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THE STATE OF SOUTH CAROLINA
In the Court Appeals

APPEAL FROM LEXINGTON COUNTY
Court of Common Pleas
Walton J. McLeod, IV, Circuit Court Judge

Appellate Case No. 2020-001089

Diane Connell, ……..Respondent,

v.

Lexington County Health Services District, Inc.
d/b/a Lexington Medical Center, ……..……Appellant.

RECORD

Patrick J. Frawley
Evan M. Gessner
Davis Frawley, LLC
140 East Main Street
PO Box 489
Lexington, South Carolina 29071
803-359-2512

ATTORNEYS FOR APPELLANT

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	ELEVENTH JUDICIAL CIRCUIT
Diane Connell,	)	CIVIL ACTION No.: 2018-CP-32-1750
	)	
Plaintiff,	)	
	)	
vs.	)	**ORDER AND ENTRY OF JUDGMENT**
	)	
Lexington County Health Services District, Inc. d/b/a Lexington Medical Center,	)	
	)	
Defendant.	)	

This premises liability matter came before this Court for a bench trial on March 2, 2020. Robert Goings, Esquire and Jessica Gooding, Esquire appeared on behalf of Plaintiff Diane Connell. Evan Gessner, Esquire appeared on behalf of Defendant Lexington County Health Services District, Inc. d/b/a Lexington Medical Center ("LMC"). Both parties were allotted thirty (30) days to submit proposed orders addressing their respective legal arguments.

Plaintiff Diane Connell ("Mrs. Connell") brought this premises liability action seeking to recover damages she sustained when she fell after entering an LMC parking garage which is owned and operated by Defendant LMC. Mrs. Connell asserts that she fell as a result of LMC leaving an elevation change or curb in a concrete pedestrian walkway unpainted, which had a camouflaging effect preventing her from seeing the elevation change. This fall resulted in painful injuries, medical bills, and other damages. The undersigned received 14 Exhibits into evidence and heard testimony from: Diane Connell; Steven Connell; Christopher Brewer; James Loging, M.D. (by video); Lindsay Moore, PA-C; Charles Alford, Ph.D.; Dale Thompson (live and by deposition); and Cory Andrews (by deposition). Exhibits also included several photographs from the subject garage as well as still shots from the surveillance video showing Plaintiff's fall. No dispositive motions for summary judgment were filed by either party prior to the bench trial.

Both parties agree that the Plaintiff was injured in the LMC garage and that her fall caused

her injury. The primary issue in dispute before this court is whether Defendant is legally responsible for the injury, and if so what damages should be awarded to the Plaintiff.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

PARTIES & JURISDICTION

Plaintiff, Mrs. Connell, is a 68 year old citizen and resident of Lexington County, South Carolina. Defendant LMC is a hospital district in Lexington County, South Carolina, and the facts and circumstances surrounding this action occurred on its premises in Lexington County. Accordingly, the Court has specific and general jurisdiction over the parties and venue is proper.

FACTS

On September 26, 2017, a clear and sunny day, Mrs. Connell accompanied her husband to a doctor's appointment on the LMC campus. Mr. Connell dropped Mrs. Connell off at the entrance to the doctor's office building and went to park their vehicle in the LMC garage by himself. After the appointment, Mr. & Mrs. Connell followed the sidewalk into LMC Parking Garage 3, where their vehicle was parked. This was Mrs. Connell's first time entering the garage, and not far from the pedestrian entrance to the garage there is a curb with a greater-than-six-inch elevation drop to the driveway utilized by vehicles leaving the garage. However, the evidence showed both the sidewalk and the driveway were gray concrete, and there was no paint or other demarcation on the top of the curb signaling the sudden elevation change. Mrs. Connell was unable to see the curb or visually recognize the change in elevation. As a result, her heel caught the curb, causing her to fall forward and strike her left knee and head on the concrete. She immediately experienced severe pain in her left knee. Mr. Connell, who was walking a few feet behind Mrs. Connell, testified that his wife screamed in agony, and that he was unable to get her to her feet. Others in the parking lot came to assist the couple, and together they were able to get Mrs. Connell to a seated position on the curb.

Chris Brewer, an off duty officer with Allen University who testified at trial, arrived on the

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scene shortly after Mrs. Connell was seated on the curb. He stopped to render aid and assessed the scene. Mr. Brewer testified that he could see that Mrs. Connell had fallen off the curb, which was very difficult to discern from the direction where she was walking. Mr. Brewer also testified that other curbs in the parking garage were painted yellow, except for the curb that resulted in Mrs. Connell's fall. He recalled that she was clearly suffering and needed immediate medical attention. Another person present called for a security golf cart to come to the scene and transport Mrs. Connell to the LMC Emergency Room, as she was unable to ambulate without assistance. Mr. Brewer assisted Mrs. Connell onto the golf cart, being careful to keep her leg straight on the back seat. Mrs. Connell testified that bending her knee in any way was very painful.

In the LMC Emergency Room, Mrs. Connell was diagnosed with a right ankle sprain and displaced comminuted fracture of the left patella. She was required to spend two nights in the hospital and undergo an open reduction internal fixation surgery, where screws and metal wire were used to repair her kneecap.

After discharge, Mrs. Connell followed up with Lexington Orthopedic and went through in-home rehabilitation. Thereafter, in order to have an orthopedist not associated with LMC, Mrs. Connell sought continued treatment with Dr. James Loging of Palmetto Bone and Joint, PA. She has treated regularly with Dr. Loging for ongoing pain and discomfort in her left knee. In his video deposition, Dr. Loging opined that the hardware in Mrs. Connell's kneecap was irritating the joint and contributing to her discomfort. For this type of injury, he testified that almost a "hundred percent of the time" a hardware removal is needed "because of the high incidence of hardware irritation and problems from the hardware."

Subsequent to his *de benne esse* deposition on November 25, 2019, Dr. Loging performed a hardware removal surgery on Mrs. Connell on February 11, 2020. While Dr. Loging expressed hope that this surgery would reduce Mrs. Connell's discomfort, he also testified that the incongruity of her joint where the patella fracture healed would cause "grinding" and "mechanical

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symptoms." Over time, Mrs. Connell will develop post-traumatic arthritis, which will "progressively get worse to the point where the pain would be intolerable," and she will require a knee replacement surgery. He testified that "given the incongruity of her joint, her chance of developing post-traumatic arthritis is essentially a hundred percent guaranteed," and he was confident that she will undergo a knee replacement surgery in the future. Dr. Loging was unable to say definitively whether Mrs. Connell's knee replacement would be a partial or a total knee replacement, but he testified that she would "definitely" need a knee replacement "because of the that trauma that's there." To a reasonable degree of medical certainty, however, Dr. Loging testified that he would "recommend a full knee replacement, actually, just because the longevity and the decreased chance of having to have a revision of that knee in the future and the success rate [of a total knee replacement] would be higher [than a partial knee replacement]." In the meantime, Dr. Loging recommends that she undergo Supartz injections in her knee every six months until her condition deteriorates enough to require the knee replacement.

Mrs. Connell has incurred $55,839.38 bills to date, and she is continuing to incur medical bills in her treatment with Palmetto Bone and Joint, PA. Dr. Loging has also indicated that Mrs. Connell will most probably need pain management injections and physical therapy. Based on Dr. Loging's recommendations, Lindsay Moore, PA-C, a Certified Nurse Lifecare Planner, put together a report estimating Mrs. Connell's future medical cost needs. The report includes two scenarios: one in which Mrs. Connell has a partial knee replacement and one in which she has a full knee replacement. Ms. Moore testified that Mrs. Connell's knee replacement surgery, whether it is a partial or full replacement, would most likely be an inpatient procedure, especially due to Mrs. Connell's comorbidities. Mrs. Connell further testified that she would rather have the

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procedure in the hospital setting since it would require general anesthesia. Charles Alford, PhD took Ms. Moore's report and, accounting for inflation, provided the present value of Mrs. Connell's future medical costs.[1] Assuming Mrs. Connell does not have a knee replacement in the next three years, the present value of the pain management injections she will most probably need is $9,854.00. The present value of the knee replacement surgery ranges from $162,479.00 to $216,163.00 depending on when it takes place.[2]

In addition to the medical expenses Mrs. Connell has incurred and will continue to incur, she has suffered immense pain and been very limited by her injuries. Mrs. Connell and her husband testified that she was essentially bedridden for the first week after being discharged from LMC. She was unable to shower and used a bedside commode with assistance. After the first week, she began in-home rehabilitation, which consisted of frequent painful exercises to regain the use of her knee. She was required to use a walker for months and continued to rely upon her husband to prepare her meals, help her from the bed into a chair, assist her with bathing, handle the housework and laundry, take care of the grocery shopping, etc. The pain and discomfort limited her ability to spend time with her family and her grandchildren, as well as caused a significant loss of enjoyment of her life. She had a second open knee surgery to remove the hardware in her knee more than two years following the injury because she continued to have pain whenever she attempted to walk on an uneven surface or incline, go up and down stairs, stoop or kneel. Her limitations have forced Mrs. Connell to miss out on family holidays, time with her grandchildren, and gardening, which is her favorite hobby. Even at the time of trial, Mrs. Connell was still doing her exercises daily to attempt

[1] Because Ms. Moore's report is based on the recommendations Dr. Loging made in his deposition in November 2019, both Ms. Moore's report and Dr. Alford's report include the hardware removal surgery as a future cost. As trial was delayed and took place after the hardware removal was completed, those costs are now included in the past medical costs, and the Court has removed those expenses from the future costs projections for the purpose of determining damages in this case.

[2] Although Ms. Moore's report included alternate scenarios depending on whether Mrs. Connell had a full or partial knee replacement, the expenses in the two scenarios were very similar. Therefore, Dr. Alford's report assumed that Mrs. Connell will have a full knee replacement in the future.

to continue her slow progress with mobility.

Mrs. Connell asserts that the curb where she fell was a hazard to pedestrians, and LMC breached its duty to remedy or warn of the hazard. The curb was painted on its face (i.e. the rise), so it could be seen by vehicular traffic or pedestrians exiting the garage, but it was not painted on top (i.e the run). Importantly, it appears clear from the evidence that the remainder of the curbing throughout the parking garage is painted yellow on the top and the side. The top side painting was absent in the location where Mrs. Connell fell. There was no demarcation of the change in elevation that could be seen by a person walking in the direction Mrs. Connell was walking.

Cory Andrews, LMC's Director of Risk Management, testified that LMC is responsible for the upkeep and maintenance of their facilities, such as parking garages. Mr. Andrews recognized the purpose of painting curbs in parking garages is to make them visible and admitted that Diane Connell would not have been able to see any yellow paint on the curb where she fell from the direction she was walking. He testified that he believed yellow paint being on the side and tops of the curbs was prevalent throughout the garage and the yellow paint is used to make elevation changes visible to the human eye. He also agreed that elevation changes on concrete are hard to see without demarcations such as paint and that Diane Connell would not have been able to see any paint on the curb where she fell from the direction she was walking. Further, Mr. Andrews testified that Mrs. Connell appeared to be walking normally and at an acceptable speed, and he could not identify anything that she did wrong that contributed to her fall.

Dale Thompson, LMC's Director of Facility Services, also agreed that curbing can cause a trip hazard and that when the concrete curb is the same color as the concrete ground, it has a "camouflaging effect," making it difficult to see where there is a change in elevation. Neither party has identified any regulatory code or rule that designates when and how a curb in a parking garage must be painted, but Mr. Thompson testified that while he was not sure, he thought the yellow

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paint markings or "striping" in the garage was required by code. He recognized that LMC is responsible for maintaining and inspecting the garage building to address any safety concerns, but prior to this incident, LMC had done nothing to call pedestrians' attention to the sudden change in elevation where invitees were expected to walk. Although Mr. Thompson testified that he was not aware of anyone else having fallen on that curb prior to Mrs. Connell's fall, he conceded that there may have been other falls where the injuries were just not severe enough to cause someone to report them. Mr. Thompson also conceded on cross-examination at trial that the condition of the parking garage as depicted in the photographs constituted a "trip hazard" because it was hard to see the curb or its change in elevation. Finally, Mr. Thompson conceded that the curb and its change it elevation would be more visible and safer to pedestrians if the top was painted yellow in a similar manner that curbs were found painted elsewhere in the parking garage.

At the close of the evidence Defendant renewed its objections and made a Motion for Directed Verdict and provided a memorandum in support of its motion to this Court. The parties stipulated they would submit proposed orders in lieu of closing arguments. After reviewing its motion, and hearing all the evidence, Defendant's Motion for Directed Verdict is denied. Accordingly, this Court makes the followings findings of fact and conclusions of law.

STANDARD OF REVIEW

In a bench trial, the trial judge acts as the finder of fact. *Lollis v. Dutton*, 421 S.C. 467, 483, 807 S.E.2d 723, 731 (Ct. App. 2017). "[T]he judge, as the finder of fact, may believe all, some, or none of the testimony, even when [the testimony] is not contradicted." *Id.* (internal citation omitted). A trial judge will be accorded great deference where matters of credibility are involved. *Id.* (internal citations omitted). "Because the appellate court lacks the opportunity for direct observation of the witnesses, it should accord great deference to [circuit] court findings where matters of credibility are involved." *Forrester*, 282 S.C. at 516, 320 S.E.2d at 42. *Lollis v.*

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Dutton, 421 S.C. 467, 483, 807 S.E.2d 723, 731 (Ct. App. 2017). On appeal of an action at law tried without a jury, we will not disturb the trial court's findings of fact unless no evidence reasonably supports the findings. *Jordan v. Judy*, 413 S.C. 341, 347–48, 776 S.E.2d 96, 100 (Ct. App. 2015)

LIABILITY

Mrs. Connell has asserted a claim of negligence, and more specifically, premises liability, against LMC. "To prove a cause of action for negligence, a plaintiff must show: (1) the defendant owes a duty of care to the plaintiff; (2) the defendant breached that duty by a negligent act or omission; (3) the defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) the plaintiff suffered an injury or damages." *Roddey v. Wal-Mart Stores E., LP*, 415 S.C. 580, 589, 784 S.E.2d 670, 675 (2016). Thus, the Court must first determine, "as a matter of law, whether the defendant owed a duty of care to the plaintiff." *Huggins v. Citibank, N.A.*, 355 S.C. 329, 332, 585 S.E.2d 275, 276 (2003).

The duty of care a landowner owes to a person upon its premises depends upon the classification of the individual; she may be an invitee, licensee, adult trespasser, or child. *Larimore v. Carolina Power & Light*, 340 S.C. 438, 444, 531 S.E.2d 535, 538 (Ct. App. 2000). "An invitee is a person who enters onto the property of another at the express or implied invitation of the property owner." *Goode v. St. Stephens United Methodist Church*, 329 S.C. 433, 441, 494 S.E.2d 827, 831 (Ct.App.1997). "[A] person is an invitee on the land of another if he enters by express or implied invitation, his entry is connected with the owner's business or with an activity the owner conducts or permits to be conducted on his land, and there is a mutuality of benefit or a benefit to the owner." *Sims v. Giles*, 343 S.C. 708, 716–17, 541 S.E.2d 857, 862 (Ct. App. 2001). "Invitees include . . . patients in a physician's office" *Id.* As Plaintiff was accompanying her husband to a doctor's appointment on LMC's premises, Mrs. Connell was undeniably an invitee. LMC does

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not dispute her status as an invitee.

"[T]he invitee is offered the utmost duty of care by the landowner." *Id.* at 715, 541 S.E.2d at 861. "[A]lthough the operator of a parking lot is not an insurer of the safety of those who use the lot, reasonable care must be used by the operator to keep the premises used by invitees in a reasonably safe condition." *Hancock v. Mid-S. Mgmt. Co.*, 381 S.C. 326, 331, 673 S.E.2d 801, 803 (2009). A property owner "owes the customers the duty of exercising ordinary care to keep the passageways, sidewalks and such other parts of the premises as are ordinarily used by the customers in transacting business in a reasonably safe condition." *Bruno v. Pendleton Realty Co.*, 240 S.C. 46, 51, 124 S.E.2d 580, 582 (1962). "A landowner owes an invitee a duty of due care to discover risks and to warn of or eliminate foreseeable unreasonable risks." *Landry v. Hilton Head Plantation Prop. Owners Ass'n, Inc.*, 317 S.C. 200, 203, 452 S.E.2d 619, 621 (Ct. App. 1994). If a risk of injury is "reasonably foreseeable," the landowner must take action to prevent the injury. *Nelson v. Piggly Wiggly Central, Inc.*, 390 S.C. 382, 392, 701 S.E.2d 776, 781 (2010).

In this case, LMC admits that Mrs. Connell was an invitee on its premises and that it owes her the duty above described. LMC further admits that Mrs. Connell sustained a patella fracture when she fell in the LMC parking lot. The issue in this case is whether the scope of the acknowledged duty of reasonable care extends to the particular risk that led to Mrs. Connell's injuries. Thus, Mrs. Connell prevails only by showing that it was reasonably foreseeable that someone might fall as a result of the unpainted curb and LMC either (1) created the hazard or (2) had actual or constructive knowledge of the hazard and failed to remedy it. *Garvin v. Bi-Lo, Inc.*, 343 S.C. 625, 628, 541 S.E.2d 831, 832 (2001). Constructive notice may be proven by showing that the dangerous condition existed long enough that the defendant should have discovered it. *Wimberly v. Winn Dixie Greenville Inc.*, 252 S.C. 117, 121, 165 S.E.2d 627, 629 (1969). Based on the totality of evidence before this Court, in particular the photographs of the parking garage and the

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unpainted curb where Mrs. Connell fell, as well as the testimony of LMC's witnesses Dale Thompson and Cory Andrews, Mrs. Connell has carried the burden of proof.

This case is similar to *Bruno v. Pendleton Realty*, where our Supreme Court upheld a verdict in favor of a store patron who fell "as a result of stepping on the edge of a curbing, which was concealed by a heavy growth of grass." *Id.* at 48, 124 S.E.2d at 581. In that case, there was a sidewalk and a walkway that intersected in the parking lot, and grass had grown in the crack at the intersection, which "gave the appearance that the walkway and sidewalk were on the same level." *Id.* at 52, 124 S.E.2d at 583. Testimony established that the patron had not used that particular walkway before, the patron had the impression that the sidewalk and the walkway were the same height, and the walkway and the sidewalk were the same color, "giving the impression that it was one continuous walk." *Id.* at 52-53, 124 S.E.2d at 583. Although evidence showed the property owner inspected the premises two or three times per week, the condition had existed for a month or more at the time the patron fell. The court held, "[t]he mere fact that there is a difference between the levels in the different parts of the premises does not, in itself, indicate negligence unless, owing to the character, location and surrounding condition of the change of level, a reasonably careful person would not be likely to expect or see it." *Bruno v. Pendleton Realty Co.*, 240 S.C. 46, 51, 124 S.E.2d 580, 582 (1962). Further, the court pointed out that where a property owner knew or should have known of a dangerous condition that is unknown to an invitee, "the owner is required to give proper warning in order to relieve himself from liability for injuries incurred by reason thereof." *Id.* at 52, 124 S.E.2d at 583. The *Bruno* court found that the evidence was sufficient to find that the property owner, "in the exercise of ordinary care to make its premises reasonably safe, . . . should have given warning of the situation, or taken other precautions to guard against injury to the [patron]." *Id.* at 54, 124 S.E.2d at 584.

Like the patron who fell in *Bruno*, the Plaintiff, Mrs. Connell, was unfamiliar with the

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pedestrian walkway leading into the parking garage at LMC. She testified that she was looking ahead of her as she walked but was unable to see any curb or change in elevation and believed the surface before her to be flat. In addition, Mr. Connell and Mr. Brewer testified that both the walkway and the driveway were concrete, and it gave the appearance that they were on the same level.

It is foreseeable that a reasonably prudent person walking into the garage, as Mrs. Connell was, would not expect or observe the curb or elevation change of the walking surface. LMC completed construction of this parking garage in or around 2008 and regularly inspected the premises. Nine years is certainly sufficient time for LMC to have realized that the lack of paint on a curb between two levels of concrete had a camouflaging effect, but more than that, LMC created this hazard by failing to paint the curbs when it built the garage in 2008. The fact that LMC painted both the top and side of other curbing/elevation changes on walking surfaces throughout the parking garage, but failed to ensure that the top of the curb was painted where Mrs. Connell fell, is evidence that LMC created the hazardous condition, or at the very least, knew or should have known this condition existed. In spite of its knowledge that the concrete pedestrian walkway suddenly dropped down to the concrete driveway, with no color change or other distinguishing characteristics, LMC did nothing to alert pedestrians to this change in elevation. This failure is a breach of the duty of care LMC owes invitees on its premises.

LMC argues that *Bruno* actually supports its position on the theory that there can be no liability where there is no new defect. Essentially, LMC argues that its failure to paint the curb on the top side, which would make it visible to pedestrians walking into the garage, cannot make LMC liable for Mrs. Connell's injury because the curb has been in that state since construction, and there is no grass hiding the curb or other defect that has developed to make this area more hazardous. This argument is not persuasive. The court in *Bruno* found sufficient evidence of

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negligence to uphold the verdict based on the invitee's inability to see the change in elevation and the landowner's failure to make the elevation change visible or warn of its existence. The grass that had grown in the crack between the walkway and the sidewalk contributed to the inability to see the curb in that instance, but there is nothing to say that a curb cannot be difficult to see, and thus, hazardous, to an invitee unfamiliar with the parking area without the growth of grass or some other obstacle. This is especially true in the instant case, where there is clear evidence that the curb or change in elevation is not visibly apparent. The photographs and testimony of the witnesses, including LMC representatives, present strong and credible evidence of a trip hazard due to the inability to readily visualize the change in elevation. In this case, just like in *Bruno*, it should have been obvious to the property owner that a pedestrian using the appropriate walkway might be unable to see the change in elevation, thereby making it unreasonably hazardous. Thus, LMC's failure to remedy or warn of the potential danger is a breach of its duty to Mrs. Connell.

In addition to its argument based on *Bruno,* LMC argued at trial that it cannot be liable for Mrs. Connell's injuries because (1) Plaintiff has not identified a statute or code that LMC violated; (2) there is no evidence that it had constructive notice of this hazardous condition; (3) no one ever reported being injured by falling on this curb prior to Mrs. Connell's fall; and (4) even if LMC was negligent, Mrs. Connell was also negligent, and her negligence outweighs that of LMC, barring her claim. Each of these arguments is addressed in turn below.

First, relying on *Nelson v. Piggly Wiggly,* LMC argues that it cannot be liable because Mrs. Connell has not pointed to a statue or code regulation that requires the curb be painted on both sides. In *Nelson*, a store customer was injured when her grandmother's car drove over the wheel stop in the Piggly Wiggly parking lot and pinned her to the exterior store wall. *Id.* at 386, 701 S.E.2d 776, 778. The customer argued that the wheel stops were installed too close to the building because "there was no room for a pedestrian to escape injury if a car crossed a wheel stop" and the

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improper installation of the wheel stops "created hazards." *Id.* at 387, 701 S.E.2d at 778. The customer's expert witness testified to the hazardous design but could not identify any specific code violations. *Id.* at 386-87, 701 S.E.2d at 778. The court held that Piggly Wiggly did not have a duty to protect the customer from this injury because it was "legally unforeseeable." It explained that "the injury resulted not from the condition or placement of the wheel stops but from the operation of Grandmother's vehicle," and the grandmother's car accelerating over a wheel stop after stopping in a parking space was "unexpected and unusual." *Id.* at 394, 701 S.E.2d at 782. The court also held that the expert witness's opinion did not "as a matter of law, establish a duty on [Piggly Wiggly] to guard against the possibility that an improperly operated vehicle would injure [its customer]." *Id.* at 393, 701 S.E.2d at 781-82. In essence, the *Nelson* court found that Piggly Wiggly was not required to protect this customer from her grandmother's negligence. *Id.* at 394, 701 S.E.2d at 782.

LMC's interpretation of this case to say that a plaintiff cannot recover unless she is able to identify a code violation is flawed. A code violation is not required to prove negligence. The lack of liability in *Piggly Wiggly* was not based on the failure to point to a code violation, but based upon the unforeseeability of the intervening cause of injury to its customer. A violation of statue or code is relevant because if a violation is found, it may establish that there was a duty as a matter of law, and constitute negligence *per se*. However, the absence of a code violation does not rule out the possibility of negligence. LMC has an obligation to use due care to keep its parking garage in a reasonably safe condition. Regardless of whether there is any regulatory code that required the tops of the curbs to be painted, doing so was evidently the Defendant's standard custom in the subject garage. [3] Visible yellow painting on the top and side of the curbs is prevalent throughout

[3] Black's Law Dictionary defines "Standard" as "a model accepted as correct by custom, consent, or authority." See STANDARD, Black's Law Dictionary (11th ed. 2019)

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the remainder of the garage, and Dale Thompson testified that he believed this striping was required by code. Further, Corey Andrews testified that curbs were generally painted in order to make changes in elevation visible to the human eye. Painting the top of the curbs, where pedestrians are intended to walk, clearly falls within what acts should be performed to eliminate foreseeable risks and to keep the parking garage reasonably safe whether or not it is specifically required by a code.

Next, LMC argues that there is no evidence that it had notice of the condition of the curb, and therefore, it cannot be held liable for Mrs. Connell's injuries. First, this argument is without merit because it ignores the fact that LMC created this hazard. LMC's own witnesses testified that LMC built the parking lot and had it "striped" (painted) in or around 2008 and thereafter would routinely inspect the garage for hazards. However, there is nonetheless evidence that LMC should have known of this condition because it had existed for years in a parking garage it maintains and is regularly accessed and utilized by its employees. Constructive notice may be proven by showing that the dangerous condition existed long enough that the defendant should reasonably have discovered it. *Wimberly v. Winn Dixie Greenville Inc.*, 252 S.C. 117, 121, 165 S.E.2d 627, 629 (1969). Defendant argues, without reliance on any authority, that the time a hazard existed may only provide evidence of constructive notice in foreign substance cases, such as where a store customer slips on something spilled on a floor. However, *Bruno*, discussed above, and *LeFont v. City of Myrtle Beach Convention Center*, App. Case No. 2017-001258, Opinion No. 5175 (S.C. Ct. App. Mar. 11, 2020), are both parking lot cases where an invitee tripped on an uneven surface, not a foreign substance, and the respective courts found evidence of notice based on the amount of time the hazards existed.[4] In *LeFont*, the invitee tripped in a pothole in the defendant's parking lot. *Id.* at slip op. *2. The trial court held that there was no evidence the defendant had constructive

[4] The *Bruno* court cited testimony indicating that the walkway and sidewalk had been in the same condition for at least a month before the patron fell there. *Id.* at 52, 124 S.E.2d at 583.

notice of the pothole, but the court of appeals reversed, citing testimony that the pothole contained dirt and debris, which would allow a fact finder to infer that the hole had existed long enough for the defendant's employees to discover it. *Id.* at slip op. *8. Thus, it is appropriate to impute knowledge of the hazardous curb on LMC based on its opportunity to observe the hazard over the nine years since construction.

LMC also argues that it did not have notice of the hazardous condition because no one reported any injuries resulting from a fall in that location prior to Mrs. Connell falling. To hold that this lack of report was proof that there was no constructive notice of the hazard that existed would be to grant property owners a "one free fall" rule, excusing them from liability the first time a hazardous condition on their property caused an injury. This idea is inconsistent with the law of this state. In South Carolina, if it is "reasonably foreseeable" that the property poses a risk to an invitee, the landowner must take action to prevent the injury. *See Nelson v. Piggly Wiggly Central, Inc.*, 390 S.C. 382, 392, 701 S.E.2d 776, 781 (2010). "The mere fact that a particular kind of an accident has not happened before does not . . . show that such accident is one which might not reasonably have been anticipated." *Bass v. Gopal, Inc.*, 395 S.C. 129, 136-37, 716 S.E.2d 910, 914 (2011). A defendant is not excused from liability based on "the fortuitous absence of prior injury." *Id.* LMC's own witnesses agreed that elevation changes could create trip and fall hazards and that the lack of paint on the top portion of the curb where Mrs. Connell fell created a "camouflaging effect" on the elevation change, such that a reasonably prudent person is likely not to see it. This creates a foreseeable risk of falling and sustaining injury, and LMC had a duty to protect against that risk.

Finally, there is no evidence that Mrs. Connell's conduct contributed to her fall. The security camera footage corroborates Mrs. Connell's testimony that she was walking straight and looking ahead when she fell. There is no evidence that she was distracted, not looking where she

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was walking, or behaving unreasonably. LMC's own witness admitted that upon reviewing the video, he did not observe any action on her part that contributed to her fall. Therefore, this court holds that there was no contributory negligence on her part. As to the question of the whether Defendant breached its duty to Mrs. Connell for which Defendant is legally responsible, this court finds in the affirmative.

INJURIES AND DAMAGES

Because the Court has concluded that LMC is liable for the injuries and damages Mrs. Connell sustained when she fell in its parking garage, it is necessary to determine the amount of Mrs. Connell's damages. "Actual damages are awarded to a litigant in compensation for his actual loss or injury." *Austin v. Specialty Transp. Servs., Inc.*, 358 S.C. 298, 594 S.E.2d 867, 874 (Ct. App. 2004). Such damages "include compensation for all injuries which are naturally the proximate result of the alleged wrongful conduct of the defendant." *Id*. The elements that are properly considered in determining the amount of actual damages for personal injury include medical expenses, pain and suffering, loss of income and earning power, and loss of enjoyment of life. *See Schumacher v. Cooper*, 850 F. Supp. 438, 453 (D.S.C. 1994) (citing *Watson v. Wilkinson Trucking Co.*, 244 S.C. 217, 136 S.E.2d 286 (1964)).

"In a personal injury action, the plaintiff must recover for all injuries, past and prospective, which arose and will arise from the defendant's tortious activity." *Haltiwanger v. Barr*, 258 S.C. 27, 32, 186 S.E.2d 819, 821 (1972). "Thus, recovery must be had for future pain and suffering, and for the reasonable value of medical services and impaired earning capacity, to the extent that these injuries are reasonably certain to result in the future from the injury complained of." *Id*.; *see also Watson v. Wilkinson Trucking Co.*, 244 S.C. 217, 228, 136 S.E.2d 286, 291 (1964) (stating a plaintiff is "entitled to recover all damages proximately resulting from the negligent acts of the defendant," including "pain and suffering, and medical expenses, including any future damages

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resulting from permanent injuries"). "An award for pain and suffering compensates the injured person for the physical discomfort and the emotional response to the sensation of pain caused by the injury itself." *Boan v. Blackwell*, 343 S.C. 498, 501–02, 541 S.E.2d 242, 244 (2001). "Pain and suffering have no market price. They are not capable of being exactly and accurately determined, and there is no fixed rule or standard whereby damages for them can be measured." *Harper v. Bolton*, 239 S.C. 541, 548, 124 S.E.2d 54, 57 (1962). "Separate damages are given for mental anguish where the evidence shows, for example, that the injured person suffered shock, fright, emotional upset, and/or humiliation as the result of the defendant's negligence." *Boan*, 343 S.C. at 501–02, 541 S.E.2d at 244. "[D]amages for 'loss of enjoyment of life' compensate for the limitations, resulting from the defendant's negligence, on the injured person's ability to participate in and derive pleasure from the normal activities of daily life, or for the individual's inability to pursue [her] talents, recreational interests, hobbies, or avocations." *Boan*, 343 S.C. at 502, 541 S.E.2d at 244. A plaintiff may also recover damages for permanent physical scarring. *Howle v. PYA/Monarch, Inc.*, 288 S.C. 586, 601, 344 S.E.2d 157, 165 (Ct. App. 1986). The monetary value to assign a plaintiff's damages is "a matter resting within the sound judgment of the" fact-finder. *Id*.

Mrs. Connell suffered significant injuries when she fell in the LMC garage. Her husband, Steven Connell, testified that as soon as she fell, she started screaming in agony. He was unable to get Mrs. Connell to her feet, but with the assistance of some passersby, they were able to get her to a seated position on the curb. She was taken immediately to the Emergency Room at LMC, where she was admitted and had surgery the next day. She testified that bending her knee at all caused her excruciating pain. Following surgery, which left a large scar on her knee, Mrs. Connell was discharged from the hospital but had very limited mobility. She was not able to shower for the first week she was home, and she required assistance to use a bedside commode. Mrs. Connell

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relied on her husband to prepare her meals, assist her with personal hygiene, and handle all household tasks such as grocery shopping, housework, and laundry, for weeks. Even after regaining some mobility, she has been very limited in her ability to squat or kneel, which has resulted in her being unable to return to gardening, which she loves. Mr. Connell still accompanies her to the grocery store so he can assist with reaching things on lower shelves because stooping causes her such pain. At the time of trial, Mrs. Connell had just recently undergone a hardware removal surgery with Dr. James Loging, which she hoped would alleviate some of her pain. Still, Dr. Loging made it clear that Mrs. Connell would develop post-traumatic arthritis in her knee because of the way her injury healed, which will lead to more pain and, ultimately, a knee replacement surgery.

LMC did not present any expert testimony or other evidence to refute that Mrs. Connell's medical treatment was reasonable and necessary or to present alternative figures for the costs of her future treatment. LMC also does not dispute Dr. Loging's testimony that Mrs. Connell will require a third knee surgery in the future. LMC's only contest to any element of the damages Mrs. Connell presented was to challenge Ms. Moore's determination that Mrs. Connell would most likely have the recommended knee replacement surgery inpatient in large part due to her preexisting comorbidities. In objecting to her testimony, LMC argues that she is not qualified to give this opinion because she does not have hospital admitting privileges. The Court disagrees and in overruling the objection holds that Ms. Moore properly based her opinion on her clinical experience, training she has received regarding common practices, and research on this subject.[5] As a Certified Nurse Life Care Planner, Ms. Moore has been trained on common practices amongst physicians in various treatment scenarios. In addition, as a Physician's Assistant practicing in the

[5] Subsequent to trial, and in conjunction with providing proposed orders, the parties emailed this Court with additional arguments on the merits including deposition evidence from witnesses, as well has Ms. Moore's testimony and opinions. As this email exchange addressed the merits of the case and was reviewed by this Court it will be supplemented to the record as a Court's Exhibit.

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Emergency Room, Ms. Moore evaluates patient risks and makes recommendations regarding when patients should be admitted. Ms. Moore's testimony and the evidence before the court supports the fact that Mrs. Connell's knee replacement surgery would be in a hospital setting due to existing cardiovascular condition and the need for general anesthesia. It is not necessary that Ms. Moore be able to make the final determination on whether Mrs. Connell should be admitted to the hospital because future damages need not be proven to absolute certainty. *See Pearson v. Bridges*, 344 S.C. 366, 371, 544 S.E.2d 617, 619 (2001) (holding that plaintiffs must prove that their future damages are "reasonably certain to occur"). While Ms. Moore's opinions are not guaranteed to occur verbatim, they are far from speculative. The evidence Mrs. Connell presented is sufficient to show that a future inpatient surgery is reasonably certain to occur.

Mrs. Connell has proven by a preponderance of the evidence that she incurred causally-related health care expenses of $55,839.38 and that she will incur additional medical expenses in the future all of which are reasonable and necessary as a direct and proximate result of injuries she suffered from the September 26, 2017 fall. In addition, Mrs. Connell has shown by a preponderance of the evidence that she has suffered significant pain, mental anguish, inability to care for herself, and loss of enjoyment of her life, and that she will suffer these damages into the future for an indefinite period of time.

Mrs. Connell has proven her case by a preponderance of the evidence and shown an award of actual damages, to include past and future medical costs, past and future pain and suffering, mental anguish, anxiety, and loss of enjoyment of life to be appropriate. In light of the all the testimony and documentary evidence, as well as the arguments of counsel, this Court awards a judgment for the Plaintiff against Defendant in the amount of $225,000.00.

IT IS SO ORDERED.

[SIGNATURE PAGE TO FOLLOW]

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Lexington Common Pleas

Case Caption: Diane Connell VS Lexington County Health Services District Inc , defendant, et al

Case Number: 2018CP3201750

Type: Order/Civil Judgment

It Is So Ordered

s/ Walton J. McLeod

ELECTRONICALLY FILED - 2020 Jul 31 5:23 PM - LEXINGTON - COMMON PLEAS - CASE#2018CP3201750

STATE OF SOUTH CAROLINA	)	**IN THE COURT OF COMMON PLEAS**
	)	**ELEVENTH JUDICIAL CIRCUIT**
COUNTY OF LEXINGTON	)	
	)	
Diane Connell,	)	**Civil Action No: 2018-CP-32-1750**
	)	
	)	
Plaintiff,	)	
	)	**ORDER DENYING LEAVE TO DEPOSIT**
v.	)	
	)	
Lexington County Health Services District, Inc. d/b/a Lexington Medical Center	)	
	)	
Defendant.	)	
	)	

This matter came before this court on Defendant's Motion for Leave to Deposit the judgment filed and awarded in Mrs. Connell's favor against Defendant into the Court.

