. My memory's shot. I can't
24 remember anything. I mean, I just get -- I mean,
25 I can sit here one minute and the next minute I'm

1 just extremely fatigued to where I'm -- just pass
2 out like I'm going to sleep.
3 Q Tell me about your fatigue. Tell --
4 can you give us an example of like anything you
5 try to do?
6 A Well, I mean, I try to cut my own
7 grass. I don't have anybody else to do it, but my
8 son and he's in school, so I try to do it and
9 can't do it.
10 Q What about your headaches?
11 A Every day.
12 Q Are there days that are worse than
13 others?
14 A Some days, but I don't know what day.
15 I mean, it's -- might be today, it might be
16 tomorrow.
17 Q Would you -- would you like to go back
18 to work?
19 A I'd like to. Love to.
20 Q Well, right now in -- in your opinion,
21 what's preventing you from going back to work?
22 A The same thing. My headaches and the
23 fatigue. I mean, 'cause -- I mean, if I work two
24 hours and miss six, I don't get paid. If I -- if
25 I work six and miss two, I don't get paid. I

1 mean, so -- I mean, I can't hold a eight-hour day
2 down.
3 Q And -- and -- and what would prevent
4 you, again, your headaches and -- and -- your
5 fatigue? Is that...
6 A Yes, sir.
7 Q Now, what kind of treatment is Dr.
8 Healy providing for you?
9 A He's trying me on different medications
10 to try to get the headaches under control.
11 Q All right. Also --
12 A And I'm also on a CPAP.
13 Q He admitted you to the hospital and did
14 all kind of tests, too.
15 A Yes, sir.
16 Q Including a E.E.G.
17 A Yes, sir, overnight.
18 Q What would you like for The
19 Commissioner to do today? What do you want?
20 A I want my life back.
21 Q Let me ask you this, if you -- we could
22 -- if they can get your headaches under control
23 and get your fatigue corrected some, do you -- do
24 you want to go back to work?
25 A I'd like to, yes, sir.

1 Q Do you believe if we could get the
2 headaches under control and the fatigue, that you
3 would handle a job?
4 A Yes, sir, I -- I mean, if I can get it
5 under control, I'd be more than happy to go.
6 Mr. McDaniel: Commissioner, I have no
7 further questions of Mr. Barr. Mr. Barr, answer
8 any questions Ms. Barr has for you.
9 The Witness: Yes, sir.
10 The Court: Thank you, sir. Ms. Barr?
11 C R O S S - E X A M I N A T I O N
12 By Ms. Barr:
13 Q Thank you. Mr. Barr, we met before
14 obviously, but my name is Kirsten Barr. And I
15 represent the Darlington County School District in
16 your worker's compensation claim. You testified
17 just a little while ago about your use of a
18 respirator at -- at work in the Darlington County
19 School District. And you said you sometimes used
20 it. Is that what you said here today?
21 A Outside, I never used it.
22 Q All right. What about inside?
23 A Mostly always.
24 Q All right. And in fact --
25 Ms. Barr: And, Your Honor, this is the

1 original of the claimant's deposition transcript
2 that I'm going to submit.
3 The Court: Okay. Thank you.
4 (Defendant's exhibit number 5
5 marked for identification.)
6 Ms. Barr: And I may need to use that
7 for --
8 The Court: Oh, okay.
9 Ms. Barr: -- Mr. Barr's edification if
10 you don't mind. I apologize.
11 The Court: Sure.
12 Ms. Barr: My copies seem to have come
13 up short.
14 The Court: That's okay.
15 By Ms. Barr:
16 Q And for the record, I'm going to refer
17 you to page 39. Do you remember having your
18 deposition taken at -- at Mr. Malloy's office?
19 A Yes, ma'am.
20 Q All right. So you were asked -- at
21 your deposition, you were asked how long have you
22 had a re--- respirator and how did you respond?
23 A Do what, now? I was trying to read.
24 Q The question was how -- how long have
25 you had a respirator? And your response was ever

1 since I started. Is that right? That's your
2 testimony at line five of page 39 of your
3 deposition transcript --
4 A Oh, yeah. Yeah, I see that answer
5 question. Yeah.
6 Q All right. And I asked you how often
7 do you use your respirator? And what was your
8 testimony? You said every job that -- I mean, if
9 I had a job on the inside, I used it. Is that
10 correct?
11 A Right. That's what it says here on the
12 deposition.
13 Q All right. And then you were asked, so
14 did you ever paint inside without the use of the
15 respirator? And your response was, I can't think
16 -- I can't remember of an instance when I haven't
17 had a respirator. Is that correct?
18 A That's what it says.
19 Q All right. And you stand by that
20 testimony as being correct today?
21 A That's -- that's what it says.
22 Ms. Barr: All right. To the extent
23 that it conflicts with the claimant's testimony on
24 direct examination, we would submit that for the
25 purpose of impeachment.

1 The Court: Thank you.
2 By Ms. Barr:
3 Q Now, Mr. Barr, you also mentioned the
4 fact that you've been told for a long time that
5 you had vertigo. Is that right?
6 A Do what, now?
7 Q That people -- doctors have been
8 telling you that you had vertigo for a long time,
9 have they not?
10 A A few times, yeah.
11 Q All right. In fact you were first
12 diagnosed with vertigo by your family -- old
13 family doctor, Dr. Chapman, back in 2005. Is that
14 right?
15 A I had an incident, yes, ma'am.
16 Q All right. And he was actually
17 treating you with prescription medications for --
18 for vertigo back in -- as early as 2005, correct?
19 Mr. McDaniel: Can we refer to a...
20 Ms. Barr: It's page 247 of the
21 A.P.A.'s, Your Honor.
22 The Court: Thank you.
23 Ms. Barr: The records of his family
24 physician, Dr. Chapman, where it says vertigo for
25 four years. It's a note dated April 20th of 2005.

1 The Court: And you said 247. Is that
2 correct?
3 Ms. Barr: Yes, Your Honor.
4 The Court: Thank you.
5 Ms. Barr: It's under tab ten.
6 By Ms. Barr:
7 Q So you don't de--- deny that you were
8 actually diagnosed with and treated for vertigo
9 years before you ever came to work at the
10 Darlington County School District?
11 A I had an episode one time.
12 Q All right. Well, this record says you
13 had vertigo for four years beginning 2005.
14 A I don't know anything about four years.
15 I know I remember having an episode, a terrible
16 episode, one time when I was working at Suburban.
17 Q All right. Can you explain why -- I
18 mean, Dr. Chapman -- or Dr. Woodberry was your
19 family doctor. This is Dr. Woodberry, excuse me.
20 A I don't even know who the heck
21 Woodberry is.
22 Q Okay. All right. Dr. Chapman has also
23 been treating you for fatigue, problems with
24 fatigue long before your employment at the
25 Darlington County School District. Isn't that

1 right?

2 Ms. Barr: I'm referring to page 250 of

3 the A.P.A.'s, Your Honor.

4 The Witness: Not that I can recall.

5 By Ms. Barr:

6 Q All right. If Doctor -- Dr. Chapman's

7 records indicate that he was seeing you for your

8 own complaints of fatigue back in 2006 and he had

9 suggested that you had a -- perhaps sleep -- you

10 needed a sleep study for possible sleep apnea back

11 then. I mean, you have no reason to doubt Dr.

12 Chapman's records, do you?

13 A I haven't any reason to doubt anyone,

14 no, ma'am.

15 Q Okay. And the same would be true of

16 the -- the complaints of headaches you made for --

17 to Dr. Chapman in 2008 prior to coming to work at

18 the Darlington County School District.

19 Ms. Barr: That's page 252 of the

20 A.P.A.'s, Your Honor.

21 By Ms. Barr:

22 Q Do you deny that Dr. Chapman was

23 prescribing Voltaren for headaches at that point

24 in time?

25 A I don't even remember taking a

1 Voltaren.
2 Q All right. But if Doctor --
3 A I don't even know it is --
4 Q -- Dr. Chapman's records indicate that
5 he prescribed Voltaren for headaches for you in
6 2008, do you deny it?
7 A How can I deny it if you got it on a
8 piece of paper?
9 Q All right. Now, you also testified
10 earlier about seeing Dr. White in 2013 -- or
11 excuse me, 2012. You said he took you out of work
12 for six weeks to see how your headaches do. Is
13 that right?
14 A Yes, ma'am.
15 Q All right. Dr. White's record --
16 Ms. Barr: And I'm looking at page 34,
17 Your Honor.
18 By Ms. Barr:
19 Q -- of November 28th, 2012 when he saw
20 your for a six-week follow up, you were still
21 having headaches even after being out of work for
22 six weeks. Isn't that correct?
23 A Six weeks after.
24 Q Yeah. So six weeks after. You -- you
25 had been out of work for six weeks and you still

1 had headaches, right? And that's what his record
2 said.
3 A I mean, I -- I'm not following you
4 whether you're saying six weeks after I went and
5 took the six weeks out or the six weeks after the
6 six weeks, 12 weeks total?
7 Q Yeah -- no. All right. So you --
8 A So --
9 Q The records indicate that you saw Dr.
10 White on October 17th of 2012 and after that, you
11 went out of work for six weeks. Is that your
12 recollection?
13 A That I'm aware.
14 Q Okay. And then on November 28th of
15 2012, you had a follow-up appointment with Dr.
16 White to determine whether or not that six-week
17 period out of work changed your headaches. And he
18 reported that you were still having headaches at
19 that time.
20 A Not severe, right.
21 Q Well, it doesn't say that. It said you
22 were still having headaches and he thought they
23 were migraines. Is that correct?
24 A Right. I mean...
25 Q All right. You discussed that with Dr.

1 White, the possibility that you were having
2 migraine headaches?
3 A Yes, ma'am.
4 Q All right. And in fact you were still
5 having headaches -- you -- you missed a lot of
6 time for work after you injured your hand. Is
7 that right?
8 A Oh, yeah.
9 Q All right. You had a very severe
10 injury to your right hand and arm?
11 A Oh, yeah.
12 Q You were out of work --
13 A Hand.
14 Q -- for about -- hand. You were out of
15 work for about six months?
16 A I don't know exactly how long it was.
17 I don't think it was six months. I think it was
18 about four.
19 Q And you were actually, during four
20 months away from the work place, still seeking
21 treatment for headaches. Is that right?
22 A I don't recall.
23 Q Okay. Just so we're clear, your --
24 your job -- not only are you wearing a respirator
25 all the time you're painting inside, you testified

1 you wear gloves and you're using a brush and
2 roller to apply -- apply the paints. Is that
3 right?
4 A Most of the time, brush and roller,
5 yes, ma'am.
6 Q All right. You -- you're not using a
7 -- an aerosolized spray paint or using a sprayer
8 of any type?
9 A Sometimes I did, yes, ma'am.
10 Q But rarely?
11 A Rare, but on occasion.
12 Q All right. And you would wear your
13 respirator if you did that, correct --
14 A Oh, yeah. Most definite.
15 Q And in your testimony you had said --
16 Ms. Barr: And Your Honor, it's page 76
17 of his deposition.
18 The Court: Thank you.
19 By Ms. Barr:
20 Q -- that you used both a particulate and
21 a fume filter at all times when you were using
22 that respirator.
23 A You can't use both at the same time.
24 Q You said you always had both filters.
25 A On hand. I never -- you can't put a

1 filter on top of a filter, no. That would be
2 stupid.
3 Ms. Barr: Your Honor, I -- I'll just
4 refer you to his deposition testimony at page 76.
5 The Court: Thank you.
6 By Ms. Barr:
7 Q All right. You've also been treated
8 over the years not only for your -- your problem
9 with your hand that you required narcotic
10 medications for your hand injury, right?
11 A Yes, ma'am.
12 Q And you've also for a long time had
13 problems with your low back and for your neck?
14 You've been treating for those problems, low back
15 and neck pain?
16 A Yes, ma'am.
17 Q But you have not seen Dr. White in over
18 a year. Is that correct?
19 A No, ma'am.
20 Q You have not?
21 A No, sir.
22 Q All right.
23 A No, ma'am.
24 Q You've also been treated over the years
25 even prior to your employment at the Darlington

1 County School District with -- with anxiety?
2 A Oh, yeah. I've had anxiety attacks
3 before, yes, ma'am.
4 Q Okay. And they were treating you for
5 anxiety attacks even before you came to work at
6 the school district?
7 A Oh, yeah. Most definite.
8 Q Okay. All right. You're a smoker,
9 aren't you?
10 A I am stopping. I am down to a half a
11 pack, thank you.
12 Q All right. Thank -- congratulations.
13 You're a long time smoker. Is that right?
14 A I say, yeah.
15 Q All right. For example in May of 2015,
16 how -- how many packs a day did you smoke?
17 A I wouldn't say no more than a pack,
18 maybe a pack and a half at the most.
19 Q All right. How long were you a pack to
20 a pack and a half a day smoker?
21 A I don't know. I don't record that.
22 Q Okay. You smoked for a long time?
23 A A good bit.
24 Q All right. And you still smoke a half
25 a pack of cigarettes a day?