PROCEDURAL HISTORY

Plaintiff commenced her premises liability action on May 22, 2018, following a fall at Defendant's parking garage located in Lexington, South Carolina on September 26, 2017. On March 2, 2020, this matter came before this court for a bench trial in Lexington County, which ultimately concluded with a verdict rendered in favor of Plaintiff in the amount of Two Hundred Twenty-five Thousand Dollars ($225,000.00) on July 10, 2020. Defendant filed a Notice of Motion and Motion for Leave to Deposit to Court on July 16, 2020, wherein Defendant also communicated its intent to appeal this Court's decision. Plaintiff filed her Memorandum In Opposition to Defendant's Motion For Leave to Deposit in Court on July 20, 2020. Defendant filed a Reply on July 27, 2020.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Defendant seeks leave from this court, via Rule 67, SCRCP, to deposit the amount of the judgment obtained by Plaintiff into the account of the Lexington County Clerk of Court. The

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South Carolina Supreme Court has held that "[t]he granting of leave to deposit money with the court pursuant to Rule 67, SCRCP is a matter within the discretion of the trial court and will not be overturned absent an abuse of that discretion. An abuse of discretion occurs when the ruling is based on an error of law or a factual conclusion without evidentiary support." S.C. Dept. of Transp. v. First Carolina Corp. of South Carolina, 369 S.C. 150, 153, 631 S.E.2d 533, 535 (2006) (internal citations omitted).

Rule 67, SCRCP, in whole, provides:

> In an action in which any part of the relief sought is a judgment for a sum of money or the disposition of a sum of money or the disposition of any other thing capable of delivery, a party, upon notice to every other party, **and by leave of court**, may deposit with the court all or any part of such sum or thing, whether or not that party claims all or any part of the sum or thing. Money paid into the court under this rule shall be deposited as directed by the court in any bank or institution upon the check of the clerk of court in favor of the party to whom the order of the court directs.

(emphasis added).

Based on the plain reading of Rule 67, SCRCP, the court determines whether a defendant may deposit judgment funds with the court. The notes to Rule 67, SCRCP indicate that the rule is "substantially" similar to the federal equivalent of the same rule. A federal district court determined that Rule 67, FRCP "is a matter committed to the sound discretion of the district court." Cajun Elec. Power Cooperative v. Riley Stoker Corp., 901, F.2d 441, 445 (5th Cir. 1990); see also Roberts v. Peterson, 292 S.C. 149, 151-52, 355 S.E.2d 280, 281 (Ct. App. 1987) (noting that where a state rule has adopted the language of a federal rule, federal cases interpreting the federal rule are persuasive to state courts interpreting the state rule) (internal citation omitted). Based on this persuasive authority, this court finds that Rule 67, SCRCP leaves to the discretion of the trial court to determine whether to permit the deposit of the funds.

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The next issue is to determine factors for considering whether to allow the deposit in the court. Again, South Carolina case law gives little guidance to the court as to any factors to specifically consider in this determination. However, courts in other jurisdictions have considered such factors including: (1) whether the judgment debtor would be able to satisfy the judgment at a later date (see Qwest Corp. v. City of Portland, 204 F.R.D. 468 470 (D.Or. 2001)); and (2) whether judgment debtor denies liability to the judgment (see Tarpey v. Crescent Ridge Dairy, Inc., 47 Mass. App. Ct. 380, 393, 713 N.E.2d 975, 984 (1991)). The court finds these factors persuasive and applicable here. The court also notes that the intent behind Rule 67, SCRCP is to benefit the judgment creditor in ensuring the funds will be available at the conclusion of a lengthy appellate process. Russo v. Sutton, 317 S.C. 441, 444, 454 S.E.2d 895, 896 (1995).

In analyzing the first factor, the court has heard no allegation that Defendant would be unable to satisfy the judgment at a later date. Based on Plaintiff's objection and argument that the judgment not be deposited, it is clear that Plaintiff is not concerned about Defendant's ability to pay the judgment upon the conclusion of the appellate process. In analyzing the second factor, it is clear that Defendant not only contested the amount of damages put forth at trial, but also challenged whether it was legally liable for the Plaintiff's injury and resulting damages.

Therefore, denying the accrual of post-judgment interest by depositing the funds with the Court would be inappropriate under the circumstances of this specific case. Plaintiff will not be denied post-judgment interest while the appellate court considers Defendant's case on appeal.

CONCLUSION

THEREFORE, based upon the foregoing, Defendant's Motion is **DENIED**.

IT IS SO ORDERED.

[ELECTRONIC SIGNATURE PAGE TO FOLLOW]

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Lexington Common Pleas

Case Caption: Diane Connell VS Lexington County Health Services District Inc , defendant, et al

Case Number: 2018CP3201750

Type: Order/Deposit Money

It Is So Ordered

s/ Walton J. McLeod

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ELECTRONICALLY FILED - 2018 May 22 11:03 AM - LEXINGTON - COMMON PLEAS - CASE#2018CP3201750

STATE OF SOUTH CAROLINA

COUNTY OF LEXINGTON

IN THE COURT OF COMMON PLEAS

FOR THE ELEVENTH JUDICIAL CIRCUIT

Diane Connell

Plaintiff,

vs.

Lexington County Health Services District, Inc. d/b/a Lexington Medical Center,

Defendant.

Civil Action No. 2018-CP-32-1750

SUMMONS

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, of which a copy is herewith served upon you, and to serve a copy of your Answer to the said Complaint on the subscribers at their offices at Goings Law Firm, LLC, 1510 Calhoun Street, Columbia, South Carolina, 29201, within thirty (30) days after the service hereof, exclusive of the day of such service; and if you fail to answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint.

Respectfully submitted,

By: /s/ Robert F. Goings

Robert F. Goings (S.C. Bar # 74855)
Jessica L. Gooding (S.C. Bar # 101210)
Goings Law Firm, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
Email: rgoings@goingslawfirm.com
jgooding@goingslawfirm.com
Phone: (803) 350-9230
Fax: (877) 789-6340
Attorneys for Plaintiff

MAY 22, 2018
Columbia, South Carolina

ELECTRONICALLY FILED - 2018 May 22 11:03 AM - LEXINGTON - COMMON PLEAS - CASE#2018CP3201750

STATE OF SOUTH CAROLINA	IN THE COURT OF COMMON PLEAS
COUNTY OF LEXINGTON	FOR THE ELEVENTH JUDICIAL CIRCUIT
Diane Connell Plaintiff, vs. Lexington County Health Services District, Inc. d/b/a Lexington Medical Center, Defendant.	Civil Action No. 2018-CP-32-1750 **COMPLAINT**

COMES NOW the Plaintiff, Diane Connell, who, by and through the undersigned counsel, files this Complaint against the above-named Defendant Lexington County Health Services District, Inc. d/b/a Lexington Medical Center:

PARTIES

1. Diane Connell ("Connell") is a citizen and resident of Richland County, South Carolina.

2. Defendant Lexington County Health Services District, Inc. d/b/a Lexington Medical Center ("LMC") is a healthcare provider organized and existing through the laws of the State of South Carolina with its principal place of business in Lexington County, South Carolina.

JURISDICTION AND VENUE

3. This Court has subject matter jurisdiction over this action and the allegations set forth herein.

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4. This Court has general and specific personal jurisdiction over LMC because it maintains significant and continuous contacts in Lexington County, South Carolina, and this suit involves tortious conduct that occurred in Lexington County, South Carolina.

5. Venue is proper because the most substantial part of the alleged acts or omissions giving rise to the cause of action occurred in Lexington County.

FACTS

6. On September 26, 2017, Connell and her husband were visiting LMC, located at 720 Sunset Boulevard in West Columbia, South Carolina, for a medical appointment.

7. While Connell and her husband were walking back to the parking garage, she unexpectedly fell as a result of an unnoticeable change in elevation in the concrete walking surface.

8. The change in elevation in the concrete was not, like the other curbing or raised concrete in the parking garage, painted yellow to alert pedestrians of the potential trip and fall hazard.

9. The change in elevation of the concrete walking surface was camouflaged and not readily visible without yellow paint on the edges or other similar markers or signs to warn of the change in elevation.

10. LMC knew or should have known this condition was a safety hazard to invitees on its property.

11. LMC knew or should have known of this unreasonably dangerous and hazardous condition existing in a location where an invitee would foreseeably walk, but

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LMC failed to take reasonable and adequate precautions to warn or otherwise prevent its invitees from encountering the dangerous condition.

12. As a result of the fall, Connell suffered significant injuries to her left knee, which required extensive medical treatment, including a reconstructive knee surgery.

13. As a result of these injuries, Connell has incurred, and will continue to incur in the future, medical treatment and expenses, and has suffered, and will continue to suffer in the future, physical and mental pain and suffering, permanent disability and impairment, emotional anguish, and a loss of enjoyment of life.

CAUSE OF ACTION
(Negligence/Gross Negligence)

14. Connell incorporates by reference the allegations of the paragraphs above as if fully repeated herein.

15. Connell was invitee at LMC.

16. LMC owed Connell a duty to warn, remedy and take reasonable safety measures to prevent latent hazardous or unsafe conditions from occurring on his property and to otherwise maintain its property in a reasonably safe condition for persons or guests that may visit the property.

17. The unmarked change in elevation in the concrete where Connell fell constituted an unsafe condition.

18. LMC knew or should have known that the unmarked change in elevation in the concrete walking surface existed in its parking garage.

19. LMC knew or should have known that a person could foreseeably fall and become injured as a result of the unmarked change in elevation.

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20. LMC failed paint the edges of the change in elevation yellow, or otherwise warn of this condition so that this condition would be visible to pedestrians.

21. LMC breached its duties and acted negligently or grossly negligently in one or more of the following particulars:

a) In creating a dangerous, unsafe and defective condition on said premises, which constituted a trip and fall hazard;

b) In allowing a dangerous, unsafe and defective condition to remain when it knew or should have known of the conditions of the grounds, and that the same was unsafe and dangerous and likely to cause serious bodily harm to Connell and others on said premises;

c) In failing to exercise that degree of care which a reasonably prudent person would have exercised under the same circumstances;

d) In failing to properly inspect, maintain and repair said premises, thus making it unsafe for the use of Connell and others invited thereon;

e) In failing to properly paint or warn of the change in elevation;

f) In failing to properly inspect the property for conditions that could foreseeably cause personal injuries to guests or persons on the premises;

g) In failing to notify or warn Connell or others of the existence of the dangerous, unsafe and hazardous condition on said premises, although the LMC knew or by exercise of reasonable care should have known of the said dangerous, unsafe and hazardous condition;

h) In failing to take every, or in fact, any, precaution to avoid the dangerous, unsafe and hazardous condition existing on the premises;

i) In failing to have proper guides or warning signals of the dangerous, unsafe and hazardous condition;

j) In maintaining a latent condition which constituted a danger to Connell;

k) In failing to warn Connell of the hazard that LMC knew, or by the exercise of reasonable diligence should have known, to be present;

l) In failing to provide Connell of a safe manner of ingress, egress, and access about LMC's premises;

m) In failing to maintain the premises pursuant to applicable regulations, codes, and standards; and

n) In failing to timely remedy dangerous conditions existing on the premises.

All of which were the direct and proximate cause of the injuries and damages suffered by Connell herein.

22. As a direct and proximate result of the acts and omissions of LMC, Connell is entitled to an award of actual damages in an amount to be determined by this Honorable Court.

23. To the extent that LMC was reckless, willful, or wanton, Connell is entitled to an award of punitive damages.

WHEREFORE, Connell prays this Honorable Court for judgment against LMC, for actual and consequential damages; for punitive damages; for costs of this action; and for such other and further legal and equitable relief as this Honorable Court may deem just and proper.

Respectfully Submitted:
/s/ Robert F. Goings
Robert F. Goings, Esq. (S.C. Bar # 74855)
Jessica L. Gooding, Esq. (S.C. Bar # 101210)
GOINGS LAW FIRM, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
Phone: (803) 350-9230
Fax: (803) 789-6340
Email: rgoings@goingslawfirm.com
jgooding@goingslawfirm.com

Attorneys for the Plaintiff

May 22, 2018

Columbia, South Carolina

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ELECTRONICALLY FILED - 2018 Jun 22 4:09 PM - LEXINGTON - COMMON PLEAS - CASE#2018CP3201750

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON	)	
	)	
Diane Connell,	)	CIVIL ACTION NO. 2018-CP-32-1750
	)	
Plaintiff,	)	
vs.	)	
	)	**ANSWER**
Lexington County Health Services District, Inc. d/b/a/ Lexington Medical Center,	)	
	)	
Defendant.	)	

The Defendant, Lexington County Health Services District, Inc. d/b/a Lexington Medical Center, answering the Complaint of the Plaintiff, alleges as follows:

FOR A FIRST DEFENSE

1. The Complaint fails to state facts sufficient to constitute a cause of action against this Defendant upon which relief can be granted, and should be dismissed pursuant to SCRCP Rule 12(b)(6).

FOR A SECOND DEFENSE

2. The allegations of paragraph 1 of the First Defense are re-asserted and re-alleged as fully as if set forth verbatim herein, insofar as not inconsistent with this Second Defense.

3. Each and every allegation of the Complaint not specifically admitted, qualified nor otherwise explained, is denied.

4. This Defendant admits so much of paragraphs 2 and 16 of the Complaint as alleges or infers that this Defendant is a political subdivision of the State of South Carolina, subject to suit under the terms, conditions, and limitations of the South Carolina Tort Claims Act, codified at *S.C. Code Ann.* §§ 15-78-10, through -220 (1986 as amended), and empowered by statute and regulation with authority, duties, and responsibilities set forth by such statute and

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regulation; and this Defendant does crave reference to such statutes and regulations for an accurate enumeration of this Defendant's duties and responsibilities.

5. This Defendant admits so much of paragraphs 3, 4, and 5 of the Complaint as allege that jurisdiction and venue are properly before this Court.

6. This Defendant lacks sufficient information to admit or deny the allegations of paragraphs 1, 6, 12, 13, and 15 of the Complaint, and therefore denies the same and demands strict proof thereof.

7. This Defendant denies the allegations of paragraphs 7, 8, 9, 10, 11, 17, 18, 19, 20, 21, 22, and 23 of the Complaint as written.

8. This Defendant is informed and believes that paragraph 14 requires no response; but to the extent that they may be deemed to allege liability on the part of this Defendant, those paragraphs are denied.

FOR A THIRD DEFENSE

9. The allegations of paragraphs 1 through 8 of the First and Second Defenses are re-asserted and re-alleged as fully as if set forth verbatim herein, insofar as they are not inconsistent with this Third Defense.

10. If the Plaintiff was injured and damaged as alleged in the Complaint, which this Defendant denies, then such damage was proximately caused by the sole negligent, grossly negligent, willful, wanton, and reckless acts or omissions of the Plaintiff, herself, in the following particulars:

A. In failing to maintain a proper lookout;

B. In ignoring an open and obvious condition;

C. In venturing into an area with an open and obvious condition, without exercising due regard for her own safety; and

D. In failing to exercise that degree of care for her own safety that a prudent person under similar circumstances would have exercised;

all of which acts or omissions on the part of the Plaintiff were negligent, grossly negligent, willful, wanton, and reckless, and were the sole and proximate cause of her alleged injury and the damages complained of; and this Defendant does plead such sole negligence of the Plaintiff as an affirmative defense and complete bar to recovery against this Defendant.

FOR A FOURTH DEFENSE

11. The allegations of paragraphs 1 through 10 of the First, Second, and Third Defenses are re-asserted and re-alleged as fully as if set forth verbatim herein, insofar as they are not inconsistent with this Fourth Defense.

12. If this Defendant was in anyway, negligent, grossly negligent, willful, wanton, reckless, or unlawful in any of its acts or omissions, which this Defendant denies, then the Plaintiff, too, was negligent, grossly negligent, willful, wanton, reckless, and unlawful in her own acts or omissions in the following particulars:

A. In failing to maintain a proper lookout;

B. In ignoring an open and obvious condition;

C. In venturing into an area with an open and obvious condition, without exercising due regard for her own safety; and

D. In failing to exercise that degree of care for her own safety that a prudent person under similar circumstances would have exercised;

all of which acts or omissions on the part of the Plaintiff were negligent, grossly negligent, willful, wanton, and reckless to a comparatively greater degree than any acts or omissions on the part of this Defendant by and through its agents and employees, and were the more proximate cause of any damages complained of; and this Defendant does plead such comparatively greater negligence on the part of the Plaintiff as an affirmative defense and complete bar to recovery; or,

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in the alternative, as a factor for the Court to consider in discounting any recovery the Plaintiff may be awarded.

FOR A FIFTH DEFENSE

13. The allegations of paragraphs 1 through 12 of the First, Second, Third, and Fourth Defenses are re-asserted and re-alleged as fully as if set forth verbatim herein, insofar as they are not inconsistent with this Fifth Defense.

14. This Defendant is informed and believes that, if the Plaintiff was injured and damaged as alleged in the Complaint, such injury and damages were proximately caused by circumstances and conditions about which this Defendant had no notice, actual or constructive; and this Defendant does plead such lack of notice as an affirmative defense and complete bar to recovery.

FOR A SIXTH DEFENSE

15. The allegations of paragraphs 1 through 14 of the First, Second, Third, Fourth, and Fifth Defenses are re-asserted and re-alleged as fully as if set forth verbatim herein, insofar as they are not inconsistent with this Sixth Defense.

16. This Defendant is informed and believes that, if the Plaintiff was injured and damaged as alleged in the Complaint, such injury and damages were proximately caused by the intervening acts or omissions of a third party or parties, which acts or omissions were negligent grossly negligent, willful, wanton, and reckless, which acts or omissions were not foreseeable to this Defendant, and about which this Defendant had no notice; and this Defendant does plead such intervening acts of negligence on the part of unknown third parties as an affirmative defense and complete bar to recovery.

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FOR A SEVENTH DEFENSE

17. The allegations of paragraphs 1 through 16 of the First, Second, Third, Fourth, Fifth, and Sixth Defenses are re-asserted and re-alleged as fully as if set forth verbatim herein, insofar as they are not inconsistent with this Seventh Defense.

18. This Defendant is informed and believes that, as a political subdivision of the State of South Carolina, this Defendant is entitled to certain limitations, immunities, and defenses to the Plaintiff's claims under the South Carolina Tort Claims Act, codified at *S.C. Code Ann.* §§ 15-78-10 through -220 (1986 as amended), including, without limitation, immunities and defenses afforded by *S.C. Code Ann.* §15-78-60 (4), (5), (8), (13), (15), (20), and (25); and to the extent that such immunities and defenses are available, this Defendant pleads the various defenses and immunities afforded by the South Carolina Tort Claims Act as an affirmative defense to the claims alleged by the Plaintiff.

FOR AN EIGHTH DEFENSE

19. The allegations of paragraphs 1 through 18 of the First, Second, Third, Fourth, Fifth, Sixth, and Seventh Defenses are re-asserted and re-alleged as fully as if set forth verbatim herein, insofar as they are not inconsistent with this Eighth Defense.

20. This Defendant is informed and believes that, to the extent that the Plaintiff seeks to recover pre-judgment interest, punitive damages, or attorney fees, recovery of such relief is barred by the South Carolina Tort Claims Act, S.C. Code Ann. § 15-78-120; and this Defendant does plead such bar as an affirmative Defense to any such prayer for relief.

WHEREFORE, having fully answered the Complaint of the Plaintiff, this Defendant prays that the same be dismissed, with costs assessed to the Plaintiff, and for such other and

further relief as the Court may deem appropriate.

Respectfully submitted,

DAVIS | FRAWLEY, LLC

s/ Evan M. Gessner

Evan M. Gessner, S.C. Bar No. 77704
140 East Main Street (29072)
PO Box 489, Lexington SC 29071-0489
(803) 359-2512; Fax: (803) 359-7478
pat@oldcourthouse.com
evan@oldcourthouse.com

ATTORNEYS FOR LEXINGTON COUNTY HEALTH SERVICES DISTRICT, INC. D/B/A LEXINGTON MEDICAL CENTER

Lexington, South Carolina
June 22, 2018

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State of South Carolina

Court of Common Pleas

County of Lexington

Diane Connell,	)	
	)	
Plaintiff,	)	Transcript of Record
v.	)	2018-CP-32-1750
	)	
Lexington County Health Services District, d/b/a Lexington Medical Center,	)	
	)	
Defendant.	)	

March 2, 2020
Lexington, South Carolina

B E F O R E:

The Honorable Walton J. McLeod, IV, Judge.

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

Robert Goings, Esquire
Jessica Gooding, Esquire
Attorneys for the Plaintiff

Evan Gessner, Esquire
Attorney for the Defendant

Bethanie K. Creppon
Circuit Court Reporter

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P R O C E E D I N G S

* * *

THE COURT: Good morning. This is the case of Diane Connell vs. Lexington County Health Services District, doing business as Lexington Medical Center, Case No. 2018-CP-32-1750. This is a bench trial.

I think all the parties -- necessary parties are here. Is that correct?

MR. GOINGS: Yes, Your Honor.

THE COURT: Mr. Gessner, are you ready to proceed?

MR. GESSNER: Yes, Your Honor.

THE COURT: Mr. Goings, are you ready to proceed?

MR. GOINGS: Yes, Your Honor.

THE COURT: I'm happy to hear kind of an opening summary of the case. And we'll proceed with opening.

Ms. Gooding, will you be opening?

MS. GOODING: Yes, Your Honor.

THE COURT: All right.

MS. GOODING: Thank you. May it please the Court?

Your Honor, we're here today with Ms. Diane

Connell. She's sitting back here. She's a mom of two, grandmom of three; has lived in Columbia most of her life.

Essentially, we're here today because Mrs. Connell fell off an unpainted curb in the Lexington Medical Center parking garage back in September of 2017 and shattered her patella, which resulted, obviously, in quite a bit of medical treatment and damages.

The Hospital has taken the position that it bares no responsibility for this terrible fall that occurred in their parking garage. But we believe that the evidence we're going to present today will show that Lexington Medical Center is liable for the fall and everything that resulted from it.

The good news for you, Judge, is that there are lot of things that the parties agree on in this case. Everybody agrees that Mrs. Connell was at the Lexington Medical Center premises for a business purpose, and that makes her an invitee; everybody agrees that that means that Lexington Medical Center owes her the utmost duty of reasonable care to discover foreseeable hazards or risks, and to warn of those or to remedy that hazardous situation; and everybody agrees that she fell on the curb in the

parking garage, and that that fall resulted in the patella fracture that she suffered; everybody agrees that the curb was unpainted at the time of the fall.

So, as she was walking into the parking garage, she was walking towards a change in elevation, kind of a standard drop-down, six-inch curb or whatever, and there was no yellow paint on that curb -- on the top part of the curb that would delineate that there was going to be a change in elevation from the direction from which she was walking. Other curbs in the parking garage did have paint, both on the side and on the top, but this curb did not, and that's not disputed, Your Honor.

Also, in the Lexington Medical Center 30(b)(6) testimony, they have admitted that they had a duty and a responsibility to maintain this garage; that an unpainted curb can be a trip hazard; that there can be a camouflaging effect where there is no color or paint or anything delineating that change in elevation.

They have admitted that it's important to be able to see a trip-and-fall hazard and that that condition existed for over a decade. The testimony is that that garage was built in 2008 and it was the contractor and/or the subcontractors that the

general contractor hired -- it was their responsibility to do all the painting in the garage, and they are the ones who did it. So this curb had, apparently, existed in that condition for quite some time.

And Mrs. Connell was walking in a place that was intended for pedestrians. She was not skipping or jumping or looking behind her or looking at her phone or anything else, and that's been admitted as well.

So, in addition to that, Lexington Medical Center testimony that we'll -- we have Mr. and Mrs. Connell here, of course, to talk about everything that she's been through. We also have Investigator Brewer here. He was at the scene when Mrs. Connell fell and had an opportunity to kind of observe the area and provide some assistance. So he'll be here this morning.

And then we also have Lindsay Moore who is a certified nurse, life care planner. She has taken a look at Dr. Loging's recommendations for future treatment and put together a future cost analysis based on that.

We have the video deposition of Dr. Loging. He is Mrs. Connell's current treating physician. He

performed the hardware removal surgery just a few weeks ago. He's an orthopedist at Palmetto Bone & Joint.

Your Honor, you'll hear in the testimony today we did the for-trial deposition by video a couple of months ago when we thought this case was going to go to trial when we thought Dr. Loging was planning to do a hardware removal surgery. He has since done that hardware removal surgery, so there will be that kind of discrepancy.

And then we also have Dr. Alford coming this afternoon. He's an economist. He works at Furman University now. And he will just be taking Ms. Moore's future cost analysis, accounting for inflation, and discounting those values back to present value so we can move those into evidence in their present-value form.

So, you know, we're really here today because we think, you know, based on everything I've just explained to you, that Lexington Medical Center is absolutely responsible for the unpainted curb in its parking garage; responsible, therefore, for Mrs. Connell's injuries, for the medical bills she incurred in their hospital and since then, because her first surgery was there at Lexington Medical

Center; that they're responsible for the medical bills that she's continuing to incur, and responsible for the pain that she's been through.

You'll hear about months and weeks with rehab, difficulty with stairs, difficulty squatting and kneeling, not able to do things she enjoyed such as walking, playing with her grandchildren, and gardening, and, really, that Lexington Medical Center is responsible for problems with her knee that she's going to have, you know, forever.

I think, after we present everything today, you're not going to have any trouble finding liability on their part and holding them accountable for that.

THE COURT: All right. And when I called the case, I believe I said Connell [pronouncing]. So it's Connell. My apologies.

Mr. Gessner?

MR. GESSNER: Thank you, Your Honor. May it please the Court? I don't need to take up too much of your time. This is a pretty simple premises liability case. Of course, counsel for the plaintiff has accurately stated the issues.

We -- the defendants -- the defendant contests liability here because there's no evidence of any

notice on the part of the defendant. There's no actual notice and there's no constructive notice. Just the fact that this curb existed in much the same state for nine, almost ten years, prior to Mrs. Connell's fall does not indicate -- or does not mean that the defendant is on notice of a defect or hazardous condition.

The curb was not in a state of disrepair. That's exactly how it was built. There's no indication that the curb should have been built any other way. Of course, the Lexington County Health Services District is not in the business of building parking garages or any other structure, so they hired a contractor to come out and build the structure.

That was built by professionals. It passed all inspections and, to the best of the defendant's knowledge, it's up to code. We can find no code indicating that the front and the top of any curb has to be painted, so there's no evidence showing that Defendant should have known to paint the top of that curb.

There's no evidence that Mrs. Connell would not have fallen if that yellow stripe was there. That's pure speculation. So while we do not contest that

Mrs. Connell was there as an invitee, we do not contest that she fell and was injured; we contest liability simply because the plaintiffs can point to nothing that Defendant has done wrong to cause that. There's no notice. That's primarily the issue here.

And I think Your Honor will see there's an absolute lack of any evidence showing notice. And we think you should rule in favor of the defendant here today.

THE COURT: All right. You can call your first witness.

MS. GOODING: Thank you, Your Honor. We're going to call Investigator Brewer.

THE COURT: All right. If anyone needs a break at any time, give us a signal. We generally will go 90 minutes to about two hours between breaks, so I just want to make everyone aware of that.

CHRISTOPHER BREWER

being first duly sworn, testified as follows:

THE WITNESS: So help me God.

THE CLERK: Have a seat please and state your name for the record, please.

THE WITNESS: Investigator Chris Brewer.

DIRECT EXAMINATION

BY MS. GOODING:

Q. Good morning, Mr. Brewer. Thank you for being here. Can you tell us about your current employment status.

A. I'm actually on medical where I -- I had back surgery that I'm currently recovering from. So I'm currently on medical leave at the Allen University Police Department as the investigator. I've been there six and a half years.

Q. And we're here today, obviously, because Mrs. Connell fell at Lexington Medical Center. Do you know Mrs. Connell?

A. Only from the day of the incident.

Q. Okay. And were you there when she actually fell?

A. I was not there when she fell; I was there right after. I pulled up right after she fell.

Q. Okay. Have you spoken to her since then?

A. Just today, briefly.

Q. Just this morning then?

A. Yes, ma'am.

Q. Were you able to give the Connells your information when you met them the day that Mrs. Connell fell?

A. I was.
Q. But have you spoken to them in the interim?
A. No, ma'am.
Q. Okay.
MS. GOODING: Your Honor, we have agreed to this video being admitted as Exhibit 1. This is the surveillance video from the parking garage at Lexington Medical Center.
BY MS. GOODING:
Q. Investigator Brewer, I'm just going to ask you to watch the video with me real quick.
A. Okay.
Q. And, if you can, identify yourself when you kind of appear on the scene, please.
MS. GOODING: And, Judge, this video kind of goes from split-screen to zooming in on its own accord, so it will keep going back and forth on us.
THE COURT: Okay.
(Video played for his Honor.)
THE WITNESS: That's my truck.
BY MS. GOODING:
Q. That black truck there?
A. Yes, ma'am. That's me walking up.
Q. So you arrived then, just after they were able to kind of get her onto the curb?

A. Yes, ma'am.

MS. GOODING: Your Honor, there's some time where Mrs. Connell is kind of sitting on the ground here. And then the golf cart is going to come and kind of help her up. So we're just going to kind of skip ahead to that part, if that's okay.

THE COURT: That will be fine. If you wouldn't mind, let me know how far we're skipping so I can have a picture in my mind.

MS. GOODING: From where we were, it will be about seven minutes. It's about a ten-minute timeframe.

MR. GOINGS: The timestamp, Your Honor: She fell 11:56 a.m. on Tuesday, September 26th, 2017. I'm going to fast-forward the video from 11:56. And then the golf cart arrives, for the record, around 12:05. And I skipped to 12:05. And you can see her being raised and put on the back of the golf cart.

(Video continued for his Honor.)

MR. GOINGS: Your Honor, let the record reflect that at 12:07, the golf cart exits the parking garage.

BY MS. GOODING:

Q. Investigator Brewer, what were you doing at

Lexington Medical Center this day?
A. I had a doctor's appointment. And then I was going to eat lunch with my aunt who works upstairs in one of the doctors' offices.
Q. And when did you first see Mrs. Connell?
A. As I was pulling into the garage.
Q. What was --
A. I saw a -- I saw a crowd right at the entrance.
Q. And were you able to determine what was going on?
A. Not at first. When I got out -- when I got out of my truck, I went over, I saw her on the ground. I then started -- I didn't know what had happened, other than she was on the ground. I started looking -- kind of in my mind, treating it like a crime scene, trying to figure out if she had been attacked or what have you. Even though I was not there on official capacity, that -- you know, you kind of can't help it.

Once I found out that it was -- that she had fallen, you know, I -- again, still looking around, seeing if there was any kind of debris or something that she might have tripped on, which I did not see anything at that point.
Q. Did Mrs. Connell appear to be in pain at that

point?
A. She did. She was holding her left knee -- I'm pretty sure it was her left knee -- and was complaining of it hurting, you know, for lack of better words, in agony. You know, she wasn't screaming, but you could definitely tell in her voice that she was in pain.
Q. And what were you able to observe about the scene that was going on around her?
A. I mean, the -- you had some nursing staff or -- let me rephrase it, hospital staff -- I'm not sure if they were nurses or not -- you know, that was around her. The curb on where she fell, the top was not painted; however, the curb on the opposite side appeared to be painted on the top. Several of the other curbs had yellow paint on the top of the curb and on the side, but this one did not.
And, you know, I just noted that, you know, she was holding herself in pain. So, at that point, I'm just trying to comfort her; trying to, you know, see if we could get someone over to, you know, get her over to the emergency room.
Q. Were you able to lend some assistance then?
A. Yes. I was able to get someone to call and get the golf cart. I was trying to. I didn't have the

number or anything, but one of the staff did, so they called and had the golf cart come over.

Q. And what happened when the golf cart arrived?

A. When the golf cart arrived, I assisted her up into the golf cart, you know, tried to get her as comfortable as she could be. I had prayer with her. I handed her my business card and, you know, went on about my business.

Q. All right. Thank you. I have no further questions.

THE COURT: Cross-examination?

MR. GESSNER: No questions, Your Honor.

THE COURT: All right. The witness may step down.

THE WITNESS: Thank you, Your Honor.

THE COURT: Is this witness free to go?

MS. GOODING: Your Honor, if it's all right with you, if we can go ahead and put on the record which exhibits we've agreed to so that we can just refer to them as we go.

THE COURT: Okay. But is this witness free to go?

MS. GOODING: Yes.

THE COURT: All right. Thank you, sir.

Yeah. We could have done that at the

beginning. If counsel can give the court reporter a rundown of the agreed-upon exhibits at this point, to make sure she has what she needs, as far as marking such exhibits.

If y'all need to chat beforehand, that's fine.

MR. GESSNER: I don't think so.

(Off-the-record discussion.)

MS. GOODING: Exhibit 1 was the surveillance video; Exhibit 2 is photographs of, kind of, screen-shots from that video; Exhibit 3 is parking garage photos as they existed on the day of the fall, which is September 26, 2017; what's been marked as Exhibit 4, we've agreed not to introduce into evidence; Exhibit 5 is the photos from September 26, 2017 that have been edited with a computer simulation. Counsel has objection to Exhibit 5.

Exhibit 6 is photographs of Mrs. Connell's knee, showing the knee braces that she wore and the scarring; Exhibit 7 is the loss summary with medical bills; Exhibit 8 is Lexington Medical Center Emergency Room records from the day of her fall; Exhibit 9 is the Lexington Orthopaedics records.

Exhibit 10 is the Palmetto Bone & Joint records; Exhibit 11 is the injury and surgery

illustrations that show the type of injuries she had and the surgery that was performed the day after the fall; Exhibit 12 is the CV for Lindsay Moore, PA, who is the certified nurse life care planner; Exhibit 13 is the future medical cost analysis that Lindsay Moore put together.

Exhibit 14 is the CV for Dr. Alford, the economist; and Exhibit 15 is the present-value medical costs that Dr. Alford has done. So we would move to introduce all of those exhibits into evidence, except number 5, without objection.

THE COURT: So, just so I'm clear, Defense's only objection is to Exhibit 5; is that correct?

MR. GESSNER: Yes, Your Honor.

THE COURT: All right. Subject to counsel's summary there, those exhibits are admitted into evidence without objection, with the exception of number 5.

(Plaintiff's Exhibit Nos. 1-4 and 6-15 admitted into evidence.)

MS. GOODING: And, Your Honor, can we go ahead and discuss Exhibit 5? We would move that into evidence and think it's an appropriate demonstrative exhibit just to show kind of what -- the difference that it would make to take a reasonable precaution

in painting the edge of the curb.

THE COURT: Mr. Gessner?

MR. GESSNER: At the outset, Your Honor, I don't know if Plaintiffs have a witness who can authenticate that as having done that, that demonstration themselves, to admit that into evidence. I think that potentially creating an exhibit like that is almost an end-run around the rule against subsequent remedial measures. So even though it's not showing anything Defendants may have done with the curb, it almost gives the exact same piece of evidence while avoiding the rule entirely.

We know what the curb looked like at the date of the incident. We don't know for sure that's what it would look like had it been painted. I think it's speculative and I think it lacks probative value, for those reasons.

And then when you apply the Rule 403 standard, I think it could prejudice Defendant, weighing that against what little probative value it may have. I think it should be excluded, Your Honor.

THE COURT: Okay.

You want to respond?

MS. GOODING: Just that I believe the rule against admitting subsequent remedial measures is

based on it not being viewed as an admission of liability from the defendant. Obviously, that could not be taken from a computer simulation.

THE COURT: It appears that this -- Plaintiff is not offering it to show what it looked like on the day of the accident; they're not offering it for what it looks like today. I think the plaintiff -- and correct me if I'm wrong -- is offering it just to show a potential demonstration of, if the curb had been painted, how it may have appeared, and nothing more.

MS. GOODING: Correct, Your Honor.

THE COURT: For demonstrative purposes.

MS. GOODING: Yes, Your Honor. And, of course, to point out where the curb is that we're talking about.

THE COURT: Yeah. Okay. Anything else?

MR. GESSNER: No, Your Honor.

THE COURT: All right. It will be admitted, subject to objection.

MS. GOODING: Thank you, Your Honor.

And we're ready to call Mr. Steven Connell.

THE COURT: Very well.

(Plaintiff's Exhibit No. 5 admitted into evidence.)

STEVEN CONNELL

being first duly sworn, testified as follows:

THE WITNESS: Yes, I do.

THE CLERK: Have a seat, please, sir, and state your full name.

THE WITNESS: I'm Steven Connell.

MS. GOODING: Thank you, Mr. Connell. Could you please introduce yourself to Judge McLeod, to the Court.

THE WITNESS: Yes, sir, Judge McLeod. I'm a retired engineer from Fort Jackson Army Installation. And I'm husband of Diane Connell for 32 years; 32 good years, I might add. And that's who I am.

DIRECT EXAMINATION

BY MS. GOODING:

Q. Thank you, Mr. Connell. Now, we're here, of course, to talk about the day that your wife fell at Lexington Medical Center. Do you recall what day that was?

A. Yes. That was in -- September 26th of 2017.

Q. Can you tell us a little bit about what happened that day?

A. I was driving myself, and Diane accompanied me, to a doctor's appointment. And it was on Lexington Medical campus. And --

Q. Was that appointment for you?

A. That appointment was for me, yes. I dropped her off at the front door of the doctor's office and went over to park the car in the parking garage that was right next to the doctor's office building.

And as we were leaving the doctor's appointment and walking back to the car in the garage, Diane walked into the garage a few steps in front of me. And the next thing I knew, she collapsed to the floor of the garage. And I was terrified. I ran over and she was in screaming in agony, just horrible, horrible pain. And I --

Q. Were you able to get her to her feet?

A. No. We tried after a few moments, but we couldn't get her. She screamed. It was just so painful for her. But we were able to drag her out of the driveway, over to the edge of the curb. And that's when I noticed there was even a curb there.