1 A Some days not even a half.
2 Q When did you go down to a half a pack
3 of cigarettes from a pack to a pack and a half?
4 A When you can't afford 'em.
5 Q But your doctors have counseled you on
6 the -- the need to stop --
7 A Oh, yeah.
8 Q -- smoking --
9 A Yes, ma'am.
10 Q -- repeatedly, right?
11 A Yes, ma'am.
12 Q Okay. This business you had on the
13 side, Kenny's Painting, you continued to operate
14 Kenny's Painting on the side after you were hired
15 by the Darlington County School District, did you
16 not?
17 A I've only had a few jobs while I was
18 working.
19 Q And you did not use a respirator while
20 you were working on your side jobs for Kenny's
21 Painting, did you?
22 A Yeah.
23 Q Did you take the one from the school
24 district?
25 A No.

1 Q All right. So you wore a respirator
2 when you were --
3 A I have my personal.
4 Q -- painting?
5 A Yes, ma'am.
6 Q All right. So you really always wore a
7 respirator when you were painting --
8 A I mean, if I'm spraying or anything
9 like that and not being -- yeah.
10 Q All right. Did you spray a lot in your
11 personal business, Kenny's Painting?
12 A Not a lot.
13 Q More than you did at the school
14 district?
15 A Somewhat 'cause it was at my disposal
16 'cause it was personally mine.
17 Q Okay. And you wear glasses. Is that
18 correct?
19 A Yes, I do.
20 Q All right. So all the times you would
21 have been painting over the, say, last five to ten
22 years, you'd be wearing your eye glasses?
23 A I mean, you have to, yeah.
24 Q Okay. Well, some people wear contact
25 lenses. And I'm just trying to make sure that

1 your eyes were protected with glasses --
2 A Glasses only.
3 Q Okay.
4 A And goggles, yeah.
5 Q All right. When you began seeing Dr.
6 Healy, he did a sleep study for you. Is that
7 right? Do you remember that?
8 A Yes, ma'am.
9 Q All right. As a result of that sleep
10 study, he gave you a CPAP machine. Is that right?
11 A Yes, ma'am. I'm -- yeah, I'm on a CPAP
12 as of today. Yeah.
13 Q As of this very day? I mean, when did
14 you --
15 A Yes, ma'am.
16 Q All right. When -- when did you get
17 the CPAP?
18 A It's in your records. I don't know the
19 exact day.
20 Q All right. So it looks here that after
21 he did a sleep study for you on April the 27th of
22 2016, your sleep apnea was so severe he told you
23 you needed to start using the CPAP machine
24 immediately?
25 A Yes, ma'am.

1 Q And how long did -- after that did it
2 take you to get the CPAP machine?
3 A I don't remember. It was a week maybe.
4 Q Okay. And he also discussed with you
5 restless leg symptoms; your legs move while you're
6 sleeping?
7 A Yeah, possibly. Yes, ma'am.
8 Q All right. And you actually -- he
9 prescribed a medication, Requip, for that restless
10 leg problem, did he not?
11 Ms. Barr: And Your Honor, this is page
12 222 of the A.P.A.'s.
13 The Court: Thank you.
14 The Witness: If it's a generic -- I
15 don't know. I mean, if it's --
16 By Ms. Barr:
17 Q You're taking medicine for the --
18 A Yeah.
19 Q -- for the sleep apnea and your
20 restless leg?
21 A I don't know what it's called.
22 Q Does Dr. Skin--- or excuse me. Does
23 Dr. Healy prescribe anything other than the
24 medications for your sleep apnea and your restless
25 leg syndrome?

1 A Depakote.
2 Q And then you say the other medications
3 you get from Jennifer Lynch at CareSouth?
4 A Yes, ma'am. It was just transferred.
5 Yes, ma'am.
6 Q All right. How long has Jennifer Lynch
7 at CareSouth been treating you?
8 A I'm not sure. It's been this year. I
9 don't know.
10 Q Since the beginning of 2016?
11 A I wouldn't say the beginning.
12 Q All right.
13 A I don't exactly know, maybe February,
14 March -- maybe. I'm not sure.
15 Q All right. I want to go through a few
16 things. Looking at the records of Dr. White --
17 Ms. Barr: And Your Honor, I'm looking
18 at page four of the A.P.A.'s.
19 By Ms. Barr:
20 Q Dr. White described the headaches you
21 complained about that you -- you would wake up in
22 the morning with headaches. Is that true?
23 A Some days.
24 Q All right. So you wake up with
25 headaches and then you feel tired all day?

1 A Some days.

2 Ms. Barr: And then, Your Honor, I'm

3 looking at page 88.

4 By Ms. Barr:

5 Q A lot of times your headaches start at

6 home before you even go to work.

7 A I wouldn't say that, no.

8 Q All right. When you went to the

9 hospital -- do you deny that you went to the

10 hospital on March the 16th of 2015 complaining of

11 dizziness, confusion, of headache that occurred at

12 home?

13 A I don't even know what day it was.

14 Q Okay.

15 A What day was it?

16 Q March -- March the 16th of 2015.

17 A What day was it?

18 Q I don't know what day of the week that

19 was.

20 A I don't either. So it could -- I mean,

21 if it was during the week at a certain time of the

22 day, I wouldn't be at home.

23 Q All right. But if you told the

24 hospital that this headache occurred at home -- I

25 mean, you wouldn't have lied to them, would you?

1 A I wouldn't lie to you, no.
2 Q Okay. And you described this incident
3 when you got confused on your way to Lowe's. Is
4 that right?
5 A Yes, ma'am.
6 Q You said that prior -- immediately
7 prior to that, you were -- you spoke with the
8 principal. Is that right?
9 A Yes, ma'am.
10 Q At the school? So you spoke with the
11 principal and then you went to Lowe's. Is that
12 right?
13 A Ten minutes later, yes, ma'am.
14 Q Okay. And even though you hadn't done
15 any painting that day, you say you were confused?
16 A I mean, yeah -- I mean, it was like it
17 hit me, yeah.
18 Q Okay.
19 A Riding down the road.
20 Ms. Barr: That's all the questions I
21 have, Your Honor. Thank you.
22 The Court: Okay. Thank you, Ms. Barr.
23 Mr. McDaniel? Wait -- wait just a second. I
24 think your attorney may have some --
25 The Witness: Oh, I'm sorry.

1 R E D I R E C T E X A M I N A T I O N

2 By Mr. McDaniel:

3 Q Mr. Barr, just -- just a couple of

4 brief questions.

5 A Yes, sir.

6 Q In reference to -- Ms. Barr referred

7 you to treatment by Dr. Chapman in February of

8 2008 in which you said that you were prescribed --

9 Dr. Chapman treated you for a headache. Do you

10 remember her asking you that?

11 A I -- Miss -- Ms. Barr, here? Yes, sir.

12 Mr. McDaniel: All right.

13 Commissioner, page 52 -- 52.

14 By Mr. McDaniel:

15 Q According to the records of Dr.

16 Chapman, your chief complaint that day was sinus

17 pressure and congestion and that you were having

18 -- that you were having sinus pressure in the

19 frontal maxillary ar--- area --

20 Mr. McDaniel: Maxillary area, Madam

21 Court Reporter --

22 By Mr. McDaniel:

23 Q -- and that you were having frontal

24 headaches along with that, that you were wheezing

25 and that you had a mild cough. So were -- did you

1 have problems -- do you remember having problems
2 in the past with sinus congestion and sinuses?
3 A On occasion, yes.
4 Q And so he treated you -- whenever you
5 had had those sinus congestions and -- and sinus
6 problems, did you have headaches?
7 A Yes, sir. I mean, I felt like a pin
8 cushion, but, yeah.
9 Q All right. Now, in reference to Dr.
10 Healy, is it consistent that you went to see him
11 and you were asking for treatment in reference to
12 your headaches? Is that why you went to see him?
13 A Yes, sir.
14 Q And if his record reflects that he was
15 doing testing in reference to persistent
16 headaches, memory loss and chronic headaches,
17 would that be consistent --
18 Ms. Barr: Objection to leading.
19 By Mr. McDaniel:
20 Q -- while you were -- would that be
21 consistent with why you were seeking treatment for
22 your headache?
23 A Yes.
24 The Court: I'll allow -- I'll allow
25 that. All right.

1 Mr. McDaniel: Nothing further for this
2 witness.
3 The Court: Okay. Thank you. Ms.
4 Barr?
5 Ms. Barr: Your Honor, we'll rely on
6 the medical records, the testimony of the experts
7 we've deposed and then with reserving that right
8 to leave the record open for both the records of
9 Dr. Lynch and the deposition of Dr. Healy.
10 The Court: Okay. And if you'll just
11 -- like I say, particular with Dr. Lynch, I -- I
12 know you already have the other one scheduled, but
13 if you'll let -- just communicate with Barbara --
14 Ms. Barr: I -- I will. I -- I've
15 already communicated with my office to -- to have
16 a subpoena sent today so that --
17 The Court: Okay.
18 Ms. Barr: -- we -- well, she gets 10
19 days, so...
20 The Court: All right. Well, I
21 appreciate it. And -- all right. Well, then
22 there'll be nothing further and that concludes the
23 hearing --
24 Mr. McDaniel: Dr. Lynch and Doctor...
25 The Court: Healy.

1 Mr. McDaniel: Healy.
2 Ms. Barr: Thank you, Your Honor.
3
4 (Whereupon, the foregoing proceedings were
5 concluded at 1:02 p.m.)
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1 CERTIFICATE OF REPORTER

2 State of South Carolina

3 County of Florence

4

5 I, Ashley Rogers, Court Reporter and Notary

6 Public for the State of South Carolina, do hereby

7 certify that the transcript of the foregoing

8 proceedings contains a true record of the hearing

9 in the above-captioned cause.

10 I further certify that I am neither attorney

11 nor Counsel for, nor related to or employed by any

12 of the parties connected to the action, nor am I

13 financially interested in the action.

14 Witness my hand at Florence, South Carolina,

15 this the 14th day of September, 2016.

16 __________________________

17 Ashley Rogers

18 MY COMMISSION EXPIRES:
March 15, 2022

19

20

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24

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BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO.: 1507304

Kenneth L. Barr, Employee/Claimant, vs. Darlington County School District, Employer, and SC School Boards Insurance Trust, Carrier, Defendants.	DEPOSITION OF: R. JOSEPH HEALY, JR., M.D.

Deposition of R. JOSEPH HEALY, JR., M.D., taken before Laura W. Little, Verbatim Reporter and Notary Public in and for the State of South Carolina, at offices of Dr. R. Joseph Healy, 805 Pamplico Highway, Suite A130, Florence, South Carolina, commencing at 5:30 p.m. on the 27th day of September, 2016.

Laura W. Little
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COPY

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1 INDEX

2 PAGE-LINE

Direct Examination by Ms. Barr 5-3
3 Cross Examination by Mr. McDaniel. 35-23
Redirect Examination by Ms. Barr 44-12
4 Recross Examination by Mr. McDaniel. 47-1

5

6

7

8

9

10 EXHIBITS

11 NUMBER DESCRIPTION PAGE-LINE
(No Exhibits Proffered)

12

13

14

15

16

COURT REPORTER'S NOTES:
17 ---Indicates Interruption;
--Incomplete Sentences; Trailing Off.
18

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1 STIPULATIONS

2 Prior to the giving of any testimony by the
3 witness, it was expressly stipulated and agreed
4 the parties to this action, through their respective
5 counsel, that:

6 By Notice and/or Consent, said deposition is
7 taken in accordance with Section 42-3-160, Code of
8 of South Carolina 1976, and Rule 30 of the South
9 Carolina Rules of Civil Procedure, which shall control
10 the taking of said deposition and its use thereof;
11 deposition shall be taken for the purpose of discovery
12 and/or for use as evidence in the above-entitled
13 action, or for both purposes;

14 That all objections would be reserved until the
15 time of the trial except as to the form of the
16 question;

17 Reading and signing of the transcript of
18 by the witness was waived.

19

20

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25

1 R. JOSEPH HEALY, JR., M.D.,
2 after first being duly sworn, was deposed as follows:
3 DIRECT EXAMINATION BY MS. BARR:
4 Q. Thank you, Dr. Healy. Again, I'm Kirsten
5 Barr and I represent the School District in a Workers'
6 Compensation claim filed by your patient, Mr. Kenneth
7 Barr. I asked you here today for your deposition
8 well, number one, to help us read your handwriting if
9 nothing else.
10 A. It's very good.
11 Q. I know you do your best. But to help you,
12 help us with some of those records, and I want to ask
13 you some questions about your treatment of Mr. Barr
14 the opinions you've given in his claim.
15 A. Yes.
16 Q. So everything should -- my intent is for my
17 questions to be straightforward and to make sense, but
18 if they don't, please ask me to repeat or rephrase my
19 questions and I'm happy to do so. Dr. Healy, from the
20 records that, that y'all were kind enough to provide
21 us, it looks like you initially saw Mr. Barr on March
22 31st of 2016, is that right?
23 A. Yeah.
24 Q. Do you know who he referred you to or
25 referred him to your practice?

1 A. I believe -- wait, I'm trying to find my
2 note, because it says on there.
3 Q. And that's part of what we want to do, too,
4 is make sure we have all the records, so.
5 A. Right. The first visit is always the
6 handwritten note that I do.
7 Q. Okay.
8 A. That's it. And it doesn't say.
9 Q. Okay. And do you know when he initially
10 to you on the 31st of March, did he have -- was he
11 accompanied by any medical records or any prior
12 for your review?
13 A. I don't know that there are any records.
14 wife accompanied him and this initial visit is always
15 just gathering all the information, doing an exam and
16 lots of times, I don't want to see anything until I've
17 seen the patient and heard from them.
18 Q. Okay.
19 A. But I did see some of his records at some
20 point.
21 Q. Okay. And what, what records did you review
22 that came from somewhere other than your practice?
23 A. Oh, I'm not sure. I think that Mr. McDaniel
24 sent me the records.
25 Q. Okay.

1 A. But I've seen his toxicology report.
2 Q. Okay.
3 A. And everything else that I believe I have, I
4 generated.
5 Q. Okay. All right. And when he came to you,
6 then the history you obtained would have been from Mr.
7 Barr himself or from his spouse?
8 A. Yes.
9 Q. Okay. And what was the history that he gave
10 to you?
11 A. Well, essentially, that he was a painter for
12 twelve years, six years with the school system. He
13 been taken out of work about a year before I saw him,
14 maybe a little less, due to chronic headache and
15 fatigue, and he told me about his history of the
16 painting and the exposure to the VOCs.
17 Q. Did he tell you that he always wore a
18 respirator when he was painting indoors?
19 A. Well, I remember asking him about it, and I
20 think that what he'd said was he wore it sometimes.
21 did talk about that.
22 Q. All right. Now, you also noted that he was
23 smoker?
24 A. Yeah.
25 Q. Do you know what kind of pack history or

1 -- how much he smoked?

2 A. Long-standing. He had a significant

3 Q. Okay. And would a significant smoking

4 history or active smoking habit, could that have an

5 impact on chronic headaches?

6 A. Oh, yeah.

7 Q. Okay. What is, what is -- do you really

8 understand -- not you, personally, but do we as a

9 society have an understanding of why there's a

10 relationship between the two; I mean, does smoking

11 cause to make it worse or even cause headaches?

12 A. Well, smoking puts carbon monoxide in your

13 blood. Your red blood cells can't tell the difference

14 between oxygen and carbon monoxide. The difference

15 being that if a red cell hooks onto oxygen and it goes

16 to your big toe, it can let go of the oxygen. If it

17 hooks onto carbon monoxide, it's a permanent bond, so

18 you render blood cells useless and, as a matter of

19 fact, if you're a big enough smoker, your body thinks

20 there aren't enough blood cells because it isn't

21 getting oxygen and it makes more which can be a

22 problem, but I think it's the hypoxia, the resulting

23 fatigue, things like that.

24 Q. Okay. So the, so the smoking could affect

25 the symptoms of both the headaches and the fatigue

1 complaints?
2 A. Definitely, the fatigue.
3 Q. Okay.
4 A. You know, headache, it depends on how much
5 a smoker you are.
6 Q. Okay. Did you get an idea from Mr. Barr
7 his habit was?
8 A. Well, I know that he is a what I would call
9 heavy smoker.
10 Q. Okay.
11 A. I talked to him several times about you need
12 to get rid of these.
13 Q. Okay. And then you also it appears got a
14 list of medications that he was taking --
15 A. Yeah.
16 Q. -- at the time he came to you?
17 A. Yeah.
18 Q. And the three medications: Tapazole, that's
19 for the hyperthyroid?
20 A. Yes.
21 Q. Okay. And I always mispronounce it,
22 Lisinopril?
23 A. Lisinopril, right.
24 Q. And that's for high blood pressure?
25 A. Right.

1 Q. Okay. And then hydrocodone, is that the
2 third that you have listed?
3 A. Correct.
4 Q. Do you know who was prescribing the
5 Hydrocodone for him or why?
6 A. Well, his primary care. I'm not sure who
7 that was and it was for his discomfort.
8 Q. Okay. Now, cannot hydrocodone contribute to
9 or exacerbate chronic headaches?
10 A. Well, if you take enough of it, it's
11 possible.
12 Q. And, in fact, there's a possibility of a
13 rebound effect?
14 A. The chronic daily headache that some people
15 have can be related to too much medication whether
16 prescribed or over-the-counter.
17 Q. Okay. Did you have any recommendations for
18 Mr. Barr at that point as far as his use of either
19 over-the-counter analgesics or the prescription
20 medications like hydrocodone?
21 A. Well, what I told him was my job was to find
22 out why you're having the headaches so that we can do
23 something more specific than just take pain medicine.
24 Q. Okay. And it looks like the first one of
25 those things you did was an MRI of the brain on April

1 11th of 2016?
2 A. Yes.
3 Q. And was that revealing at all?
4 A. No. Small vessel disease which you would
5 expect, but nothing else.
6 Q. Okay. On the report we have from the MRI,
7 says diagnosis, "Memory loss and chronic headache."
8 Was there any objective evidence of memory loss or is
9 that based on Mr. Barr's subjective complaints to you?
10 A. That's his complaint.
11 Q. Okay. All right. So then also on April
12 of 2016, I've got from your records a mini-mental
13 status exam?
14 A. Yes.
15 Q. Okay. And is that something you did here in
16 the office?
17 A. Yes.
18 Q. Now, it's my understanding that the mini-
19 mental can be a measure of cognitive impairment or it
20 can be used to screen for dementia, is that, is that
21 correct?
22 A. True.
23 Q. Okay. And it looks from this that Mr. Barr
24 scored a 30 out of 30 on this mini-mental status exam?
25 A. Yes. And in trying to reproduce the

1 pictures, he did everything perfectly.

2 Q. Okay. So he got the highest score you could

3 get on this examination?

4 A. Right.

5 Q. So would that be evidence of normal

6 cognition?

7 A. Yeah, you know, my impression and it often

8 that the memory isn't the issue, it's attention and

9 concentration.

10 Q. Okay. All right. And intention and

11 concentration could be impacted by fatigue or whatever

12 purpose?

13 A. Yes.

14 Q. All right. But even with, with the possible

15 effects of attention and concentration, there was no

16 evidence of any sort of dementia or cognitive

17 impairment on his mini-mental exam?

18 A. I don't believe so.

19 Q. Okay. All right. Now, the next record I

20 have and tell me if I'm incorrect, I believe, is April

21 19th of 2016?

22 A. Yes.

23 Q. And you noted at that point that he was

24 taking headache medication daily?

25 A. Yes.

1 Q. Do you know what that medication was or is
2 that something you were prescribing?
3 A. Well, no. A lot of the over-the-counter
4 medications. I'm not sure that I gave him anything
5 a headache, but he was taking a lot of the over-the-
6 counter medications. He was taking the narcotic at
7 times, and so the question came up of whether he could
8 have chronic daily headache at that point.
9 Q. Okay. And chronic daily headache, is this
10 what we were talking about earlier as far -- is this
11 the rebound headache or what is chronic daily
12 How would you describe it?
13 A. Well, that occurs in people. It's sometimes
14 called rebound or medication overuse headache is the
15 most recent term. But, you know, there are people who
16 if they take a lot of medication for a headache that
17 the medication itself can become a problem as far as
18 causing a headache.
19 Q. So what can you do to address the
20 of a rebound headache or the medication overuse
21 headache?
22 A. Well, if I have somebody in the hospital, I
23 will give them a dose of DHE 45 and typically, if that
24 makes their headache better, then you've made the
25 diagnosis.

1 Q. Okay.

2 A. Now, he -- actually, I'm -- I'll have to see
3 as we go through. I did have him in the hospital, and
4 I'm wondering, I think maybe I did give him a dose.

5 Q. Okay. And you said that was DHE 45?

6 A. Yes. It would be the Discharge Summary, I'm
7 pretty sure, of when I hospitalized him.

8 Q. Okay. And what is DHE 45 just?

9 A. It's Dihydroergotamine which is a vasal
10 active medication that's kind of like -- it's probably
11 stronger than your triptans, kind of like the old
12 Cafergot.

13 Q. Okay. And it could trigger a headache and
14 help you or is it?

15 A. Well, no. It can take away a headache that
16 is thought to be medication overuse headache or
17 or chronic daily.

18 Q. And it looks like you note, you commented on
19 the smoking again and the possibility of a pulmonary
20 evaluation, is that right?

21 A. Right.

22 Q. Okay. And just looking at your notes, it
23 looks like COPD was a question mark?

24 A. Right.

25 Q. And chronic headache or question rebound.

1 Would, would there be a different type of chronic
2 headache or the chronic daily headache? Is a rebound
3 subset of that or are they the same thing?
4 A. Well, I mean, there are certainly people
5 are in such an emotional state that they just have
6 headaches and they're constant and usually the clue is
7 that if you had developed your headache and you go to
8 bed and you wake up and it's still there, then there's
9 typically a psychogenic etiology to that headache.
10 Migraine -- the treatment of ultimately of migraine is
11 sleep.
12 Q. And it sounds like from some of your notes
13 and from what we've seen from other providers and from
14 Mr. Barr itself that he did frequently wake with
15 headaches?
16 A. Yes.
17 Q. Okay. So does that then tell us that
18 perhaps a psychogenic component to his, his headache
19 syndrome?
20 A. Well, no. I mean, in him the whole time I'm
21 thinking, you know, this fellow's breathing is bad.
22 He's got a lot of reasons to be relatively hypoxic,
23 which leads to stress, fatigue and that that might be
24 what causes his headache.
25 Q. Okay. And the waking headache, too, I see

1 that it looks like you, you write sleep disorder here
2 and is that something that you were looking at as a
3 possible cause for the headaches or a factor?
4 A. Yeah, he snored. His sleep was fragmented
5 and it was non-productive in the end.
6 Q. Okay. People with sleep disorders, is the
7 morning headaches or waking with the headaches a
8 finding for them or?
9 A. It can be, yes.
10 Q. Okay. So, and I'm just trying to read your
11 notes up at the top under the date of birth. MRI had
12 negative and EEG negative, is that right?
13 A. Correct.
14 Q. And then to the next thing we have was the
15 sleep study and you did that hear in the hospital or
16 was that?
17 A. I think it was down the street.
18 Q. Okay. So that wasn't the hospitalization
19 talked about?
20 A. No, no.
21 Q. Okay.
22 A. He came in for a couple of days, but the
23 sleep study is an outpatient study.
24 Q. All right. So the sleep study it looks like
25 was done on April 27th of 2016, is that right?