The next thing I knew, Mr. Brewer, who testified earlier, came and gave us a lot of assistance to call a golf cart over. We were able to get her up and into that golf cart without

completely unbearable pain. And we drove her over to the emergency room at the hospital, which was about a hundred yards away. Medical staff came out and got her into the emergency room and that --

Q. So she was able to be treated there?

A. Yes. Yes.

Q. Now, before your wife fell, did you see that she was about to fall? Did you anticipate that?

A. She just collapsed. No. I was just completely shocked. No. I just --

Q. Were you able to see the curb that she fell off of?

A. I did not see the curb until we were trying to pull her back onto the curb. That's when I noticed that there was a curb there.

Q. Did you have an opportunity, after you got your wife into the emergency room, to go back to the garage and kind of look around?

A. I did. They took her back for X-rays. And they didn't let me come back, so I just walked over to look. And as I entered that pedestrian entrance into the garage, I noticed the curb really wasn't visible --

Q. I want to show you some pictures on the screen here from Exhibit 3. Is that the curb where she

fell off?
A. That is. Now that I know a little bit about the area, there's a slight curve that -- or a slight curb that -- that's where -- yeah.
Q. Is this the edge of the curb here?
A. Yes.
Q. Is it easy to see on this picture?
A. I really can barely see it at all. And only because I'm familiar with that site is how I know that that curb is there. But it was painted on the sides, but it was not on the top. And all the other curbs in there were painted on the top.
Q. Is this is a copy of that --
A. Yes.
Q. -- curb as well?
A. Yes.
Q. And this is what it looked like on the day that Mrs. Connell fell; is that right?
A. Yes, that's what it looked like.
Q. Now, did you -- I think you kind of mentioned this: But did you observe some of the other curbs in the parking garage?
A. After I walked over there, yeah. I kind of walked around just a little bit and saw some of the other curbs. And they were painted both on the

sides and on the top. Yes.
Q. And this is also a photo that's part of Plaintiff's Exhibit 3. And it shows what you're talking about here, where there's paint kind of on the top side of the curb and then on the side, closest to the ground. Is that correct?
A. Yes. It makes it much more visible. Yes.
Q. And did you take some of these pictures or some of these pictures?
A. I did take some of those pictures.
Q. On these curbs where you have paint on the top of the curb, is it visible to pedestrians approaching from the opposite side, from the high side, if you will?
A. Yes. The curbs that are painted on top, they are visible from the high side. That is correct.
Q. Did you notice a contrast between the curbs that were painted on top and the curb that your wife fell off of?
A. Oh, yes, yes. The curb my wife fell off of, I mean, there was really was no contrast at all, coming in the direction of entering into the garage. But, yeah, all the other curbs are very, very visible.
Q. And from when you walk in and you're seeing

this, did you come from a sidewalk?
A. No. I walked through the same pedestrian entrance that my wife did. That's what you see.
Q. And the pedestrian entrance leads into the garage from a sidewalk that connects it to other buildings there on campus; is that right?
A. That is correct. Yes.
Q. Okay. And then you walk through a regular kind of doorway, for lack of a better term, to get into the garage, correct?
A. Correct. Yes.
Q. Is this the front side of that same curb?
A. Yes, I believe it is. Yes.
Q. So you can see the yellow on the front of it, but not on the top?
A. Nothing on the top. Yes.
Q. Now, you already mentioned that your wife went directly to the emergency room. I think you said it was about a hundred yards away and that they took her back and started doing X-rays and treating her there. What all treatment did Mrs. Connell receive for this injury?
A. She had a knee operation the very next morning, and there was metal hardware that was placed in her knee. And she was -- she had to keep that leg

straight. She was put in a leg immobilizer. They had to cut her knee and open it up and place all this metal hardware and pins in there to hold the knee in place.

Q. And after that surgery the next day, did she have another night in the hospital?

A. She had another night in the hospital, yes.

Q. And what about once she went home? Was there any continued treatment from there?

A. Yes. She had some home therapy treatment to come in and teach her how to do knee exercises so that she wouldn't have any further damage, but she would strengthen that knee. Yes.

Q. Has she had any other operations?

A. Yes. She recently had another operation to remove the hardware. That was about three weeks ago she had that operation done.

Q. Okay. I'm going to go back and talk a little bit about the effects of the injury and the resulting treatment. And I'd like to show you some pictures. I believe these are Plaintiff's Exhibit 6. And these show Diane's knee. Do you recall her knee looking this way?

A. Yes. Yes.

Q. And when would that have been?

A. That would have been just after the surgery, you know, where they had stapled up where it was cut. And it was so badly swollen and very, very painful for her.

Q. And it looks like those are staples in the knee incision there.

A. Yes.

Q. Did she have to go and have those removed at some point?

A. She did have to have those removed, yes.

Q. And that first week that she was home, did she have her leg in any kind of device?

A. The first week, she was in a leg immobilizer. She was pretty much confined to the bed during that week because she really couldn't bend that leg. And we had to set her up a Porta Potty right next to the bed so that -- and I had to help her. I had to kind of hold her leg straight.

And then we had a little stool where she could prop the leg up to keep it straight, because, the problem was, if she bent it, she would just be in so much pain. And --

Q. And about how long was she kind of in that state?

A. That state really lasted for about three weeks.

The first week, she was in an immobilizer. And then she was put into a leg cast following that.

Q. And what does this photo show?

A. Well, that shows the knee brace there, the adjustable knee brace that they put on after a week so they could -- because they had to limit the motion of that knee to heal properly.

Q. So that was when she was wearing the hinged brace for a few weeks?

A. Yes. Yes.

Q. And this is also part of Plaintiff's Exhibit 6. Can you explain to the Court what that shows.

A. This is the knee brace where they can adjust this so that she cannot move this knee -- this leg at all. And then they can adjust the angle so that she can slowly start to move this knee, but not at too severe an angle to hurt her knee.

Q. And so she would have used that immobilizer for a while and then the brace that we've looked at on the screen; is that correct?

A. That's correct. Yes.

Q. Now, after the first week, you said, she was able to change the brace that she was in. But for a couple weeks she was still in the bed. Is that right?

A. Yes. She was, yes.
Q. And what about after those first couple of weeks? Was she pretty much back in action after that?
A. No. No. After that, she could get around the house in a walker. And she was on that walker for several weeks. It was about three or four weeks on the walker. And -- but she just couldn't -- she wasn't able to do things for herself. Fortunately, I was retired and I was able to be there all the time.

But she couldn't prepare meals; she couldn't, you know, wash clothes, do any household chores, you know. She was -- she was basically confined and really unable to do things for herself.
Q. And was she working at that time to become more mobile?
A. Yeah. She worked very, very hard. She did her knee exercises as they showed her every day, religiously. And, you know, she slowly made progress. But she still -- she still is making progress. She's not all -- and I don't know if she ever will be completely healed.
Q. About how long was it before she was able to kind of get out of the house again and go to the

grocery store and do those kind of things?
A. Oh, it was -- to go to the grocery store, oh, that was months. We did go out -- the first outing that we went -- other than doctors appointments, we went to a Thanksgiving get-together that our nephew had. That was two months later. She was using a cane at that time. And we got out and stayed for a short period of time. But, yes, that --
Q. Did she have any kind of pain with those kind of trips?
A. Well, she did. It -- you know, it was hard for her. But, you know, she'd been in the house so long, you know, she really wanted to get out. So --
Q. What about a year or so after the surgery? Was she back to taking care of herself or was there still things that you needed to do for her?
A. No. There still were things that I needed to do for her, even after a year. In fact, I go to the grocery store a lot more than I used to do and a lot of different things. But after about a year, things were much better. But, still, she had a long way to go.
Q. Is there anything that she still, to this day, has been unable to do because of her injuries and the surgery?

A. Well, she loves to garden. I remember, those first few weeks, you know, she planted all these pretty flowers. And this -- she couldn't -- they were out there dying. I looked out the window and -- sad time. It was a very sad time.
Q. Is it difficult for you to talk about?
A. Yeah.
Q. Those -- did seeing those dead flowers indicate something to you about your wife?
A. Yeah. Yeah. She was -- you know, quality of life she had just wasn't the same at that point. Yeah. So yeah.
Q. And what about now that she's had the hardware removal surgery? Is she back to her prior state before she fell?
A. She could get out and work with her flowers some, you know. It's just hard for her. She -- the metal, the hardware, we think, maybe hurt her trying to kneel. You know, you can't garden without kneeling and getting down with your plants and the soil and stuff. But we're hoping that after this injury heals up, that she'll be able to get back to that again.
Q. And you said after this injury heals up. Are you referring to the second operation?

A. I'm referring to the second operation, yeah.
Q. And she's still kind of in her recovery period?
A. Still in recovery, yeah.
MS. GOODING: I have no further questions, Your Honor.
THE COURT: Any cross-examination?
MR. GESSNER: Briefly, Your Honor. May it please the Court?
THE COURT: Yes, sir.

CROSS-EXAMINATION

BY MR. GESSNER:
Q. Mr. Connell, you had said earlier you are a retired engineer; is that correct?
A. Yes, sir.
Q. What kind of engineer?
A. Electrical.
Q. Okay. Thank you.
MR. GESSNER: No further questions.
THE COURT: Any redirect?
MS. GOODING: No, Your Honor.
THE COURT: All right. The witness may step down.
MS. GOODING: Your Honor, our next witness is to read in 30(b)(6) deposition testimony. So Mr. Goings is going to serve as the witness and I

will be the attorney. And, if it pleases the Court, Your Honor, we'd like to designate their depositions in their entirety, except for those portions that we've agreed, you know, not to admit into evidence that deal with subsequent remedial measures and falls after the fact. But we would like to just read in those portions that we're kind of focusing in on, just for the sake of efficiency, since we have a bench trial here today.

THE COURT: Sure. So, to be clear, you're not going to read the entire deposition?

MS. GOODING: Correct.

THE COURT: Okay. And you want to note which sections you're not reading? Will I have a transcript to review?

MS. GOODING: You have a transcript in your notebook there.

THE COURT: Okay. But I want to make sure I know what sections are -- y'all are agreeing not to read.

MR. GESSNER: Your Honor, I have copies marked, actually, with sections highlighted as to the portions we object to as far as the ones we have agreed to.

THE COURT: Well, if it's not objected to, I'm

going to say it's agreed to.

MR. GESSNER: Right. But I know it's -- this is --

MS. GOODING: There are some portions that they object to that we want to still introduce.

THE COURT: Oh, okay. Okay.

MR. GESSNER: Right. I have a listing here of the ones that we do agree are not to be entered today.

THE COURT: Just note those for me, please.

MR. GESSNER: All right. On the 30(b)(6) deposition of Cory Andrews, page 15, lines 23 to 24, then page 16, line 16 to page 18, line 23, that entire block. And, finally, page 21, line 11; page 22, line 15.

THE COURT: Okay.

MR. GESSNER: And then, Your Honor, we had spoken pretrial that we have some objections as to the admissibility with some of these questions being off-topic for a 30(b)(6) witness. Did you want to address that prior or -- I can raise that when it comes up, but it's not exactly subject matter -- well, it is subject-matter specific, but it's not going to depend on Your Honor hearing the testimony itself, I don't think.

THE COURT: So you're fine with it just being read and then you noting your objection?

MR. GESSNER: No, Your Honor. I'd like it kept out in its entirety.

THE COURT: Well, then I kind of need to hear it to know to keep it out. How much are we talking about?

MR. GESSNER: It's another -- I noted six objections to Mr. Andrews' deposition and then there's a second 30(b)(6) deposition with ten.

THE COURT: Tell me how it's outside the scope.

MR. GESSNER: Your Honor, real quick, I'll look at their Plaintiff's 30(b)(6) notice. I have to look at them individually. But, generally, the topics Plaintiffs had sent were fairly specific.

For example, with the second witness, Mr. Thompson, they asked for a witness that could talk about the construction of a parking garage, who built the parking garage, when was it built, things like that.

Then they asked Mr. Thompson questions about what he thought about the parking garage, saying, you know, do you think it would be more safe if the top of the curb were painted, things like that; do you think this could have a camouflaging effect, yet

that witness was only designated to talk factually about when it was built and the Medical Center's knowledge of building codes or when -- really, just the construction of the structure itself, nothing about building codes; nothing about what we think about the status or the -- whether or not the curb was more safe or less safe. So that witness was totally unprepared for any questions --

THE COURT: What are his other topics?

MR. GESSNER: I'm looking for a copy of the notice, Your Honor. I've got that in the main file.

THE COURT: And he was a 30(b)(6) designee to talk about --

MR. GESSNER: It was made as Exhibit 1 to Mr. Andrews' deposition. But, as I'm looking through the copies we brought, I don't see any exhibits with it -- oh, here it is.

(Off-the-record discussion.)

THE COURT: Judge Kelly was involved in this case earlier?

MR. GESSNER: Yes, Your Honor. There was a motion to compel filed fairly early over some interrogatories and requests to produce, asking things like all falls that occurred on the campus or all personal injury claims on the campus, and we

objected to that. Judge Kelly had ruled that any falls outside of the parking garage in question were not relevant to this case.

So, subsequently, any discovery responses I made, I've limited to complying with Judge Kelly's order. So that's why there's reference to Judge Kelly in there.

MS. GOODING: And just to be clear, Your Honor, there were no motions filed related to the 30 (b)(6) topics. That was just related to requests for production and interrogatories in the earlier stage of the case.

MR. GESSNER: That is correct.

And, Your Honor, I've addressed this in cases before, typically when we have a 30(b)(6) deposition and Plaintiff's counsel will go off topic and ask questions. And my research indicated that the proper way to handle that is just object. But the attorney is still able to ask the questions and get the answers at the deposition. The proper way to handle that is to bring it up at trial, like we are now, Your Honor.

I did some research and did not find anything in South Carolina that was really indicative of how that's supposed to be handled. So, looking solely

at Rule 30, Rule 30(b)(6) in particular, it talks about having a representative of the entity authorized to speak on the entity's behalf.

So if Lexington Medical Center, Lexington County Health Services District has never identified either of these witnesses to speak as to those specific topics, I don't think anything those witnesses said could be held against the entity.

THE COURT: I've got your Defendant Lexington County's Response to the Notice of 30(b)(6) Deposition where it appears that you --

MR. GESSNER: That lists all the --

THE COURT: You state -- right. But -- so, obviously, if it's in your response, this is also a list of all the topics that were --

MR. GESSNER: Yes, sir.

THE COURT: -- sent in the original notice.

MR. GESSNER: Yes, sir.

THE COURT: I just haven't seen the original notice.

MS. GOODING: I have a copy of it here, Your Honor, if you'd like to look at it.

THE COURT: Yes.

So the questions to this designee had to deal with: The sidewalk would have been more safe had

there been paint there? And that's --

MR. GESSNER: Correct. It did ask him some questions to that effect. They asked some additional questions to Mr. Andrews that were not within the topics for which we designated him. So we just objected and just moved on; otherwise, the deposition would not have been able to go forward.

THE COURT: Okay.

And I'm trying to figure out what Judge Kelly's objections here -- or rulings are, noted in these objections. I'm trying to figure out --

MR. GESSNER: The --

THE COURT: These are objections from a prior ruling he did in a motion to compel. But they're not objections on the 30(b)(6) notice itself?

MR. GESSNER: Correct. Judge Kelly had ruled that only incidents in the parking garage would be relevant to this lawsuit. So, for example, on page 2, Your Honor, I think it's subparagraph N asked for fall-prevention protocols, instructions, policies, and procedures at Lexington Medical Center.

Fall-prevention protocol doesn't deal with trip-and-falls outside of the hospital itself. Those are protocols that medical staff follow when you have a patient that's, let's say, postsurgical.

They might be labeled as a fall risk, so those prevention protocols indicate what you have to do with this patient to make sure that they don't get up out of bed and fall and hurt themselves. They're not applicable to a parking garage. That's why I referenced Judge Kelly's order just saying, no, those protocols are something else; they're outside the scope of relevance here.

Likewise, paragraph P just asks for falls at Lexington Medical Center related to curbing. Per Judge Kelly's order, if a visitor tripped on a curb right out in front of the hospital and not in front of -- not in the parking garage specifically, that would not be relevant. So I limited that objection for that reason.

MS. GOODING: And, Your Honor, I don't believe that there's any evidence actually in these depositions falling into those categories that he's referring to.

THE COURT: Yeah. Well, I mean, without really having reviewed the deposition -- which, obviously, if the jury were here, that would be one thing. But for me, I may just let you renew these after I've heard them.

MR. GESSNER: And I can give you another

example, Your Honor. Mr. Andrews' deposition, page 25, Mr. Goings asked Mr. Andrews, you know, who was responsible for doing the painting and the curb markings for this parking garage, when Mr. Dale Thompson was identified to speak as to that.

So some of these are really not anything that I think would change the outcome of this trial, Your Honor. Just --

THE COURT: But you don't want it read because he couldn't answer it because it was for somebody else?

MR. GESSNER: Specifically, I'm being a stickler for the rules, Your Honor. There are some that ask for speculation; like I said, having an individual employee speculate, you know, well, could you have painted the curb or wouldn't it have been better if you did paint the curb, when that was never a topic.

THE COURT: Well, I --

MS. GOODING: Your Honor, one of the topics is referring to the circumstances that existed surrounding the fall. And I think all of our questions related to the curb being painted clearly fall into that category.

THE COURT: And the only thing -- and not to

cut you off, Ms. Gooding, but by that logic, every 30(b)(6) notice would have to have 500 topics and go over every single question. I mean, I haven't seen it, haven't heard it yet. But I suspect that the 30(b)(6) deposition had to do with a corporate representative's testimony about the operation of the garage, you know, their knowledge of what happened the day thereof, and the way it's operating and the way it looks in the past, present, and the future. Some of that stuff, apparently, was dealt with by -- well, at least in an interrogatory standpoint, was dealt with by Judge Kelly. But --

MS. GOODING: Your Honor, I believe that the rule allowing for this kind of corporate deposition says that the designees can testify as to whatever they have personal knowledge of. And we certainly are not trying to hold any lack of knowledge against Lexington Medical Center in -- really, in any sense, but certainly not outside of the topics.

THE COURT: Well --

MR. GESSNER: And specifically, Your Honor, the topic about the circumstances surrounding Plaintiff's fall, Mr. Andrews was designated to speak to that. And then at deposition, Mr. Goings asked Mr. Thompson about specifics about the fall or

whether the curbs had been painted and things like that.

That's where we had a witness designated to speak to that -- this is Mr. Andrews right here.

THE COURT: Okay.

MR. GESSNER: So then for Plaintiff to ask a different witness that's designated for a different purpose, I thought, was improper.

THE COURT: Okay. Were the topics different too, for the two different 30(b)(6) --

MS. GOODING: We provided one notice --

THE COURT: You provided one witness for a group of topics and provided another witness for another?

MR. GESSNER: Correct, Your Honor, all on the same notice.

MS. GOODING: And that's where the response -- his response to our 30(b)(6) deposition that's the first exhibit to the deposition, that's where he's indicated which areas he designated each witness for.

And we asked a lot of -- some of the questions of both witnesses and just asked for what they had personal knowledge of for those questions. And, to the extent that they were able to answer those and

provide their personal knowledge, we think that that's admissible.

THE COURT: Okay.

Anything else, Mr. Gessner?

MR. GESSNER: No, Your Honor.

THE COURT: We're going to proceed. Obviously, I'll let you renew all this after our verdict. But I need to hear it --

MR. GESSNER: Okay.

THE COURT: -- to really be able to understand it. If I think something is improper, going off our arguments as they stand -- and, again, it would be a different thing if there were 12 people in the box.

MR. GESSNER: I understand, Your Honor.

THE COURT: Under these circumstances, we're just going to proceed forward. Note on the record which testimony you're objecting to and, when he gets to it, you can stand up and just say --

MR. GESSNER: I was just going to ask, Your Honor, would it be better, after everything I just -- and I have it written down. Would it better if, after everything, I just -- and I have it written down. I can hand that up to Your Honor so it's part of the record, rather than me jump up and object every time.

THE COURT: Well, note it once. But if you're going to give me something or put something on the record that says specifically what you object to, that would be great for the court reporter and good for us.

MR. GESSNER: Understood.

THE COURT: It will be efficient. And after we hear it all, maybe I'll reserve the right to take appropriate measures, if I think it is appropriate. But we'll cross that bridge when we get to it.

MR. GESSNER: Yes, sir. Thank you, Your Honor.

THE COURT: All right.

MS. GOODING: Your Honor, we're going to begin with the 30(b)(6) deposition of Corey Andrews, who is the director of risk management at Lexington Medical Center. And, as I mentioned, we're going to jump around a bit. So we're going to begin on page 19. And I'll just indicate, as we kind of change pages, that we're doing that so that Your Honor can follow along, if you'd like. We'll begin on page 19 at line 20.

COREY ANDREWS

being previously sworn, testified as follows:

(Transcript being read by Ms. Gooding and Mr. Goings.)

DIRECT EXAMINATION

BY MS. GOODING:

Q. And you've seen the video, haven't you?

A. Yes, sir.

Q. Okay. And do you agree with me that it appeared, on the video, to be a pretty violent fall?

A. It was a hard fall.

MS. GOODING: Continuing on page 26.

BY MS. GOODING:

Q. Okay. And the condition I'm showing you in this document that has painting on the top and side of the curb, is that prevalent throughout the parking garage?

MR. GESSNER: Objection; off topic.

THE COURT: Proceed. Overruled.

MS. GOODING: Beginning on line 17. I'm sorry, Your Honor. Page 26, line 17.

THE COURT: Yeah. If you could, give me a little bit of a delay so I can catch up.

MS. GOODING: Sure.

THE COURT: All right.

The witness --

MR. GOINGS: Yes. And the witness was shown,

actually, photographs when he answered this question. So I'm just putting the photographs up so Your Honor can see what we're talking about. It was Exhibit 4 in the deposition.

And the answer is: I believe it was. I have not parked over there in quite some time, so I couldn't say with a hundred percent.

MS. GOODING: And then continuing on page 29, we're looking at Exhibit 3. And we're going to be -- page 29. And we're going to begin on line 6.

THE COURT: Okay.

BY MS. GOODING:

Q. She walked through the door opening, correct?

A. Yes, sir.

Q. And she was -- after she walked through the door opening, she was walking on what is considered a walking surface, correct?

A. Yes, sir.

Q. And from her vantage point, she's not able to see any yellow paint on the curb that she would eventually step on or step off of, correct?

A. She would not see yellow paint on the curb that she was actually on.

Q. That's correct.

A. Yes, sir.

Q. All right. Because the -- only the front face of that curb is painted yellow, correct?
A. Yes, sir.
Q. And the top of the curb, which would allow her to see that it would change in elevation, was not painted yellow, correct?
A. Correct.
MS. GOODING: Going down to line 10.
BY MS. GOODING:
Q. Well, let me ask you this: Why are curbs painted at all in the parking garage?
MR. GESSNER: Objection; off topic.
A. For -- to make the change in elevation visible to the human eye -- excuse me. I'm sorry. I would assume that they would have been painted such as this to make it easier to see.
Q. For -- to make the change in elevation visible to the human eye, correct?
A. Yes, sir.
Q. Because oftentimes it can be hard to see changes of elevation without demarcations through paint or other type of signage, correct?
A. Yes, sir.
MS. GOODING: Page 31. We'll begin at line 12.
BY MS. GOODING:

Q. Is Lexington County Medical Center responsible for the upkeep and maintenance of their facilities such as parking garages?
A. Yes, sir.
Q. Okay. So it's the responsibility of Lexington County Medical Center to maintain their own property and their facilities, correct?
A. Yes, sir.
MS. GOODING: Beginning again on page 34 at line 5.
BY MS. GOODING:
Q. You've seen the video where Mrs. Connell fell, yes?
A. Yes, sir.
Q. She didn't appear to be distracted in any way in that video, did she?
A. From what I can recall, she was walking maybe a few feet in front of her husband. But as far as other distractions from there, I did not observe any.
Q. Okay. So it's not like she was looking in the direction that she was -- she wasn't in the direction that she was walking, based on the video?
A. She was looking forward. I don't recall if she was actually looking down.

Q. Okay. She wasn't looking to the side or looking backwards when she was walking, was she?
A. I don't recall that.
Q. It appeared that she was walking at a normal and acceptable speed, correct?
A. Yes, sir.
Q. All right. She wasn't running or skipping or hopping, was she?
A. No running or skipping or hopping.
Q. Okay. And from what you saw in the video, did she actively do anything wrong?
A. Ask me that again.
Q. Based on what you saw in the video, did she actively do anything wrong in -- resulting in this fall?
A. Not that I observed.
MS. GOODING: Continuing on page 37 at line 19.
BY MS. GOODING:
Q. Do you agree with me that if the top edge of the change in elevation of the curbing was marked yellow, like it was throughout the rest of this parking garage, that if it was, in fact, painted yellow, that Mrs. Connell would have been able to more readily see the change in elevation which would have likely prevented this fall from occurring?

MR. GESSNER: Objection, Your Honor. That one's calling for speculation.

THE COURT: All right. Very well. I'm going to overrule it for now. Thank you.

MR. GESSNER: Thank you, Your Honor.

MR. GOINGS: Answer: I believe that it would have given her a better chance to see the curb.

BY MS. GOODING:

Q. Okay. And you agree with me that at any time you're dealing with trips and slips that result in falls, that being able to adequately see the potential hazardous condition is important, correct?

A. I would agree with that statement.

MS. GOODING: And that's all the testimony we're going to read in from Corey Andrews.

And then we have some from Dale Thompson, who is the director of facility services at Lexington Medical Center and was designated for some of the other topics.

THE COURT: Okay. Mr. Gessner, anything you want to put on the record for this?

MR. GESSNER: Mr. Thompson's deposition? It's the same.

THE COURT: Okay. I just want to make sure you noted what you want to note on this objection -- on

this deposition.

MR. GESSNER: As far as the one we just read, Your Honor?

THE COURT: Yeah.

MR. GESSNER: No. It's the same arguments I've been making.

THE COURT: All right.

So we're going to Dale Thompson now?

MS. GOODING: Yes, Your Honor.

THE COURT: Where are you going to start?

MS. GOODING: We are starting on page 6.

THE COURT: One second. Okay.

MS. GOODING: Line 15 on page 6.

DALE THOMPSON

being previously sworn, testified as follows:

(Transcript being read by Ms. Gooding and Mr. Goings.)

BY MS. GOODING:

Q. What is your job duty and job title at Lexington Medical Center?

A. I am director of facility services.

Q. How long have you been director of facility services?

A. I have been director since 2012.

Q. Where did you work before 2012?

A. I worked at Lexington Medical Center for roughly 35 years. But I did do a stint for a time at Mary Black Hospital in Spartanburg, South Carolina.

MS. GOODING: And then we're going to skip to page 15 and begin on line 18.

THE COURT: Sorry. Tell me that again, Ms. Gooding.

MS. GOODING: Page 15, line 18.

THE COURT: 15, 18. Okay. Thank you.

BY MS. GOODING:

Q. Outside of just meeting the local code, is there anything else done to ensure safety?

A. The grounds manager and myself will ride the campus monthly looking for different things that we notice that may be unsafe that we can address.

MS. GOODING: On page 16, skipping down to line 9.

BY MS. GOODING:

Q. Why does this parking garage even have yellow paint in it?

A. My guess is that it's going to be a code requirement.

Q. So you think it's painted yellow just because it's a code requirement?

A. I do.

MS. GOODING: And on page 18, reviewing Exhibit 2, I'm going to start right at the top.

BY MS. GOODING:

Q. Do you see any yellow paint in that area where Mrs. Connell fell?

A. I don't know the area. Can you show me where?

Q. Your colleague identified that she fell somewhere between where these two blue lines are, just for reference.

A. Right. I don't see any yellow paint.

MS. GOODING: And on line 17.

BY MS. GOODING:

Q. Do you see any yellow paint in that area?

A. I do not.

Q. Can you give me an explanation as to why that area does not have any yellow paint?

A. I cannot.

Q. And this is a curb, isn't it?

A. It is a curb. But I don't know if it's anything different, based on the lighting close to the entrance. The passageway is different than these.

Q. Now, not only is this a curb, but this is actually a walking surface, as shown in Exhibit 3,

that lends ingress and egress for pedestrians out of the parking garage, correct?

A. Correct.

Q. All right. So this is not only a walking surface, but a walking path, correct?

A. It looks to be.

Q. All right. So if a person is walking from their car out of the parking garage, they're able to see that this is a curb, because they can see the yellow florescent paint on this curb, correct?

A. Correct.

Q. But if they're walking from outside going back inside to where their car is, there's no yellow paint for this curb for them to visually see, is there?

A. Correct.

MS. GOODING: Continuing on page 20 at line 5.

BY MS. GOODING:

Q. The reason that there is striping, painting, and marking is to aid in one's vision, correct?

A. Yes.

Q. All right. And not only does it aid in a pedestrian's vision, it also aids in a driver's vision as well, correct?

A. Correct.

Q. All right. And there's a good safety reason for marking curbs with yellow paint, correct?
A. Yes.
Q. All right. It helps prevent unnecessary falls, doesn't it?
A. It does. And visual for, as you said, the drivers coming through.
Q. And pedestrians, correct?
A. Uh-huh. Yes.
MS. GOODING: Continuing on line 24.
BY MS. GOODING:
Q. Nothing prevented Lexington Medical Center from having the face of this curb where Mrs. Connell fell painted yellow or white or any other color; is that correct?
A. Yes.
MS. GOODING: That's all the excerpts from that witness, Your Honor.
THE COURT: Okay.
MS. GOODING: Oh. No, it's not. Sorry. Sorry, Your Honor. Continuing on page 23, line 21 --
MR. GOINGS: Actually, it's 22, then it goes to 23.
MS. GOODING: Page 22 at line 8.

BY MS. GOODING:
Q. In fact, it's the right thing to do, to paint curbs in a parking garage, isn't it?
MR. GESSNER: Objection, Your Honor; speculation.
THE COURT: Overruled.
Proceed.
A. I think in traffic areas, it is the right thing to do.
MS. GOODING: Page 23 at line 21.
BY MS. GOODING:
Q. You agree with me that, from the naked eye, it can be hard to see where this walking surface has a change in elevation?
MR. GESSNER: Objection, Your Honor; off topic.
THE COURT: I'm sorry. Where were you?
MS. GOODING: Page 23 at line 21. We're jumping around a lot on you.
THE COURT: Okay. You can ask the question again.
BY MS. GOODING:
Q. You would agree with me that, from the naked eye, it can be hard to see where this walking surface has a change in elevation?
MR. GESSNER: Objection; off topic. Further,

it calls for speculation, Your Honor.

THE COURT: And just for your record, how is it off topic?

MR. GESSNER: Mr. Thompson was not identified to speak as to the circumstances of Plaintiff's fall. He was only identified to talk about the construction.

THE COURT: Okay. But he was noticed to talk about the facts and circumstances alleged in the lawsuit, was he not?

MR. GESSNER: Only -- subject only to the specific items in Plaintiff's notice, Your Honor. I thought Mr. Thompson was identified to talk about persons with Lexington Medical Center that oversaw the design, build, and construction of the parking garage where Mrs. Connell fell; contractors, companies, entities, or persons that apply the yellow paint; plans, specifications, drawings, plats, sketches, detail work orders, or other related documents related to the design and construction; plans, specifications, drawings, plats, sketches, detail work orders, invoices, or other related documents relating to the painting of the parking garage where Mrs. Connell fell.

It says: Facts and circumstances related to

when painting of the parking garage where Mrs. Connell fell was performed, who painted the parking garage, and the plans and specifications for painting the parking garage.

So, Your Honor, those topics are fairly specific, and I don't think those topics encompass the questions being asked by the plaintiffs here.

THE COURT: Okay. Each topic dealt with painting in some way, shape, or form; who did what, when they did it, how they did it, their knowledge of it. It appears that --

MR. GESSNER: Correct. But whether or not --

THE COURT: -- the question --

MR. GESSNER: -- it can be hard to see on a walking surface is not related to those topics as to who painted and when, I don't think, Your Honor.

THE COURT: Okay. I'm trying to understand your objection. And I'm going to respectfully overrule it for now. Thank you.

MS. GOODING: So you want me to begin at --

THE COURT: I think -- to be clear, I think it deals with -- it's really -- it deals with the paint and the fact that there wasn't paint, I think. So I just think it's -- I respect your position, but it's overruled.

MS. GOODING: Your Honor, I'll begin again on page 23 at line 21.

THE COURT: 23, line 21. Okay -- oh, you'll begin again. Okay. Go ahead.

BY MS. GOODING:

Q. You agree with me that, from the naked eye, it can be hard to see where this walking surface has a change in elevation?

A. Based on this photograph, yes.

MS. GOODING: And on page 24, beginning on line 10.

BY MS. GOODING:

Q. If this was -- if there was a yellow stripe through this photograph, one would be able to see it a lot better, wouldn't they?

MR. GESSNER: Same objection, Your Honor.

THE COURT: Overruled.

A. Yes, they would.

Q. Okay. And you don't -- you're not contesting, are you, that it would be -- from a safety standpoint, it would improve safety in this location to have a yellow stripe on top of this change in elevation where visitors and patients walk?

A. Yeah. No. I'm not arguing with that point. I think it would.

MS. GOODING: Continuing on page 26 at line 16.

BY MS. GOODING:

Q. Now, what's the point of using yellow instead of some other color?

MR. GOINGS: I'm just waiting for him to get there.

THE COURT: I'm sorry. What page?

MR. GOINGS: Page 26 at line 16.

THE COURT: Thank you.

BY MS. GOODING:

Q. Now, what's the point of using yellow instead of some other color?

A. As a caution.

Q. It means caution, right?

A. To me, it does. Yes.

Q. Would you agree with me that curbing can, in certain circumstances, cause a trip hazard?

MR. GESSNER: Same objection, Your Honor, off topic. Mr. Thompson was not identified for trip hazards or any safety standards. He was identified, as I stated earlier, solely for who painted what in the garage and when. And I think that's way off topic, Your Honor.

MS. GOODING: Just for the record, there's no

objection in the deposition transcript.

THE COURT: All right. Proceed. Overruled.

MS. GOODING: I'll ask the question again.

BY MS. GOODING:

Q. Would you agree with me that curbing can, in certain circumstances, cause a trip hazard?

A. Yes.

Q. Would you agree with me that when the curb is the same color of the concrete or the ground, which is concrete, that it can have a camouflaging effect to a pedestrian?

A. It does blend, yes, I could say.

Q. And when it blends, it can be hard to see where the elevation change actually is located, correct?

A. Correct. I agree.

Q. And that could result in a trip hazard, correct?

A. Correct.

MS. GOODING: And continuing on -- at line 19 on the same page -- sorry, at line 18 on the same page.

BY MS. GOODING:

Q. Do you know how much a can of paint costs to paint that?

A. It depends on the type of paint. But I would

say under a thousand dollars.
Q. Under a thousand dollars to paint that area?
A. I would say. I would think so.
MS. GOODING: Continuing on page 28 at line 22.
BY MS. GOODING:
Q. But this parking garage is a facility of Lexington Medical Center, correct?
A. That's correct.
Q. And it's a piece of property that is maintained and inspected by Lexington Medical Center, correct?
A. That is correct.
Q. And it's a piece of property that is under, essentially, your jurisdiction as the director of facility services, correct?
A. That is correct.
MS. GOODING: Continuing on page 30, line 16.
BY MS. GOODING:
Q. You would agree with me that if this curb was painted like all this curbing in the parking garage, that it would actually improve the safety of this area, correct?
MR. GESSNER: Same objection, Your Honor. Additionally, I believe that question calls for speculation.
THE COURT: Okay. Overruled.

A. I do believe that.

MS. GOODING: And that is all we have from this witness.

THE COURT: All right. Is that it for that witness?

MS. GOODING: Yes, Your Honor.

THE COURT: Anybody need a short break?

MS. GOODING: Your Honor, our next witness was going to be by video, so it might be a good time to take a break.

THE COURT: All right. Let's take five to ten minutes.

(Brief recess.)

MS. GOODING: Your Honor, I have the original deposition transcripts for the 30(b)(6) depositions, as well as Dr. Loging. If we could have you open them so we can make them part of the record.

THE COURT: Sure. Dramatic opening.

MR. GOINGS: We tried to hand them to the court reporter, but she said that you had to grace us with this dramatic moment of opening the transcripts, so here we are.

THE COURT: All right. Okay. So I've opened Dr. James Loging and two 30(b)(6) deposition transcripts for Corey Andrews and Dale Thompson,

respectively.

MR. GOINGS: Thank you, Your Honor.

THE COURT: And this is 45 minutes? 40 minutes?

MR. GOINGS: 35 minutes, Your Honor.

THE COURT: Okay. Are we ready to proceed?

MR. GOINGS: At this time, the plaintiff would call Dr. James Loging.

THE COURT: All right.

(Videotaped deposition of Dr. James Loging played for his Honor.)

THE COURT: Okay.

MS. GOODING: Our life care planner, Ms. Lindsay Moore, is here. If you -- she'll be a quick witness, if you want to take her before lunch or we can take lunch now.

THE COURT: We can just plan to break for lunch at 1:00-ish. It's 12:30 now. I mean, how long?

MS. GOODING: Definitely less than 30, Your Honor.

MR. GESSNER: I do have some objections to her testimony, Your Honor, so it may be longer.

MS. GOODING: I don't intend to have her on the stand longer than 15 minutes for my part. I was already accounting for him.

THE COURT: Okay. We can go ahead and proceed and we can just break around 1:00.

MS. GOODING: Sounds great, Your Honor.

Plaintiff calls Lindsay Moore to the stand.