1 A. Yes.
2 Q. Okay. And what was your impression after
3 sleep study?
4 A. Well, it showed that he had severe sleep
5 apnea, and so, I mean, in anybody that has headaches,
6 you got to correct your sleep, you got to correct
7 breathing and then, too, it showed that he was a
8 kicker.
9 Q. Okay.
10 A. He kicks all night long which is a pattern
11 that means you have periodic leg movements of sleep,
12 and so we checked his iron level, which I think it can
13 occur in people that have low iron. So we checked
14 that, and then I put him on Requip at bedtime which
15 quiets that.
16 Q. Okay. So even -- this may seem like a silly
17 question. But sleep apnea, help us understand what
18 that is; what that means?
19 A. Well, what that means is is that you have
20 disruption at night in your breathing which typically
21 is obstructive. You drop your oxygen levels which
22 causes apneic episodes; you stop breathing.
23 Q. Okay. And when you stop breathing is this
24 one of the pieces of, you said, the lack of oxygen
25 contributing to the headaches, so this sleep apnea

1 could be---
2 A. It could, and then you wake up, and so your
3 sleep is fragmented and it's not productive and you're
4 tired the next morning and fatigued all that next day.
5 Q. Okay. And I know we're starting to hear
6 and more on the news about truck drivers and the like
7 and how much sleep we all need, but I would imagine
8 that if the sleep apnea is ongoing for a long period
9 time that there could be other complications from the
10 sleep apnea?
11 A. Well, heart attack, diabetes. The number
12 time for a heart attack is 5:00 in the morning.
13 what happened to Anthony Scalia.
14 Q. Can it lead to some mental effects,
15 confusion---
16 A. Oh, yeah.
17 Q. ---that sort of thing?
18 A. Yeah.
19 Q. Okay.
20 A. People aren't as awake. They're not as with
21 it. Their attention and concentration is bad.
22 Q. Okay. I read something that some people are
23 even considered for dementia or Alzheimer's when
24 sleep apnea is the problem?
25 A. Oh, I see it all the time.

1 Q. Okay. So you got to get -- you said you
2 needed to address the sleep apnea and correct that,
3 his sleep was also affected or impaired by the kicking
4 or the, the periodic limb movement?
5 A. Yes, he had two sleep disorders.
6 Q. Okay. And so, I believe, you said Requip
7 the way to treat that?
8 A. Yeah, the periodic leg movements of sleep is
9 treated with Requip.
10 Q. Okay. And then how do you treat the sleep
11 apnea?
12 A. CPAP.
13 Q. Okay. And it looks like he came back and
14 next note I had was May 4th of 2016?
15 A. Correct.
16 Q. Okay. And is that when you placed him on
17 Requip trial?
18 A. That's when I started the Requip and gave
19 a trial of CPAP at home.
20 Q. Okay. And then there's another line if you
21 can help me.
22 A. Yes, his arterial blood gas---
23 Q. Oh, okay.
24 A. ---on room air was abnormal.
25 Q. Okay. And is that something separate and

1 apart from the sleep apnea or?
2 A. Yes. Yes.
3 Q. So this was a daytime measurement of his
4 arterial blood gas?
5 A. Right. And you can bet that if your blood
6 gas is abnormal during the day when you're awake and
7 upright that it's worse at night.
8 Q. So with the -- what did you -- what's behind
9 that? I mean, is that a part and parcel with the
10 apnea or is that something else?
11 A. The abnormal blood gas?
12 Q. Yes, sir.
13 A. That's due to structural lung disease.
14 Q. Okay. All right. And so could that be
15 playing a role in his headaches and fatigue as well?
16 A. Oh, I think it definitely is.
17 Q. And what -- is there treatment for it? Is
18 that something outside of your wheelhouse? What do
19 do?
20 A. Yes, this is the pulmonologist who I---
21 Q. Okay.
22 A. I think I got him hooked up with a
23 pulmonologist.
24 Q. Okay. All right. And so then the next
25 I assume that PFT for Pulmonary Function Test?

1 A. Testing, yes.

2 Q. Okay. So again for the pulmonologist?

3 A. Right.

4 Q. And then the last note does that say, "Go

5 eye doctor"?

6 A. Yeah, he was -- he would complain that his

7 vision was very poor and getting worse, and so I told

8 him we need to know if you have eye, intraocular

9 problems or if it's not intraocular, then is it the

10 brain.

11 Q. Okay. All right. So I would imagine even

12 poor vision or uncorrected vision, could that lead to

13 headaches?

14 A. It can contribute, yes. Not commonly, but

15 can.

16 Q. All right. And it appears he came back June

17 28th of 2016, is that right?

18 A. Yes.

19 Q. Okay. You mentioned the CPAP and then the

20 PLMS. That's the Periodic Limb Movement?

21 A. Right. And his iron level was borderline so

22 I supplemented it.

23 Q. Okay. All right. And that's what you --

24 that's what it says next to PM -- that's what you're

25 referring after the PL -- PLMS on that line?

1 A. Right. Ferritin level was borderline.
2 Q. Okay. All right. So that, you said, could
3 be contributing to the restless leg or the kicking in
4 his sleep?
5 A. Right.
6 Q. Okay. All right. You mentioned the
7 a heavy smoker. I'm just trying to read again.
8 A. Right.
9 Q. Heavy smoker and palpitations?
10 A. Yes. He was having palpitations. He was
11 having episodes where he would get palpitations. He
12 would get chest discomfort. He would start to
13 and then get disoriented and have his headache
14 worsening. He'd had two episodes the day before and
15 then I started wondering since he was such a heavy
16 smoker and whether or not he had any cardiac issues.
17 Q. Okay. Did he tell you about -- he had a
18 history of anxiety. Could that play a role in the
19 palpitations or the chest discomfort?
20 A. Oh, yeah.
21 Q. All right. And so AMS episodic?
22 A. Yeah. He was having those episodes of the
23 altered mental status.
24 Q. Okay. And then questioned CAD, Coronary
25 Artery Disease?

1 A. Correct.
2 Q. Okay. And so what, what's -- how do you
3 with that, a cardiologist or?
4 A. Yeah. I told him that he needed to see one,
5 and then I told him that since I was going to bring
6 into the hospital to do the long EEG, that I would
7 probably get somebody to see him while he was there.
8 Q. Okay. So, and then the PLMS, I believe it
9 says, "Didn't---
10 A. Yeah.
11 Q. ---get the Requip."
12 A. Right.
13 Q. So couldn't really determine whether or not
14 that was helpful or not?
15 A. Right.
16 Q. Okay. And at that point he had not started
17 the iron supplement?
18 A. No. I had just prescribed it then.
19 Q. Okay. All right. Now, it looks like -- I'm
20 just trying to get it in order. That you did -- you
21 put him in the hospital, admission date July 6th of
22 2016 and that was for the long EEG?
23 A. Right.
24 Q. What is the long EEG? What's the purpose of
25 that?

1 A. Well, it's a better recording in the sense
2 that the brain gets irritable when you go between
3 stages and so sometimes things show up that a routine
4 EEG that might only be made in the awake state doesn't
5 show.
6 Q. Okay. And, and was this long EEG revealing?
7 A. No. No, it looked okay.
8 Q. Okay. Anything else that you had done or
9 were able to determine as a result of that
10 hospitalization?
11 A. Well, he did see the cardiologist.
12 Q. Okay.
13 A. And I think they did a stress test and it
14 unremarkable, so he did okay with that. We had a lot,
15 lot of talking about his smoking.
16 Q. Okay.
17 A. And I think I set him up to go to pulmonary
18 clinic.
19 Q. Okay. And was that because of the smoking?
20 A. His lung function just isn't normal.
21 Q. Okay. Do you know if that was ever
22 accomplished?
23 A. I'm not, I'm not sure.
24 Q. Okay.
25 A. I don't know.

1 Q. All right. Now, the last office note I have
2 is dated July 21st of 2016.
3 A. Yes.
4 Q. Okay. And I assume that's the next one
5 the hospitalization for the EEG and is that your final
6 last time you saw him?
7 A. Right.
8 Q. Okay. How was he doing at that point in
9 time?
10 A. Well, still smoking. Still having
11 Still having these spells where, you know, he becomes
12 somewhat confused, has trouble talking. He still
13 complained of poor memory and apparently he went to
14 eye doctor and was seen to have bilateral retinal
15 hemorrhages.
16 Q. Okay.
17 A. He was -- he's not diabetic. We checked the
18 homocysteine level which was just borderline. He was
19 using his CPAP.
20 Q. Okay. Do you know if he had started the
21 Requip or tried that even?
22 A. Well, I'm not sure that he said. I don't
23 have that in here.
24 Q. Okay.
25 A. And then I decided to give him a trial of

1 Depakote to try and prevent his headaches.

2 Q. Okay.

3 A. And I think that's the last time that I've

4 seen him.

5 Q. Okay. This bilateral retinal hemorrhages

6 that he notes, how might this be playing a part in the

7 constellation of symptoms he's reporting to you?

8 A. Well, he has abnormal vasculature and these

9 -- and it's bilateral, so it's a systemic process and

10 he's not diabetic. He's not the usual player and so

11 is curious, but it certain argues that he has a

12 vasculopathy.

13 Q. Okay. All right. Other than the Depakote,

14 did you have any other recommendations for him that

15 last time you saw him on July 21st of 2016?

16 A. Well, just to make sure you're using the

17 and to quit smoking which I never actually felt he

18 would.

19 Q. Okay. And was the Requip still recommended?

20 A. Yes, he definitely needs to take that.

21 Q. And what about the iron supplement, is that

22 something you just test periodically to see what his

23 iron levels were and to make sure they were optimal?

24 A. Yeah. You know, I put people on it, and

25 what's hard to know is are they better because the

1 or are they better because of the Requip.
2 Q. Okay.
3 A. But at some point if you want to know, then
4 you would stop the supplement and check their iron
5 the road to see if it's back down meaning that they're
6 losing it somewhere or if it's normal meaning that at
7 one time they were a little deficient and now they've
8 been supplemented and now they're normal.
9 Q. Okay. And at that time you'd last seen him
10 on July 21st, any other referrals other than the
11 pulmonology referral?
12 A. No, no other referrals.
13 Q. All right. And so did you have a working
14 diagnosis for him when you saw him on July 21st or was
15 he -- were you still trying to tease out the possible
16 factors in his headaches and fatigue?
17 A. Well, my impression with this guy is that
18 he is a heavy smoker, but to compound his pulmonary
19 problems is his exposure to the VOCs and so he has two
20 pulmonary insults. He has an abnormal blood gas which
21 is essentially his oxygen level was just probably a
22 little bit low, but his carbon dioxide level is too
23 high, so he's retaining carbon dioxide, which, you
24 know, causes the brain to not totally function
25 properly. It's a metabolic problem. But I do think

1 that his exposure to the VOCs combined with his
2 has caused him to have pulmonary problems which lead
3 other problems.
4 Q. All right. Would you defer to a
5 pulmonologist insofar as it concerns any pulmonary
6 injury from Volatile Organic Compounds?
7 A. Well, I would want to see if what the
8 pulmonologist found is consistent with what I think.
9 Q. Okay.
10 A. But, obviously, the pulmonologist and the
11 toxicologist, they're the expert in their areas.
12 Q. Okay. But you're not professing to be an
13 expert in pulmonology or pulmonary injuries?
14 A. No. But I did do internal medicine before
15 neurology, and the guy clearly has pulmonary disease.
16 Q. Okay. And that's not uncommon for heavy
17 lifelong smokers, is it?
18 A. No.
19 Q. Okay. All right. So could you say with any
20 certainly what, what portion of any pulmonary problems
21 he may have would be due to smoking versus other
22 exposures?
23 A. Probably not, and that would be a question
24 for the pulmonologist, but my gut feeling is that it
25 would be hard to breakdown, you know, how much this,

1 how much that.

2 Q. Okay. And if, and if Mr. Barr's testimony

3 was that he was always painting in either a ventilated

4 area such as outdoors or with the use of a fume filter

5 on a respiratory would that---

6 MR. MCDANIEL: Objection. That misstates

7 testimony.

8 Q. Assuming for the sake of argument and Mr.

9 Barr has testified that he always wore a respirator

10 while painting inside or was otherwise painting

11 in, obviously, a ventilated area. Would that weigh

12 against the potential VOC exposure as being more

13 significant than, than his smoking history?

14 A. Well, it might, but I'm not -- I think

15 another issue that would be difficult to know to a

16 reasonable degree of medical certainty.

17 Q. Okay. Now, I know you did a questionnaire

18 answered a questionnaire for Mr. McDaniel. You

19 you didn't see Mr. Barr in connection with the

20 completion of this, is that correct?

21 A. I'm not sure. What's the date on it?

22 Q. 8/16 of 2016.

23 A. That was after I had last -- I guess about a

24 month after I last saw him.