LINDSAY MOORE

being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. GOODING:

Q. Good afternoon.

A. Good afternoon.

Q. Please introduce yourself to the Court.

A. Sure. My name is Lindsay Woods Moore.

Q. Can you tell us about your education and training.

A. Sure. I attended the University of Georgia from 2001 until 2005. I graduated with a Bachelor of Science, exercise in sports science; I worked for about a year in the home health industry. And then I moved to Charleston, South Carolina where I attended the Medical University of South Carolina from 2006 to 2008.

And I've got my Master of Science and Physician Assistant Studies from MUSC. Then I began working clinically in the emergency room. So I've been there for about 11 years, where I still continue to

work.

And then while I was doing clinical practice, I went to Capital University Law School from 2013 to '14 where I did my certification to become a certified life care planner. And then I started accepting medical consulting and life care planner cases in 2014, and have kind of been working both roles since then.

Q. Okay. Thank you. Are you still a licensed physicians assistant today?

A. Yes.

Q. How many years have you been a licensed physician assistant?

A. For 11 years, since 2008.

Q. And how many years have you been a certified life care planner?

A. I completed that certification in 2014. So about five to six.

Q. Can you give us kind of a general description of what you do as a certified life care planner?

A. Sure. As a life care planner, I evaluate individuals with injuries, disabilities, chronic health conditions, to understand what their future medical needs will be. And then, in addition to outlining what those future needs will be, I assign

the costs for those needs over an individual's lifetime.

Q. Have you ever been qualified as an expert in this field before?

A. Yes.

MS. GOODING: Your Honor, we would move to have Ms. Moore qualified as an expert witness in the field of expertise as a physician's assistant and certified nurse life care planner.

MR. GESSNER: We request voir dire of this witness.

THE COURT: Very well.

VOIR DIRE EXAMINATION

BY MR. GESSNER:

Q. Good afternoon. I took your deposition a while back, so we had talked. You are a physician assistant, correct?

A. Yes, I'm a physician assistant.

Q. Okay. What does a physician assistant do?

A. As a physician assistant, I'm -- particularly in the emergency room or in general?

Q. In an emergency room.

A. So in an emergency room, in the clinical setting where I work, I evaluate and treat patients under the direct supervision of a licensed

physician, although I do work independently.

So I evaluate individuals that come in, take a history, determine what would be the appropriate diagnostic studies or labs that need to be ordered, and create a differential diagnosis, do a physical exam. I evaluate that patient; I interpret the results, once those studies are back; determine diagnosis, speak with the individual about that diagnosis and appropriate treatment, whatever that may be.

Q. Now, as a physician's assistant, do you have admitting privileges at any hospital?

A. So I don't -- in the emergency room, I evaluate and treat patients in the emergency setting. I determine if they are appropriate to be discharged home or whether they require admission. I'm not an inpatient provider, so I do not particularly admit patients myself.

Q. Okay. So if you're not working in the emergency setting though, is it possible for you, as a physician's assistant, to have admitting privileges at any hospital in the state of South Carolina?

A. Are you asking if PAs in general can admit patients in the state of South Carolina?

Q. Correct.
A. So they always work directly with a physician. And with that collaboration and team effort, they do admit patients to the hospital.
Q. Okay. I don't think that answered my question.
Physicians, at times, they don't have to have, but they have admitting privileges; meaning that the physician can admit a patient to a specific hospital; is that correct?
A. Sure. A physician can admit a patient to a hospital with admitting privileges, yes.
Q. Okay. Is it possible for you to do that, not as a member of a team, but just as a physician's assistant? Is it possible for you to admit a patient to a hospital?
A. Considering I don't -- I don't work in that role, I work in the emergency setting, I'm not a hundred-percent certain. I know they always work together with their physician. I don't know that they directly have their own, you know, name associated solely with that for admitting privileges in that, like, particular technical term.
Like I said, they're always working with a supervising physician who can admit. I've never been in a situation where I'm attempting or have

asked for privileges to admit myself. So...

Q. Okay. I'll say it's my understanding that in the state of South Carolina, a physician's assistant cannot have admitting privileges at any hospital. Do you have any knowledge as to that?

A. That may be true. But --

MS. GOODING: Your Honor, I'd like to make an objection to this line of testimony. We are not going to ask Ms. Moore her opinion as to whether Mrs. Connell should have been admitted to any hospital or will be admitted to a hospital in the future. We are asking her to provide opinions as to what the costs of her future medical treatment. That is her primary role.

And, here today, she's focused on the costs that are associated with that. She's using Dr. Loging's opinions in order to develop those costs. And we're not going to ask her to -- whether she thinks Mrs. Connell should be admitted to a hospital.

MR. GESSNER: I can cut to the chase, Your Honor. My issues with this witness' testimony is she has provided two future cost analyses. The other increased the future cost projection by about a hundred thousand dollars on a single line item.

And that line item is for a potential knee replacement for the plaintiff, wherein her report states that this -- that Plaintiff would have to be inpatient to have the surgery.

However, a life care planner can only testify within the scope of their profession. So Ms. Moore can testify as to anything a PA can testify to. In the state of South Carolina, PAs cannot admit patients to a hospital on their own.

They can make a recommendation to a physician; that physician can either agree with it or disagree with it. But it's the physician that is admitting, not the PA. So our position is Ms. Moore is unqualified to talk about whether or not Mrs. Connell, the plaintiff, can or should be admitted to the hospital for any future surgery.

Further, a life care planner can rely on a physician's testimony stating that the patient would have to be inpatient for future surgery. However, Dr. Loging did not testify as to that. And, in fact, in the testimony you just heard, Dr. Loging reviewed Ms. Moore's original cost projection, which had all these surgeries done as outpatient.

He reviewed that and said that it was appropriate. He further even commented on the

facility fee for an outpatient surgery for a knee replacement. I don't think, if Dr. Loging had any issues with Mrs. Connell having a surgery inpatient versus outpatient, he would have said, no, this patient needs to be inpatient for this surgery.

So there's no evidence indicating that the plaintiff will have to be inpatient for the future surgery. So the whole purpose of my voir dire is to exclude those portions of Ms. Moore's testimony as to whether or not Mrs. Connell would need to be inpatient or outpatient for any future surgery.

THE COURT: Just so I understand your -- the way you started off, you mentioned she did two separate projections. Are you referring to Scenario A and Scenario B or are you --

MR. GESSNER: No. There are two separate reports; one dated June 20th, 2019 --

MS. GOODING: They're both parts of Exhibit 13, Your Honor.

MR. GESSNER: Correct. The second one is dated December 6th, 2019.

MS. GOODING: She updated her report following Dr. Loging's deposition testimony. So there are two reports.

THE COURT: Okay. That may --

MR. GESSNER: And I --

THE COURT: Just for a moment. I'm looking at Exhibit 13, future cost analysis, dated and completed December 6th, 2019.

MR. GESSNER: Correct. That's the updated report, Your Honor.

THE COURT: Well, I want to be clear. I don't have another one. That's why I --

MR. GESSNER: Okay. I have --

MS. GOODING: I have a copy of it for you here, Your Honor.

THE COURT: All right. So I've been handed a copy of future cost analysis, which is dated -- date completed, June 20th, 2019.

MR. GESSNER: It should be three pages with the cover, Your Honor.

THE COURT: Is she here to testify about both or just the one from December 6th?

MS. GOODING: She will testify regarding both and explain why there are two, why she updated it.

MR. GESSNER: And briefly, Your Honor, she did clear up a few things from the first report to the second report that make sense. And we don't contest that.

What we are contesting is, if you look in the

first report, the -- sorry, the June 20th report, she listed the -- it's only partial knee replacement, not the full knee replacement -- but lists the facility fee, hospital, outpatient, estimated to cost somewhere between $7,338 and $13,352.

And the updated report, the December 6th report, that outpatient facility is replaced with a hospital DRG. But that's how hospitals charge for inpatient care. And the estimated cost for that is $124,373. So that single line item increased Plaintiff's projected future medical costs by over $100,000 from a witness who is not qualified to give testimony as to that.

THE COURT: Well, can't she give testimony -- well, the potential of whether it were inpatient or outpatient, what the different costs would be? I mean, not whether she needs it or not. The issue, at least at the time I think the report was done, is Dr. X -- Dr. Loging says she's going to need a replacement. Well, if it's inpatient, it might be this; if it's outpatient, you're looking at this range.

Is the point -- is she trying to say that he -- or, excuse me, she needs inpatient or outpatient, or

that these are the ranges of costs you're looking at, depending upon which is done?

MR. GESSNER: I believe the witness can testify as to what a particular procedure would cost. She is qualified to do that. However, I think admitting testimony about a procedure or an aspect of a procedure when there's no evidence to support that -- I guess if you're asking me does that go to the weight as to --

THE COURT: Well, I'm not saying that yet. I just want to make sure I understand what it's being offered for. I think I understand the objection. Let me let Ms. Gooding respond, since I haven't let her respond yet.

MS. GOODING: Thank you, Your Honor. I would just say that Ms. Moore has knowledge and expertise in when surgeries are done inpatient versus outpatient. She's not required to have individual admitting privileges in order to have knowledge of when that tends to be done.

And she -- in being trained as a certified nurse life care planner, her training is to take the recommendations of a doctor and kind of determine, okay, what are the aspects of that future treatment? If you're going to have future knee replacement

surgery, is that going to include X-rays? Is that going to require a surgery center? Is that going to require a hospital? Is it going to require anesthesia? Because all of those things are aspects of what make up the cost of a future surgery that's being recommended by a doctor. So that's specifically what she's been trained for as a certified nurse life care planner.

And she also has a great wealth of knowledge in why patients are doing inpatient procedures versus outpatient procedures because of her clinical role as a physician's assistant. And she's not required to be able to admit a patient to a hospital in order to give an opinion based on her knowledge and expertise.

MR. GESSNER: Respectfully, Your Honor, I disagree. I believe that life care planners -- well, again, while they can say what the costs for a particular service are, with -- or if they're entering testimony saying this individual is going to need the service, they either have to be in the field where they are, in fact, doing that service or they have to rely on the appropriate expert saying that.

And, as I said, because Dr. Loging never said

it would need to be inpatient, there's a lack of evidence for her to say, hey, she should be inpatient and here's why. And, respectfully, as a physician's assistant, because she cannot, under any circumstances, admit a patient, I think, as an expert witness, she is not qualified to testify as to that.

THE COURT: Well, I don't think she's here to say what she needs. But, I mean, obviously, Dr. Loging testified that she will need a knee replacement, in his opinion, and it was a hundred-percent guaranteed that she was going to have arthritic conditions arise out of it.

And, as far as what she can and cannot do as a PA in her individual practice, I'll let you point that out to her on cross-examination at your leisure. But she can testify about what the potential -- what she believes, in her opinion, is the future cost, in part, certainly based upon what we just heard from Dr. Loging.

So it goes to -- but back to what you just said a moment ago. I think this goes to weight and not admissibility.

MR. GESSNER: Thank you, Your Honor.

THE COURT: She'll be qualified as an expert as

a certified life care planner and as a physician's assistant.

MS. GOODING: Thank you, Your Honor.

CONTINUED DIRECT EXAMINATION

BY MS. GOODING:

Q. Ms. Moore, are you familiar with Mrs. Connell's medical care and treatment following her injuries on September 26th, 2017?

A. Yes.

Q. Have you reviewed all of her medical records related to those injuries?

A. Yes, I have.

Q. What were you asked to evaluate in this case?

A. I was asked to take Dr. Loging's recommendations for future care and to assign the usual and customary fees in her community to outline the cost of her care over her lifetime.

Q. And did you prepare a report for this case?

A. Yes, I did.

Q. Do you have a copy of it with you?

A. Yes, I do.

Q. What is the date of that report that you're referring to?

A. The date of the report I have here -- I have both, actually.

Q. Okay. So let's look first at December 6th, 2019 --

THE COURT: Ms. Gooding.

MS. GOODING: Yes, sir?

THE COURT: Just quickly. We're making references to this June 20th report, but it's not in my binder. So is it not in evidence? Do you want -- I want to make sure we're not referring to something that's not in the record.

MS. GOODING: Sure. So --

THE COURT: Well, I mean, I have no preference what you do. But, I mean, we've been talking about this objection --

MR. GOINGS: It was in our binder --

THE COURT: Oh, okay.

MR. GOINGS: -- and in opposing counsel's binder. But, somehow, it didn't get into your binder.

THE COURT: Okay. If she has it -- if the court reporter has it, fine with me.

MR. GOINGS: We'll make sure the court reporter has both reports that are Exhibit 6 --

MS. GOODING: 13.

MR. GOINGS: 13.

THE COURT: I just don't want to make reference

to something down the road that is not in evidence.

MS. GOODING: Yes. Yes, Your Honor. And I'm happy to lay the foundation for that, I'm just not quite there yet.

THE COURT: Again, if it's in evidence, I'm good. I just want to make sure.

BY MS. GOODING:

Q. Ms. Moore, tell me again what the dates are on your two reports.

A. Sure. I have June 20th, 2019, and then December 6th, 2019.

MS. GOODING: We'd move to have both of those reports in evidence as Exhibit 13.

THE COURT: To the extent they aren't already.

MS. GOODING: To the extent that they aren't already, yes, Your Honor.

You have any objection?

MR. GESSNER: Subject to my earlier objection about the single line item.

THE COURT: All right. Very well. So noted.

(Plaintiff's Exhibit No. 13 admitted into evidence.)

BY MS. GOODING:

Q. So, Ms. Moore, first we're going to focus on the December 6th, 2019 report, since that's your

more recent report. Will you please kind of go over the report for us and just tell us, first, in each of the columns, you know, what wasn't contained in each column.

A. Okay. Sure. So just as an overall kind of heading, the two -- this updated report includes two scenarios: Scenario A, which has medical interventions; so that would be the Supartz injections that Dr. Loging recommended, as well as the patella hardware removal. And, in this scenario, it's a partial knee replacement.

And then there's a Scenario B. And, in that case, it's similar with the medical interventions; the Supartz injections, the patella removal, and then a total knee replacement.

So he mentioned and recommended either a partial or a total knee replacement, although he said a total knee replacement would be more likely. So this report outlines both scenarios that he discussed and recommended for her future.

Q. And I see, in the first column, it has the item or service. That kind of gives a description of what it is that you're considering. And then the second column says diagnostic code. Can you tell us what that means?

A. Yeah. Sure. And, technically, it's actually a procedure code. Some of the most updated reports do say procedure code. But those include either a CPT code, a DRG code, an APC code, which is a bunch of kind of lingo to tell you that they are very specific to what that item is; that everyone uses the same kind of code to -- like I said, that correlates with that item. And then we can research the costs associated with it, based on the code.

Q. Okay. And then the next column says frequency or replacement. What goes in that column?

A. So that's how often or how frequently she would need it. So as we said before -- or through Dr. Loging's testimony, the Supartz injections, she would need three to five injections, because they come in a cluster where you do kind of several in a row. And she would benefit from that three to four times over her lifetime, or at least that would be a reasonable amount to help hold off on that surgery until her pain is intolerable and it becomes necessary. So that would be your frequency of how frequent, whereas you see the surgeries are one time only.

Q. And in any instance where Dr. Loging didn't give a specific recommendation as to the frequency

of the treatment that would be required or exactly when it would happen, where did you come up with that frequency?

A. So we used what is most likely to occur. Again, as you said, I mean, I practice in the medical profession, so a lot of these things, through my own experience and knowledge. Sometimes I research information on particular things, if that's necessary.

And then, again, with the Supartz injections, although I didn't have a particular conversation in detail of how that occurs, based on my own -- you know, my knowledge and -- we know that they occur in three to five injections within a series. So it's a combination.

I either use my knowledge base, my clinical expertise, research the topic, or, in some cases, I do specifically ask the provider that is going to --

Q. So if you don't -- if you're not able to have a specific conversation with a provider, it's kind of based on kind of the standard patient or what would be most common?

A. It would be what's most common and what's most likely to occur. That's right.

Q. And then the next column is item cost. Can you

tell us what that means?
A. Sure. So this would be the range of the cost in a community. So I don't take one particular cost. On most line items, I research at least three of the community costs in that area and then provide a range of the lowest that might be provided for and what the highest that might be provided for in the community, and prevent -- present a range.
Q. And then the average lifetime cost, where does that number come from?
A. So that would be an average of the -- of each data point that I use. So, in some cases, it's three data points; in some cases it's maybe four. I mean, in particular, things like when we get down to facilities, I'm looking at particular facilities where it may occur that are in her area and using their own data. So that would be the average cost of those data points for that item.
Q. And for items that the service is going to be needed more than once, do you then take the frequency or the number of times it's needed into account for the average lifetime cost?
A. Yes. Whatever that frequency may be over her lifetime and I multiply it out.
Q. Okay. And, again, whose opinions did you rely

on in formulating your cost projectors?
A. These are all based on recommendations and opinions by Dr. Loging on her future care.
Q. And I think that you kind of mentioned this earlier: But there are two scenarios here. And both scenarios include injections; is that right?
A. Yes.
Q. Both scenarios include a hardware removal surgery, correct?
A. Yes. That's true.
Q. And then the difference is that the Scenario A assumes there's going to be partial knee replacement, and Scenario B assumes there's going to be a full knee replacement; is that correct?
A. Yes, that's correct.
Q. And why did you do both scenarios?
A. Because Dr. Loging's testified that it may be either a partial or a total; although, again, like I said, he mentioned that the total would be more likely for her, and, essentially, to kind of show both scenarios.

The only significant line item that's different is actually the professional fee. So that would be -- everything else that you see is -- pretty much mirrors each other, except for the professional fee.

So that is the work that the doctor is doing during the surgery.

He does one particular type of, you know, level of work on a partial knee replacement and he does a more extensive or a different type of level of work offered on a total knee replacement.

Q. So a total lifetime cost for Scenario A is $149,129. And the total cost for Scenario B is $151,209. Is that correct?

A. Yeah, that's correct. They're pretty close in dollar value. Correct.

Q. Now, I think you've already referred to this: But you had the benefit of Dr. Loging's trial testimony when you created this report; is that correct?

A. Yes, that's correct.

Q. And prior to Dr. Loging testifying, had you already created a report for this case?

A. Yes. I created a report based on Dr. Loging's medical record and his specific recommendations that were written in his medical report.

Q. Okay. And is that report we've been referring to, which was dated in June -- was it June 9th? June 20th. I'm sorry.

A. That's correct.

Q. Okay. And I know you've already explained this some: But how does the June report differ from the December report?

A. Sure. The June report was, again, based on the medical note from Dr. Loging after a visit. And he recommended the Supartz injections; he recommended hardware removal. And, in that note, he mentioned a partial knee replacement. In that note, there was not a reference to a total knee replacement.

So, therefore, after reviewing his deposition -- or testimony, I went back and updated the report to reflect that he mentioned and recommended a total knee replacement. So the initial report only included a partial.

Q. Okay. And so the first report contemplates, in its two scenarios, that she would either have a hardware removal or a partial knee replacement, whereas in the second report, it's clear that she is going to have a hardware removal and then will also have a second surgery, but it may be a partial or a full; is that correct?

A. Yes, that's correct. And, again, like you noted there in the first one, it's an either/or scenario for the hardware removal or the partial knee replacement. He clarified that to include that

both of those would be necessary, so kind of reorganized and make -- to reflect the information as most accurately as possible.

Q. And both reports include costs for a partial knee replacement, correct?

A. Yes, they do.

Q. And I noticed the number for the facility's fee in both scenarios in the December report is significantly higher than the number for the facility's fee in the partial knee replacement for the June report.

And, if we can -- if you can, kind of point out to the Court where to find that information on the June report?

A. Sure. So under -- on the June, the initial report, under Scenario B, we're looking at the partial knee replacement facility fee, and it says: Hospital, outpatient. And then you'd see the costs listed there.

Q. And that's on page 2 of that report, correct?

A. Yes. It's on the second page. That's correct.

Q. Okay. And where would we find the facility's fee for the partial knee replacement on your December report?

A. On the December report, it's on the first page

of the report. And the -- excuse me. I take that back. It's also on page 2 of the report where it says: Partial knee replacement facility fee. So it's about a third of the way down from the top of the page. And that says: DRG 467.

Q. Okay. Why is it that the facility's fee is more on your December report than it was on the June report?

A. Sure. So there's a couple things that go into that. So on the initial report, we were doing, again, just the partial knee replacement only. And on the updated report, it's a partial knee replacement and a total knee replacement. And some additional information came to my attention, and that is some of her comorbidities.

So in reviewing her medical records from her hospitalization, she has atrial fibrillation, which is a cardiac condition where her a atrium kind of flutters or kind of -- well, it doesn't beat regularly. And so she's on medication to treat that, which increases her risk associated with surgery and general anesthesia. So, therefore, once I recognized that, I changed that surgery to an inpatient facility for the partial.

As far as the total knee replacement, that one

is an inpatient procedure as well; for one, for the comorbidity. But, in addition to that, in the southeast -- I had done research when I wrote this report. But, in the southeast, knee replacement procedures are still more likely than not and more often than not performed in the inpatient setting. The research didn't specifically apply to partial knee replacements; it did to total knee replacements.

But, again, knowing that the total knee replacement is done more often than not in the inpatient setting, as well as knowing that she has comorbidities such as atrial fibrillation where you would want her to be in the safest environment, it's costed as an inpatient, so you see that change.

Q. All right. So the big difference in cost is based on it being inpatient versus outpatient?

A. Yes. I mean, that is -- that is the case. Facility fees are significantly different when they're done and performed in an outpatient setting versus an inpatient setting. And, so, that is the data. The inpatient procedures cost more, and you saw that reflected in the increased amount.

Q. And is it your opinion, to a reasonable degree of certainty within your field, that Mrs. Connell,

when she had this surgery, would most likely have the surgery inpatient?

A. Yes. I do believe that she -- most likely, according to Dr. Loging, it would be total knee replacement. And, as such, either procedure, I do believe it would be in an inpatient setting.

Q. And in reviewing your June report, does it indicate anywhere on that report that that report may be updated if you had additional information or if any additional information was called to your attention?

A. Yes. Future costs can always change. And it's what an individual -- it's kind of organic. I mean, if somebody -- as they're treating, that would be updated. And so I do reserve that, whereas if more information does become available that I can reflect that, to most accurately show any data that is provided. So it does say that.

And, at the top of my report, I mention that if there is new information, I will incorporate it into the report, which is why after the deposition -- and I have not costed out the total knee replacement and a few other items, and we talked about some reorganization of the data -- I elected to make those changes and update the report.

Q. And were those updates based primarily on Dr. Loging's trial deposition testimony?
A. Yes, they were based on that testimony.
Q. And which of your reports best summarizes the future treatment that Mrs. Connell will most probably undergo?
A. The most recent report best reflects what I believe she will need in the future and based on Dr. Loging's testimony and recommendations.
Q. Okay. Now, do your reports include or consider the cost of inflation or provide any kind of present-day value of those costs?
A. No. The costs that I outlined here are today's dollars for each of these items.
Q. And are you aware that Dr. Alford has prepared a report in this case that gives the present value of the medical costs that you have included in your report?
A. Yes.
Q. Are the numbers in your report or in his report kind of the final numbers showing the future costs?
A. His report is going to most accurately reflect inflation and adjustment for present-day value.
Q. Okay. And all of the opinions that you have given me today, do you hold those opinions to a

reasonable degree of certainty?
A. Yes.
MS. GOODING: No further questions.
THE COURT: Cross-examination?
MR. GESSNER: Yes, Your Honor. Thank you.

CROSS-EXAMINATION

BY MR. GESSNER:
Q. Now, Ms. Moore, we talked earlier about your ability to admit patients. Would you agree with me that you, as an individual, cannot admit any patient to any hospital in the state of South Carolina?
A. Again, I don't personally admit patients. I determine whether someone needs to be admitted, every shift that I work in an emergency room. And whenever a patient needs to be admitted, they end up being admitted. I would say that next to rarely ever or never has anybody that I recommended be admitted end up not needing to be admitted.
Q. Okay. But you still have to rely on someone else, someone that has admitting privileges to actually admit the --
A. Oh, my goodness.
(Brief interruption in the proceedings.)
(Off-the-record discussion.)
BY MR. GESSNER:

Q. Okay. I think I had asked you, you have to rely on someone else, someone that does have admitting privileges, to admit a patient, correct?
A. I mean, I -- again, I think that -- I mean, the -- technically, you're looking for -- the answer is yes. But, again, I don't -- it's -- that's not the way it's actually done in practice. If a patient needs to be admitted, they need to be admitted.
Q. Well, I asked if you have admitting privileges. And you're saying that's not how it's done in practice.
A. So, no, I don't actually admit the patient. No. I call the admitting team --
Q. Correct.
A. -- and say this patient needs to be admitted. They admit the patient and they take over care from there.
Q. And, it sounds from your testimony, part of that has to do with your specific position in the emergency department. Correct?
A. Right, in the emergency room when, essentially, we're kind of gatekeepers.
Q. Right. But also, as a physician's assistant though, hospitals do not give PAs admitting

privileges.
A. I believe that's accurate. But, again, that's not my area. I know that I can tell you for a fact that we have plenty of midlevel providers, physician assistants, nurse practitioners that are on the admitting team, and they do admit to the hospital.
Now, does that -- I believe that there is a possibility that the physician comes behind and makes sure that what they're doing is accurate. But they are still doing -- essentially, admitting the patients. But, again, technicalities, whose particular name is on it, they work as a team. We always work as a team in the hospital. So...
MR. GESSNER: Your Honor, I'm willing to move along, if necessary. I can brief the topic. But a PA cannot admit a patient in any hospital in the state of South Carolina. It's a limitation on their license.
THE COURT: I think the Court understands --
MR. GESSNER: Okay. Thank you.
THE COURT: -- the point of the question.
BY MR. GESSNER:
Q. Now, Ms. Moore, as a certified life care planner -- and I had asked you this at deposition, if you agree or disagree with the following

statement: That a life care planner must rely on appropriate medical- and health-related resources and not assume decision-making responsibility behind the scope of his or her own discipline, do you agree or disagree with that?

A. Will you read that one more time so I can make sure I know what I'm --

Q. Sure. The actual quote I have here is this: In being a life care planner, you must rely on appropriate medical- and health-related resources and not assume decision-making responsibility beyond the scope of his or her own discipline.

A. Essentially, I'd say that's accurate.

Q. Okay. And you testified earlier that your report is based on Dr. Loging's recommendations. Is that correct?

A. Dr. Loging's recommendations, yes, as well as my knowledge of the procedures he's recommending and her medical records. That includes her past medical history.

Q. And specifically though, Dr. Loging never said in his deposition that Mrs. Connell would have to be inpatient for any specific procedure, did he?

A. No. He testified that she needed, you know, a partial or a total knee replacement --

Q. Okay.
A. -- as well as the other items that were -- that were in the report.
Q. Okay. Did you ever speak with Dr. Loging about this specific case?
A. No. I have not spoken with Dr. Loging.
Q. Did you speak with any other physicians about this specific case?
A. No.
Q. You had said you had done some research and it's your conclusion that a full knee replacement, I think you had said, is, more times than not, done in the inpatient setting and not the outpatient setting. Is that correct?
A. Based on some articles that I read related to the southeast that -- yes. Presently, total knee replacements are done, primarily, in the outpatient setting.
Q. Okay. So primarily in the outpatient setting. Do you know the percentage?
A. I can't tell you offhand. I did that in preparing this report a few months ago. I can't remember the exact statistics. But, again, I would cost something in a scenario of what's most likely to occur. So I obtained the information I needed to

determine that and then costed it to reflect it.
Q. But you don't know if it's 51 percent or 90 percent?
A. I would say it's not all the way up to 90 percent, just based on, you know, the industry right now. But I don't know the exact answer to that question. I'm sorry.
Q. And so you wouldn't know if a patient -- or Mrs. Connell, for example, would fall into one category or the other?
A. One category or the other, meaning --
Q. As far as inpatient or outpatient.
Let me ask another question first. What are the driving factors then between one group versus the other, or do you know?
A. Yeah. Sure. There's several factors that would be involved in making that determination. There would be comorbidities, risk factors. It would be -- I mean -- and, also, part of it is actually patient preference.
Q. So what comorbidities does Mrs. Connell suffer from?
A. That would be directly related to her risk factors for general anesthesia and surgery, which would be atrial fibrillation, which is a cardiac

condition.
Q. Okay. Are you aware of any others?
A. I reviewed that in preparing the report. But, offhand, I can't tell you what exactly all her prior medical conditions were. Again, I was looking for things that would affect her future care.
Q. Do you recall testifying at deposition that it was your belief that Mrs. Connell suffers from hypertension?
A. Yes. That might have been -- I might have, like, just, you know, read it, her prior history, closer to that time. So that's probably true.
Q. Well, would it change your opinion any if I told you that Mrs. Connell, in fact, does not suffer from hypertension and, at deposition, testified that she does not?
A. No. I mean, hypertension does increase the risks associated with general anesthesia. But you also have to consider whether it's controlled hypertension or not. And, again, the one that affected or played into part of my assessment of whether inpatient or not was the atrial fibrillation, not particularly the hypertension.
Q. So if you testified at deposition that you were basing some of your opinions on comorbidities --

which you included hypertension in that -- then at least that aspect of it would have been incorrect; would you agree?

A. I don't recall at this time. I -- again, hypertension does increase the risks associated with general anesthesia. If she has that, that would be a part of it. Again, the driving factor would be atrial fibrillation. Even if she had hypertension alone and nothing else, she still could potentially have a procedure in the outpatient setting. I don't recall all of her comorbidities offhand. I know that that one particularly changed her risk assessment.

Q. Do you know the status of her atrial fibrillation?

A. Not at this time.

Q. Is it controlled?

A. There's nothing I read that said that it was not controlled.

Q. All right. Now, looking at your two reports, between the June report and the December report, how much of a cost increase was there, going from an outpatient facility fee to an inpatient hospital DRG?

A. So for the outpatient partial knee replacement,

your facility fee went from $7,338 up to $13,352. And the inpatient procedure -- the inpatient procedure -- and I'm -- just to verify -- but it would be the same DRG. So whether it was partial or total knee replacement in the inpatient setting would be one -- sorry. I just happened to have lost the number there -- 118 -- 118,951 up to 130,986.

Q. So it's an increase of over $100,000?

A. I mean, it reflects what the cost is in the community of receiving the surgery outpatient versus inpatient. And when I'm looking at the data, it's not so much of how much dollar value it increased, it's that that's the cost of it in her community for an inpatient knee replacement procedure.

Q. What numbers did you look at in determining that estimated DRG? Is that regional? Is that local? Is that a specific facility you were looking at?

A. For the facility fee? Is that what you're asking?

Q. For the hospital DRG?

A. I'm sorry. I'm not -- are you asking me how I determined the DRG or are you asking me how I determined the costs?

Q. The costs for the specific DRG.

A. The costs for that specific DRG, I used Lexington Medical Center, Prisma Health Baptist, as well as Providence Health. I used those three facilities particularly for that facility fee. And that was through published -- through charges, specifically for those individual hospitals for that DRG over prior years that have been researched and, you know, collected to represent the cost.

Q. And in your earlier report, how did you arrive at the outpatient facility fee? Was that the same way, essentially?

A. Same way. And, I believe, those were also the same three facilities with similar data. But I was using an inpatient code that I was researching versus the -- I mean, an outpatient code versus the inpatient code, but also the facility-specific information.

Q. So would it make sense then that if we were going to, at least hypothetically, say Mrs. Connell goes forward with the full knee replacement and it's going to be an outpatient procedure, then in your updated report, would it make sense to remove the facility fee which you have listed as DRG 467; remove that and replace it with the facility fee from your earlier report?

A. For one, I would say that Dr. Loging testified it was more likely than not -- or, excuse me. He testified, from what I understood, that it was more likely that she would need a total knee replacement versus the partial. And, again, total knee replacements are most often done in the inpatient setting. And then she has comorbidities that is the -- you, know, that lend to that as well.

But as far as if, in a different individual or in a different circumstance or something was different here, this was to be done in an outpatient setting, no, you can't just kind of replace the information because the APC number that we have and that were provided here is for a partial knee replacement in the outpatient setting.

And although in the inpatient setting, the partial and total knee replacement uses the similar DRG, I don't know that -- I don't have that data in front of me to say that that is the same APC code that would be utilized in the same outpatient facility costs.

Q. Okay. So as you sit here today, you don't know what the projected cost for that -- for -- an outpatient facility fee for a total knee replacement, you don't know what that would --

A. I don't have that data specifically in front of me because, again, in this particular case, I used what I felt would be most accurate to reflect what may occur in the future.
Q. Do you know Dr. Loging?
A. No.
Q. Have you ever interacted with him prior -- or heard of him prior to doing these reports?
A. I may have had a conversation with him once on another person. But no.
Q. Not that you can recall, at least?
A. No. I mean, I haven't -- I've never met him in person.
Q. Okay. And, again, I believe you were in the courtroom when we heard Dr. Loging's video testimony. Is that correct?
A. Yes, I was.
Q. Okay. Do you recall Dr. Loging reviewing your first report?
A. Yes. He did.
Q. Okay. And so he looked through and, in fact, he even commented on the outpatient facility fee, did he not?
A. Yes, he did.
Q. Would you expect a physician treating the

plaintiff -- if she needs to have the procedure done inpatient, would you expect her treating physician to look at that and say, no, that's not proper; that should actually be an inpatient fee because she needs to be inpatient?

A. Would I expect -- sorry. I was reviewing your question. You asked if I would expect, when he's reviewing the report, that he would make a comment on inpatient versus not? Is that your question?

Q. Well, my comment is this -- or my question is this: Dr. Loging looked at your first report. He even looked at your outpatient facility fee for a knee replacement; looked at it and said that the actual procedure itself, everything was appropriate. And he even commented on the outpatient fee.

So if Mrs. Connell, the plaintiff, has to be inpatient for a knee replacement, why wouldn't he have said that at that time?

A. I would think that he's the best person to answer that. I don't think that, particularly, he is making the consideration at that moment of, like, we're planning to schedule her for surgery right now. It needs to kind of be that detailed and -- you know, in considering it. But you would have to ask him because, at that point, she was more

scheduling the hardware removal.
Q. Sure. But he looked at that line item, outpatient for knee replacement --
A. Right.
Q. -- and said it was appropriate, correct?
A. He said that the items in the report were appropriate. Again, there was no comment on inpatient versus outpatient.
MR. GESSNER: No further questions, Your Honor.
THE COURT: Any redirect?
MS. GOODING: Just briefly, Your Honor.

REDIRECT EXAMINATION

BY MS. GOODING:
Q. Ms. Moore, earlier, when you were talking about inpatient versus outpatient, I think you might have gotten your words mixed up a little bit. Are total knee replacements primarily done as inpatient procedures or primarily done as outpatient procedures?
A. So for clarity -- and sorry if I did misstate my words on the knee point. But a total knee replacement, based on the research, is currently done more often in the inpatient setting. So total knee replacements are done in the inpatient setting.
Q. Okay. And you talked about having done some

research regarding, you know, whether they were typically done inpatient or outpatient, and that's how you made that determination.

In doing that research, did you use sources that are typically relied upon in your industry?

A. Yes. I used peer-reviewed resources only in doing any research that I would rely upon.

Q. Something a little bit more elaborate than a Google search?

A. Oh, definitely not a Google search. It's a subscription -- a paid subscription service for peer-reviewed articles.

Q. Okay. And did you have an opportunity, when you were creating your report, to review all of Mrs. Connell's medical records related to this injury and her treatment?

A. Yes, at the time of creating my report, I did.

Q. And do you recall whether her first knee surgery was as an inpatient or outpatient procedure?

A. It was done as an inpatient.

Q. And I'd like to hand you Exhibit 9. This is a Lexington Medical Center record. I call your attention to past surgical history kind of in the middle of the page there. What is her past surgical history listed on that record?

A. Atrial ablation surgery and spine surgery.
Q. And what is an atrial ablation surgery?
A. So that would be a surgery that would be directed at a particular area of the atrium of the heart to help resolve irregular -- and irregular heartbeat --
Q. So then --
A. -- caused by atrial --
Q. -- the condition that you were referring to earlier, Mrs. Connell has actually had surgery for that condition; is that right?
A. Yes, that's right. It appears that she has had surgery for that condition before.
Q. Okay. And this is Exhibit 10. And if you'll look at the history there, what is indicated in the history on the top line at the bottom of that page?
A. Under medical history?
Q. Yes.
A. That she has -- patient has a history of blood thinners and depression.
Q. And is that history of being on blood thinners something that you could consider in determining a patient's comorbidities, as you were referring to earlier?
A. A blood thinner would be the appropriate

treatment for atrial fibrillation to prevent blood clots.

Q. Okay. So that's part of her doctors controlling the heart condition that she has; is that correct?

A. Yes. That is most likely a role in controlling her atrial fib- -- atrial fibrillation.

Q. Okay. And there's a medications list on there as well. Any of those medications impact your opinion related to Mrs. Connell's need to be inpatient when she's under general anesthesia?

A. I don't know that any of them in particular stand out as -- as -- but she is on a rate-controlling medication. It looks like, maybe, a calcium channel blocker.

Q. Okay.

A. Again, a rate control would be to treat atrial fibrillation as well.

Q. Okay. So do the medical records indicate then that she has ongoing treatment for the atrial fibrillation?

A. Yes.

Q. Okay. Thank you.

MS. GOODING: No further questions, Your Honor.

THE COURT: Any recross?

MR. GESSNER: Your Honor, very quickly.

RECROSS-EXAMINATION

BY MR. GESSNER:

Q. I believe Ms. Gooding had asked you about Mrs. Connell's first knee surgery and whether that was conducted in an inpatient setting. And it's your understanding that it was inpatient; is that correct?

A. Yes. I believe it was.

Q. Okay. Which surgery in particular were you talking about?

A. For the ORIF, the open reduction internal fixation of a patella.

Q. Okay. So it was the initial repair of the shattered patella, correct?

A. Correct.

Q. Okay. Do you know when that was conducted?

A. I believe it was -- and this is offhand. I'm not looking at a specific date. It might be on this, actually. But March of 2017, I believe, roughly.

Q. Or September of 2017?

A. Maybe it was September.

Q. Okay.

A. I'm sorry.
Q. But for our purposes here today, the first surgery that Mrs. Connell has had, right?
A. Okay.
Q. Okay. Do you know why Mrs. Connell was admitted inpatient at that time?
A. At the time of her injury? Is that what you're asking?
Q. For that -- for that procedure.
A. I don't remember all the details. I mean, I know that she had -- she had the injury that day. And, I mean, I know she had the surgery within a few days of it. But I don't really -- I'm not particularly sure of the --
Q. If I told you the surgery was the day after her fall, would you have any reason not to believe that?
A. No.
Q. Okay. And do you know if Mrs. Connell had actually been admitted inpatient the day prior to the procedure for pain management purposes and because she could not ambulate and get back home?
A. Right. That sounds correct now. Yep.
Q. Okay.
A. Absolutely.
Q. So nothing to do with comorbidities; nothing to

do with anything related to the procedure itself, but for another reason altogether?
A. I agree she had an injury. She was admitted, from what I recall now, looking at the records, for pain control and to have the surgical procedure. I do not know -- to me, that does not exclude that she did not have it as well due to her comorbidities.
Q. Didn't exclude it. But is there any evidence you've seen to support the idea that Mrs. Connell had inpatient surgery for the initial repair because of her physical condition or anything other than the fact that she needed pain management and couldn't be -- couldn't go back home?
A. Right. I mean, I don't know that it's directly stated. But, again, that would be part of decision-making -- the decision-making process.
Q. No, no. My question was, is there anything, any evidence or anything you've read in the record, to state that Mrs. Connell had that initial knee repair surgery done inpatient for any reason other than pain management or -- pain management or the fact that she couldn't ambulate back home?
A. Right. I did not specifically read anything in the record that stated that she had it --
Q. Thank you.

A. -- inpatient.

MR. GESSNER: No further questions.

THE COURT: All right. The witness may step down. Thank you, ma'am.

THE WITNESS: Thanks.

THE COURT: Okay. Can everybody eat and recharge in an hour?

MS. GOODING: Yes, Your Honor. That is perfect.

THE COURT: All right. Let's get started back at 2:20.

(Luncheon recess 1:21 PM - 2:27 PM.)

THE COURT: All right. Is the plaintiff ready to proceed?

MS. GOODING: Thank you, Your Honor. Plaintiff calls Dr. Charles Alford to the stand.

DR. CHARLES ALFORD

being first duly sworn, testified as follows:

THE WITNESS: Yes, ma'am.

THE CLERK: Have a seat and state your full name, please, sir.

THE WITNESS: My name is Charles Alford.

DIRECT EXAMINATION

BY MS. GOODING:

Q. Good afternoon, Professor Alford.

A. Hi.
Q. Are you an economist here in South Carolina?
A. Yes.
Q. Can you tell the Court about your training, education, and experience in the field of economics.
A. Bachelor of Arts, major in economics, Wafford College, 1968; Ph.D. in economics and business administration, University of Alabama, 1971.
Q. And what have you done in terms of employment since then?
A. From 1971 to 2003, I was on the faculty of the Department of Economics and Business at Furman University. For a while, I was chair of that department; for a while, I was chair of the faculty at Furman. I retired in 2003.
Q. And what have you done since 2003?
A. Well, before I retired, I started a consulting practice dealing with litigation issues and with business appraisal. I've continued that practice.
Q. And you achieved the accolade of Professor Amerituss at Furman, didn't you?
A. Well, I -- yeah. If you retire, they -- that's Latin for old.
Q. Okay. Dr. Alford, have you ever been qualified as an expert in state courts in South Carolina?

A. Yes, ma'am.

MS. GOODING: At this time, Your Honor, I would tender Dr. Alford as an expert in the field of economics.

MR. GESSNER: No objection, Your Honor.

THE COURT: All right. So admitted.

MS. GOODING: Thank you.

THE COURT: Or so qualified. Excuse me.

BY MS. GOODING:

Q. Dr. Alford, Lindsay Moore testified just before the lunch break. Do you know Ms. Moore?

A. Only professionally. I've reviewed her reports in some cases and base my testimony on her report.

Q. Okay. And are you aware that, in this case, Ms. Moore compiled the cost of a future treatment recommended for Mrs. Connell?

A. Yes.

Q. Were you asked, in this case, to provide some economic calculations to account for inflation and discount those numbers back to present-day value?

A. I was.

Q. Do you understand that the law requires that inflation and present-day value be considered when calculating future medical expenses?

A. Yes.

Q. And you've done this kind of report before?
A. I have.
Q. Can you explain to us what inflation means?
A. Inflation is general increase in price levels. Inflation varies, according to the category. For some medical expense categories, the rate of inflation, historically, has exceeded the overall rate of inflation. For other medical expense categories, it's been less than the overall rate of inflation.
Q. And do you take all that into consideration in making your calculations and putting together a report?
A. Yes. Generally, what I do is this: We know what the Social Security Administration projects as the long-run rate of inflation is now; that is the general overall rate of inflation. That is projected at 2.6 percent annually going forward.

We have data from 20 or 30 years back showing the relationship between price increases for, for example, physician services or hospital services or pharmaceuticals and how they have related to the prices of the general inflation rate.

Specifically, with regard to the categories that were identified by the life care planner,

professional medical services have increased at a rate .43 higher than the rate of inflation; physician services at a rate 2.9 percent higher than the rate of inflation.

Other professional providers, such as therapists, their prices actually have increased at a rate a little bit less than the rate of inflation. Over-the-counter medications, less; medical equipment, less; inpatient hospital services and prescription drugs, more than the rate of inflation.

So what I do is to take the 20-year difference, looking at historical inflation rates, and I apply those differences to the projected rate of 2.6 percent for the general inflation rate. I do 20 years. I test it, though, at 10 years and 30 years, and the relationships pretty much hold.

Q. Okay. So in creating your report in this case then, you assume, based on the data that you have, that the products and services that Mrs. Connell will require in the future will go up, based on the rates that you found. Is that --

A. That is exactly right.

Q. And what about present-day value? Tell us about what that is and how that applies to a case like this.

A. It really is a simple concept. It simply reflects the fact that if we identify that Mrs. Connell is going to need some services at some point in time in the future and if we can project what the cost of those are going to be, but if there is an award to her today or this week with regard to that need, she'll have an opportunity to earn interest on whatever award she receives.

So, essentially, reducing the present value is -- it's a highfalutin way of saying we're just backing out the interest that someone can earn between now and the time that the need will occur.

I use treasury rates; that is, interest rates payable on U.S. treasury issues maturing in each respective future year. I use those because they allow management of liquidity -- that is, making the money available when it will be needed -- and they minimize risk.

Q. Okay. Thank you. And your report has been admitted as Plaintiff's Exhibit 15 in this case. Do you have a copy of the report there?

A. Yes, ma'am.

Q. Okay. And I believe you already said this, but does that report rely on the report that you received from Ms. Moore in this case?

A. Sure.
Q. Does the report account for both scenarios in Ms. Moore's report?
A. No.
Q. Which scenarios did you use?
A. Full knee replacement. I should point out that I don't have an opinion about what she's going to need. That was really done at the direction of your office.

But the difference between the cost of a partial knee replacement and full knee replacement is related to two items, and that is the physician's charge and the anesthetic fee. And the total difference in the two is about $3,000.

So while I could have done them both, if the -- if the Court decides that partial knee replacement is appropriate instead of full knee replacement, my numbers can be adjusted down by a very small amount.
Q. So the results would be very similar for either a partial or a full knee replacement because of the similarity and the values that Ms. Moore calculated?
A. Exactly. If you look item by item at her report, each of the items is exactly the same for partial and full replacement, except for those two that I mentioned.

Q. And, based on your calculations, what is the total present-value costs of Mrs. Connell's future medical care?

A. I computed the range. That range is based on alternative replacement dates. The present value -- I'm going to be a little bit longwinded here, but not much.

The present value depends on when you expect the procedure to occur, because the prices of the procedures, the prices of medical care items, generally will increase at a rate a little bit higher than treasury yields.

So the further out in the future we expect something will be needed, the higher that present value today is. Okay? Because, while she'll have an opportunity to earn interest, the prices of those items are going to grow at a greater than the interest rate that she can earn.

That said, I computed it based on -- and, again, this was at your request, assuming a replacement in 2023 of $179,308 present-value cost or 2030, and that is $237,032 present-value cost.

Q. And did you have to consider her Mrs. Connell's life expectancy for anything in this calculation?

A. Not in this case. In -- and, as you know, in

many life care cases, you do, because certain types of care are projected to be needed through the remainder of an individual's life, in which case, I would use state statutory rate.

In this case, that's not true. We're projecting replacements in specific years and we're projecting -- we're projecting injections for a period of up to five years. If -- and those, only if the -- if the replacement incurs -- occurs beyond 2023. So, you know, in this case, her life expectancy is not relevant.

Q. So you weren't asked to assume that there would be any treatment following the knee-replacement surgery; is that correct?

A. Well --

Q. You --

A. -- as you know, all I did was use Ms. Moore's report. She didn't identify anything beyond there, so I didn't identify anything beyond there.

Q. And you already kind of explained this: But your range is based on whether she has the knee-replacement surgery in a few years or further out into the future. And, depending on where she falls in that range, that determines the value of her future medical needs; is that right?

A. Correct.
Q. All right. And are these generally accepted in your field of expertise?
A. Yes.
Q. Did I or Mrs. Connell or Mr. Goings or anyone else have any input into your calculations or how to do those calculations?
A. No.
Q. And are your opinions held today to a reasonable degree of professional certainty?
A. Yes.
Q. Thank you.
THE COURT: Okay. Any cross-examination?
MS. GOODING: Oh, sorry.
MR. GESSNER: Thank you, Your Honor. May it please the Court?
THE COURT: Yes, sir.

CROSS-EXAMINATION

BY MR. GESSNER:
Q. Dr. Alford, good afternoon. My name is Evan Gessner. I'm an attorney here in Lexington. I represent the defendant, the Lexington County Health Services District. And I did want to ask you, so looking at your report, Table 1 is your projections for the anticipated costs for the future medical

needs for Mrs. Connell; is that correct?
A. Correct.
Q. Okay. So that gives a range of, if these services were to occur by 2020, so this year, your present value cost is $179,308. Is that correct?
A. That is actually incorrect. My report is incorrect. That should be 2000 -- I computed them for 2023, '25 and '30.
Q. I see. So your first --
A. So I identified --
Q. -- should have been 2023.
A. I identified those -- yeah.
Q. Okay.
A. Yeah. It should have been 2023, 2025, and 2030. I apologize.
Q. Very well. That answers that question.
Assuming these services were to occur by 2023, you find the total present-value cost for all the medical services -- or future medical services would be $179,308, correct?
A. Correct.
Q. Okay. So then the same numbers for if it were to occur by 2025 or 2030, correct?
A. Correct.
Q. Okay. And, of course, I think you testified

earlier, you're going off of Ms. Moore's numbers, correct?

A. That's right.

Q. Okay. So if we had to -- let's say Ms. Moore's numbers were incorrect for any reason. How would we change that here today?

A. Well, I can't change it. If you tell me, make this assumption about something being incorrect, I can make an adjusted computation, probably not as I'm sitting here today --

Q. Okay.

A. But, you know, I'm not going to be argumentative with you. And I heard her testimony. And I know one of the issues is inpatient versus outpatient. And if she's going to require outpatient surgery, the numbers would be less.

Q. Okay. Can you give us a ballpark figure? Say, if the numbers I was talking about with Ms. Moore, if they reduced -- give me one second.

A. I can ballpark.

Q. I'm sorry. You can?

A. I can ballpark. That is, if you assume that -- I think her inpatient number was in the, roughly, 10- to $12,000 range and her outpatient number was around 150,000.

Q. Right. And I'll switch those numbers for you. It's actually the inpatient that she had estimated --

A. I'm sorry. Yeah.

Q. The inpatient fee is about $124,000, whereas, I think, the outpatient facility fee, we're not exactly certain because we only have the figures for a partial knee replacement, not a full replacement.

Going off the partial knee replacement, the facility fee is no more than $13,300. So we're looking at about a $110,000 reduction. Would you agree?

A. Yeah. But I think the way you'd have to do it would be based on the percentage. In other words, if I was going to rough it out, I would say, roughly, the outpatient cost is about 10 percent of the inpatient cost. Okay?

Q. Okay.

A. You asked me to rough it. Okay?

Q. Okay. I did.

A. Well, if you look at my Table 4, that facility fee, instead of being 158,000 or 178,000 or 242,000, the number would be about 16,000 and 18,000 and 24,000. Okay?

So the total present-value cost would be the

difference. I mean, I -- it would be roughly -- I mean, don't hold me to these. Just roughly, that number would be 16- instead of 158-, so that's a $142,000 difference. The total present-value cost would be about $20,000 for the replacement in 2023.

In 2025, it would be, roughly, $17,000. And in 2030, I'm not sure. I didn't bring my calculator.

Q. I have a calculator on my phone.

A. Okay. Take --

Q. I can hand it to you. I'm good at math, but I'm going to venture to guess you're better.

A. All right. Take 10 percent of the -- or take 90 percent of the 242, subtract that, and you get about -- looks like about 40,000.

Q. Thank you. And your Table 3, you had assumed that the hardware removal would take place in 2020; is that correct?

A. Yeah. Ms. Gooding asked me to assume that that replacement of the hardware would be immediate -- or the removal of the hardware would immediate.

Q. Understood.

MR. GESSNER: No further questions, Your Honor.

THE COURT: Redirect?

MS. GOODING: No redirect, Your Honor.

THE COURT: All right. You may step down, sir.

MR. GOINGS: Any problems with this witness being --

MR. GESSNER: No.

THE COURT: Have a good day, Doctor.

MR. GOINGS: Your Honor, the Plaintiff would call Ms. Diane Connell.

DIANE CONNELL

being first duly sworn, testified as follows:

THE WITNESS: Yes.

THE CLERK: Have a seat, please, and state your full name.

THE WITNESS: My name is Diane Connell.

DIRECT EXAMINATION

BY MR. GOINGS:

Q. Good afternoon, Diane.

A. Good afternoon.

Q. Where do you live?

A. I live at 304 Trentwood Drive. And that's here in Columbia -- or in Columbia.

Q. All right. And is Steve your husband?

A. Steve is my husband of 32 years, 32 good years.

Q. And are -- do y'all have any children together?

A. We do. We have two adult children and three grandchildren.

Q. All right. Are you presently working?

A. I have recently retired.
Q. And what did you retire from doing, Mrs. Connell?
A. The first thing I did, I was -- I had a small business in my home where I placed private-duty nurses and sitters on assignments. And I was able to do that when my children were young, so I worked at home and was there when they got home. I did that for 20 years. Then I went into real estate and did that for somewhere between 10 and 15 years. And I recently retired.
Q. Wonderful. When you did your home health -- when you had the home health job, did you do that with your mother?
A. It was actually a family business. It was my mother's business. And when she got ready to retire, the timing was perfect for me and I took over.
Q. And you said that was good when you were raising your children, right?
A. Very good.
Q. All right. And the last ten years, you've been a real estate agent?
A. Exactly.
Q. And what is your date of birth?

A. May 31st, 1951.
Q. How old would that make you?
A. That would make me 68.
Q. Will you describe your general health condition prior to your fall.
A. Good.
Q. Okay. Any medications that you were on?
A. I was on some medications that my doctors had me on for cholesterol, high cholesterol, and anxiety, and lower back pain.
Q. Okay. Had you ever undergone an ablation procedure in your heart?
A. I did.
Q. When did you have that procedure?
A. That's been about between six and seven years ago. I went to MUSC for that.
Q. Was that inpatient?
A. That was inpatient.
Q. Okay. Have you been diagnosed with AFib or atrial fibulation?
A. That's what I had. And the procedure they did just stopped the irregular heartbeat so that I was able to come off all the medications for that. And I do -- I no longer experience the AFib and irregular heartbeat.

Q. Wonderful. Mrs. Connell, I want you to explain to the Judge your general health condition before you fell. Let's talk about exercise. What type of exercise did you do before you fell in 2017?
A. I was in good health. And I was an avid walker; that was my favorite thing to do, especially outside. And in good health, I did a lot of stretches, things like that.
Q. Any prior injuries with your left knee?
A. None.
Q. Any prior injuries with your left leg?
A. None.
Q. Do you have a history of falling?
A. No. No.
Q. Okay. Your eyesight -- what is your eyesight?
A. My eyesight is good. I'm 20/20.
Q. Do you wear corrective lenses?
A. No, I don't.
Q. And you don't have glasses on today, do you?
A. No.
Q. No contacts?
A. No contacts.
Q. Okay. Did you -- before you fell in 2017, were you routinely checked by a doctor for health on a yearly basis?

A. Yes. Yes.
Q. All right. Any cancer or anything such as that?
A. Nothing. Nothing like that.
Q. Let's go to September 26th, 2017. It's been stated that was the date of the fall. Do you recall that to be the date of the fall?
A. I do. I do.
Q. Tell us what you were doing that day. And kind of start from the very beginning and explain to the Court what you recall. Really start as early as you can remember from that day.
A. Okay. Well, I was accompanying my husband to a doctor's appointment at Lexington -- on the Lexington campus. And as we got there, he dropped me off at the front and I went on in. And he went and got a parking place and came in later. As we came out --
Q. Let me stop you there.
A. Okay.
Q. Did ever have the opportunity to walk through the parking garage on September 26th before your husband's appointment and procedure?
A. No. No.
Q. So, as I'm clear, Mr. Connell dropped you off

at a medical park entrance?
A. Correct.
Q. He told you to go in?
A. Yes.
Q. And instead of you parking the car, he went and parked the car by himself?
A. He went and parked the car by himself. He's a gentleman.
Q. Okay. Well, have you ever had the opportunity to even enter or walk through this parking garage ever before?
A. No.
Q. This is your first time?
A. First time.
Q. The only time?
A. The only time. I think so. I only say that because we drove back later, after I got better, and we drove through there and looked. And I looked at the paintings and all that. And he went and --
Q. But the only time you had walked through it --
A. Absolutely. Yeah.
Q. -- was the day of this?
A. I didn't know where we were going when we came out of the doctor's office until he said, we're parked over here.

Q. Okay. So you and your husband are in the procedure -- or he has a doctor's appointment. Y'all leave, and the video shows y'all walking down the sidewalk.

A. Right.

Q. Okay. From that point, take us through what happened.

A. Okay. We were on the pedestrian sidewalk and then kind of went off to the left and into a door that led into the garage. So I, of course, followed that and --

Q. Let me stop you right there --

A. Okay.

Q. -- so I can put on the monitor what you're talking about.

Do you see this exhibit --

MS. GOODING: And it's one of the photographs, Your Honor, that's in evidence.

BY MR. GOINGS:

Q. Is this the entrance that you went through?

A. That looks like the entrance I went through.

Q. And I circled it.

A. Uh-huh.

Q. Is that correct?

A. Yes.

Q. That would be the entrance you walked through?
A. Uh-huh.
Q. Is that a yes?
A. Yes. Yes.
Q. What happened next?
A. I walked through there and took just a few steps. And, before I knew it, I stepped down like -- I felt like I had stepped in a hole. And I just went down on the concrete very hard. And I tried to get back up, and it hurt even worse, so I went back down again.
Q. So we're clear, you were walking from the outside through this entryway --
A. Right.
Q. -- and, you said, as you walked on this concrete surface --
A. Uh-huh.
Q. Is that a yes?
A. Yes.
Q. What happened?
A. Oh, I tripped. I went down. I went down and fell on the concrete. There was nothing to tell me that there was a curb there.
MR. GOINGS: Your Honor, making reference specifically to Exhibit 2, the first picture in

Exhibit 2. I just want to show the witness.

BY MR. GOINGS:

Q. Is that a -- your -- is that you coming off the curb with your foot halfway on the curb and --

A. Yes. Yes.

Q. -- and halfway off the curb?

A. Yes. I've not seen that picture. Yes.

Q. Was it the curb that caused you to fall?

A. Yes, it was. Absolutely.

Q. Okay. So the video is still -- it's a still-shot of the video?

A. Right.

Q. Okay. Were you talking to anyone when you were walking through the garage?

A. No.

Q. Were you on your phone?

A. No, I was not.

Q. Okay. Were you distracted in any way?

A. No distractions.

Q. Okay. Were you looking back towards your husband?

A. No. No.

Q. Which direction were you looking?

A. I was just looking -- walking like I usually

walk, looking ahead a little bit in front, like I normally would walk. There were no distractions, so I was just careful walking forward.

Q. When you fell, did you feel pain immediately?

A. Yes, I did, very bad.

Q. Describe to the Judge, in the best words you can, what you felt, what you experienced, after you fell.

A. When I went down, it hurt so bad. But it hurt even worse as I tried -- I thought I can could get up. And, as I tried to get up and fell back down, I can honestly say, without a doubt, it's the worst pain I've ever felt. That -- that was some kind of pain.

Q. Have you -- you gave birth to two of your children, correct?

A. I did.

Q. When you gave birth to two of your children, were you given an epidural?

A. No.

Q. Okay. How would you describe the pain that you felt on the ground with the pain that you experienced in childbirth and labor?

A. In all honesty, that fall, that pain, was worse than giving birth to my children. It was worse.

Q. Do you recall crying?
A. I cried. I screamed out. I cried a lot.
Q. Do you recall anybody helping you at the scene?
A. I know my husband came to the scene. And there were a couple of women. I couldn't see them. I almost -- I think I almost got knocked out. But I heard one of the women say, she hit her head, she hit her head. And I was there and I was worried that I was lying there on the ground where the cars may be coming. And I wanted to get up, but I couldn't get up.

So, finally, Mr. Chris Brewer, he came up in his truck. And he was a saint because he came out there and helped my husband get me up and get me on the curb. I could look out and see the emergency room over there. I could actually see it. But it was like it was a thousand miles away. It was like, how am I going to get there?
Q. Had you ever met Mr. Brewer before?
A. No, I had never met him.
Q. Do you remember him praying with you?
A. He did. After he got me on the cart and we got over to the emergency room, he asked me if he could pray. And I said, oh, yes, please. And he took the time and made those ladies wait for a minute and he

prayed with me.
Q. You were unable to walk to the emergency room?
A. Oh, no, I couldn't.
Q. You went to the emergency room by way of a golf cart?
A. Right.
Q. Okay. I have a photograph up, which has been marked as the first page of Exhibit 3. Does this appear to be the area and location where you fell?
A. Yes. Yes.
Q. Okay. From where you are, do you have a hard time seeing --
A. Very hard.
Q. -- a change in elevation?
A. Oh, and it was even worse that day, if you can imagine; worse than that picture, because the picture -- I guess I know because I know it's there. But you could not see the change in elevation. Everything looked the same.
Q. But that photo, does it accurately reflect the condition on the day of the fall, the location in which you fell?
A. Yes.
Q. Okay. Let me show you another photograph. This is taken from a different angle. Do you see

yellow paint --
A. Uh-huh.
Q. -- on the curb?
A. I do.
Q. Okay. And is it on the top of the curb or on the side of the curb?
A. It's on the side.
Q. From your vantage point of walking from outside to inside on this walking surface, could you see this yellow paint on the side of the curb?
A. No, not at all.
Q. Did you see any paint on the top of the curb?
A. None.
Q. Now, you said that you and your husband rode through a while later and looked at different portions of the garage. Do you remember saying that?
A. Uh-huh.
Q. Is that a yes?
A. That's a yes.
Q. All right. I'm going to show you some more photographs that have been made exhibits, particularly Exhibit 4 -- excuse me, Exhibit 3 -- compiled within Exhibit 3. Do you see this curb?
A. I do.

Q. Is the top and the sides painted?
A. It sure is.
Q. Do you see this curb?
A. Yes.
Q. Are the tops and the sides painted?
A. Uh-huh.
Q. Is that a yes?
A. Yes. I almost wanted to cry. And when we rode through there and I saw so many of those curbs, all of those curbs painted, except for the one where I fell, it was real disheartening.
Q. Now let's talk about the emergency room. How long were you in the emergency room?
A. Oh, wow. This was early afternoon. And I think I -- they took me up to a room early evening. You know, maybe four hours.
Q. Can you describe to the Judge your pain level when you were in the emergency room.
A. Well, as I first got in, it was a 10; it was terrible. But they gave me some medication and then took me for X-rays. And they kept trying to control the pain while I was there.
Q. So you believe you were in the emergency room for four or five hours?
A. Something like that.

Q. And then you were admitted into the hospital that night?
A. Correct.
Q. Okay. So you didn't have your surgery the day of the fall, did you?
A. No, I did not.
Q. You had the surgery the following day?
A. The following morning.
Q. And how long did you stay in the hospital after the surgery?
A. I stayed an additional night. So I stayed two nights.
Q. Can you describe to the Judge the pain that you experienced in the hospital after the surgery.
A. It was pretty severe. And I was in the immobilizer, so I was lying there, not being able to move. So it was uncomfortable, hard to sleep, and pain, pain.
Q. When you were discharged -- where did you go after you were discharged from the hospital?
A. We went home.
Q. Okay. And what condition was your left leg in when you were discharged?
A. It was still in the immobilizer and very sore. It hurt.

Q. I have some photographs, Exhibit 5. Do you see this photograph?
A. Uh-huh.
Q. Is this the immobilizer that you said you were in?
A. That is actually what I got in after the immobilizer. That's the cast, I called it.
Q. Okay.
A. They called it the brace, which was horrible. I was in that for about three weeks. I was in the immobilizer for about a week. The immobilizer could not come off, not at night or anything. I had to sleep in it, stay in it the whole time.
Q. So the immobilizer you were in kept your leg exactly straight?
A. Exactly straight, yes.
Q. And it did not have these holes in it, did it?
A. Exactly.
Q. You don't have a picture of the immobilizer?
A. I don't. I don't.
Q. How long were you in the immobilizer?
A. A little over a week.
Q. And then you graduated into this device?
A. Into that one.
Q. How long were you in this device?

A. I'd say about three weeks in that one -- three to four weeks, maybe.
Q. Also, I'm showing a photograph of your knee. When was this photograph taken?
A. That was taken not long after the surgery.
Q. What does this picture show, Diane?
A. Well, that shows the staples they had to put in there and the swelling from the surgery on the kneecap.
Q. Mrs. Connell, how long -- well, how did you get around for the first couple weeks after the surgery?
A. I got around on a walker.
Q. A walker?
A. Now, the first week, I didn't get around at all.
Q. What did you do the first week?
A. Mostly in bed with the immobilizer. Once I went into the other thing, I was able to sit in the recliner and then have the walker. And my husband would help me, but he had to help me keep that leg straight, so sometimes it was hard. I couldn't get up by myself or down.
Q. How did you use the restroom?
A. He had to help me. I had a potty chair that was brought in -- well, he went out and bought it.

And we had to put it in the bedroom because when I went to get out of the bed, he actually had to put a stool there so my leg stayed straight while I sat on the potty chair. And that went on for a week.

Q. How did you take a shower?

A. I didn't take a shower. I couldn't take a shower. I just washed off a little, upper body.

Q. How long were you confined to a walker?

A. To a walker, about two months.

Q. Were you doing physical therapy that was recommended for you?

A. I started it. Not at first, but the physical therapist, I think she waited a week or so before she came out. And once they started loosening the cast that I was in, she showed me how to take it off and just slightly start bending my -- just slightly bending. And then she informed me to -- each week, to do a little more, a little more, and a little more.

Q. Was physical therapy painful?

A. Yeah, it was. Yes, it was.

Q. How long did you do physical therapy for?

A. Well, I did it with her for two weeks. She came for two weeks. She also showed me how to get in the car and out of the car and just certain

little tricks that were helpful. But I continued the physical therapy. She left me a printout of what to do, so I continued that.

Q. You said it took about -- you were with a walker for about two months. After the walker, did you use something else?

A. I used a cane.

Q. Okay. How long were you ambulating, walking, getting around with assistance, through a walker or a cane? How long did all that last?

A. Over three months. I think -- what I remember is that six-month point when I could -- where I felt comfortable and easy walking without having that cane as my security.

Q. How long has your recovery been?

A. Well, it's still going on.

Q. You're still recovering?

A. Yeah. I'm still in recovery.

Q. So this happened in September. Did this impact your Thanksgiving plans or your Christmas plans for 2017 with your children and grandchildren?

A. It did greatly. I wasn't -- I'm the one who usually has all the get-togethers in my family. I'm the one. And so Thanksgiving, I went to my nephew's with my cane and just stayed a short time because I

felt like somebody might knock me down or do something; not on purpose, of course.

Christmas, I was not able to have the Christmas family get-together to see my grandchildren and to decorate the tree and all that. I just wasn't up to it yet at Christmas. So I didn't get to have any of that, that year.

Q. Now, who performed the surgery?

A. Dr. Dedmond.

Q. Have you seen Dr. Dedmond before, before this surgery?

A. No.

Q. And who is your current treating provider?

A. Dr. Loging.

Q. Explain to the Judge how you got to Dr. Loging or why you were treating with Dr. Loging.

A. Okay. Dr. Dedmond had said that I would eventually need, probably need, to have the hardware removed, so I did go to him. And he said, yeah, it needs to come out. But I needed a second opinion. And I didn't think it was right, with the lawsuit going on, to go to him. So I had asked around and even asked my attorney for some names. And I had heard of Palmetto Bone & Joint, and that's how I got with Dr. Loging.

Q. And so we're clear, Dr. Dedmond is a part of Lexington Medical Center; is that correct?
A. He is part of Lexington Medical Center.
Q. And Dr. Loging, is he a part of Lexington Medical Center or not?
A. No, he is not.
Q. Okay. And you said you're still recovering?
A. Right.
Q. Tell the Court about where you stand in your treatment and your recovery.
A. Let's see. Three weeks ago, I did have the hardware removed. And so I'm still recovering from that. And just last Friday, they took the staples out. I had 13 stables, so they took those out. So I'm recouping from that.

And my hope is, once I get over that, that I will see a difference in being able to, hopefully, stoop a little better, get on down in the ground and working in the yard and things like that, that I could not do before.

Q. So I hear people say they enjoy gardening. My wife sometimes says she enjoys gardening.
A. Oh, yeah.
Q. But do you really enjoy gardening?
A. I love it. I do.

Q. That is your passion, isn't it?
A. I do. And I haven't been able to do it. And I haven't even been able to do yard work much because our house is kind of up on a hill. And so I cannot -- still cannot walk on uneven or unlevel ground.
Q. You send Steve out to do the yard work now?
A. I send him out to do it.
Q. So you're three weeks out from this hardware removal surgery. You don't have a brace or anything on your leg, do you?
A. No. No.
Q. Okay. How does this surgery that you just had to take out the hardware compare to the first surgery you had?
A. Oh, it's much, much easier.
Q. Okay.
A. Much easier.
Q. Okay. Where was the surgery performed to get the hardware out?
A. Dr. Loging, he has a clinic right next to his office, and we had it done there.
Q. Okay. How long did the procedure last?
A. Probably 15 or 20 minutes. It's a simple procedure to take the hardware out.

Q. Were you put under general anesthesia or did they do something else?
A. No, not general. They did the -- put the mask and had me breathing deep. And when I woke up, I was alert and awake.
Q. Okay. And was it a successful surgery?
A. I hope so. You know, it's going to take a while. But I think -- so far, I haven't had any problems.
Q. All right. Is your leg real swollen from this surgery or not?
A. It's not real swollen.
Q. Okay. Are you glad you got the hardware out?
A. I'm glad.
Q. Before you got the hardware out, tell the Judge what you were feeling in your knee.
A. It felt like something was sticking me; like somebody would take a pin and stick you hard. But it was from the inside, out.
Q. Okay.
A. And I think it was the wire that was in there and the pin. And it got worse as time went by.
Q. Do you still notice that sensation now?
A. Huh-uh.
Q. Is that a no?

A. No, I don't.
Q. Okay. Your medical bills, we've introduced those as an exhibit that the parties agreed on. They're Exhibit 7. Your medical bills, we have Palmetto Bone & Joint, Tri County Home Health, Lexington Orthopaedics, and Lexington Medical Center. And it shows that the past medicals were $48,893.38. Do you see that?
A. I do.
Q. All right. Now, you just had the procedure done three weeks ago, correct?
A. Correct.
Q. Had you gotten any bills yet from the surgery to take the hardware out?
A. No, I haven't gotten any yet.
Q. Did you call to see if they are available?
A. I haven't called yet because it usually does take a while. So I have not called them.
Q. I gotcha. You haven't gotten any yet though, have you?
A. I have not gotten any yet.
Q. So for the last two years --
A. Uh-huh.
Q. -- because this happened in 2017. 2018, 2019, now we're --

A. Two and a half years almost.
Q. -- going into 2020. So it's two and half years.
A. Uh-huh.
Q. Okay. For the last two and a half years, I want you to tell Judge McLeod what you've dealt with with your knee and what you've experienced and any limitations that you've had in the last two and half years. So it's a pretty open-ended question. I just want you to tell the Judge what you've gone through.
A. Okay. And I may have covered some of it already. But it's just -- my knee is just not the same. I have difficulty going up stairs and down; more so, coming down the stairs. I can't stoop and I can't -- to stoop down, like if you wanted to get something off of the lower shelf, I can't stoop. I can't get on my knees.

And a lot of people think, well, why do you want to get on your knees? You'd be surprised how many times you really do that when you're maybe cleaning or out in the yard, working in the yard, things like that. So it's affected me in a lot of ways.

I have a special-needs grandson that we like to

get. And I've kind of -- early on. Now, lately, I've been able to get him more. But you never know what he's going to do, whether he's going to pull on you or whatever. So Steve and I have kind of had to slack off on that for a while. And those are just some of the things.

Q. Would you do things like ice and elevate your knee?

A. Yes. Yes. And I'm doing that now, too, with it.

Q. When is the last time you iced or elevated your knee?

A. Monday night.

Q. Okay.

A. I'm sorry. Sunday -- Saturday.

Q. Okay.

A. Saturday night.

Q. Today is Monday. So --

A. Because today is Monday.

Q. Do you think you'll have to ice and elevate your knee today?

A. Yes, I do.

Q. Okay. Is it certain times of day you experience more difficulty with your knee than others?

A. Sometimes, in the morning, it may bother me more; sometimes, when it's raining, it bothers me more. And just being on it a lot or doing too much, I always have to then get off it. But I try to elevate it every time I sit. I try to keep it elevated.
Q. Were you having any knee problems whatsoever before this?
A. No.
Q. Ever seen a doctor for knee pain?
A. No.
Q. Your left knee?
A. No.
Q. Okay. When is your next appointment with Dr. Loging?
A. April the 4th.
Q. Okay. April the 4th?
A. Uh-huh.
Q. Is that a yes?
A. That's the next one, April 4th.
Q. Okay. You heard Dr. Loging's testimony here today?
A. Uh-huh. I did.
Q. Did you hear him talk about the injections --
A. I did.

Q. -- that he's going to try to get you into?
A. I did.
Q. Okay. And y'all have talked about that?
A. I think we'll talk about that at this next appointment. The one I just went to was just about taking out the staples. And he did X-rays. So when I go back on the 4th of April, he will discuss all those things with me.
Q. Okay. Is it your intentions, Diane, to do everything that Dr. Loging recommends you to do?
A. Oh, absolutely. I have a lot of confidence in him and I'll do whatever he recommends that I do.
Q. And have you been compliant with his treatment so far?
A. I have.
Q. Now, you remember, in January, we were supposed to have this hearing?
A. Right.
Q. In January, you hadn't had the surgery then, right?
A. Right.
Q. Okay. It was actually scheduled at that point, right?
A. Uh-huh.
Q. So, in the meantime now, you've actually had

the surgery?
A. Right. Correct.
Q. Do you understand that, eventually, you will need a knee-replacement surgery?
A. I do. I do. And I'll do what he recommends for as long as I can to put it off for as long as I can. But I do understand that it's inevitable.
Q. Okay. For a surgery like that, do you feel more comfortable having it at a hospital or a surgery center?
A. I'd want to be in the hospital for a total knee.
Q. Okay. Those are all the questions I have for you. Please answer any questions the Court may have or opposing counsel. Okay?
A. Okay. Thank you.
THE COURT: Cross-examination?
MR. GESSNER: Yes, Your Honor. May it please the Court?
THE COURT: Yes, sir.

CROSS-EXAMINATION

BY MR. GESSNER:
Q. Mrs. Connell, I'm going to show you a photograph. This is the first photograph in Exhibit 3. I think you've already identified that's

the area at the medical center where you fell. Right?

A. Correct.

Q. Okay. And as we sit here today, can you see this line?

A. Just barely.

Q. Okay. And that's where the curb is, in fact, right?

A. Right.

Q. Okay. I believe you had testified earlier that you have 20/20 vision.

A. Uh-huh.

Q. Okay. Now, on the date of the accident, I think you had said, while you were walking, you were just looking ahead; is that correct?