25 Q. Okay. And one of the questions you were

1 asked was if it was your understanding that he was
2 exposed to a high level of volatile organic compounds.
3 How did -- where did this supposition come from? I
4 mean, where, where did, where did this idea come from?
5 A. Well, I first heard it from the patient.
6 Q. Okay. So you don't have any independent
7 knowledge whether or not that that's true or not?
8 A. No.
9 Q. Okay. And on the final question when you
10 were asked about the cause of his chronic headaches
11 fatigue, you said it was causally related to his
12 exposure to volatile organic compounds that he may
13 been using at work. How do you rule out all the other
14 possible causes of chronic headaches or fatigue in
15 reaching that conclusion?
16 A. Well, I think it's contributory, and I do
17 think it's a significant contributor. But also, you
18 know, he has the smoking history. So from the
19 standpoint of his lung issues, he's got two issues,
20 I would defer as to which is felt to be the larger
21 issue.
22 Q. Okay. And is this, is the basis of this,
23 correct me if I'm wrong, I'm trying to understand
24 you're coming from, you feel that the role that the
25 VOCs may have played would be pulmonary in nature or

1 contributing to the hypoxia?
2 A. Well, there's two probable causes or two
3 probable things that they cause and one is the
4 pulmonary problem, but the other is the more
5 problem since they're absorbed and distributed and,
6 know, I see an awful lot of heavy smokers and they
7 don't have headaches, and I don't see bilateral
8 hemorrhages without usually other explanations
9 including diabetes. Again, heavy smokers, I don't
10 necessarily see bilateral retinal hemorrhages.
11 Q. But the bilateral retinal hemorrhages, again
12 would you leave that to an ophthalmologist to deduce
13 the cause?
14 A. If they -- yeah, if they did, I mean.
15 Q. Okay. I'm just wondering what, what
16 evidence, what objective evidence there is that he has
17 a systemic problem from any source?
18 A. It's a gestalt. It's a matter of putting
19 together everything that you have with the history and
20 then working through it.
21 Q. All right. So there's no blood test or
22 tissue samples or anything else that have been done to
23 diagnose him with any sort of systemic illness?
24 A. No, there -- they haven't been done.
25 Q. Okay.

1 A. They could be.
2 Q. All right. And the constellation of
3 we're dealing with here, his primary complaints are
4 chronic headaches and fatigue, correct?
5 A. Yes.
6 Q. All right. And I think for your testimony
7 there are a number of things, known factors in Mr.
8 Barr's life, including the smoking and the use of
9 analgesics and narcotic pain medications that could be
10 contributing both to the chronic headaches and to the
11 fatigue?
12 A. Right. Although, you know, then you get
13 involved in, well, it's the chronic medication use
14 because of the primary problem which may be the
15 and the VOCs. So it's the actual need to use chronic
16 medications driven by the underlying problem.
17 Q. Did he get into you or did you review any of
18 the records or speak to Mr. Barr about when he started
19 using the narcotic medications, because he had some
20 significant orthopaedic problems, some hand surgeries,
21 that led to his use and maybe even abuse of narcotic
22 pain medications?
23 A. Right. There are other pain issues besides
24 headache.
25 Q. Okay. And could that be part of what you

1 said maybe the psychological factors here that could
2 contributing to the headaches and to the poor sleep
3 hygiene?
4 A. Well, you know, his psychological issues, I
5 think a lot of them are driven by his poor sleep.
6 a very anxious fellow which is not unusual if you're
7 not a good sleeper. I think, you know, he doesn't
8 sleep well. The next day, he runs on adrenaline and
9 that's the hormone that makes you anxious. I think he
10 has a lot of problems, you know, physically and
11 probably psychosocially in that this drives his
12 anxiety.
13 Q. And then on top of it, the sleep apnea and
14 the periodic limb movement, that's further
15 any of these others?
16 A. It all, it all serves to disrupt his sleep
17 and so his sleep is nonproductive. He really doesn't
18 feel better when he wakes up for the sleeping.
19 Q. Okay. And, I assume, you would have to see
20 him back before you could say whether or not he's seen
21 any improvements with the, with the treatment that you
22 recommended for the restless, I keep saying restless
23 leg, for the periodic limb?
24 A. The periodic limb movement, the Depakote
25 trial, the CPAP, those are probably the three big

1 therapeutic interventions.
2 Q. Okay. And before I forget, did you see
3 anything in your -- when you got the hospital records
4 from when you had him in there for the long EEG, you
5 tried that medication you mentioned to rule out the---
6 A. The DHE.
7 Q. ---the DHE?
8 A. I don't remember seeing it in the Discharge
9 Summary.
10 Q. Okay.
11 A. I see where I mentioned that I was going to
12 give it. I'm not, I'm not exactly sure, because now
13 that I think about it, this fellow -- I got done doing
14 what I wanted to do and he was under the impression
15 that he was going home.
16 Q. Okay.
17 A. And I said, no, no, no, no, I want the
18 cardiologist to see you, and he was hot to get out of
19 the hospital, probably so he could smoke. So I
20 wouldn't give DHE to somebody if I knew they had
21 coronary artery disease, and he literally got his
22 cardiac evaluation and left.
23 Q. Okay.
24 A. So I think in retrospect, while I planned on
25 giving it, I didn't.

1 Q. Okay. So with the coronary clearance, you
2 could do it, but it would need to be done in a
3 setting?
4 A. Well, no, no.
5 Q. Okay.
6 A. You could -- you could give it a -- you
7 I would tell him if you ever end up in the Emergency
8 Room because of headache, you should ask -- of course,
9 the patients can't go in and ask for what they -- but
10 I, I have given people a slip before, a prescription
11 saying if they end up in the Emergency Room either
12 me or I would recommend if it's for headache that they
13 get a dose of this.
14 Q. Okay. So it would be something you would do
15 in a supervised setting?
16 A. It has to be, yes.
17 Q. Okay.
18 A. Yes.
19 Q. Okay. All right. Dr. Healy, I appreciate
20 your time and your patience, and I'm sure Mr. McDaniel
21 has some questions for you.
22 A Thank you.
23 CROSS EXAMINATION BY MR. MCDANIEL:
24 Q. Let's go back again and what would the DHE
25 tell you, Doctor, in reference to his chronic daily

1 headache?
2 A. Yeah. If, if his headaches are chronic
3 headaches because of his medication excess.
4 Q. Okay. All right. Because of his medication
5 excess. Is there any other reason for chronic daily
6 headaches?
7 A. Well, I'm sure there's a lot of
8 I think this fellow walks around relatively hypoxic.
9 He retains carbon dioxide. The blood chemistry isn't
10 exactly ideal for a properly functioning in any organ
11 system you can name.
12 Q. Now, let's talk a little bit more about the
13 bilateral retina---
14 A. Retinal hemorrhages.
15 Q. ---hemorrhages.
16 A. Yes.
17 Q. And you were telling Ms. Barr, and then you
18 sort of changed focus there. But in other words, you
19 said that you norm -- you don't normally see those
20 associated with heavy smokers?
21 A. No, I don't.
22 Q. And you -- it's one of the things related to
23 that is diabetes?
24 A. Right.
25 Q. But he doesn't have diabetes, right?

1 A. Correct.
2 Q. Now, you were about to explain, I think, a
3 little bit more about that in reference to -- you were
4 talking about it in reference to this VOC exposure, I
5 believe. Can you explain to me a little bit more
6 what you were talking about in reference to what
7 these or explain that a little bit more about -- maybe
8 the part -- is there any relationship between, for
9 example, the systemic VOC exposure; in other words,
10 meaning exposure to VOCs in reference to what you
11 referred to, is it absorbed through the skin or
12 through the lungs, and then it causes systemic effect?
13 Can you explain to me about how, in reference to that
14 about what that might tell you because he has
15 retinal?
16 MS. BARR: And I'm just going to object for
17 the record.
18 MR. MCDANIEL: Yeah.
19 MS. BARR: As to the qualifications of the
20 witness to testify as to retinal hemorrhages.
21 A. Well, I mean, the primary root of the VOCs
22 affecting an individual is inhalational, and so it's
23 distributed to the body in general. It's a toxin to
24 all the cells of the body, which often the rapidly
25 proliferating cells are most sensitive and part of

1 is the blood vessels, the lining of the blood vessels,
2 and so it does have an effect on the vasculature, and
3 so that's one of the reasons why I said that the
4 fellow, I believe, is a vasculopath, although he has
5 the smoking and the VOCs. But the vessels are not
6 normal. I don't typically see the retinal hemorrhages
7 in smokers alone. So it is curious as to why those
8 present. I have not seen an explanation and yes, I
9 would defer, you know, to an ophthalmologist about
10 that, but I think it's very curious in view of his
11 history. I think that, you know, the lung disease
12 certainly contributes to him being hypoxic relatively.
13 It's mild, but it's there. More importantly, the
14 carbon dioxide levels are elevated, so he does not get
15 rid of toxic products within the body the way he's
16 supposed to from the pulmonary standpoint. So that's
17 an issue. So the carbon dioxide levels are slightly
18 elevated which doesn't produce a milieu for the brain
19 to exactly work properly and often when the brain
20 doesn't work properly from a metabolic standpoint,
21 headache is the end result. So that, that's my
22 reasoning for thinking that his breathing is
23 contributory to his headaches. But what's
24 to his breathing beyond smoking, again, I would defer
25 to a pulmonologist, although that is my clinical

1 gestalt of what's wrong with him.

2 Q. According to the MSDS sheets and according

3 the toxicologist, the acute effects of like VOCs are

4 headache, dizziness, possible nausea, and also loss of

5 coordination?

6 MS. BARR: Objection. Facts not in

7 Calls for speculation.

8 Q. The MSDS sheets are in evidence, Doctor, and

9 I'd like to ask you a couple of questions. Let me

10 go back and right now, do you stand by the opinions

11 expressed in that questionnaire?

12 A. Yeah. Yes.

13 Q. And, I think, it's your opinion, he's not a

14 Maximum Medical Improvement?

15 A. No.

16 Q. Now, just assume as a fact that's true that

17 Mr. Barr went to work with the School District in

18 in May/June 2009, and that there is no evidence of

19 chronic headaches at that time. That he then reported

20 with a history of two to three weeks of headaches,

21 fatigue and was taking Tylenol for those on June 15th,

22 2010, and saw his family doctor, Dr. Chapman. He

23 again, returned after being given some medications to

24 treat those on September 1st of 2010. He reported

25 a history in September 1st of 2010 and then, again, on

1 September 13th after having worked with the School
2 District for over a year, approximately 15 months, in
3 September, and he was reporting with problems with
4 dizziness, fatigue and balance issues on September
5 13th, and a history of four weeks unrelenting
6 had persisted and he had had those for going on four
7 weeks and could not control them with medications.
8 What does that tell you in reference to we've
9 already to the volatile, exposure to volatile organic
10 compounds and the fact that he's a long-time smoker
11 now, all of the sudden, after 15 months being a
12 commercial painter? What does that -- does that tell
13 you anything or strengthen your opinion?
14 A. Well---
15 MS. BARR: Objection to the form. It calls
16 for speculation. It's based on facts not in evidence.
17 A. I think that it suggests that the VOCs are a
18 big component of what's wrong with him.
19 Q. Okay. Let's talk a little bit about one
20 thing that's ruminating in my mind and it has for
21 some time and it's something you've expressed. If a
22 person has persistent daily headaches, persistently,
23 let's say, is exposed on a daily basis to VOCs as a
24 painter, all right, which Mr. Barr was and he
25 to have headaches and he continued to take medications

1 to treat those headaches and he's continued to take
2 those from 2009 to 2016. What would be the
3 relationship between the medications if there -- if he
4 does, in fact, suffer from medication overuse in
5 reference to the fact that his headaches are being
6 caused, at least on an acute basis, by VOCs?
7 MS. BARR: Objection to the form. It's
8 on facts not in evidence and it calls for speculation.
9 A. Well, I think that, and I might have
10 discussed this a little bit already, but that the
11 chronic headache, you know, has caused him to use a
12 of medications which then has possibly turned into an
13 overuse phenomenon, still unproven, because I
14 personally think he has metabolic reasons to have
15 chronic headache, so I'm not totally convinced that
16 it's an overuse headache but, you know, he qualifies
17 the sense of how much medication he used daily, but it
18 may well be that he was driven to try and do that in
19 effort to try and get some relief. Oddly enough, you
20 might think, well, if people did that, why would they
21 continue to do that if it didn't work, but they do,
22 it certainly didn't afford him any relief, I don't
23 think.
24 Q. In reference to the -- he reported -- you
25 referred to them and he refers them at times in the

1 history of like spells. He talks about weakness and
2 dizziness, but what are you referring to when he
3 to these spells that he's having?
4 A. Well, he was having these episodes where he
5 would get headache. He would then get anxious,
6 palpitations, and then he would stutter and have
7 trouble talking. And so it was almost like a TIA,
8 which he's at risk of because of his vascular
9 and it wasn't -- I didn't see evidence that this was
10 seizure. I don't know if periodically his breathing
11 gets worse. You do see people with underlying lung
12 disease who will get what we call mucus plug; in other
13 words, they'll get an area of mucus, block off a
14 bronchial which removes an entire segment of the lung
15 from providing adequate respiration and that's enough
16 to kick him over into being hypoxic. Most of us have
17 enough reserve that that wouldn't be an issue, but
18 people that are borderline sometimes don't. So I was
19 curious about what was causing these spells, although
20 didn't turn up a neurologic cause.
21 Q. What do you mean by metabolic in origin?
22 A. The blood chemistries aren't right.
23 Q. Okay. And now you also kind of answered the
24 question I believe. Can you tell me your experience
25 an neurologist in treating people, painters? Have you

1 treated painters in the past with problems in
2 to chronic headaches?
3 MS. BARR: Objection to the relevance.
4 A. I have. You know, you don't see it a lot.
5 It's not something I specialize in.
6 Q. Yeah.
7 A. But I see headaches for all kinds of reasons
8 and that has been one in the past, painters or people
9 exposed. Often it's carbon monoxide. But people
10 exposed to substances.
11 Q. The toxicologist and also the MSDS sheets in
12 reference to the paints and solvents that he was using
13 to paint with refer to them being heavier than air.
14 Does that -- and that means that instead of being --
15 they were lighter in air they would, of course,
16 dissipate into the air. But when they're heavier than
17 air, they then roll downward like radon does to the
18 floor. Does that tell you anything in reference to
19 amount of exposure you would get from painting?
20 MS. BARR: Objection to the form. It's
21 on facts not into evidence. It calls for speculation
22 and it's beyond the qualifications of this witness to,
23 to, to even speak to.
24 A. Well, it would suggest that normal
25 ventilation isn't going to be an absolute.