A. Uh-huh.

Q. Is that a yes?

A. I'm so sorry. Yes.

Q. That's fine. Don't worry about it.

A. That's a yes.

Q. Okay. So you weren't looking down at your feet as you walked?

A. When I walk, I walk looking ahead and maybe down a little bit.

Q. Just normal walking?

A. Normal walking.
Q. Okay. And, of course, you're in a parking lot.
A. Right.
Q. So would you agree that you were just exercising caution?
A. Sure.
Q. Sure. Okay.
The second photograph, can you see that line there?
A. I can see that one.
Q. Okay. You can see that one a little bit better than the first one, right?
A. A little. Not a lot, but a little.
Q. Okay. And you can see it better than the photograph that was up on the TV earlier, right?
A. I don't know.
Q. Okay.
MR. GESSNER: Can we put the photographs back on the TV, if it's not too much trouble?
MR. GOINGS: Yes, we can.
All right. Is that the one you want?
MR. GESSNER: Yeah. Thank you. At least from my vantage point, it looks really washed out.
THE WITNESS: Yeah.
BY MR. GESSNER:

Q. So would you agree that, in this photograph -- and this is the second photograph in Exhibit 2 -- that you can see that line a lot better? Right?
A. A little bit better.
Q. Okay. So it seems dependent on which photograph we're looking at here.
Now, when you walk in a parking lot, I think we had said, you're keeping an eye out -- I mean, you're exercising in a reasonable caution so you don't fall or get hit by a car or anything like that, right?
A. Right.
Q. Okay. But, of course, obviously, you didn't see the curb there on that date?
A. There was nothing to see.
Q. Okay. I mean, in your experience, do you usually see curbs and parking blocks and other things in a parking lot?
A. If they're painted, I do. Or it may depend on the sunlight or --
Q. Okay.
A. It's just that that was all the same.
Q. Sure.
A. It did not look like there was any elevation there.

Q. It's all concrete, correct?
A. It is.
Q. Okay. But, generally, in a parking lot, you'd expect to see curbs, parking blocks, steps, things like that, correct?
A. Well, I could see some across the way. You can see them, you know --
Q. Right.
A. -- but --
Q. My apologies. That was a bad question.
I should have said, you would expect to encounter things like curbs, steps, parking blocks, things like that --
A. Probably. Yeah.
Q. -- in a parking lot, correct?
Okay. And this area up ahead, would you say that this is a roadway, an area where cars are normally traveling?
A. Yes.
Q. Okay. Is it your experience, typically, if you're walking on a sidewalk and entering into a roadway, that there's usually a curb or something? It's not all just plain, flat land?
A. I -- I don't know. I don't walk in -- I don't walk in a lot of parking lots.

Q. When was the last time you had your vision checked?
A. It was -- it's been less than a year.
Q. So since the accident or incident?
A. I guess it has been since the incident.
Q. And, at that time, your vision was still 20/20?
A. It was still, yes.
Q. Looking at Exhibit 7, I'll show that to you. It's your Exhibit 7 for the past medical expenses. Of course, that doesn't include anything relating to the hardware removal. But prior to the hardware removal, what does it say there as your past medical expenses?
A. I need my readers for that. Is that a trick?
Q. Oh, no.
A. I need my readers. The last line --
Q. Yes, ma'am. Are your readers here?
A. They're in my purse. I think most people my age wear reading glasses.
Q. I had assumed that.
(Tenders glasses to witness.)
A. Thank you.
MR. GOINGS: That day is coming for me, too.
MR. GESSNER: I think it's coming for all of us.

THE WITNESS: Okay. $48,893.38.

BY MR. GESSNER:

Q. Okay. And that includes, right after you fell, you were taken into Lexington Medical Center and you stayed there for two nights; is that right?

A. Correct.

Q. Okay. And, I think, that would be the first line item here, Lexington Medical Center. What's the amount right there?

A. $41,398.66.

Q. Okay. And my belief is that encompasses the emergency room visit, your two-night stay, and your surgery by Dr. Dedmond to put that kneecap back together; is that right?

A. Uh-huh.

Q. I'm sorry. Is that a yes?

A. Yes.

Q. Okay. I'm going to flip forward to Exhibit 13, which is Ms. Moore's future cost analysis. You see, on the last page, the total cost for Scenario B. Can you read that into the record, please.

A. That's $151,209.90.

Q. Okay. And that's for the hardware, the knee injections, and a total knee replacement, correct?

A. Correct.
Q. Okay. And that's about more than three times as much as the past medical expenses you've already incurred?
A. I don't do math.
Q. Okay. And I thought I heard you say -- I just want to clarify for the record. Who referred you to Dr. Loging?
A. I had asked around and I had heard of Palmetto Bone & Joint. But I asked him if -- what he thought about them. And he said, yeah, they were great. So I didn't know of anyone else, so I went to them.

I will say this though: When I went in for a consultation that day, when we came out, there was a lady out there with -- her car had broken down. And she was a patient. And she was just singing his praises and telling me how good he was. So that kind of helped me make my decision as well.

Q. When you said, "I asked him," were you referring to your --
A. I'm sorry. My attorney.
Q. Okay. Now, I believe you testified earlier that you're going to do whatever Dr. Loging says you should do with respect to the future care of your knee; is that correct?

A. Yes.
Q. Okay. Now, has Dr. Loging always told you, you will need a total knee replacement?
A. No. He has said I would probably need one. I don't think he had came out and said to me, you're going to have to have one. I think he said, you're probably going to need this; like, you know you're probably going to need the knee replacement, he told me.
Q. Okay. Did he give you a percentage or he just told you exactly that way?
A. No. Just...
Q. Okay. I'll show you Exhibit 10. Does that say Palmetto Bone & Joint at the top?
A. Right.
Q. And second line down, it says provider. Who is listed as the provider?
A. James Loging.
Q. So it's my understanding these are Dr. Loging's records -- or your records from Dr. Loging.
A. Okay.
Q. We'll flip to the last page. If you could, just read that last blurb right there.
A. Okay.
Discussed with her partial -- possible partial

replacement later on. She wants to discuss options with husband. Will call back when she decides.

Q. Okay. Is there a date right underneath that?

A. Four -- let's see. April the 5th, 2019.

Q. So you would have seen Dr. Loging about April 5th, 2019, correct?

A. Correct.

Q. And they're discussing a possible partial replacement. And I assume that means knee replacement, of course, right?

A. Of course.

Q. So you're talking about a possible partial knee replacement?

A. That's what he was saying then.

Q. And then we heard Dr. Loging's testimony by deposition earlier today where he said, a hundred percent chance you'd need a knee replacement and it should be a full knee replacement, correct?

A. Correct.

Q. Okay. Now, of course, when I asked you to look at that exhibit, you had to put your readers on. So when you said your vision is 20/20, is that for distance?

A. Uh-huh.

Q. I'm sorry. Is that a yes?

A. Yes.
Q. Okay. But for --
A. I'm so sorry.
Q. You're fine. For reading, you require glasses, right?
A. Just for reading.
Q. Do you wear glasses when you drive?
A. No.
Q. So needing readers, does that affect, in any way, your ability to see a curb or anything right in front of you?
A. No, it doesn't. All these are, are magnifiers for small print.
Q. Okay.
A. That's it. They're over-the-counter readers.
Q. I understand. I heard you testify a little bit about you had an ablation done for an irregular heartbeat; is that right?
A. That's correct.
Q. Okay. When did that surgery occur?
A. That, I don't know.
Q. As best you can remember. I don't need a --
A. All right. Around six years ago.
Q. Okay. So prior to this incident?
A. Yes, prior.

Q. I believe you've said, since having the ablation surgery, you don't have any issues with an irregular heartbeat; is that correct?
A. I don't.
Q. Okay. And do you have any other conditions? Any diabetes, hypertension, anything like that?
A. I just started, in the last month, taking a very low dose of medicine for hypertension.
Q. Okay. When were you diagnosed with that?
A. About a month ago. I'd say right at a month.
Q. Now, the day you fell in September of 2017 and you were in the emergency department, were they going to send you home that day?
A. They talked about sending me home.
Q. Okay. Do you recall if you or your husband said you couldn't go home that day?
A. Right.
Q. Okay. So you were admitted inpatient at that point, right?
A. That's right.
Q. Bear with me one moment.
MR. GESSNER: Nothing further, Your Honor.
THE COURT: Redirect?
MR. GOINGS: Yes, sir. Thank you, Your Honor.

REDIRECT EXAMINATION

BY MS. MR. GOINGS:
Q. Mrs. Connell, it's actually very dangerous to walk with readers on, isn't it?
A. Oh, it is. They tell you not to dare wear readers doing anything but reading.
Q. I dressed up like Will Muschamp lately and I put on a pair of readers and tried to walk with them, and it was kind of hard to see.
A. You can't.
Q. You can't, can you?
A. You can't.
Q. All you can do is read.
A. That's exactly right. That's why they call them that.
Q. Now, when you went to this eye doctor about a year ago, you know they say, is it clear, can you see it here or here? Do you remember that?
A. I do.
Q. And let me show you this, this is Exhibit 5. Can you see what you fell over better here, condition on date of fall, or here, yellow paint simulated?
A. Oh, wow. That's amazing. If that had been there, there's no way I would have fallen.
Q. So here, yellow paint simulated, can you see it

better, or here, condition on date of fall?
A. What a difference. What a difference. I mean, I can see me falling there. I can't -- on the other one, not so.
MR. GOINGS: No further questions.
MR. GESSNER: Your Honor, that's what we were talking about earlier. I said I understand it's a demonstrative exhibit. But, I mean, there's no telling that, if a curb were painted, that's exactly what it would look like. I mean, that's just pure speculation on the part of counsel and Plaintiff.
THE COURT: Your objection is noted.
MR. GESSNER: I'd be more worried if it were a jury trial, Your Honor.
THE COURT: And that's -- I mean, I would be talking with y'all in private if it were a jury trial. It is what it is. Your objection is noted.
MR. GESSNER: Thank you, Your Honor.
THE COURT: And that was just yellow paint simulated?
MR. GOINGS: That's right, Your Honor. And I did it; I simulated it. I'm the computer guy.
THE COURT: Read the slide again, what it says.
MR. GOINGS: Stimulated. Judge, I didn't have my readers on when I did that.

THE COURT: I just wanted -- I'm just glad we could establish what stimulated yellow paint looks like.

Okay. Any other questions?

MR. GESSNER: No recross, Your Honor.

THE COURT: Okay.

Ma'am, you may step down.

MS. GOODING: Plaintiff rests, Your Honor.

THE COURT: And you have one witness?

MR. GESSNER: Yes, Your Honor. Well, directed verdict and then --

THE COURT: Oh, okay.

MR. GESSNER: If it's all right with Your Honor, if we could take a quick break?

THE COURT: Yeah. Let's take a real five minutes. I won't go anywhere else and get trapped by anybody.

(Brief recess.)

MR. GESSNER: We move for directed verdict, Your Honor. I have a memo prepared.

THE COURT: All right.

MR. GESSNER: I'll give the original to you.

THE COURT: Did y'all ever move for summary judgment in this case?

MR. GESSNER: I did not, Your Honor.

THE COURT: Okay. I'm happy to hear from you.

MR. GESSNER: Thank you, Your Honor. May it please the Court? The defendants request directed verdict. I have handed up a memo that has our full argument contained in there. I'll go through that briefly.

Of course, this is a negligence cause of action. Plaintiffs have to show duty, breach, injury. Most notably, at the outset, Plaintiffs have failed to show that the defendant violated a standard of care.

Now, of course, we had said early on that the defendants admit Mrs. Connell was an invitee of the property. Now, the duty of care we owe her is a duty of care to warn of unsafe conditions, which Defendant knew or should have known and of which Plaintiff was reasonably unaware.

Plaintiff's argument is that the Medical Center or the Health Services District should have painted that curb yellow. However, you've noticed here -- or you've probably noticed here today that they've provided no expert witness, no engineer, nothing like that to say, no, the standard in the industry here is to paint the tops of all the curbs. You haven't heard any testimony from that. And it's

because there is no building code that says that.

So when this parking garage was built, as best we know, it was built in accordance with the codes, it passed inspections, everything's fine. So how would the Health Services District know we have to paint the top of this curb yellow?

THE COURT: How did they know to paint the other curbs yellow?

MR. GESSNER: We don't know.

THE COURT: Well, it's your client. I mean, that's the question. I mean, why are most of the curbs painted yellow but this one is not?

MR. GESSNER: We don't know. The contractor was hired. It was built. My client is in the business of running a hospital, not building a parking garage.

THE COURT: Well, but they happen to own a parking garage.

MR. GESSNER: They do. They do.

THE COURT: All right.

MR. GESSNER: But that's what it happens to come down to.

There's a case cited on page 3 in our memo. It's Nelson vs. Piggly Wiggly Central. And in that case, what happened, a woman stopped at Piggly

Wiggly -- and whenever you look at the premises liability cases, most of them seem to be Piggly Wiggly or Food Lion-related.

But this lady gets out of the car -- I think it's her grandmother is behind the wheel -- and she's walking in front of the car to go into the store. And, for whatever reason, her grandmother pressed the accelerator and wound up pinning this poor woman between the car and side of the building.

And what their theory was -- is, in front of the car, in the parking spot, they call it a wheel stop. I call it a -- one of those parking blocks, just those little trapezoidal concrete blocks that you see so the car doesn't roll too far forward. But the car hopped over one of those and then pinned the plaintiff against the wall. The plaintiff's theory was, had you installed a sidewalk and a curb here, the car wouldn't have come up and hit me.

The Court rejected -- I believe they granted -- it was either summary judgment or directed verdict in this case. But they said, you can point to no standard that says you put curbs in this situation and not wheel stops. The plaintiff in that case did have an engineering expert. And what he testified to is that it would have been more safe if there

were curbs.

On cross-examination, he had to admit there was no standard for that; there was no building code for that; he was just kind of pulling something out of his own belief that he thought the accident wouldn't have happened if there was a curb and not a wheel stop.

THE COURT: In that case, did that Piggly Wiggly have curbs in some spots and not in others?

MR. GESSNER: Yes.

THE COURT: Okay.

MR. GESSNER: And -- yes. And I have the citations in my brief, if Your Honor cares to look at that.

But they took particular note that there's no code or safety standard which established this is the standard of care as opposed to the duty of care. So, again, while the plaintiffs can argue it would have been more safe for the curbs to be painted yellow, that may or may not be. But that's not the issue here.

In fact, the language from the Court in the Nelson case says: The issue is whether the scope of the acknowledged duty of reasonable care extends to the particular risk that led to her injury. And

that's what we're arguing here, Your Honor. There's no source which says that you paint the top of the curb yellow.

THE COURT: Okay.

MR. GESSNER: So we think Plaintiffs have failed to establish the standard of care -- or that a standard of care, in this case, and their claim should be dismissed for that reason.

THE COURT: Are you aware of any cases that deal with -- I think the testimony we've heard in this case was camouflage, where one surface is camouflaged from the decrease in elevation.

MR. GESSNER: There is, Your Honor.

THE COURT: It may be in your brief.

MR. GESSNER: It is. And my next section is talking about a defective or dangerous condition. There's been no testimony here today, and you've seen the pictures themselves, that's, as best we can tell, the way the curb was built. It wasn't in a state of disrepair; it wasn't broken. This isn't a case of the defendant failing to maintain it. Everything looked clean and in order. The only issue, according to Plaintiffs, is there is no paint on the top of the curb.

Now, there's a case, it's Bruno vs. Pendelton

Realty. I believe there's a -- they call it a concrete sideway [sic] and a concrete walkway of the same color. It essentially made like a little T intersection. And the plaintiff there didn't notice the change in elevation and fell and was injured.

But the Court noted, unlike our case here, the property owner in Bruno had allowed grass to grow in a crack in between the sidewalk and the walkway to the extent the grass concealed the change in elevation.

In upholding the jury verdict, the Court in Bruno pointed to the testimony that the property owner was aware that the grass had grown to the extent it concealed the change in elevation and had failed to remove or even trim the grass.

So I think that's very different than we've seen here today. You know, if there was grass or debris or something in the way such that Mrs. Connell would not have been able to see it because it was covered by a foreign substance is one thing; the curb being in exactly the condition it was meant to be in is a whole thing -- a different thing altogether.

The next and, I think, most important argument here is the lack of any notice on the defendant.

We're dealing with a premises liability case here. So Plaintiffs have to prove that Defendant knew or should have known about the dangerous condition. They've not presented any evidence of any notice whatsoever. Certainly, there's no evidence of any actual notice. But they haven't even touched on anything that could be construed as constructive notice.

I believe they're relying simply on the fact that this curb has been there about nine years, so, surely, you should have known it was bad. Well, how? Doing the research, I came across some older cases that talk about being put on inquiry, and there was some archaic language in some of these cases.

But, essentially, what inquiry -- or constructive notice means, is there has to be something that tells the property owner there's an issue in that particular area and it requires further investigation. Plaintiffs have failed to show even that.

One of the best examples I can give, if you'd stretch notice out as far as it will go, my firm had a case some years ago on I-20. A section of I-20 had been resurfaced and, unbeknownst to anyone, was

allowing water to pool to a very small degree when it would rain. Cars would hydroplane and crash into the trees. Now, when you went out there and looked at the roadway, you couldn't tell that when it wasn't raining.

Well, you would notice, when you looked at the accident report, right after that roadway was resurfaced, all of a sudden, you have a lot more accidents in a very short section of I-20. And if you think about it, okay, if you're on inquiry, DOT is looking at these accident reports and should suddenly notice, wait a second, we're getting a lot of accidents in this one little area of I-20; what's going on? Go out there and look, conduct an investigation.

That investigation then revealed there's water pooling very slightly and is leading to it. So you don't need evidence that -- you know, you don't need somebody calling and saying, hey, I tripped over the curb because there's no paint on the top. It doesn't need to be that specific.

But there needs to be evidence of something putting the defendant on notice that there is an issue, to the extent that it would cause the defendant to conduct an investigation, and a

reasonable investigation would reveal the problem. We have no evidence of any of that from Plaintiffs and, for that reason, we believe directed verdict should be granted.

THE COURT: Okay.

MR. GESSNER: The last section in here deals with comparative negligence. There's another case, Denton vs. Winn-Dixie Greenville, where the court said: Speed bumps, curbing, or concrete dividers, all of which are commonly found in or along public streets and places to park, are common structures that a person taking reasonable care for his own safety would likely expect and see while on the premises.

So I think it's established in South Carolina that if you're talking about a parking lot, or along the street, and you're walking around, you need to be on the lookout for these sorts of things.

Now, respectfully, I think the photographs that have been shown on the TV here today are a little washed out and kind of --

THE COURT: Well, you said parking lot. But it says places to park.

MR. GESSNER: Okay.

THE COURT: Well, there's a public parking spot

on a public street and then there's a building which is owned by an entity. So it's a little bit --

MR. GESSNER: It is. But --

THE COURT: Your words --

MR. GESSNER: The general thrust is when you're walking in a place where there's cars parked and cars moving, generally be on the lookout for these sorts of things. And they do specifically mention curbing.

THE COURT: Okay.

MR. GESSNER: But when Your Honor looks at the scene, if you look at Exhibit 3 in the binder you've been provided by Plaintiffs, you'll see those photographs are a lot different than, I think, what was on the television, the television being a bit washed out today. I mean, I can clearly see where that line is.

THE COURT: Washed out?

MR. GESSNER: Yeah. How do I describe that?

THE COURT: You mean, the resolution is a little different?

MR. GESSNER: Yes, sir.

THE COURT: Okay.

MR. GESSNER: So, here, you can see a difference in color slightly from the sidewalk

portion and the roadway portion. And I think it's much more readily visible on the paper document -- the paper exhibit, than what was shown on the screen here today.

THE COURT: Okay.

MR. GESSNER: So we think, taking everything into consideration, the plaintiff herself would have been comparatively negligent more so than Lexington County where the allegation is-- or the Health Services District should have been clairvoyant and understand that we have to paint the top of this curb because, nine years from now, someone is going to fall.

I don't see where the negligence was in that, especially when there's no violation of any building code, nothing, Your Honor. So, for those reasons, we respectfully request that you grant directed verdict.

THE COURT: All right.

Counsel?

MR. GOINGS: Thank you, Your Honor. May it please the Court?

So the photographs, let me address this. And you can see this in the deposition of the 30(b)(6) witness: The photographs of the parking lots that

we're showing you to show that it is camouflaged were all taken by, not the plaintiff, but the defendant. It was the defendant's photographs that we've used this whole time.

In the depositions of the two 30(b)(6) witnesses that the defense allowed us to depose, we showed the pictures that they took that were printed out. And this is a blowup of the same picture. And in these photographs that were printed on paper, their own witnesses say it's very difficult to see the change in elevation.

We, today, have a monitor. And we showed it on the monitor and it's still hard to see. Whether you print it out, whether you put it on a monitor, or whether you walk through the garage, it's very difficult to see.

If you go back to actually what the law says, and the defense has given an eight-page memo in support of their motion for directed verdict, in response, we -- well, before we started today, we handed up Plaintiff's trial brief. And we would call the Court to our trial brief as our response in writing to their memo.

But it's clear what the law is: An invitee is offered the utmost duty of care -- so that's the

standard -- owes an invitee a duty of care to discover risks and to warn of or eliminate foreseeable and reasonable risks.

The hospital, in this case, has a duty to inspect and a duty to seek out the risks and, at the very least, warn of the risks. Now, for this type of case, we must either show, one, that the landowner created the hazard or the dangerous condition. And that's the truth; they created it. It's their parking garage that was built for them that they had oversight to make. It's their parking garage.

And if you look at the case of Wimberly vs. Winn-Dixie, the standard is something was on the floor that was placed through an agency of the store. Well, it was their contractors; it was their people; it was their department of facilities that oversaw this; they created the risk. And what's very telling is, is that every single curb in this parking garage is painted, top and bottom, every single curb.

What's not painted is the walking area coming from outside to the inside, going through the pedestrian door that you can't see, that's not painted from the direction she was walking. If

there's any question whatsoever as to overcoming directed verdict for purposes of is there any evidence, look no further than the 30(b)(6) depositions of Corey Andrews and Dale Thompson where both of them said that this created -- it's a hazard. It's a hazard; they said it. That's why I didn't have to call any of their witnesses because they said, in the deposition, it was a hazard.

Why do you paint?

You paint for visibility.

Why do you have -- why is it important to paint?

Well, you can see it better when it's visible.

Yes, if it was painted, you could see it a lot better; yes, if it was painted, you're much less likely to trip over it.

You see, it wasn't painted. And when you talk about what is the standard, premises liability cases don't always involve a violation of the building code; it doesn't always involve a violation of industry standard. The case law says that can be evidence of negligence, but it doesn't have to be evidence of negligence.

What we have here is the hospital who undertook

something, i.e., painting of the curbs. They painted the top and bottoms, everywhere else but one place where she fell. And that is the standard. The standard is, from a negligence and undertaking standpoint, they knew that they were supposed to be painted on the top and the sides, but they left this part out, they just did.

You don't need an expert to look at the photographs; you don't need a highly trained engineer to look at the photographs; you can look at the photographs as a layperson, just as we've all done here today, and say to yourself, man, yeah, it's hard to see from the camouflaging effect from the direction that she was going.

It would be different if she was walking the other direction where it was painted yellow. But she was walking in the only direction possible that it wasn't painted that you can't see. The video was very clear she was walking reasonable; the video was clear she was not doing anything in a distractive manner. The 30(b)(6) deponents of the hospital admitted that Mrs. Connell was not doing anything wrong.

When you take the still-shot of her fall, we know how she fell. Half of her foot went over the

change in elevation. So it's not like she tripped before that location. It -- we know exactly how she fell. It's clear that she did not see the change in elevation. All they had to do was paint it. When you see the difference between the -- with a yellow stripe and without a yellow stripe, it's clear to the naked eye. It wasn't clear to her.

And the issue of notice, I disagree with my colleague. You don't have to prove notice, if they created it, which they did. Even if you do have to prove notice -- let's say you have to prove notice. Case law is very clear that constructive notice means if it's existed for a period of time where someone should have reasonably picked up on this and fixed it. Well, based on the evidence today, it was there at least nine years. And that's also reflected in the deposition testimony.

It's been there. They had constructive notice. They go and ride around -- presumably, they say, they go ride around once a month looking for stuff. Well, you can clearly see in the photographs that it's halfway painted; it was halfway done. And this lady fell and had a pretty bad injury. And she's not whining; she's not complaining about it; she's getting through it. I commend her for that.

So, we think, when you look at the standard for directed verdict, is there any evidence that this motion has to be denied? I think we've presented overwhelming evidence of notice and overwhelming evidence that if they used reasonable care, would have discovered this.

And ask yourself this: They had nine years to discover it and fix it. She had a millisecond to discover it, and she fell. And we'd respectfully request that this Court deny this motion. And, like I said, if you look at their own testimony, the 30(b)(6) deposition testimony, we have it culled out in our trial brief that we handed up on pages 5 and 6. He talks about it being blended and it's hard to see and it can --

And this could result in a trip, hazard, correct?

Correct.

And the yellow stripe -- if you actually had a yellow stripe, one would be able to see it a lot better, wouldn't they?

Yes, they would. And I'm not contesting, from a safety standpoint, that it would be a whole lot easier to see if we actually painted the top, because it would actually reflect the

change in elevation. I'm not arguing with that one bit, sir. I think it certainly would.

Last question: Do you agree with me that if this curbing was painted like all the curbing in the parking garage that it would actually improve the safety of this area?

Yes, I do. I believe that, sir.

We believe the evidence in this case is overwhelming and that this motion should be denied. Thank you.

MR. GESSNER: Briefly, Your Honor. And, in fact, those segments of the 30(b)(6) depositions and what I was talking about was off-topic. Mr. Thompson was -- the topics for which he was designated was to talk about the construction, when it was constructed, who built it, who was the painting subcontractor, things like that. Then they asked him questions like that, and he was unprepared for that.

So that's where I think he's not authorized to speak on behalf of the Health Services District for those topics. I don't think that testimony can be held against us.

THE COURT: Okay.

MR. GESSNER: So that's why I took issue with

that, because it was potentially probative. And I don't believe anybody, in either of those depositions anyway, said that the lack of paint created a hazard.

As best I recall, the question was: Would you agree that if you have a sidewalk with concrete and then a walkway -- or a roadway that's concrete, that it can have a camouflaging effect? And the witness said: I agree, it can have that effect. It's much more hypothetical. I don't think anybody in either of those depositions specifically said that curb is a hazard.

THE COURT: Let me ask you a quick question about some of the testimony we did hear. This is really for both sides. I want to make sure -- I took notes, of course. I thought when Investigator Brewer testified that when he was at the scene with Mrs. Connell that he saw that the face of the curb was painted, but the top was not. But on the other side -- in other words, that the curb directly, the mirror-image curb, did have paint on the top.

MR. GOINGS: I can clear up exactly what I was saying. Let me put it up on the screen --

MR. GESSNER: I think he was talking in a different direction --

THE COURT: Direction. Because I --

MR. GESSNER: Or is he talking about the median?

THE COURT: Because the pictures, I mean, are --

MR. GOINGS: So look at this, Your Honor. See the picture I'm talking about? He's saying -- and keep in mind that Diane was on the ground right here.

THE COURT: Okay.

MR. GOINGS: He's saying, from this vantage point, meaning, walking from the -- where the cars were parking to outside --

THE COURT: Yes.

MR. GOINGS: -- it's painted yellow. But, coming from the other way, it's not painted.

THE COURT: I got that. I wrote this down because --

MR. GESSNER: He said another curb was painted on the top. I was asking which one he's talking about.

THE COURT: I just wrote: Hospital staff came out, top of curb was not painted there, but on the other side, it was. So I -- that --

MR. GOINGS: I think the evidence is --

MS. GOODING: Mr. Brewer's testimony was regarding the mirror image, as you've pointed out; where the garage entrance side, it was painted, and on garage exit side, it was not.

MR. GESSNER: I don't think that's accurate.

THE COURT: That's his testimony. That's what I heard. That's why it was important for me. And I'm looking now at Exhibit 4. What I'm really trying to say is, this curb over here, across the median, basically where traffic would come -- well, I think that would be the entrance. So it would be --

MR. GESSNER: If it's Exhibit 4, that's a subsequent remedial measure, Your Honor.

THE COURT: No, no, no, no, no.

MR. GESSNER: Or is it the fourth page of Exhibit 3?

THE COURT: No, no. This is the -- we'll call it the --

MR. GESSNER: Okay. Exhibit 3.

THE COURT: I'm talking about right here. That's how I read his testimony, which is important if I --

MR. GOINGS: That's always been -- the top has always been yellow over there on that side. You're

correct.

THE COURT: Okay. So, I mean, you have a --

MR. GESSNER: I don't think it's painted on the top, Your Honor. I can show you. That's the face or the front of the curb because you can see, right here, as it leads up to that column, it's not painted on the top there.

THE COURT: Okay.

MR. GESSNER: So that was his testimony. He may have been mistaken.

THE COURT: Okay. Well, I --

MR. GESSNER: But the photographic evidence, I think, shows otherwise.

THE COURT: That leads to why I noted that testimony.

MR. GOINGS: Your Honor, from Plaintiff's standpoint, it's always been our contention and we always understood Mr. Brewer to say that the mirror image, meaning, the other side --

THE COURT: Uh-huh.

MR. GOINGS: -- where the entrance -- vehicles would drive in, that top was painted yellow.

THE COURT: Okay.

MR. GOINGS: That's what I've always understood. And my clients have testified that

everywhere else in that entire parking lot, the top has been painted yellow. The only place that's not painted yellow, to our understanding, is the location where she fell.

THE COURT: Okay.

And I'll let you respond because --

MR. GESSNER: Your Honor, I would just say, respectfully, I don't think any witness has stated they went through the entire garage and changed every single --

THE COURT: I --

MR. GESSNER: But we will -- we do stipulate, some of the curbs, the tops are painted yellow; some are not.

THE COURT: I understand that. Just keeping it to the pictures we have here today --

MR. GESSNER: Yes, Your Honor.

THE COURT: -- I've made my comment --

MR. GESSNER: Okay.

THE COURT: -- regarding the investigator's testimony. And I think you've had a chance to reply. So --

MR. GESSNER: Just to finish up on reply for the purposes of directed verdict, the law clearly states that a premises owner is not the ensurer of

everyone's safety. We have a duty to exercise reasonable care and that's it. And I think that the hospital was exercising reasonable care.

Plaintiff's whole argument is, you could have done more. But that's not the issue. The fact they can't point to any building code or anything to put the defendant on notice really kills their case. I think what they state about constructive notice is inaccurate; that they do have to show that there is some indication to the defendant that there's an issue there. The case law supports that.

Plaintiffs point to Wimberly. I think that's Wimberly vs. Winn-Dixie. That's a foreign substances case. That's where some rice had spilled on the floor, Plaintiff slips on the rice in the grocery store and falls. Now, there shouldn't be rice on the floor in a grocery store. If you're operating a grocery store and something spills, you clean it up.

So the issue with foreign substance is, has it been there long enough that a grocery store or whoever owns the premises should have seen it, if they're exercising due diligence? You know, had it been there for five minutes; had it been there all day? If it's been there all day, I think it's

reasonable to expect that some employee would have seen it and cleaned it up prior to the plaintiff falling.

That's not applicable here, because we're not dealing with a foreign substance. You know, if there had been oil spilled on the curb and had been left there and Mrs. Connell slipped in the oil, you could say, hey, you know, if you had done your inspection, you would have seen that.

But this isn't a foreign substances case. There's no defect in that curb. According to the building code, that's how you build a curb. Why would we think it's defective?

As Plaintiff has said -- or counsel for Plaintiff has said numerous times, that parking garage was there for nine years; nine years with zero reported incidents prior to Mrs. Connell falling. So if it's such a hazard to not have yellow paint there, how do we go nine years without an incident?

THE COURT: Well, I thought Judge Kelly kept out the previous incidents and --

MR. GESSNER: No. No. It's outside of the parking garage, Your Honor. Any falls in that parking garage were relevant.

THE COURT: Oh, okay.

MR. GESSNER: That was Judge Kelley's limitation.

THE COURT: Obviously, a lot of this, I'm reading on the fly.

MR. GESSNER: Yes, sir.

THE COURT: So let me be clear: I want the opportunity to read your memo. I'm denying your motion for directed verdict. However, to the extent that the way this case ultimately resolves, it's certainly useful and when it -- you know, down the road. You follow me?

MR. GESSNER: Yes, Your Honor.

THE COURT: All right. Let me ask y'all a quick question.

(Sidebar conference.)

THE COURT: All right. Defense may call their first witness.

MR. GESSNER: Thank you, Your Honor. We call Dale Thompson.

DALE THOMPSON

being first duly sworn, testified as follows:

THE WITNESS: I do.

THE CLERK: Have a seat, please, and state your full name for the record.

THE WITNESS: Dale Alan Thompson.
MR. GESSNER: Thank you.
May it please the Court?
THE COURT: Yes, sir.

DIRECT EXAMINATION

BY MR. GESSNER:

Q. Mr. Thompson, where are you currently employed?
A. Lexington Medical Center.
Q. Okay. What is your title there?
A. I am assistant vice president for facilities and property.
Q. Okay. And how long have you held that title?
A. Since 2012.
Q. All right. We're here today for -- in relation to a lawsuit filed by Mrs. Connell. Are you familiar with that lawsuit?
A. Yes.
Q. Okay. Is it your understanding that Mrs. Connell fell in one of the parking garages at Lexington Medical Center?
A. That's correct.
Q. Okay. Which parking garage, exactly?
A. It's now called Parking Garage 3. At that time, it was LMP Parking Garage 2.
Q. Okay. So at the time of the fall, it was

Parking Garage 2?
A. Correct.
Q. Okay. And it's now Parking Garage 3.
How long has that parking garage been open?
A. I believe it was open in 2008 --
Q. Okay.
A. -- is when they finished construction.
Q. Did the Lexington Medical Center build that parking garage?
A. No. A contractor built the parking garage.
Q. Okay. Do you know who that contractor was?
A. McCrory Construction.
Q. Okay. Do you know how many parking spaces are in that garage?
A. There are 817 parking spaces in that garage.
Q. Is that parking garage usually full?
A. Yes.
Q. Okay. And it has been for many years?
A. Yes; ever since.
Q. Okay. So who all parks in that parking garage?
A. We -- currently, I believe, we have one level that's assigned to employees, the top level, which would be, I believe, 163 spaces. And the rest are for visitors and patients of the physician practices or the hospital.

Q. How many floors is that garage?
A. Five.
Q. Five. Okay.
So, you know, throughout the history of the garage, has it always just been the top floor for employees only or --
A. That varied. But, depending on the census of the hospital, what the flows were, it's currently up on the top floor.
Q. Okay. Would you say that that parking garage is filled on any given day; every spot taken up at some --
A. Yeah. They actually assign people to park in the garage, the employees; and then the lower floors for the patients and the visitors are typically always full.
Q. Okay. So when the employees that park there -- do you have multiple employees assigned to the same spot on different shifts?
A. We do. And, typically, it will be the first shift that's assigned. And then second shift can park in various locations. But they don't assign specific spaces, they just assign the number that would fill those spaces.
Q. Okay. I see. So do you have any idea how many

times this parking garage is filled; you know, how many times over in a given day?

A. A safe estimate, because we have no true way of tracking, would be they probably turn over a minimum of four times because they're coming and going to the physician practices.

Q. And, roughly, each space, correct?

A. That's correct.

Q. So 817 spaces four times over would be 3,268. Does that sound about right?

A. Close to that.

Q. Okay. Every day?

A. Except for weekends. Weekends would be different. But five days a week.

Q. Okay.

A. When those physician practices are open, yes.

Q. Okay. So five days a week though, you're talking 16,340 individual vehicles going through that parking garage?

A. Yes. That would be a good estimate.

Q. Okay. And 52 weeks in a year, almost 850,000 individual vehicles in a given year; does that sound about right?

A. Yes. That would be a good estimate.

Q. Now, prior -- well, in your position, do you

have reason to know whether or not there's been any falls in that parking garage prior to Mrs. Connell's fall in 2017?

A. Not to my knowledge.

Q. And that's something you've looked into, right?

A. Yes.

Q. So, to best of your knowledge, after doing research and checking everything out, there's no reported falls prior to Mrs. Connell falling in September of 2017?

A. Correct.

Q. And that's thousands of vehicles every year. Now, are there multiple ways in and out of that garage?

A. Yes. There are two entrances; one in the front and one in the back.

Q. Okay. Was this the front entrance or the back entrance where Mrs. Connell fell?

A. What we consider to be the front entrance.

Q. Okay. Does Lexington Medical Center conduct any safety inspections of the garage?

A. We do. We have a grounds manager that rides around looking for areas, areas that we've been made aware of that are issues. We look and check those out.

Q. Okay. You said made. How is Lexington Medical Center made aware of an issue?
A. We get occurrence reports. We get phone calls from staff that make us aware of different things.
Q. Okay. And are you aware of any such notice relating to that particular curb in that particular parking garage?
A. Not to my knowledge.
Q. Okay. Are there periodic inspections not related to any specific complaint of that parking garage?
A. Yes. I typically ride the grounds. We do grounds inspections.
Q. Okay. And how often do you do that?
A. Typically, I do them monthly.
Q. Monthly. Okay.
And when you do those inspections, what are you looking out for?
A. We're looking for spots that have broken concrete, sidewalks where they've heaved and they're uneven; we look for standing water in different areas, and those types of things.
Q. And to the best of your knowledge, were there any issues with the curb in question, with it being broken up or -- I think you said heaved or it caves

in, creating a trip hazard from broken concrete. Are you aware of anything in that -- on that --

A. No, I'm not aware of anything.

Q. Okay. Are you aware of any building code that requires the tops of any curbs to be painted yellow or any other color?

A. No, not to my knowledge.

MR. GESSNER: Thank you. No further questions.

THE COURT: Cross-examination?

MR. GOINGS: Yes, sir.

CROSS-EXAMINATION

BY MR. GOINGS:

Q. You are the director of facility services; is that correct?

A. I was. I'm currently assistant vice president of facilities and property.

Q. All right.

A. Still have the same oversight.

Q. Now, when I asked you in your deposition why the parking garage had yellow paint in it, you told me that that's a code requirement, right?

A. The yellow paint itself, the markings, is a code. That's right.

Q. All right. And you've seen the location in which Mrs. Connell fell, haven't you?

A. Yes.
Q. And the direction that she was walking from, outside and going into the pedestrian door, as she looks forward, the walking surface that she's on has no yellow paint on the top, does it?
A. Correct.
Q. And, in fact, it's a change in elevation, about ten feet into that door; is that correct?
A. It would be close. Yes.
Q. And the change in elevation is more than a quarter of an inch, isn't it?
A. Yes.
Q. In fact, the change in elevation is somewhere between six and eight inches, correct?
A. Close, yes.
Q. All right. And as a pedestrian is walking and looking ahead, they see curbing that's painted, correct?
A. Correct.
Q. All right. But the curbing that this pedestrian, such as Mrs. Connell, sees, that she's immediately about to walk off, has no painting in the direction in which she's walking, correct?
A. Correct.
Q. All right. But it is painted on the other

side, right?
A. Correct.
Q. So top of the curb is not painted, but the side of the curb is painted, correct?
A. Correct.
Q. And it's painted yellow, right?
A. Yes.
Q. And yellow's a color that denotes visibility, right?
A. That's correct.
Q. And yellow is an important color because it also tells people caution, right?
A. That's correct.
Q. And that's why yellow is used to paint changes of elevation, correct?
A. Correct. In some situations, yes.
Q. And, in fact, camouflaging effects can occur with concrete; isn't that true?
A. I'm sorry. Can you repeat that?
Q. The camouflaging effect can occur with concrete; isn't that true?
A. Yes. I would say that is correct.
Q. All right. And, in fact, from the naked eye, you can have concrete that is all one color of that grayish tone, and there may be changes in the

elevation, but you can't see it because it's not painted, correct?
A. Correct.
Q. All right. And concrete, in and of itself, can cause that camouflaging effect to occur to the eye, right?
A. Yes. I would say so.
Q. And that's why curbing is painted all throughout the parking garage, right?
A. In the other locations, yes. Yes. I would say yes.
Q. Okay. And it's reasonable to paint the curbs, top and bottom, yellow, isn't it?
A. It is. But they don't paint all curbing yellow. They'll do certain sections. And then the rest of it, they don't paint, you know.
Q. Now, all through this parking garage, you'd agree with me, except in the location where Diane fell, that the top and the side of the curbs are painted, correct?
A. I'm not positive if all of them are. But I would say the majority of them are.
Q. Do you have any pictures here today to show this Court of places in the parking garage that the curbs are not painted yellow on the top?

A. I do not.
Q. All right. And you know that's a big issue in this case, is curbs being painted on the top versus curbs being painted on the sides versus curbs being painted on the tops and the sides, right?
A. Correct.
Q. All right. That's kind of what this case is about, right?
A. Yes.
Q. All right. And you presented no documentation, no photographs, in discovery or here today, showing anywhere else in the parking garage that the top was not painted yellow, correct?
A. That's correct.
Q. All right. Now, this parking garage was built by Lexington Medical Center, correct?
A. Yes.
Q. All right. And the Facilities Department was involved in the design and the construction of the parking garage, correct?
A. The Facilities Department hired an architect -- a licensed architect and a licensed contractor to build the garage.
Q. And it was Lexington Medical Center's decision to hire that --

A. That's correct.
Q. -- architect, right?
A. Yes.
Q. And when you got bids, you hired that contractor, correct?
A. Yes.
Q. Okay. And Lexington Medical Center permitted these contractors to work in the garage, right?
A. That's correct.
Q. And the painting contractor, whoever that person was, was selected by McCrory, right?
A. That's correct.
Q. And they had the permission to do the painting?
A. Correct.
Q. And, ultimately, Lexington Medical Center paid for that, didn't they?
A. Correct.
Q. And this parking garage was built about nine years ago?
A. It was 2008, is when it opened.
Q. And you said you haven't seen any evidence of anybody previously falling in this area. You would agree with me that just because no one else has been injured in this location, allegedly, doesn't mean that other people haven't fallen? You'd agree with

me, right?
A. Right.
Q. Okay.
A. Only the ones who have reported are the ones --
Q. Okay. Because you would expect someone to report if they were injured, correct?
A. Correct.
Q. And through your years and history as the facilities coordinator, you know that, generally speaking, people don't report things that don't cause injury or harm to them?
A. I'd say that's a true statement.
Q. Okay. So you can't rule out that there were prior falls, can you?
A. No, I cannot.
Q. Okay. This is Exhibit 5. Do you remember, in your deposition, when I showed you this photograph? And I can give you a copy of it right here. It was actually Exhibit 2 to your deposition. And I actually have another blowup of it right here.
Do you remember the photo that was marked with two lines on either side --
A. Yes.
Q. -- in your deposition? And here's a blowup of it.

Do you remember when I asked you, in your deposition, if it was hard to see the change in elevation in this photograph where Mrs. Diane Connell fell? Do you remember me asking that question?

A. Yes.

Q. And you said -- admitted that it was hard to see, didn't you?

A. I said, based on that picture, it's hard to see.

Q. All right. Based on the pictures you see, it's hard to see, isn't it?

A. Yes.

Q. And you actually took these pictures, didn't you?

A. No, I did not.

Q. Was that Corey Andrews that took the pictures?

A. I'm not certain who it was.

Q. Okay. In your deposition -- or Lexington Medical Center's deposition, didn't y'all say that y'all actually went out and took the photographs?

A. I don't remember.

Q. You don't?

A. Being honest with you.

Q. Okay. Let me ask you this: Is it easier to

see this curb where Mrs. Connell fell in this photograph or in this computer-simulated photograph showing yellow paint?

MR. GESSNER: Objection, Your Honor. That --

THE COURT: Same objection is noted. Overruled.

THE WITNESS: So answer the question, Your Honor?

THE COURT: Yes, you can answer.

THE WITNESS: Yes, you can see it better. Yes.

BY MR. GESSNER:

Q. Okay. You agree that this curb is much more visible and easier to see if it's painted, correct?

A. Yes.

Q. Okay. And that's no dispute, right?

A. No, not based on that photograph.

Q. Okay. And you agree with me that it can be difficult for a pedestrian to see this drop-off when it's not painted?

A. That's correct.

Q. And you'd also agree that the reasonable and prudent thing to do would be to paint all curbs, top and sides, so a pedestrian could actually see and appreciate the hazards, correct?

A. Yes.
Q. Okay. And you would agree with me that curbing can become hazardous to pedestrians?
A. Curbing can be hazardous, yes.
Q. And when curbing is hazardous the most, is when people can't see or appreciate the curbing is there, correct?
A. Yes. I'd say that.
Q. All right. And if the curbing is not visible, that can cause people to fall, correct?
A. Yes.
Q. And you've seen the video, haven't you?
A. Yes, I have.
Q. And Mrs. Connell was not doing anything but walking reasonable that day, was she?
A. That's what it appeared.
Q. All right. She wasn't running, was she?
A. No.
Q. She wasn't skipping?
A. No.
Q. She wasn't on her phone, was she?
A. No.
Q. She appeared to be kind of looking ahead like a normal person walks, right?
A. Appeared. I couldn't tell.

Q. It's not your testimony, is it today, that Mrs. Connell did anything wrong, is it?
A. No.
Q. Okay. Now, not only is this a walking surface, but this is also a walking path, too, isn't it?
A. Yes. It comes to that door.
Q. So you'd expect pedestrians to walk through that door, correct?
A. Yes.
Q. In fact, you'd rather pedestrians walk through the door than walk through where cars come in and out, right?
A. That is correct.
Q. All right. Because that's the safer thing to do, right?
A. Correct.
Q. So she took the safest route, didn't she?
A. Yes.
Q. All right. But the route she took led her to this; isn't that true?
A. Yes.
Q. All right. Has your testimony here today been truthful?
A. Yes, to the best of my knowledge.
Q. You agree that this can create a trip hazard?

A. Yes. Based on that picture, I agree with you.

MR. GOINGS: No further questions, Your Honor. Thank you.

THE COURT: Redirect?

MR. GESSNER: Nothing further, Your Honor.

THE COURT: All right. The witness may step down. Thank you, sir.

Is he free to go?

MR. GESSNER: Yes, Your Honor.

THE COURT: All right. Is that your only witness?

MR. GESSNER: That is our only witness, Your Honor. We'd rest our case.

THE COURT: Okay. And just for DV purposes, do you want to just renew everything --

MR. GESSNER: Yes, please.

THE COURT: -- that you previously argued?

Okay. The record will reflect that the defendant here has renewed all his previous objections and arguments that were argued after the plaintiff's case in chief.

Do you want to renew all your responses?

MR. GOINGS: Renew my responses. But I will also add, now that this case has -- he's closed -- Defense has closed his case, one, I would -- and I

respectfully understand that you're going to deny it. But I would move for directed verdict on the idea of negligence. I think this is the second time the witness has admitted liability in this case; in a deposition and then on the stand.

Now, number 2, as it relates to the defenses of comparative negligence, we would move for directed verdict on comparative negligence because there is no evidence of comparative negligence. And, in fact, the testimony in the depositions and from the witness is that she did nothing wrong.

I mean, it would be different if they were showing you evidence that she actually did something wrong. There's not one bit of evidence she did anything wrong.

Now, I think reasonable minds could differ, potentially, at this stage, as to negligence. But, as it relates to comparative negligence, there's no evidence of comparative negligence. So we'd move that comparative negligence, at directed verdict, be stricken from their defenses. Thank you.

THE COURT: Mr. Gessner?

MR. GESSNER: In response, Your Honor, I believe that the witness' testimony was that they couldn't tell from the video whether or not the

plaintiff was doing anything wrong. Obviously, she wasn't looking down at her phone; she wasn't turned around yelling at her husband or anything; she appeared to be looking straight ahead. But the witnesses couldn't tell exactly what she was or wasn't doing, and I think their testimony reflected that.

In response, on the comparative negligence argument, Your Honor, we have a picture of the scene. This one has been Bates-stamped. But on Exhibit 3, my whole argument, based on that, is, I can see that line. Why didn't she? I understand their argument that if it were painted yellow, it would be more visible. And I've already addressed that. But I think that line right there is very clear.

So I think, if you're walking in a parking garage and you're exercising care for your own safety, you're going to be on the lookout for things that you can trip on or things that can --

THE COURT: Uh-huh. I think Mr. Goings' point is just the testimony that he said that she did nothing wrong. However, were the situation different, I'd still -- well, I'll let you respond to him.

MR. GOINGS: I have nothing, Your Honor.

THE COURT: I'm going to deny the directed verdict motion. I'm going to take it all and it will be encapsulated in whatever the final order is.

MR. GESSNER: I know we had mentioned closing arguments before. Is there anything else in lieu of closing arguments the parties should submit or...

THE COURT: Well, I do want proposed orders. One thing I think y'all should discuss and think about is, we haven't had a lot of -- this hasn't been a case where there's an overwhelming amount of exhibits.

I don't think -- I'll defer to y'all. I don't think we need to get a full transcript for this order. So in lieu of that, I would just say, you know, 30 days for a proposed order, not the usual 10. We've gone through a lot today.

Obviously, Mr. Gessner, your order needs to focus on notice --

MR. GESSNER: Yes, Your Honor.

THE COURT: -- because that's your case.

MR. GESSNER: Yes. That's in a nutshell, Your Honor.

THE COURT: Obviously, if there's an issue of notice -- well, that's what you're going to be

addressing, I'm sure, primarily --

MR. GESSNER: Yes, primarily.

THE COURT: -- going in line with your directed verdict motions.

Let me see what else I want you to address. Bear with me, folks. I had some questions beforehand, but they've been answered through the trial. Obviously, your -- at least in the notice, that you, in the alternative, behaved reasonably, under the circumstances.

There's no doubting damages. Those are clear. So I think you just have to focus on the real legal issue of the case because, depending upon the result of that legal issue -- now, granted, we talked about getting the additional medical bill from the surgery that just happened two to three weeks ago, which, I think, we can coordinate amongst ourselves to try to work that out.

But there are some damages that I think even the defendant would agree that if there were liability or if a court ruled so, there certainly are some reasonable damages. And as far as the future, I'll let y'all address that in your order and --

MR. GOINGS: So my suggestion, and just to

reflect on what we did talk about at sidebar, is that we've agreed to hold the record open for purposes of getting the -- her new bills that are coming in from the surgery she just had.

THE COURT: Yep.

MR. GOINGS: And since Your Honor gave us 30 days to get -- submit proposed orders, I assume within 30 days -- I'm going to follow up with the providers to get those bills. When we submit our proposed orders, before I submit the proposed order, I'll give you the bill, as soon as I get it.

THE COURT: Okay.

MR. GOINGS: But when we submit our orders, we will also -- when the plaintiff submits its order, I'll actually send those bills to Your Honor as well.

THE COURT: And, obviously, if you need more time, just tell me.

MR. GESSNER: I was going to say, I practiced as a healthcare attorney for about four years. I can tell you that those bills should definitely be available within 30 days, but I've seen them go way, way, way longer.

THE COURT: Yes.

MR. GOINGS: I'll do what I can to get them.

MR. GESSNER: Yeah. And then we'll just address it, if you can't.

Respectfully, Your Honor, I did have one more question. Because I had moved to limit Lindsay Moore's testimony -- she was the life care planner -- because -- and I've done some research. Unfortunately, there's nothing in South Carolina that would really --

THE COURT: Well, I --

MR. GESSNER: -- draw a clear path.

The issue is, generally, a life care planner can testify what the costs of things are, as we had said. If their underlying expertise is sufficient to make judgment calls and to render opinions, they can testify as to that. But, otherwise, a life care planner has to rely on qualified professionals.

So if you had Dr. Loging say she needs to be inpatient for this procedure in the future, then there's no questioning it. And she can say, okay, well, this is what it would cost. But he didn't testify as to that.

So for her to say she would need care over and above specifically what has already been identified, because she's a physician's assistant and is not qualified to make that judgment call, she can't

testify as to that. And I can write up a brief to that.

THE COURT: Well, I just think you --

MR. GESSNER: I can put that in a proposed order.

THE COURT: I mean, that -- I mentioned a lot of this goes to weight, not admissibility. I mean, she's not a doctor and she's not saying she's a doctor. But she did, you know --

MR. GESSNER: Right.

THE COURT: She has the -- was able to provide a future cost basis.

MR. GESSNER: My understanding, Your Honor, is that it does go to the admissibility though, because she's not a physician.

THE COURT: Okay. I'll let you --

MR. GESSNER: So I'll brief that as best I can. Like I said, there's not a lot in South Carolina.

THE COURT: Obviously, I'm -- if you guys need more time, you just tell me.

MR. GESSNER: Thank you, Your Honor.

THE COURT: I'm not here to beat up on anyone if you can't get it done within 30 days. But I do -- I'd rather it be done right than be done in 30 days.

MR. GOINGS: Yes, Your Honor. Thank you.

THE COURT: Anything else for the record today?

MR. GOINGS: No, Your Honor.

THE COURT: Thank you-all for being here today. Both counsel did a good job presenting their cases. Thank you for that.

I would say this to the parties: Although we're essentially done here, it's going to be some time before I come up with a decision. Once I get the orders, I'm going to have to spend a lot of time reviewing the law. And the only thing I would tell you is that you still have control of the outcome of this case. Okay?

You can still work together until the order is filed. Once the order is filed, it's truly out of your hands and you can take it up the appropriate chain after that. But you have the opportunity still to talk to each other, and I would encourage both sides to do that.

MR. GOINGS: Yes, Your Honor.

-- END OF TRANSCRIPT OF RECORD --

C E R T I F I C A T E

STATE OF SOUTH CAROLINA

COUNTY OF LEXINGTON

I, the undersigned, Bethanie K. Creppon, Circuit Court Reporter for the Eleventh Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete transcript of record of all the proceedings had and the evidence introduced in the trial of the captioned cause, relative to appeal in the Circuit Court for Lexington County, South Carolina, on the 2nd of March, 2020.

I do further certify that I am neither of kin, counsel, nor interest to any party hereto.

October 5, 2020

s/Bethanie K. Creppon

Bethanie K. Creppon
Circuit Court Reporter

McLeod, IV, Walton

From: Jessica Gooding <jgooding@goingslawfirm.com>
Sent: Tuesday, April 7, 2020 1:12 PM
To: Evan Gessner; Robert F. Goings; McLeod, IV, Walton; McLeod, Walton Law Clerk (Robert Pillinger)
Cc: Leslie Price; Leslie Clamp
Subject: RE: Proposed Orders - Connell v. LCHSD (2018-CP-32-1750)

*** **EXTERNAL EMAIL:** This email originated from outside the organization. Please exercise caution before clicking any links or opening attachments. ***

Judge McLoed,

I hope you, your staff, and your families are all doing well. As the parties submitted proposed orders in lieu of presenting closing arguments, we wish to briefly respond to Mr. Gessner's points in the email below.

First, with regard to the 30(b)(6) testimony, Dale Thompson testified that he believed the "striping" or curb painting in the parking garage was required by code, but he was not aware of which specific code applied. This testimony begins on page 14, line 6:

> Q: Are you aware of any codes or standards that would apply to parking lot painting, marking or striping?
> A: I don't know specific codes that would apply to it, but **I'm certain there are.**
> Q: Okay. And I said parking lot. . . . I meant a parking garage. Are you aware of any codes that do apply?
> A: Yes, we have handicap striping codes with, you know, different markings for handicap. And there are different, you know, fire codes that we had to reach that goes with that. But as far as the striping on curbing, I am not aware. I'm not an expert. I'm sorry.

Continuing on page 16, line 9:

> Q: Okay. Why does this parking garage even have yellow paint in it?
> A: **My guess is it's going to be a code requirement.**
> Q: **So you think it's painted yellow just because it's a code requirement?**
> A: **I do.**
> Q: Do you know what code that you're ---
> A: I do not. I'm sorry.
> Q: So you're speculating when you say it's a code requirement?
> A: Yes. Yes

Clearly, at the time of his deposition, Mr. Thompson believed that the striping or yellow paint was required by code, but he could not identify a specific code. His trial testimony was consistent with this, and both 30(b)(6) witnesses agreed that painting the top and side of the curb was prevalent throughout the garage. The photographic evidence demonstrated the practice as well. Thus, Plaintiff's proposed order does not mischaracterize Mr. Thompson's testimony in any way. His belief that code required curbs to be painted yellow is evidence of an industry standard, even if there is no such code.

Second, with regard to the anesthesia required for Mrs. Connell's surgeries, the testimony established that the hardware removal surgery was very quick and fairly simple. The anticipated knee replacement, on the other hand, will be a longer more complicated surgery. I believe Mrs. Connell testified that she wore a mask for the administration of anesthesia for the hardware removal, as opposed to it being administered intravenously. Ms. Moore's opinion was that for the longer, more complicated surgery, which will also be occurring when Mrs. Connell is a few years older than she is now, Mrs.

Connell would most probably have the surgery in a hospital. She based her opinion on Mrs. Connell's medical condition, the length and complexity of the surgery, and the type of anesthesia that would be required. She testified that she researched this issue, and full knee replacement surgeries are still most commonly done as inpatient surgeries. Notably, LMC received Ms. Moore's updated report and deposed her to obtain her opinions approximately three months prior to this trial going forward. LMC was well aware that Ms. Moore would testify that Mrs. Connell would most probably require an inpatient surgery, but it produced no expert to give a different opinion. This is especially noteworthy because LMC is a hospital, who presumably employs many physicians who would be qualified to give such an opinion. Nonetheless, Ms. Moore's testimony remains uncontradicted.

Ultimately, the value of Mrs. Connell's future medical costs is unimportant because the value of the noneconomic damages in this case exceed the $300,000 statutory cap that applies. Mrs. Connell suffered what is undeniably an exceedingly painful injury. Her kneecap came down so hard on the concrete floor of the parking garage that the bone shattered. Because of that, she has already undergone two surgeries, and she will require another surgery still. Each surgery comes with additional risks, pain, and rehabilitation. She has been required to exercise her knee almost daily, and sometimes multiple times per day, for over two years in an attempt to regain functionality, mobility, and the ability to live her life as she did one day prior to this fall. Both the exercises and her activities of daily living cause her pain. This injury cost her precious time with her family, made it impossible for her to host holiday gatherings and carry on family traditions, and prevented her from being able to care for her special needs grandson. She has also been unable to garden, which has always been one of her favorite pastimes, and something she enjoyed even more in retirement. Although she is still working hard to improve her mobility, Mrs. Connell's knee is permanently impaired because of this injury, and thus, her life has been permanently altered. These facts alone justify an award of over $300,000, regardless of her economic damages.

Thank you for indulging our extra commentary on this case. We promise you will not hear from us again on the merits of this case unless the Court requests it.

Best regards,

Jess

Jessica L. Gooding
Attorney
Goings Law Firm, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
(803) 350-9230 (ph)
(877) 789-6340 (fax)
jgooding@goingslawfirm.com

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Real Lawyers – Real Results
CATASTROPHIC INJURY | WRONGFUL DEATH | WORKERS' COMPENSATION

From: Evan Gessner <evan@oldcourthouse.com>
Sent: Monday, April 6, 2020 2:06 PM
To: Jessica Gooding <jgooding@goingslawfirm.com>; Robert F. Goings <rgoings@goingslawfirm.com>; wjmcleodj@sccourts.org; wjmcleodlc@sccourts.org
Cc: Leslie Price <lprice@oldcourthouse.com>; Leslie Clamp <lclamp@goingslawfirm.com>
Subject: RE: Proposed Orders - Connell v. LCHSD (2018-CP-32-1750)

Judge McLeod:

Having reviewed the additional medical records and bills, and Plaintiff's Proposed Order, I must bring several things to your attention.

First, the additional medical records indicate that Plaintiff had outpatient surgery wherein she was placed under general anesthesia for the removal of the metal hardware in her left knee. This evidence refutes Ms. Moore's testimony about Plaintiff requiring inpatient surgery for the anticipated full knee replacement. Ms. Moore testified that due to Plaintiff's condition, she will require inpatient surgery for anything that would require general anesthesia. The additional records reflect that Dr. Loging performed the hardware removal in the outpatient setting while Plaintiff was under general anesthesia.

Second, Ms. Moore's estimation for the cost of the hardware removal was off by 28.42%. Ms. Moore had estimated the hardware removal would cost $8,920.07. The actual cost was $6,946.00. I respectfully request your honor take this into consideration if you find for Plaintiff and award her damages for future medical expenses.

Finally, Plaintiff's Proposed Order contains misstatements about Defendant's 30(b)(6) testimony. Plaintiff states that Dale Thompson "testified that he believed the paint markings or 'striping' on the curbing was required by code." Plaintiff also states that "Visible yellow painting on the top and side of curbs is prevalent throughout the remainder of the garage, and Dale Thompson testified that he believed this striping was required by code." Mr. Thompson actually testified that he was aware of "handicap striping codes" and "fire codes", but "as far as the striping on curbing, I am not aware." (*See* Deposition of Dale Thompson, a copy of which was previously submitted to the Court, at 14:6-21.) There is no evidence in the record regarding any code or regulation requiring paint on any curb nor is there any evidence of any industry standard.

Thank you for your time and consideration in this matter. My apologies for adding more argument to this case, but my thinking was that it would be better to bring this up now as opposed to a potential motion to reconsider.

Evan M. Gessner
Attorney
Davis Frawley, LLC
140 East Main Street (29072)
PO Box 489
Lexington, South Carolina 29071-0489
Direct - 803-951-7425
Fax - 803-359-7478

From: Jessica Gooding [mailto:jgooding@goingslawfirm.com]
Sent: Friday, April 03, 2020 5:46 PM
To: Evan Gessner; Robert F. Goings; wjmcleodj@sccourts.org; wjmcleodlc@sccourts.org
Cc: Leslie Price; Leslie Clamp
Subject: RE: Proposed Orders - Connell v. LCHSD (2018-CP-32-1750)

All,

Attached is Plaintiff's Proposed Order for this case. The Order includes the updated total for past medical bills, $55,839.38, and I've also attached the updated bills and records. We will file these updated documents with the court on Monday so that they may be part of the record. Please let us know if you need anything further.

Hope everyone is healthy and enjoys the weekend!

Jess

Jessica L. Gooding
Attorney
Goings Law Firm, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
(803) 350-9230 (ph)
(877) 789-6340 (fax)
jgooding@goingslawfirm.com

From: Evan Gessner <evan@oldcourthouse.com>
Sent: Thursday, April 2, 2020 4:37 PM
To: Robert F. Goings <rgoings@goingslawfirm.com>; Jessica Gooding <jgooding@goingslawfirm.com>; wjmcleodj@sccourts.org; wjmcleodlc@sccourts.org
Cc: Leslie Price <lprice@oldcourthouse.com>; Leslie Clamp <lclamp@goingslawfirm.com>
Subject: RE: Proposed Orders - Connell v. LCHSD (2018-CP-32-1750)

Thank you.

Hope all is well with everyone.

From: Robert F. Goings [mailto:rgoings@goingslawfirm.com]
Sent: Thursday, April 02, 2020 4:26 PM
To: Evan Gessner; Jessica Gooding; wjmcleodj@sccourts.org; wjmcleodlc@sccourts.org
Cc: Leslie Price; Leslie Clamp
Subject: Re: Proposed Orders - Connell v. LCHSD (2018-CP-32-1750)

Evan-
I'm sorry, we had this calendared to be due tomorrow. You didn't communicate that you were sending over your proposed orders yesterday. I haven't read your proposed orders, so don't worry there will not be any

perceived advantage. I believe the bills from the recent surgery will be available tomorrow. I've called and emailed the surgery center several times for it and I hope it will be faxed over tomorrow. I'll let you know the status on getting those bills.

I hope you and your family are safe and well.

Regards,

Robert

Robert F. Goings
Goings Law Firm, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
(803) 350-9230 (ph)
(877) 789-6340 (fax)
rgoings@goingslawfirm.com

CATASTROPHIC INJURY | WRONGFUL DEATH | WORKERS' COMPENSATION

Confidentiality Note: The preceding message may be confidential or protected by the attorney-client privilege. It is not intended for transmission to, or receipt by, any unauthorized persons. If you have received this message in error, please (i) do not read it, (ii) reply to the sender that you received the message in error, and (iii) erase or destroy the message. Legal advice contained in the preceding message is solely for the benefit of the Goings Law Firm, LLC client(s) represented by the firm in the particular matter that is the subject of this message, and may not be relied upon by any other party.

From: Evan Gessner <evan@oldcourthouse.com>
Date: Thursday, April 2, 2020 at 3:53 PM
To: Jessica Gooding <jgooding@goingslawfirm.com>, "wjmcleodj@sccourts.org" <wjmcleodj@sccourts.org>, "wjmcleodlc@sccourts.org" <wjmcleodlc@sccourts.org>
Cc: "Robert F. Goings" <rgoings@goingslawfirm.com>, Leslie Price <lprice@oldcourthouse.com>, "lclamp@goingslawfirm.com" <lclamp@goingslawfirm.com>
Subject: RE: Proposed Orders - Connell v. LCHSD (2018-CP-32-1750)

Respectfully, I believe proposed orders were due yesterday. I further believe that proper protocol is to send proposed orders at roughly the same time so neither side has the opportunity to amend their proposed order and gain an

advantage. While this is not an issue in many cases, when the proposed orders are being sent in lieu of closing arguments, it is important insofar as it relates to the preservation of issues on appeal.

Please send your proposed order as soon as is reasonably possible. I believe we are all operating under the assumption that once the bill is available, the information can be plugged into whichever order Judge McLeod ultimately issues.

Thank you,
-Evan

From: Jessica Gooding [mailto:jgooding@goingslawfirm.com]
Sent: Thursday, April 02, 2020 3:44 PM
To: Evan Gessner; wjmcleodj@sccourts.org; wjmcleodlc@sccourts.org
Cc: Robert F. Goings; Leslie Price; Leslie Clamp
Subject: RE: Proposed Orders - Connell v. LCHSD (2018-CP-32-1750)

Good afternoon,

I hope you are all well. We are working on getting the surgery center bill tracked down. As soon as we have that, we will submit our proposed order with an amended Exhibit 7 (Past Medical Expense Summary) and copies of the new bills. We are happy to accommodate any phone conference or provide any additional information at the Court's request.

Best regards,

Jess

Jessica L. Gooding
Attorney
Goings Law Firm, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
(803) 350-9230 (ph)
(877) 789-6340 (fax)
jgooding@goingslawfirm.com

From: Evan Gessner <evan@oldcourthouse.com>
Sent: Wednesday, April 1, 2020 4:43 PM
To: wjmcleodj@sccourts.org; wjmcleodlc@sccourts.org
Cc: Robert F. Goings <rgoings@goingslawfirm.com>; Jessica Gooding <jgooding@goingslawfirm.com>; Leslie Price

<lprice@oldcourthouse.com>
Subject: Proposed Orders - Connell v. LCHSD (2018-CP-32-1750)

Judge McLeod:

Attached, please find draft proposed orders relating to the above referenced bench trial that was held on March 2, 2020. The first proposed order relates to Defendant's Motion for Directed Verdict. The second relates to Defendant's Motion to Limit the testimony of Plaintiff's expert witness Lindsay Moore.

After the trial, the parties discussed Plaintiff submitting bills to show the cost of a recent surgery. I have not yet received any such information and as a result, I was not able to address those figures. I may request a quick phone conference once that bill is available.

Thank you for your time and consideration in this matter. I am currently working from home but can be reached by email or cell phone (803-727-4489).

Regards,

Evan M. Gessner
Attorney
Davis Frawley, LLC
140 East Main Street (29072)
PO Box 489
Lexington, South Carolina 29071-0489
Direct - 803-951-7425
Fax - 803-359-7478

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	C.A. NO. 2018-CP-32-1750
_____		
DIANE CONNELL,	)	
	)	VIDEOTAPE DEPOSITION
PLAINTIFF,	)	
	)	OF
VS.	)	
	)	30(b)(6) DEPOSITION OF
	)	CORY ANDREWS
LEXINGTON COUNTY HEALTH	)	
DISTRICT, INC. D/B/A	)	
LEXINGTON MEDICAL CENTER,	)	
	)	
DEFENDANT.	)	

THE 30(b)(6) DEPOSITION OF CORY ANDREWS, TAKEN BEFORE HOLLY W. WILSON, PROFESSIONAL VERBATIM REPORTER AND NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF 12:53 P.M., WEDNESDAY, THE 23RD DAY OF OCTOBER, 2019, AT GOINGS LAW FIRM, LLC, 1510 CALHOUN STREET, COLUMBIA, SOUTH CAROLINA.

APPEARANCES

FOR THE PLAINTIFF
ROBERT F. GOINGS, ESQUIRE
GOINGS LAW FIRM, LLC
1510 CALHOUN STREET (29201)
POST OFFICE BOX 436
COLUMBIA, SOUTH CAROLINA 29202
rgoings@goingslawfirm.com

FOR THE DEFENDANT
EVAN M. GESSNER, ESQUIRE
DAVIS FRAWLEY, LLC
POST OFFICE BOX 489
LEXINGTON, SOUTH CAROLINA 29071-0489
evan@oldcourthouse.com

ALSO PRESENT
DALE THOMPSON
SEAN STROEHLE, VIDEOGRAPHER

REPORTED BY
HOLLY W. WILSON
BISHOP REPORTING SERVICES, LLC
POST OFFICE BOX 1207
GREENVILLE, SOUTH CAROLINA 29602
864-640-1634
Jill@BishopReporting.com

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*DIGITALLY RECORDED AUDIO RETAINED FOR TWELVE (12) MONTHS FROM DATE OF CERTIFICATION.

STIPULATIONS

IT IS STIPULATED BY AND BETWEEN COUNSEL FOR THE RESPECTIVE PARTIES THAT ALL OBJECTIONS ARE RESERVED UNTIL THE TIME OF TRIAL, EXCEPT AS TO THE FORM OF THE QUESTION.

THIS 30(b)(6) DEPOSITION IS BEING TAKEN PURSUANT TO THE SOUTH CAROLINA RULES OF CIVIL PROCEDURE.

- - - -

THE READING AND SIGNING OF THIS 30(b)(6) DEPOSITION IS RESERVED BY THE DEPONENT AND COUNSEL FOR THE RESPECTIVE PARTIES.

VIDEOGRAPHER: We're going on the record. The time on the monitor is 12:51. This is the 30(b)(6) video deposition of Defendant, Lexington County Health Services District, Inc., in the matter of Diane Connell vs. Lexington County Health Services District, Inc. d/b/a Lexington Medical Center under the jurisdiction of South Carolina, County of Lexington in the Court of Common Pleas, 11th Judicial Circuit, Case Number 2018-CP-32-1750. This deposition is being held at 1510 Calhoun Street, Columbia, South Carolina on October 23, 2019. Will counsel please state their appearances for the record, and the court reporter will swear in the witness.

MR. GOINGS: My name is Robert Goings for the plaintiff.

MR. GESSNER: Evan Gessner for defendant.

WHEREUPON, CORY ANDREWS BEING DULY SWORN AND CAUTIONED TO SPEAK THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH, TESTIFIED AND DEPOSED AS FOLLOWS:

EXAMINATION

BY MR. GOINGS:

Q Can you state your full name for the record, sir.

A Sure. Cory Garrett Andrews.

Q Mr. Andrews, my name is Robert Goings, and I represent Ms. Diane Connell in a civil action brought against Lexington County Health Services District, Incorporated. And we're here today for a 30(b)(6) deposition. You've been designated as one of the witnesses that will testify on behalf of Lexington.

Have you ever given a deposition before?

A No, sir.

Q This is your first time?

A Yes, sir.

Q Well, I'm sorry that you have to do the honors with me, but I don't think we'll be too long today.

A All right.

Q I know your attorney has given you some instructions

about what we're going to be doing here today, and he's talked to you before the deposition. But there are a couple of things I need to tell you. If you have any questions about my questions, you don't understand my question, you need me to rephrase or clarify, please direct any of those requests to me. Okay?

A Okay.

Q If you answer my question, I'm going to assume you understood my question. Fair enough?

A Okay. Sure.

Q And if you don't understand my question, like I said, just ask me. I'm happy to rephrase. All right?

A All right.

Q You're doing a real good job so far. We have a court reporter and a videographer. But for the court reporter's sake, let me finish my question before you answer. I'm going to let you finish your answer before moving on to the next question. Okay?

A All right.

Q It's hard to take down what we're saying at the same time.

A Right.

Q So, I want to just try to help us both and the court reporter on that.

A Okay.

Q If you just -- if you nod your head or say uh-huh or uh-uh, I may say, “Is that a yes? Is that a no?” Because we need audible responses for purposes of the record. Okay?
A All right. Sounds good.
Q All right. Just a couple of background questions about you. Where do you live?
A Columbia, South Carolina.
Q All right. And what’s your address?
A 310 Beckerton Road, Columbia, South Carolina 29212.
Q So you live in Richland County?
A Lexington.
Q You live in Lexington.
A I do, yes, sir.
Q But it’s a Columbia address.
A It’s kind of right there on the line.
Q Gotcha. All right. And who is your employer?
A Lexington Medical Center.
Q How long have you worked for Lexington Medical Center?
A I have been with them almost four years.
Q And what is your role and job description?
A Director of Risk Management.
Q What does that mean?
A So, I am over the risk department. All of our occurrence reporting, litigation type activities -- not

all of them, but the malpractice from the medical side -- general liability, that type thing. All of that flows through our office. We have, kind of, the patient safety arena, if you will, as well.

But primarily, we're looking at occurrences, and going through things and seeing how we can improve the care of patients; and then, of course, also the environment, if you will.

Q Is your office within the legal department office or outside the legal department office?

A Outside.

Q Okay.

MR. GOINGS: I'm going to mark as Exhibit 1, which would be the response to this deposition notice. And it lists topics that you are going to be designated to testify about. And those are topics A through W. I don't have another copy but, hopefully, you have one there.

MR. GESSNER: Okay. Thank you.

(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 1, NOTICE OF DEPOSITION, ATTACHED.)

BY MR. GOINGS:

Q Is this -- does this document adequately set forth the topics in which you are designated to speak about here today on behalf of Lexington Medical Center?

A Yes, sir, it does.
Q And are you the person most knowledgeable, as to these topics, to testify on behalf of Lexington Medical Center?
A Yes, sir.
Q All right. Hand me that back, and I'll -- so I can reference it in some of my questions. Did you have first-hand knowledge of this incident?
A First-hand, meaning what? I'm sorry.
Q Did you actually witness this incident?
A No, sir.
Q Okay. Were you working at Lexington Medical Center on the day of this incident?
A Yes, sir.
Q All right. Do you remember when you first learned about this?
A I don't remember the specific day, but I can kind of outline how that unfolded.
Q Yeah, do that for me.
A So, the fall happened, of course, and this lady ended up going to our emergency room. And the ED physician that treated her placed an occurrence report and, of course, all of those come to my department. And so that's how we actually learned that this occurred.
Q Okay. And what did you learn about what happened?