1 Q. Did you know -- are you aware of studies
2 say that over 50 percent of the exposure by painters
3 and similar type are to the solvents and VOCs is in
4 reference to absorption?
5 MS. BARR: Objection to like the form.
6 Speculation; facts not in evidence. It's a leading
7 question. It's totally improper, I mean.
8 Q. I was asking if you are aware?
9 A. No.
10 Q. All right. I don't think I have any more
11 questions.
12 REDIRECT EXAMINATION BY MS. BARR:
13 Q. Just a few. The records from the
14 ophthalmologist we believe Mr. Barr has seen, did you
15 have benefit of those actual records---
16 A. I never---
17 Q. ---or consultation?
18 A. I never saw them.
19 Q. All right. Do you know who the
20 ophthalmologist was?
21 A. No. I just told him to make sure it's an
22 ophthalmologist and not an optometrist.
23 Q. Okay. So at this point, we're just assuming
24 Mr. Barr correctly understood what he was by a
25 qualified physician, and then repeated that correctly

1 to you?
2 A. Yes.
3 Q. And as far as the medical records you may
4 have reviewed, did Mr. Barr or Mr. McDaniel provide
5 with the records from Dr. Woodberry from back in 2005
6 when he was treating for vertigo, dizziness, and
7 imbalance back in 2005 which was prior to his
8 employment at the School District?
9 A. I don't have any recollection of seeing
10 Q. Okay. Having that history of vertigo and he
11 was, he was treated with Antivert for that problem,
12 could that be relevant in the constellation of
13 that you're trying to determine an etiology for?
14 A. Well, it's hard, hard for me to comment. I
15 don't know.
16 Q. Okay. And also as Mr. McDaniel mentioned,
17 Dr. Chapman was his family doctor for a time and back
18 in 2006, Mr. Barr was complaining of chronic fatigue
19 and Dr. -- and just for the record, I'm referring to
20 page 250 of the APAs -- complaining of fatigue and Dr.
21 Chapman was urging him to consider a sleep study back
22 at that point in time. Could the sleep apnea that,
23 that you found on your sleep study as something to
24 been a problem for him for a long time and, and,
25 ultimately, resulted in the progression of headaches

1 and fatigue?
2 A. Could, yes.
3 Q. I would imagine that untreated that
4 obstructive sleep apnea or other sleep disorders could
5 create progressive problems or symptoms and
6 complications?
7 A. It can, yes.
8 Q. All right. And I've tried to shy away from
9 the toxicology questions, but Mr. Barr has had over
10 years his own painting business aside from his work at
11 the School District. Do you have an opinion regarding
12 his exposures in his employment with the School
13 District versus the painting he did in his own private
14 business as far as their relevance on any pulmonary or
15 neurological problems he may have?
16 A. Well, nothing beyond speculation.
17 Q. Okay. And just so I'm clear. When we
18 about the -- we've called them the spells where he
19 feels a headache and onset of other strange symptoms.
20 I believe you testified a few minutes ago that you
21 found no neurologic cause for those spells?
22 A. Didn't find seizure or anything like that.
23 Q. Okay. All right. Thank you very much, Dr.
24 Healy.
25 A. Thank you.

1 RECROSS EXAMINATION BY MR. MCDANIEL:
2 Q. Dr. Healy, we established that Mr. Barr went
3 to work for the School District in 2009, as discussed
4 earlier, and Ms. Barr referred to a treatment on one
5 occasion or a treatment in 2005 for vertigo. She also
6 referred to a question of treatment for fatigue in
7 2006. Did she give you any treat -- did she refer to
8 you or did you hear any consistent treatment for
9 fatigue and/or vertigo from 2006 through 2009 or even
10 up till today?
11 A. I didn't.
12 Q. Okay. Thank you. Nothing further.
13 MS. BARR: I think the medical records will
14 speak for themselves. So that's all. Thank you.
15 A. Thank you.
16 MR. MCDANIEL: Thank you.
17 DR. HEALY: Thank you.
18 (THERE BEING NO FURTHER QUESTIONS,
19 DEPOSITION CONCLUDED AT 6:30 P.M.)
20
21
22
23
24
25

1 CERTIFICATE OF REPORTER

2 STATE OF SOUTH CAROLINA)

3 COUNTY OF DARLINGTON)

4 I, Laura W. Little, Verbatim Reporter and Notary

5 Public in and for the State of South Carolina, certify

6 that I did have R. Joseph Healy, Jr., M.D., appear

7 me at 5:30 p.m. on the 27th day of September, 2016 at

8 office of R. Joseph Healy, M.D., 805 Pamplico Highway,

9 Suite A130, Florence, South Carolina; that the witness

10 was duly sworn and cautioned to tell the truth and

11 but the truth; that the foregoing pages constitute a

12 and accurate transcript of his testimony given at that

13 time and place.

14 I certify that I am not of counsel or kin to any

15 the parties, nor am I interested in any manner in its

16 outcome.

17 IN WITNESS WHEREOF I have hereunto set my hand

18 and seal this the 1st day of October, 2016.

19 Laura W. Little

20 Laura W. Little, Verbatim Reporter

21 Notary Public, State of South Carolina

22 My Commission Expires August 19, 2025.

23

24

25

STATE OF SOUTH CAROLINA
BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC No. 1507304

Kenneth Barr,	)
Claimant,	)
v.	)
Darlington County Schools,	)
Employer,	)
and	)
South Carolina School Board Trust,	)
Carrier/Defendants.	)

FULL COMMISSION HEARING

****

COPY

Tuesday, February 20, 2018
4:13 p.m. - 4:42 p.m.

The Full Commission Hearing was heard before Commissioners Gene McCaskill, Susan S. Barden and Aisha Taylor, Chair, at the Workers' Compensation Commission, 1333 Main Street, Suite 500, Columbia, South Carolina, on the 20th day of February, 2018, before M. Sean Cary, Court Reporter and Notary Public in and for the State of South Carolina.

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INDEX

PAGE

CALL TO ORDER:
COURT REPORTER 3

CLAIMANT'S ARGUMENT:
MR. McDANIEL 3

RESPONDENT'S ARGUMENT:
MS. BARR 12

CLAIMANT'S REPLY:
MR. McDANIEL 23
Certificate 28

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.

1 **CALL TO ORDER:**

2 **COURT REPORTER:** Today is Tuesday, February 20th,
3 2018. This is South Carolina Workers'
4 Compensation case number 1507304. This is the
5 case of Kenneth Barr, the Claimant, versus
6 Darlington County Schools, the Employer, and
7 the South Carolina School Board Trust, the
8 Carrier. The Appellant is the Claimant,
9 represented by Preston F. McDaniel. The
10 Respondent is represented by Kirsten L. Barr.
11 Each side is allowed ten minutes for oral
12 argument and the Appellant three minutes in
13 reply. You are requested to argue the grounds
14 of exception and stay within the record.

15 **MR. McDANIEL:** Add to the record Gerald Malloy, co-
16 counsel.

17 **CHAIR:** Noted for the record. All right. Mr.
18 McDaniel?

19 **CLAIMANT'S ARGUMENT:**

20 **MR. McDANIEL:** May it please the Commission. I'm
21 going to try to argue -- there are multiple
22 issues in our brief, but I'm going to try to
23 argue two of those. And the first argument
24 that I'm going to make and ask you to consider
25 is based on a preponderance of the evidence.

1 But I want to also, along with that, state that
2 this argument's gonna go along two time lines.
3 One time line in reference to the facts and the
4 development of Mr. Barr's problems, and the
5 other time line is gonna be in reference to the
6 proceeding before the Commission. Now what --
7 as we all know -- and something gets confused
8 all the time, the Claimant's burden of proof is
9 by preponderance of the evidence. And we
10 always a lot of times talk of that, and I even
11 see people quoting in orders reference to the
12 substantial evidence. Of course that has
13 nothing to do with that. And I'm gonna ask the
14 Commission to consider this case in light of
15 the preponderance of the evidence, which is
16 that the Claimant only has to put forward
17 evidence suf- -- of sufficient substance to
18 afford a reasonable basis for an award. If the
19 scales tip ever so slightly in favor of the
20 injured worker then the Commission should award
21 benefits. And I'm gonna submit in this case
22 that the evidence tips ever so slightly in that
23 favor, but more than that it actually is all in
24 his favor in reference to the case. In our
25 pre-hearing brief we pled in the alternative,

1 not as to compensability but we pled that in
2 the alternative that he had sustained a
3 compensable injury by accident, that he was not
4 at maximum medical improvement, and that he
5 should be placed under his current treating
6 neurologist down in Florence, Dr. Healy, for
7 treatment of his chronic pain -- his chronic
8 headaches that were due to the exposure
9 stemming from the exposure to volatile organic
10 compounds, which we'll refer to as VOCs, in the
11 commercial paints he used. Now what you'll
12 find is at page 12 of the hearing record, and
13 I'm -- like I said, I'm going to mix this in a
14 little bit, is on page 12 of the hearing record
15 you're gonna find that we -- I cited to the
16 Commission what we were asking for. One
17 neurologist said that he had suffered a chem-
18 -- a toxic encephalopathy, the other -- and was
19 totally and permanently disabled, the other
20 neurologist, his current treating neurologist,
21 Dr. Healy, said no, I don't think he's at
22 maximum medical improvement, I think his
23 chronic headaches come from this exposure; I
24 think he needs additional treatment. And we
25 were hoping that we could get him back to work

1 as we said in the record. In other words,
2 everybody agrees that this man has severe
3 headaches. I'm gonna go into that in a minute
4 from the factual basis. And we are pleading,
5 we are asking for you to today to focus as to
6 ask you to fins this case to be compensable,
7 that the case be found -- that he placed under
8 the care of Dr. Healy, that he's not at maximum
9 medical improvement, and that Dr. Healy be able
10 to treat this man and hopefully be able to get
11 him back to work in some capacity. This man
12 was a sole-supporter of his family and we were
13 trying to obtain that. We wanted treatment as
14 we so many times do. Now, in the record you're
15 going to find, and on pa- -- starting at page
16 15 of our brief you're gonna find that Mr. Barr
17 had been a painter for a long time but there's
18 absolutely no evidence of any exposure to
19 commercial paints, which are the paints that
20 require MSDS sheets for a period of ten years
21 before 2009 when he started to work with the
22 school district. You're also going to find
23 that there's absolutely no treatment for
24 chronic headaches for a period of at least ten
25 years prior to the date of him beginning work

1 with commerci- -- with the school district as
2 a commercial painter. Prior to 2009 he had
3 been a house painter. He worked with latex
4 house paints that don't require, that don't
5 have the substantial level nor the same kind of
6 VOCs that are in commercial paints. In 2009 he
7 took a job in May with the school district.
8 And in 2010, on June 15th, and this is at page
9 16, he went to his family doctor, Dr. Chapman,
10 he said -- gave him a 4 week history of
11 persistent headaches, that he's having
12 dizziness, that he was having difficulty
13 concentrating, and had some nausea. Dr.
14 Chapman prescribed some medication, and on
15 September the 13th he returned with a 4 week
16 history of consistent unrelenting headaches and
17 same kind of problems with memory,
18 concentration and fatigue and dizziness. And
19 stated that his headaches had become so bad and
20 his condition had become so bad that he had to
21 take off four days from work. Now at that time
22 Dr. Chapman, and hearing goes to line in
23 reference to headaches, found him to be having
24 persistent headaches and began treatment. And
25 then at the latter part of September he

1 referred him to Dr. Skinner. What you're going
2 to find in the record at page 168 is persistent
3 headaches on September 13th, 2010 by Dr.
4 Chapman; September 23rd, 2010, Dr. Skinner, a
5 history of severe headaches for five weeks; on
6 -- at page 182 you going to find Dr. Skinner
7 saying -- changing that diagnosis to continual
8 chronic headaches. Now, what I want to point
9 to you is from 2010 in September through now,
10 Mr. Barr has been under consistent treatment
11 for chronic unrelenting headaches throughout
12 that entire time. Dr. Chapman -- in addition
13 to Dr. Chapman and Dr. Skinner, Dr. Marshall
14 White in Sep- -- in 2012, because he wasn't
15 getting any better, because Dr. Skinner ac- --
16 Dr. Chapman sent him to Dr. White for a second
17 opinion. And what you're going to find from
18 the evidence is that Dr. White, for the first
19 time, got a specific detailed history of what
20 he did. As soon as he got that history, at
21 that point in time, he said I want him out of
22 these VOCs because they're possibly causing his
23 problem. And that's in the record at page 75
24 and 75-A. Now, in 2012 he diagnosed him with
25 sever chronic headaches possibly related to VOC

1 exposure. He continued under treatment by Dr.
2 White. Dr. White moved his practice but he
3 continued by him and Dr. Chapman. And in 2015
4 he had several serious events and he came back,
5 in other words where he was -- in one where he
6 was on the side of the road completely dizzy,
7 couldn't concentrate, couldn't focus, sever
8 headaches to the extent that he could not drive
9 the automobile. He wound up getting back to
10 the thing and then he went to the hospital and
11 then he immediately went over to Dr. White.
12 Dr. White said, this is being caused by
13 exposure to those volatile organic compounds
14 from those commercial paints; you gotta get out
15 of there. And basically told him in something
16 that's not quoted in the record. It's
17 something I want to address about what I think
18 the Commissioner overlooked, was the fact that
19 he then went to his supervisor, Mr. Larry
20 Stagner, and Mr. Stagner and him talked, and
21 they said -- eventually in May Mr. Stagner
22 wrote a note saying, like look, I've got --
23 you've either gotta come back here with a
24 statement saying you're able and available to
25 return to full-duty work, or you've got to

1 bring me a statement that you're disabled and
2 you cannot go back to work and it's a permanent
3 condition. Which, on May 25th -- I mean May
4 21st, Mr. Barr brought a note back from Dr.
5 White saying, in my opinion he's suffering from
6 headaches, migraine headaches, memory loss and
7 fatigue due to exposure to volatile organic
8 compounds on the job, and he needs to be out of
9 work. That was the posture of the case when we
10 filed the claim on his behalf, and from there
11 we go forward. Now, in addition to -- so we
12 have Dr. Chapman, no question that he's having
13 persistent and -- he diagnosed him with chronic
14 headaches. Dr. Skinner agrees he had severe
15 chronic headaches. Dr. Marshall White agrees
16 he has severe chronic headaches. Dr. Healy
17 agrees he has severe chronic headaches. Dr.
18 Pritchard agrees that he has sever chronic
19 headaches. Every one of the neurologists,
20 everybody that saw him, agrees he has severe
21 chronic headaches. Now, Dr. Marshall White
22 says that in his opinion those were due to
23 exposure on the job to the volatile organic
24 compounds, and stated that opinion to a
25 reasonable degree of medical certainty, and

1 that it stemmed from -- he had the MSDS sheets,
2 and stated that opinion. Dr. Healy has, when
3 he was presented with the MSDS sheets, also
4 stated the opinion to a reasonable degree of
5 medical certainty that these problems stem from
6 his exposure to volatile organic compounds.
7 One thing I want to point out about Dr. Healy
8 also, Dr. He- ---
9 (Alarm goes off.)
10 **CHAIR:** Finish your thought. Go ahead.
11 **MR. McDANIEL:** Okay.
12 **CHAIR:** You can finish your thought.
13 **MR. McDANIEL:** All right. But anyway, Dr. Healy
14 stated the opinion that these stem from his
15 exposure and he had had numerous painters in
16 the past and had experience with this. Dr. ---
17 **MS. BARR:** That is not in the record. Exactly the
18 opposite testimony was given by Dr. Healy.
19 **CHAIR:** Okay. The objection's noted for the record.
20 Please finish your thought. You'll have three
21 minutes in rebuttal.
22 **MR. McDANIEL:** Thank you. Anyway, well Dr.
23 Pritchard reco- -- found that he had chronic
24 headaches but it was outside his area of
25 expertise and he referred him to an

1 occupational medicine specialist. You will
2 find in reviewing the Commissioner's notes that
3 there is no reference to our alternative
4 pleadings. We ask him to amend that by
5 reconsideration. And in addition to that, I
6 also ask him to sue that when the first
7 proposed order. The next day Ms. Barr
8 presented another proposed order, and in that
9 second proposed order she said that I have --
10 in light of Mr. McDaniel's argument that the
11 Claimant may be entitled to benefits for
12 headaches unrelated to his allegation of brain
13 damage, I have modified the findings and
14 conclusions. You will not find any reference
15 to any findings or conclusions by the
16 Commissioner in reference to our alternative
17 pleadings of asking to find that he was not at
18 maximum medical improvement, and that his
19 chronic headache condition stemmed from the
20 accident.
21 **CHAIR:** All right. Thank you, sir. Ms. Barr?
22 **<u>RESPONDENT'S ARGUMENT:</u>**
23 **MS. BARR:** Thank you. May it please the panel. On
24 behalf of Darlington County School District and
25 the South Carolina School Board's Insurance

1 Trust we would ask that the Hearing
2 Commissioner's decision and order be affirmed
3 in its entirety. I'm going to speak briefly
4 toward -- to the objection I made during
5 counsel's argument, which I don't take lightly.
6 But I would direct your attention to Dr.
7 Healy's deposition testimony starting at page
8 42 line 23 and going onto the following page
9 where, when asked if he had treated painters
10 with chronic headaches he said, you know, you
11 don't see it a lot, was his response. That
12 comports with the testimony from Dr. Pritchard,
13 the neurologist who evaluated him at our
14 request who testified that headaches are the
15 number one reason Americans see doctors, it's
16 the number one reasons for doctor's visits in
17 the U.S. This issue -- this whole case, I mean
18 we've got a voluminous record, a lot of it has
19 become moot at this point and so I want to try
20 to get down to the heart of the matter. The
21 Claimant originally claimed encephalopathy,
22 brain damage, memory loss, confusion and I
23 quote, neurological/nerve -- central nervous
24 system injury. Those claims have been
25 abandoned on appeal. The only injury alleged

1 in the Claimant's brief and only injury
2 preserved for argument was for headaches
3 generally. So, those other claims have been
4 abandoned. So the vast bulk of the discovery
5 and the testimony and the medical records in
6 this case is simply not relevant anymore
7 because he's abandoned those brain damage,
8 encephalopathy and nervous system claims.
9 Likewise, they've abandoned their claim for an
10 occupational disease claim. It wasn't made
11 clear at the hearing, he seemed to pursue
12 occupational disease, accident and repetitive
13 trauma. In their brief they abandoned the
14 occupational disease claim as well as the claim
15 for medical and compensation benefits. You'll
16 see that the Hearing Commissioner made specific
17 findings of fact and rulings of law regarding
18 his entitlement to benefits for medical and
19 indemnity benefits under 42-9-10, 42-9-20, 9-
20 30, 42-15-60. None of those findings or
21 concomitant conclusions were appealed, so that
22 is the law of the case. Right or wrong, an
23 unappealed ruling is the law of the case. And
24 so even if you were to find headaches were
25 compensable, I believe what they're going with

1 is a -- a result of repetitive trauma, then it,
2 again, it's moot because he wouldn't be
3 entitled to medical or compensation benefits.
4 With regard to the headaches and repetitive
5 trauma claim, we feel that both the greater
6 weight of the evidence and the applicable law
7 support the Hearing Commissioner's finding.
8 You know, the repetitive trauma statute
9 requires medical evidence stated to a
10 reasonable degree of medical certainty that the
11 headaches, the injury, was the direct result of
12 the alleged repetitive trauma. I would submit
13 to you that the record, which includes the
14 testimony of Dr. Eagerton and the testimony of
15 -- who's the toxicologist formally with SLED,
16 and also Dr. Pritchard who said that, you know,
17 the number one reason people go to the doctors
18 is for headaches that -- they're just simply
19 not something that is the direct result of this
20 alleged exposure to VOCs. I would also note
21 that the Claimant testified that he always wore
22 a respirator and always worked in a ventilated
23 area, so any exposure to VOCs would be
24 necessarily limited. And in fact Dr. Edgerton
25 testified that the -- what were being called

1 volatile organic compounds in the -- the
2 painting products that Mr. Barr worked with
3 most normally, most people wouldn't even
4 consider those VOCs because they had such a low
5 volatility. So we deny that there's any
6 repetitive trauma, but like I like to say, you
7 don't need to know the constituents of
8 gunpowder to determine if somebody has a
9 gunshot wound; and here, Mr. Barr simply
10 doesn't have that proverbial gunshot wound. He
11 relies, as you know, heavily on Dr. White.
12 Marty White admitted that he had no objective
13 evidence to support his conclusions. He
14 basically said I'm the expert and it's what I
15 think, I don't need evidence, and then when
16 backed into a corner finally said well, I
17 haven't finished working him up but I'm certain
18 that if he gets neurologic- --
19 neuropsychological testing it will show that he
20 has severe dementia and memory loss which means
21 that his headaches are a result of toxic brain
22 damage. Well, we finally, after a number of
23 motions, hearings and a trip to the -- the
24 Circuit Court, where write of mandamus were --
25 were issued, finally got that

1 neuropsychological testing which showed not
2 only did he not have any signs of cognitive
3 impairment, none whatsoever, but his memory was
4 actually better than the average adult. So the
5 entire tent poles upon which Dr. White's
6 opinion were based are based on, number one,
7 speculation, and number two, not unproven
8 hypotheticals but disproven hypotheticals. And
9 you'll see very clearly that's the reason the
10 Hearing Commissioner discounted the opinions of
11 Dr. White entirely. Dr. Healy, now, at the eve
12 of the hearing did sign a questionnaire
13 endorsing compensability in this case, but
14 you'll see from his deposition testimony, I'd
15 refer you specifically to pages 30 and 38, that
16 any exposure to volatile organic compounds in
17 the past was merely contributory to these
18 headaches that Mr. Barr is currently
19 experiencing. He went on to explain all the
20 different things that were causing and
21 impacting his headache symptomology. Those
22 include a previously untreated sleep apnea that
23 was so severe that they had to stop the sleep
24 study to give him medication. He was so
25 hypoxic, his oxygen levels were so low -- which

1 explains why Mr. Barr wakes up in the middle of
2 the night with headaches and wakes up in the
3 morning with headaches and with fatigue. Even
4 at the date of the hearing he was not using a
5 C-Pap and was not taking the medication for his
6 chronic sleep apnea which was first diagnosed
7 back in 2006 and went untreated all that time.
8 Similarly he has a problem with restless leg
9 syndrome which means he's not getting any
10 sleep. He similarly was not getting treat- --
11 treated for that. Dr. White also felt like he
12 had a significant problem with analgesic
13 rebound. The record's replete with references
14 to his addiction to Goody Powders and Mountain
15 Dew, not a good combination for somebody with
16 tension headaches. He also had vision
17 problems, some sort of retinal hemorrhage which
18 was impacting headaches according to Dr. Healy.
19 Dr. Healy's recommendations where that all of
20 these things, his cardiac issues, his restless
21 leg syndrom, most significantly that sleep
22 apnea and the analgesic rebound were what were
23 causing this constellation of symptoms and
24 these headaches; and he recommended that he be
25 treated by an opthomologist, a cardiac

1 specialist and a pulmonologist, nothing to do
2 with his brain damage or neurological injury
3 which was the claim originally made. The
4 evidence that does support a finding that there
5 was no relationship would include Dr. Skinner,
6 he's the neurologist who treated him for the
7 longest, had the longest relationship with him.
8 He said the diagnos- -- the headaches were due
9 to analgesic rebound and common tension type
10 headache. He does not believe that there's a
11 direct causal relationship to a reasonable
12 degree of medical certainty and therefore does
13 not support the Claimant's burden of proof in
14 this case. Dr. Pritchard -- and Dr. Skinner,
15 I would reference pages 28 and 30 of his
16 testimony speak to that. Pages 105 and 106 as
17 well as 83 and 27 of Dr. Pritchard's testimony
18 make it clear that he believes that the
19 Claimant's headaches were due to muscle tension
20 or simple migraines. Dr. Pritchard also stated
21 that, starting at page 105, that to a
22 reasonable degree of medical certainty that
23 there's no causal relationships between the
24 Claimant's employment and his headache. So
25 again, I think it's a little more than to say

1 hey, he didn't have headaches when he was in
2 his 20s, but he's been working at the school
3 district and now he has headaches and he used
4 paint, so therefore he should be entitled to
5 benefits. You've got to have proof of a direct
6 causal relationship and the closest he came was
7 having one doctor say there was a contributory
8 relationship. But again, even if we were to
9 found that to be a sufficient upon which to
10 award him a finding that repetitive trauma
11 caused his current headaches, it's the law of
12 the case, you can't award medical or
13 compensation benefits because those findings
14 were not appealed. Accident's still out there.
15 I'm not sure if they've abandoned their claim
16 under 42-11-60, but it's clear that anything
17 gradual in nature would not be compensable as
18 an accident as a matter of law. With regard to
19 the documentary evidence, we believe all of our
20 documentary evidence was both properly
21 submitted and timely submitted and that there
22 was no error by admitting our documentary
23 expert reports. The Claimant also argues that
24 Dr. Pritchard's report should -- and the
25 deposition testimony should be stricken from

1 the record because they don't believe the time
2 and place of the IME were appropriate. He went
3 to that IME, I think that argument is moot now,
4 and certainly doesn't go to the sufficiency or
5 admissibility of that evidence especially given
6 the fact that they were able to cross-examine
7 Dr. Pritchard. And lastly, regarding these
8 arguments that the Hearing Commissioner didn't
9 fully address the headache claims, I think I
10 addressed that pretty -- with sufficient detail
11 in my brief to the Appellant Panel, it's my
12 final argument, but there -- the Hearing
13 Commissioner's order that he signed, it
14 addresses headaches repeatedly with respect to
15 whether or not it was repetitive trauma, with
16 respect to the occupational disease claim, with
17 respect to the accident statute, with respect
18 to medical benefits, and with respect to
19 compensation benefits. So the idea that it's
20 impermissibly vague is simply untrue. Counsel
21 had an opportunity to review the original order
22 -- and again, this claim was for encephalopathy
23 brain damage. It was only after the order
24 instructions that they somewhat amended the
25 claim to say hey, if we can't prove brain

1 damage, maybe you can just give me the
2 headaches. So we subtly clarified that in the
3 order.
4 **CHAIR:** And Ms. Barr, I know your time has run, but
5 I have ---
6 **MS. BARR:** Yes.
7 **CHAIR:** --- question on your assertion at the
8 beginning of your argument that they had
9 abandoned several claims.
10 **MS. BARR:** Yes.
11 **CHAIR:** When I read number one of the actual -- of
12 the attachment to the Form 30, it specifically
13 requests a review of all of the findings of
14 fact and conclusions of law.
15 **MS. BARR:** Right, but they weren't briefed. And a
16 matter that's not briefed -- just a summary
17 assertion or raising something on a Form 30
18 does not preserve it for appeal. You must have
19 legal argument with analysis and legal
20 authority to support that claim. I think
21 that's well established precedent that you
22 can't merely just say hey, I'm reserving
23 everything, you have to make an argue- --
24 argument for it specifically. And here in this
25 case you'll see that not only is the brain

1 damage encephalopathy, fatigue, vertigo, all of
2 that, not mentioned in the brief, there's no
3 mention of those statutes at issue: 42-9-10,
4 20, 30, 42-15-60 or 42-9-260. They make no
5 reference to them whatsoever in any argument in
6 their brief. So, I would submit to you it's
7 insufficient to put it on your Form 30, you
8 actually have to brief that argument as well.
9 Thank you.
10 **CHAIR:** Good. Thank you, ma'am.
11 **MS. BARR:** Thank you.
12 **CHAIR:** Mr. McDaniel, you have three minutes.
13 **CLAIMANT'S REPLY:**
14 **MR. McDANIEL:** Of course you actually took care of
15 one issue for me, but I would submit that that
16 is incorrect what Ms. Barr just argued. She is
17 correct in reference to once items were
18 appealed to the Court of Appeals or up to the
19 Circuit Court, but as far as appeal from the
20 Single Commissioner to the Full Commission,
21 this is the fact finder, and I have
22 specifically asked this Commission to review
23 all the findings of fact and conclusion of law.
24 We also set out numerous exceptions in which we
25 ask you to look at all those in reference to

1 our various claims that were filed. Now, I
2 want to get back to a couple of things very
3 quickly. This is very important, and this is
4 what I was going to give you about the
5 timeline. You know, the Commissioner issued
6 his notes in November 17th of 2016, and those
7 -- I would ask you to review those, you're not
8 going to find any reference to what I just
9 quoted to you from our -- from the brief -- I
10 mean from the hearing transcript that day where
11 we specifically ask him saying, Commissioner,
12 Doctor, you know, White thinks he's at maximum
13 medical improvement and his condition is
14 permanent. Dr. Healy says, no, he's not at
15 maximum medical improvement and that he can be
16 helped. And we would ask you to place him
17 under the care of Dr. Healy and get him some
18 help. You know, it's really funny, I was
19 thinking about this on the way over here, we
20 got a hundred and fifty day statute even after
21 they start paying compensation if they could
22 still ask the doctors the questions -- but
23 anyway, I digress. In reference to the
24 statement that Dr. Healy did not address that,
25 I would point the Commission to page 43 in

1 which Dr. Healy said, but I see headaches for
2 all kinds of reasons and that has been one in
3 the past, painters and por- -- or people
4 exposed, often it's called monoxide, but people
5 exposed to substances. Dr. Healy confirmed his
6 previous statement that he had treated painters
7 and all that, and it's also throughout the
8 record. Next, yes, Mr. Malloy wrote a letter
9 in January in which he asked the Commissioner
10 specifically to review his notes and -- and
11 make findings of fact and conclusions of law
12 concerning our alternative pleading asking him
13 to be found not at maximum medical improvement,
14 and that his chronic residual headaches stem
15 from the accident. I then again repeated that
16 whenever I reviewed the order. And by letter
17 dated September 18th of 2017, I again asked the
18 Commissioner, based on this we pled in the
19 alternative for the finding that he was not at
20 maximum medical improvement, that the
21 continuing headaches were either directly
22 caused or aggravated and caused to become
23 symptomatic by his daily exposure to volatile
24 organic compounds. On that evening at 6:25
25 p.m. September 18th, Ms. Barr sent the

1 Commissioner that note I referred to earlier,
2 that in light of Mr. McDaniel's arguments ---
3 (Alarm goes off.)
4 **MR. McDANIEL:** --- that Claimant may be entitled to
5 benefits for headaches, I had -- I had modified
6 the findings of fact and conclusions of law to
7 address those issues. The -- I then wrote a
8 letter, I couldn't believe that she was doing
9 that without the direction from the
10 Commissioner. And then on that afternoon --
11 that was on the -- September the 19th, on the
12 morning of September 20th the Commissioner
13 signed the order the second -- the la- -- the
14 third revised order, which was that second one
15 that I just referred to, without addressing our
16 request for a conference on reconsideration.
17 All that's in the record and I think I heard
18 the buzzer go off ---
19 **CHAIR:** You did.
20 **MR. McDANIEL:** --- so I -- I can only stretch a
21 sentence out for so long. I hope one day I'll
22 be given an award for having the longest run-on
23 sentence in the history of the Commission.
24 Thank you very much.
25 **CHAIR:** Thank you. Thank y'all very much. That

1 concludes this matter.

2 **(There being nothing further, the full commission**

3 **hearing concluded at 4:42 p.m.)**

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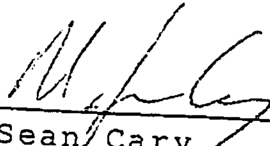
CERTIFICATE

This is to certify that the within hearing consisting of twenty seven (27) pages, is a true and correct transcript of the testimony given by said witnesses after being duly sworn; said hearing was reported by the method of Stenomask with Backup.

I further certify that I am neither employed by nor related to any of the parties in this matter or their counsel; nor do I have any interest, financial or otherwise, in the outcome of same.

IN WITNESS WHEREOF I have hereunto set my hand and seal on August 2, 2018.



M. Sean Cary
Court Reporter

Notary Public for South Carolina
My Commission Expires: January 29, 2023

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Proudly representing injured workers for over 30 years.

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Facsimile (803) 252-0709

November 24, 2015

VIA EMAIL - sdebruhl@wcc.sc.gov
AND US MAIL
Commissioner T. Scott Beck
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

RE: Kenneth Barr v. Darlington County Schools
WCC File No.: 1507304

Dear Commissioner Beck:

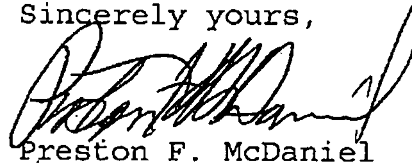
I am in receipt of the Administrative Order compelling Mr. Barr to appear before Dr. Mark Wagner, Ph.D. in Charleston, SC for a, "medical examination". I would respectfully request that the Order be withdrawn or stayed and that we be granted at least a telephone conference concerning the Motion before issuance.

As I know you are aware, this is an Administrative Order which is not directly appealable but more importantly as I know you are aware, I previously filed a Writ of Mandamus over this same issue, requiring my client attend an examination by a non-medical doctor, and because the Full Commission ruled it was interlocutory and I could not appeal it directly.

The same exact issue was involved in that case as is involved in this case. Dr. Mark Wagner, Ph.D. **is not** a medical doctor. The Supreme Court has specifically ruled concerning an IME that the defendants are not entitled to send a plaintiff to a anyone other than **a licensed physician or surgeon** for evaluation. In this case, my client has been out there without any benefits, totally disabled, ever since May and to order this without a hearing or at least a telephone conference in light of the wording of the statute, the previous Supreme Court decision, and assuming the hearing is delayed because of having to challenge this, most respectfully this would be a violation of my client's constitutional rights under color of State Law.

I would most respectfully request at least a telephone conference on the Record before making a decision. By copy of this letter, I am notifying and serving a copy of this Request for Reconsideration and for a telephone conference and/or hearing before you on this issue.

Sincerely yours,



Preston F. McDaniel

PFM/kth
Enclosure

cc: Gerald Malloy, Esquire (Via email and US Mail)
Kirsten L. Barr, Attorney (Via email and US Mail)

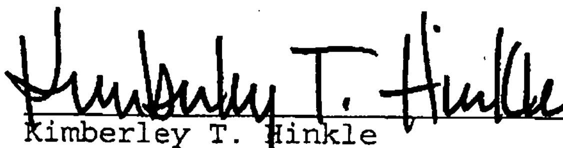
CERTIFICATE OF SERVICE

WCC FILE NO.: 1507304

I hereby certify that I have on this day served the following in the matter of Kenneth Barr v. Darlington County Schools with a copy of the **REQUEST FOR RECONSIDERATION** by depositing the same in the United States Mail, with adequate postage thereon, addressed as follows:

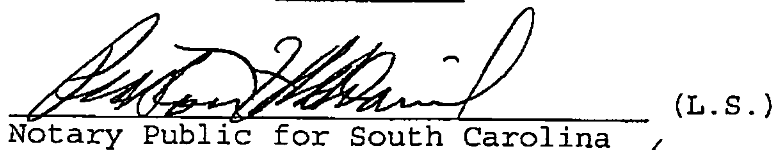
VIA EMAIL - sdebruhl@wcc.sc.gov
AND US MAIL
Commissioner T. Scott Beck
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202

VIA EMAIL - kbarr@trask-howell.com
AND US MAIL
Kirsten L. Barr, Attorney at Law
Trask & Howell
P.O. Box 2167
Mt. Pleasant, SC 29465



Kimberley T. Hinkle

SWORN TO BEFORE ME this
24th day of November 2015.



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