A So, we learned that there was a fall. The ED physician put that in for us. And at that point, we go back and pull film to see what we can find. And, so, we were able to find where she did fall and view that material.
Q Okay. Did you review the video on the date of this incident?
A Either the day of, or probably a day or two after.
Q Okay.
A I don't remember the exact day.
Q Were you the one that went and got the video?
A Yes, I believe I was.
Q Okay. And it's been produced in this case; correct?
A That's -- yes, sir.
Q And were you the one that actually secured the video? Is that fair to say?
A It would have been my department. At that time, I'm pretty sure it would have been me.
Q All right. You or somebody in your department?
A Yes, sir.
Q Have you seen the video?
A Yes, sir.
Q Where did this fall occur?
A So, it happened in the Lexington Parking Garage Number 2, which is now Number 3. But back then, it was Number 2. And it happened on the first floor in that parking

garage.
Q Can you explain where the parking garage in question is located, in respect to the hospital, and maybe what road it's on?
A So, let's say you are on 378 and you're pulling, kind of, in the main entrance to go into the hospital. The main facility will be on your left-hand side. But if you keep going all the way down that road, which is Hospital Drive -- I'm not sure if it's West Hospital Drive or not, but it's Hospital Drive. And as you go all the way down that road, that garage will be right there on the right-hand side.
Q All right. If you're standing out in front of this garage looking forward, looking straight ahead, what does that look towards?
A If you're looking at the parking garage or the ---
Q Looking away from the parking -- you're standing in front of the parking garage, looking straight ahead, away from the parking garage. What -- where are you looking at?
A So, you would be looking over the campus. The main buildings will be off to your right-hand side. There is now a Medical Park 3 to your left-hand side. I don't believe it was there when this fall occurred.
Q Okay. So, is this a -- is this parking garage the

parking garage that is used often for patients or guests that are coming into the main hospital, or to an office complex?

A So, it's kind of both. There is an office complex right there beside it. Employees can park there also, but it's not uncommon for the hospital guests to park in there for the main facility.

Q Okay. The office complex -- the medical office complex that's beside this parking garage, which is -- was parking garage 2, now it's parking garage 3; correct?

A That's right. Yes, sir.

Q What is the name of that building?

A That is Medical Park 2.

Q Okay. At least y'all are creative in your name.

A There you go.

Q I think Mr. Thompson had something to do with that, maybe.

A I think so.

Q Yeah, I think it's his fault.

When was this garage built, to your knowledge?

A I do not know the date that it was built. I'm not ---

Q Were you working there when it was built?

A No, sir.

Q Okay. What documents did you review in preparation for today's deposition?

A So, I've reviewed the internal documents that we've had, all the communication that you guys have had back and forth, as far as the answers to production and interrogatories and all of that.
Q Yes, sir.
A Of course, I've reviewed all of those. I did review the public safety incident report, and I believe that is all.
Q Okay. There were some additional documents that I think haven't been produced yet in discovery, but will be, I understand, produced. We talked about that as soon as -- right before we went on; correct?
A Yes, sir.
Q What are those documents?
A Those involve the contractor that we used to build the garage, from what I understand.
Q And that would be the contractor document contract. Is that right? What would that document be described as?
A I'm not entirely sure what it would be categorized as. I believe maybe when you talk with Dale, a lot of that kind of falls up under his arena.
Q Okay.
A So, perhaps, hopefully, he can better answer that for you.
Q Okay. But you were not able to print those out today

because of a security feature on your computer; correct?
A That's right. Once I arrived here.
Q Once you arrived here.
A Yes, sir.
Q That's right. Okay. And after today's deposition, you're going to get with your attorney and y'all are going to get that produced; correct?
A Yes, sir.
Q Other than that contract with the general contractor, I understand, is -- any other documents that you looked at?
A Not that I can recall looking at. There are things in the discovery phase that counsel asked us to provide and, of course, we got those from the engineering department, and then I gave those over to our counsel. But I did not spend time going entirely through all of those.
MR. GOINGS: Do we have those documents yet?
MR. GESSNER: Yeah.
MR. GOINGS: Which ones are those?
MR. GESSNER: That's -- Jessica had asked for maintenance records, I believe. And I think that's what that was.
MR. GOINGS: I didn't see that. Is that something

you can send that we can just print off while we're here, if you don't mind. Or if you have a copy there, then I'll just photocopy it.

MR. GESSNER: Yeah, we're -- my firm is a little -- the one I'm thinking of, in particular -- that was one of them. I know y'all have got that.

MR. GOINGS: Anything -- yeah, I've seen this. Anything other than this document?

MR. GESSNER: No.

MR. GOINGS: Okay.

MR. GESSNER: Because they didn't have -- they really don't have anything pertaining to the construction. So that's where ---

MR. GOINGS: All right.

MR. GESSNER: Somewhere, at least at some point, there would have been a whole bunch of documents pertaining to that, but Lexington Medical Center did not have copies of it.

BY MR. GOINGS:

Q All right. What do you know about the history of falls in the parking garage at Lexington Medical Center?

A So, prior to that, I am not aware of any that happened. But we have had two additional falls that have happened after this one.

Q All right. So, prior to Diane Connell, you're not

aware of any.
A I'm not aware of any. That's right.
Q Okay. That doesn't mean they didn't happen. You're just not aware of them; correct?
A Yes, sir, that's correct.
Q Okay. And -- because you would agree with me that patients, guests, visitors can fall, perhaps not have any injuries from a fall, then that just is not reported; correct?
A Absolutely. Yes, sir.
Q Okay. So, you can't rule out any prior falls, but you're just not aware of any; correct?
A Yes, sir.
Q Did I state your testimony correctly?
A Yes, sir.
Q Okay. You said that in the time being, there had been two additional falls?
A Yes, sir.
Q All right. When was the first fall?
A So, I don't have the specific dates. They did both occur after the first fall. But as far as the specific dates, I don't know those right offhand.
Q All right. Tell me what occurred in the first fall after Diane Connell fell.
A All right. So, the first one, I believe -- there were

two, and I believe I have the order correct. The other one happened also on the first level in the same parking garage. It happened on the opposite side of the driveway, if you will, across from where Ms. Connell fell.

The other one happened -- I believe it was on level C, but it was not on that first level where the others happened. And in that particular one, a lady had just opened the door and come out, and she stepped wrong off the curb also and fell.

Q Okay. Are both of these on -- caught on video?

A Yes, sir.

Q Okay. And do you have possession of that video?

A Yes, sir, I do.

Q You've given that to your attorney?

A He has viewed it.

Q Okay.

A I don't know if he, in fact, has it. I do not think he does.

Q All right. Are you going to give him a copy of that as well after the deposition?

A I certainly can.

Q Gotcha.

MR. GOINGS: Is that all right?

MR. GESSNER: Yeah.

MR. GOINGS: All right. Good.

BY MR. GOINGS:

Q So, one of those falls happened on the first floor, the same level that Ms. Connell fell. And another fall happened -- the other fall happened on the second floor?

A Floor 3, I believe.

Q Floor 3. Was there an issue in both of those falls with the curb not being painted?

A There was paint on both of the curbs. I can't state a hundred percent if there was paint on top of the curb.

Q Okay. Do either one of these falls, have they resulted in a claim being filed?

A No, sir.

Q Okay. No claims -- any injuries?

A Not that I'm aware of.

Q Okay. You were just -- so, just a fall was reported.

A That's right.

Q Okay. And we're talking about within the last year. Both of these falls occurred in the last year?

A It would have been within the last two years, because I believe Ms. Connell fell September of 2017. So, it would have been within the last two years.

Q Okay. Do you know the date of Ms. Connell's fall?

A I believe it was September 26, 2017.

Q Give me that date again.
A September 26, 2017.
Q Okay. Did you actually speak with Ms. Connell, at any point in time, prior to the -- or after the fall?
A I did not, no, sir.
Q Did you ever speak to her husband?
A I did not, no, sir.
Q Did anybody on behalf of Lexington Medical Center ever talk to her or her husband about what happened?
A I certainly believe so. At that time, I was in a different role. But we have a patient safety advocate. He's no longer with us, but we did file a claim on Ms. Connell. And a standard part of that, usually, is him reaching out and talking with the person.
Q Do you have any knowledge, whatsoever, as to what Mr. or Ms. Connell told this patient safety advocate?
A No, sir, I do not.
Q It's not written down anywhere, to your knowledge?
A No, sir, not that I saw.
Q Okay. And you've seen the video, haven't you?
A Yes, sir.
Q Okay. Do you agree with me that it appeared on the video to be a pretty violent fall?
A It was a hard fall.
Q Okay. Are you aware that she was injured as a result

of the fall?
A Yes, I was.
Q What do you know about the nature and extent of her injuries?
A I know that after the fall, she was taken to the emergency room. She did have to have a procedure on her knee and she's had follow-up care since that time. And that is pretty much all that I know to the extent of that.
Q Have you, or anyone on behalf of Lexington Medical Center, obtained any statements from any witnesses from this fall?
A No, sir.
Q Are you aware of any witnesses from the fall?
A Not that actually witnessed the fall occur. We had a public safety officer respond, and I believe there were some employees that responded as well.
Q Okay. But I take it that the best witness of the fall was the video camera itself; right?
A As far as the actual fall? Yes, sir.
Q Yeah. Okay. Are there any policy, procedures, instructions, documentation of any nature at Lexington Medical Center related to parking lot or parking garage safety?
A Can you ask that again for me?

Q Yeah. Are there any policies, procedures, protocols, instructions of any nature at Lexington Medical Center that relate to concern or speak of safety in a parking lot or a parking garage?
A Not that I recall, no, sir.
Q Okay. Do you know who constructed this parking garage?
A I do not.
Q Okay. That would be a question best presented to Mr. Thompson. Is that correct?
A Yes, sir.
Q Okay. Are you aware of any lawsuits, other than this one against Lexington Medical Center, that relate to any curbing, parking stops or raised surfaces in or around the parking lot or outside walking surface?
A Yes, sir, we have one other.
Q Okay. What does that relate to?
A We have an entrance, which is now our main entrance -- back at the time of her fall, that would have been termed the North Tower entrance. But there's a sidewalk there, and you have joints where the pieces of the sidewalk meet. Pardon me for not knowing the specific term. But there was a lady who was on a rollator walker, and she was sitting on it and a person was pushing her. And when it reached the place where the two pieces joined, if you will, it tipped over.

Q Okay. And what's the name of the lady that got injured in that situation?
A I can't recall her name, but Evan is our counsel for that as well.
Q For that one as well.
A So, we can certainly get the name.
Q Is that pending in court, that case?
A It's still in litigation.
Q Okay. Do you know who the lawyer is on that case for the person that brought the case?
A I can't recall, but we can certainly get that.
Q So, other than that incident, are you aware of any other lawsuits against Lexington Medical Center related to any falls outside?
A No, sir.
Q One of the questions that we have here, numb- -- you're designated to answer, the question relates to the topic is names of any potential parties that may be liable in whole or part for the injuries to Ms. Connell for falling in the parking garage. You're designated as one of -- as that person. What is the answer to that, the names of any other potential parties?
A So, we've recently gotten documents regarding the contractor that built that. We've given that to counsel, and they're fleshing out that kind of as we

speak.
Q All right. So that -- the name of that person would be listed on this document that you're going to send to me?
A Yes, sir.
Q Okay. Have you been out to where Ms. Connell fell?
A Back at that time, yes.
Q Have there been any changes or modifications to the location in which she fell?
A Not that I'm aware of.
MR. GOINGS: I want to mark what is Exhibit 2, which has been produced in discover by the parties in this case.
(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 2, PHOTOGRAPH, ATTACHED.)
BY MR. GOINGS:
Q Do you know who took this picture?
A I do not know for sure who took it.
Q Okay. Who would you -- if you had to narrow it down to several people who potentially took it, who would it be?
A If I'm going off of that, it would probably be either Earl Boyett, who is our patient safety advocate. When we submitted this as a claim, our insurance was involved, and they may have gone out there and taken it

as well.
Q Okay. You've seen this picture before, haven't you?
A Yes, sir.
Q Okay. It was -- to the best of your knowledge, it was taken by somebody from Lexington Medical Center, but you just don't know who; correct?
A Yes, sir.
Q And it was taken as a part of the claim process?
A Yes, sir.
Q Okay. Does this photograph accurately depict the condition of the area in which Ms. Connell fell?
A Yes, sir, this is the area where she fell.
Q Okay. Do you know what part of this picture she fell at?
A Not specifically. But if I had to guess, based on what I've seen from the film and then seeing it reversed like this (indicating), I would think it would be somewhere right in here (indicating). Between here (indicating).
Q And since we have a video camera here, hold the picture up and just kind of point to the area in which Ms. Connell would have fallen.
A I believe it would have been between these areas here (indicating).
Q Okay. So, towards the middle of the page.

A I believe so. Yes, sir.
Q Okay. Now who was responsible for doing the painting and the curb markings for this parking garage?
A I can't answer specifically who would be responsible, but that would fall to the engineering and facilities department.
Q Okay. So that wouldn't be a question that you would be able to fully answer; correct?
A Yes, sir.
Q Okay. Do you know how long this garage has been in the condition as depicted in Exhibit 1?
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: I do not know. I started at LMC about four years ago, and I actually parked in this garage. And, so, I would say, for the most part, the conditions that I see here are about the same as they have been since I've been there.
BY MR. GOINGS:
Q Okay. Has -- is -- has there been any painting to the first level of the parking garage since the date of her fall to present?
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: Not that I'm aware of. But ---

BY MR. GOINGS:
Q Okay. In the photos that have been produced in discovery, it appears that most of the curbs have yellow fluorescent paint -- and I can show you these if you want to look at them -- on the top and the side of the respective curb. And I'll just show you this one as an example.
A Okay.
Q This is Plaintiff's -- Bates labeled Plaintiff 3 and Plaintiff 4. You can flip, both sides show curbing that has -- have painting on the top and the side of the curb.
A Yes, sir.
Q So, essentially, the nose of the curb is fully painted. Do you see that?
A Yes, sir.
Q Okay. And the condition that I'm showing you in this document, that has painting on the top and the side of the curb, is that prevalent throughout the parking garage?
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: I believe that it is. I have not parked over there in quite some time. So, I couldn't say with a hundred percent.

BY MR. GOINGS:
Q So, you've been in the parking garage before; correct?
A Yes, sir.
Q Okay. Do you have any explanation as to why the curb -- the top of the curb was not painted in the location depicted in Plaintiff's Exhibit 1 to this deposition?
MR. GESSNER: Objection. This witness is not designated to testify with respect to the condition or the construction of the parking garage. But I'd ask the witness to answer, if he can.
BY MR. GOINGS:
Q Okay. Subject to those objections, do you have any knowledge?
A I don't have any knowledge firsthand. I believe there was some discussion, perhaps, on building codes and that type of thing. And I think, from what I've heard, now, I don't believe that the building codes require paint on the top. But I could not speak to that a hundred percent.
Q What building code are you referencing, if you know?
A I couldn't speak to that either.
Q Okay. Is that another question Mr. Thompson can answer?
A Perhaps.
Q Okay. But the curbing elsewhere in this parking garage

is painted fluorescent yellow on the top and on the sides; correct?

MR. GESSNER: Objection. Please answer if you can.

THE WITNESS: I'm not sure if the majority of it has paint on the top and side. I do believe that the majority has paint on the side.

(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 3, PHOTOGRAPH, ATTACHED.)

BY MR. GOINGS:

Q Now I'm going to show you what has been marked as Exhibit 3. And looking at this photograph, does this photograph show a different angle where the fall occurred?

A It is a different angle, yes, sir.

Q Okay. And it shows that this ledge that Ms. Connell was on extends to a pedestrian walkway, where you have a door casing. Do you see that?

A Yes, sir.

Q And that would be a pedestrian walkway?

A Can you re-ask that for me?

Q Right. Let me put it in this -- in these terms. The -- a pedestrian such as Ms. Connell -- and you saw the video -- actually came through the door opening -- the pedestrian door opening; correct?

A Can I point to it for you?
Q Yes, sir.
A This one here (indicating)?
Q Yes, sir.
A Okay.
Q And she walked through that door opening; correct?
A Yes, sir.
Q And she was -- after she walked through the door opening, she was walking on what is considered a walking surface; correct?
A Yes, sir.
Q Okay. And from her vantage point, she's not able to see any yellow paint on the curb that she would eventually step on or step off of; correct?
MR. GESSNER: Object. Please answer if you can.
THE WITNESS: She would not see yellow paint on the curb that she was actually on.
BY MR. GOINGS:
Q That's correct.
A Yes, sir.
Q All right. Because only the front face of that curb is painted yellow; correct?
A Yes, sir.
Q The top of the curb, which would allow her to see that it would be a change in elevation, was not painted

yellow; correct?
A That's correct.
Q And you understand that the reason curbing is painted yellow, is so that it is visible to people that are navigating or drivers that are navigating throughout a parking garage; correct?
MR. GESSNER: Object. Please answer if you can.
THE WITNESS: Can you re-ask that?
BY MR. GOINGS:
Q Well, let me ask you this. Why are curbs painted at all in a parking garage?
MR. GESSNER: Object. Please answer if you can.
THE WITNESS: I would assume that they would have paint, such as this, to make it easier to see.
BY MR. GOINGS:
Q For -- to make the change in elevation visible to the human eye; correct?
A Yes, sir.
Q Okay. Because oftentimes, it can be hard to see changes of elevation without demarcations through pain or other type of signage; correct?
A Yes, sir.
Q Okay. And Lexington Medical Center didn't actually do the painting in the parking garage, did they, to your knowledge?

MR. GESSNER: Object. Please answer if you can.
THE WITNESS: I am not sure. The hospital would have, of course, been over that type of activity, but I couldn't speak as to if a contractor did that or if our staff did that.
BY MR. GOINGS:
Q Okay. Is Lexington Medical Center responsible for the maintenance and upkeep of their facilities?
MR. GESSNER: Object. Please answer if you can.
THE WITNESS: Will you ask that again for me?
BY MR. GOINGS:
Q Yeah. Is Lexington Medical Center responsible for the upkeep and maintenance of their facilities, such as parking garages?
A Yes, sir.
Q Okay. So, it's the responsibility of Lexington Medical Center to maintain their own property and their facilities; correct?
MR. GESSNER: Object. Please answer if you can.
THE WITNESS: Yes, sir.
BY MR. GOINGS:
Q And there is actually a facilities department within Lexington Medical Center; correct?
A Yes, sir.
Q And do you interact or interface with the facilities

department much?

MR. GESSNER: Object. Please answer if you can.

THE WITNESS: Yes, we do interact. I don't know if I would say much.

BY MR. GOINGS:

Q I understand. If there is a claim related to a facility issue, then that's when you would interact with them; correct?

A Yes, sir.

Q Okay. Has there been any recommendations made by you to paint the curb in the area which Ms. Connell was walking?

MR. GESSNER: Don't answer that. Objection. That's attorney-client privileged and work product.

BY MR. GOINGS:

Q Well, outside of what your lawyer has told you, has there been any discussions by you to paint this area where Ms. Connell fell?

MR. GESSNER: Objection. Please answer if you can.

THE WITNESS: Please ask that again for me.

BY MR. GOINGS:

Q You're aware of the area where Ms. Connell fell; correct?

A Yes, sir.

Q And you're aware that the area that she fell had a change in elevation that did not have yellow paint demarcating that change in elevation; correct?

MR. GESSNER: Objection. You can answer.

THE WITNESS: On the top of the curb, yes, sir.

BY MR. GOINGS:

Q In the direction she would be walking?

A Yes, sir.

Q All right. Has there been any discussion by you or anybody internally at Lexington Medical Center that it -- that this area should be painted?

MR. GESSNER: Objection. Please answer if you can.

THE WITNESS: We've had discussions regarding painting and perhaps how it should be done. I can't recall if it specifically related to this event.

BY MR. GOINGS:

Q Right. And not necessarily related to this event or not, but has there been discussions that this area, this walking surface that has a change in elevation that's not painted from the vantage point of a pedestrian walking inside -- walking inside the parking garage, needs to be painted?

MR. GESSNER: Object- -- same objection. Please answer if you can.

THE WITNESS: It's been discussed. I don't know if I would go so far as to say discussed to the extent that it needs to be painted.

BY MR. GOINGS:

Q Okay. You've seen the video where Ms. Connell fell?

A Yes, sir.

Q She didn't appear to be distracted in any way in that video, did she?

A From what I can recall, she was walking maybe a few feet in front of her husband. But as far as other distractions from there, I didn't observe any.

Q Okay. You -- it's not like that she was not looking in the direction that she was walking, based on the video?

A She was looking forward. I don't recall if she was actually looking down.

Q Okay. She wasn't looking to the side or looking backwards when she was walking, was she?

A I don't recall that.

Q Okay. It appeared that she was walking at a normal and acceptable speed; correct?

A Yes, sir.

Q All right. She wasn't running, or skipping or hopping, was she?

A No running, or skipping or hopping.

Q Okay. From what you saw in the video, did she actively

do anything wrong?
MR. GESSNER: Object to form. Please answer if you can.
THE WITNESS: Ask that again for me.
BY MR. GOINGS:
Q Based on what you saw in the video, did she actively do anything wrong in -- resulting in this fall?
MR. GESSNER: Same ---
THE WITNESS: Not that I observed.
MR. GESSNER: Same objection.
BY MR. GOINGS:
Q Okay. Do you know who made the decision that the curbs needed to be painted, or is that outside of your knowledge?
A That would be outside of my knowledge.
Q Okay. Were there any inspections that are performed of the parking garage, to determine if there's any trip hazards, or slip hazards or any safety issues?
A I wouldn't be the one ---
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: I wouldn't be the one to be able to speak to that.
BY MR. GOINGS:
Q You would?

A I would not be the one.
Q You would not? Okay.
A Yes, sir.
Q So, from a risk management standpoint, are there any inspections done of the parking garage to determine or identify any safety concerns?
A Not from the risk management department.
Q Are you aware of inspections that are performed to address safety concerns or considerations?
A Not firsthand, no, sir.
Q Okay. And you -- do you know the name of the person or company that actually did the painting inside of the parking garage?
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: I do not know.
BY MR. GOINGS:
Q Have you personally, yourself, seen or reviewed any codes or standards related to painting of the curbing inside the parking garage?
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: I have not, no, sir.
MR. GOINGS: All right. I think those are all the questions I have right now. But let me step out,

review my notes. And if I'm done, then we can just -- we can move on to your colleague, Mr. Thompson. Okay?

THE WITNESS: Okay. Thank you.

VIDEOGRAPHER: We're going off the record. The time on the monitor is 1:30.

(OFF THE RECORD 1:30 PM - 1:40 PM)

VIDEOGRAPHER: We're going back on the record. The time on the monitor is 1:40.

BY MR. GOINGS:

Q Mr. Andrews, do you agree with me that if the top edge of this change in elevation in the parking garage where Ms. Connell fell had been painted the color yellow, that this would have likely prevented this fall from occurring?

MR. GESSNER: Objection. Please answer if you can.

THE WITNESS: Say that again for me.

BY MR. GOINGS:

Q Do you agree with me that if the top edge of the change in elevation of the curbing was marked yellow, like it is throughout the rest of the parking garage, that if it was, in fact, painted yellow, that Ms. Connell would have been able to more readily see the change in elevation, which would have likely prevented this fall from occurring?

MR. GESSNER: Objection. Please answer if you can.

THE WITNESS: I believe that it would have given her a better chance to see the curb.

BY MR. GOINGS:

Q Okay. And you agree with me that any time you're dealing with trips and slips that result in falls, being able to adequately see the potential hazardous condition is important; correct?

A I would agree with that statement.

Q Just like inside the hospital, if there is a wet substance that is on the floor, sometimes it can be hard to visibly see that wet substance; correct?

MR. GESSNER: Objection. Please answer if you can.

THE WITNESS: Yes, sir, it could be hard.

BY MR. GOINGS:

Q Yeah, and that's why you put up those caution wet floor signs, to give visual cues to people who may potentially encounter that hazardous condition; correct?

A That's right. Yes, sir.

Q Okay. Is there anything else about this situation, this incident involving Ms. Connell, that you know that we haven't talked about?

A Not that I can recall, no, sir.
Q Okay. Are there any defenses to this fall that the hospital has that we've not talked about?
A Could you restate that a different way for me?
Q Are there any defenses to this fall that Ms. Connell had that we've not talked about?
A I don't believe so.
Q Okay. And have -- has all your answers today been truthful and accurate to the best of your knowledge?
A Yes, sir.

MR. GOINGS: All right. Those are all the questions I have, and thank you very much.

THE WITNESS: All right. Thank you.

MR. GESSNER: No questions.

VIDEOGRAPHER: We're going off the record. The time on the monitor is 1:43.

MR. GOINGS: I'm going to hold the deposition open to the extent necessary, based on additional documents.

MR. GESSNER: Right.

(WHEREUPON, THE DEPOSITION CONCLUDED AT 1:43 P.M.)

CERTIFICATE

This is to certify that the foregoing 30(b)(6) deposition of CORY ANDREWS, consisting of 39 pages, is a true and correct transcript of the testimony given by said deponent after first being duly sworn; said deposition was reported by method of Stenomask with digital backup. This transcript may contain quoted material; said material is transcribed as read or quoted by the speaker.

I further certify that I am neither employed by nor related to any of the parties in this matter nor their counsel; nor do I have any interest, financial or otherwise, in the outcome of the same.

IN WITNESS WHEREOF I have hereunto set my hand and seal this 3rd day of November, 2019.

_____

Holly W. Wilson
Professional Verbatim Reporter

Notary in and for the State of South Carolina
My Commission Expires: February 22, 2022

ROBERT F. GOINGS, ESQUIRE
GOINGS LAW FIRM, LLC
POST OFFICE BOX 436
COLUMBIA, SOUTH CAROLINA 29202

RE: CONNELL V. LEXINGTON MEDICAL CENTER

Dear Mr. Goings,

Enclosed you will find both the original and copy of the 30(b)(6) deposition of CORY ANDREWS, taken WEDNESDAY, THE 23RD DAY OF OCTOBER, 2019, in the above-referenced action.

As you may recall, the deponent requested to read and sign his/her deposition. Therefore, by copy of this letter, I am forwarding a copy of the transcript to the deponent's counsel, along with the original signature page, errata sheet and instructions for reading and signing.

Upon completion of the signature page and errata sheet, the original of these pages will be sealed under separate cover and forwarded to you with a copy to all counsel. If the said pages are not completed within the thirty-day period or when required in court, the original deposition shall be considered complete with this letter in lieu of the signature page.

It was a pleasure working with you. If we can be of assistance to you in the future, please give us a call.

Very truly yours,

Jill Bishop Edwards, CVR-CM
BISHOP REPORTING SERVICES, LLC

Enclosures
cc: EVAN GESSNER, ESQUIRE
CORY ANDREWS
Original Deposition
Copy of Deposition

SIGNATURE PAGE

Diane Connell v. Lexington County Health Services District, Inc. d/b/a Lexington Medical Center
(C.A. No. 2018-CP-32-1750)
30(b)(6) Deposition of Cory Andrews
Taken Wednesday, October 23, 2019

I do hereby certify that I have read the foregoing deposition given by me before Holly W. Wilson, Notary Public for South Carolina, Spartanburg County, South Carolina.

PLEASE CIRCLE EITHER "A" OR "B".

(A) Said deposition is correct as is and requires no changes.

(B) I desire that the changes attached hereto, described on the "Errata Sheet" be incorporated into said deposition.

_____
CORY ANDREWS

SWORN BEFORE ME THIS _____ DAY OF _____, 20__

_____
NOTARY PUBLIC FOR S.C.
MY COMMISSION EXPIRES:

ERRATA SHEET
FOR THE DEPOSITION
OF CORY ANDREWS
(TAKEN WEDNESDAY, THE 23RD DAY OF OCTOBER, 2019)

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STATE OF SOUTH CAROLINA COUNTY OF LEXINGTON Diane Connell, Plaintiff, vs. Lexington County Health Services District, Inc., d/b/a/ Lexington Medical Center, Defendant.	IN THE COURT OF COMMON PLEAS OF THE ELEVENTH JUDICIAL CIRCUIT Civil Action No. 2018-CP-32-1750 **DEFENDANT LEXINGTON COUNTY HEALTH SERVICES DISTRICT'S RESPONSE TO THE NOTICE OF 30(b)(6) DEPOSITION NOTICE AND DESIGNATION OF WITNESSES**

TO: ROBERT F. GOINGS, ESQ. AND JESSICA GOODING, ESQ., ATTORNEYS FOR THE PLAINTIFFS:

The Defendant, Lexington County Health Services District, by and through its undersigned counsel and pursuant to Rule 30(b)(6) of the South Carolina Rules of Civil Procedure, hereby responds to the Plaintiffs' August 14, 2019 Notice of 30(b)(6) Deposition and subject to the specific objections set forth with the listed topics below, and such objections as may be asserted at the deposition or at the trial of this matter, designates the below named witnesses **Cory Andrews** and **Dale Thompson** to testify on behalf of Defendant, to the extent that anyone with Defendant has knowledge, on October 23, 2019, at the offices of the Goings Law Firm, LLC, 1510 Calhoun Street, Columbia, South Carolina 29201, to the topics listed covering the subject areas set forth by the Plaintiffs in their Notice.

The designated witnesses and the matters for which they will be prepared to testify on behalf of the Defendant, subject to the objections stated, are as follows:

Cory Andrews, Director of Risk Management, will testify on behalf of Defendant as to the following matters, with any caveats or limitations to her testimony indicated in italics, subject to any objections listed below or asserted at deposition or prior to trial:

a) Defendant's Answers to Plaintiff's First Set of Interrogatories and Request for Production;

b) Defendant's Answers to Plaintiff's Second Set of Interrogatories and Request for Production;

c) Documents produced in discovery, including any photographs;

d) Defendant's defenses asserted in the answer;

e) Defendant's factual assertions as to the nature, cause, and circumstances related to Mrs. Connell's fall at Lexington Medical Center;

f) Statements of any witnesses to Mrs. Connell's fall at Lexington Medical Center;

g) The facts and circumstances related to Mrs. Connell's fall at Lexington Medical Center;

j) The nature and circumstances of how Lexington Medical Center learned of Mrs. Connell's fall;

n) Fall prevention protocols, instructions, policies, and procedures at Lexington Medical Center; *The Defendant objects to this topic to the extent it seeks information not relevant to this lawsuit as ruled by Judge Kelly on Plaintiff's Motion to Compel.*

o) Fall in the parking garage where Mrs. Connell fell from the date the parking garage was opened to present.

p) Falls at Lexington Medical Center related curbing, parking stops, or other raised surfaces that the patron alleged was not visible, properly painted, or otherwise defective; *The Defendant objects to this topic to the extent it seeks information not relevant to this lawsuit as ruled by Judge Kelly on Plaintiff's Motion to Compel.*

q) Lawsuits or claim against Lexington Medical Center related curbing, parking stops, or other raised surfaces that the patron alleged was not visible, properly painted, or otherwise defective; *The Defendant objects to this topic to the extent it seeks information not relevant to this lawsuit as ruled by Judge Kelly on Plaintiff's Motion to Compel.*

w) Names of any other potential party that may be liable in whole or part for the injuries to Mrs. Connell for falling in the parking garage at Lexington Medical Center.

Dale Thompson (Director of Facility Services), will testify on behalf of Defendant as to the following matters, with any caveats or limitations to her testimony indicated in italics, subject to any objections listed below or asserted at deposition or prior to trial:

r) Persons with Lexington Medical Center that oversaw the design, build and construction of the parking garage where Mrs. Connell fell; *The Defendant objects to the extent this topic would require Defendant to produce a specific individual. Pursuant to Rule 30(b)(6), SCRCP, Mr. Thompson will be prepared to testify regarding Defendant's oversight of the design, build, and construction of the subject parking garage.*

s) The contractors, companies, entities, or persons that applied the yellow paint to the parking garage as depicted in photos produced as Plaintiff 0000001-0000012.

t) Plans, specifications, drawings, plats, sketches, detail work orders, or other related documents related to the design and construction of the parking garage where Mrs. Connell fell;

u) Plans, specifications, drawings, plats, sketches, detail work orders, invoices or other related documents relating to the painting the parking garage where Mrs. Connell fell;

v) Facts and circumstances related to when painting of the parking garage where Mrs. Connell fell was performed, who painted the parking garage, and the plans and specifications for painting the parking garage.

General Objections:

k) Written and oral communications, including incident reports, emails, or other documents, of Mrs. Connell's fall in the parking garage at Lexington Medical Center; *The Defendant objects to this topic to the extent it seeks information protected by the Attorney-Client privilege and Attorney Work Product Doctrine. This Defendant believes that no non-privileged communications ever took place and as a result, no witness will be designated by Defendant to testify as to this topic*

l) Email communication about Mrs. Connell's fall in the parking garage at Lexington Medical Center; *The Defendant objects to this topic to the extent it seeks information protected by the*

Attorney-Client privilege and Attorney Work Product Doctrine. This Defendant believes that no non-privileged communications ever took place and as a result, no witness will be designated by Defendant to testify as to this topic

DAVIS FRAWLEY, LLC

Patrick J. Frawley, S.C. Bar #2118
Evan M. Gessner, S.C. Bar #77704
140 East Main Street (29072)
PO Box 489
Lexington SC 29071-0489
803-359-2512
pat@oldcourthouse.com
evan@oldcourthouse.com

ATTORNEYS FOR DEFENDANT

October 22, 2019
Lexington, South Carolina

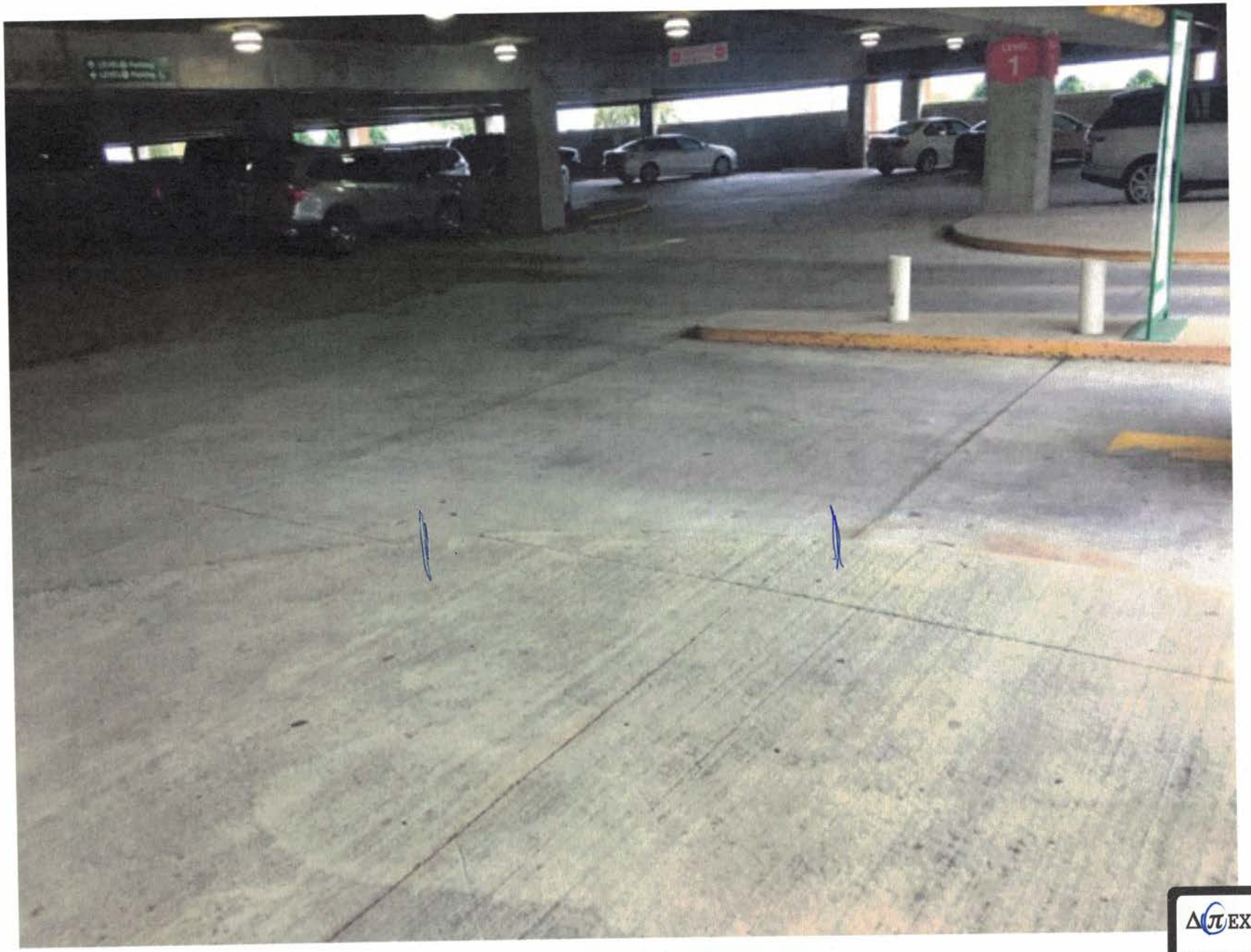

EXHIBIT 2
Deponent C. Andreas
Date 10/23 Rptr. HW
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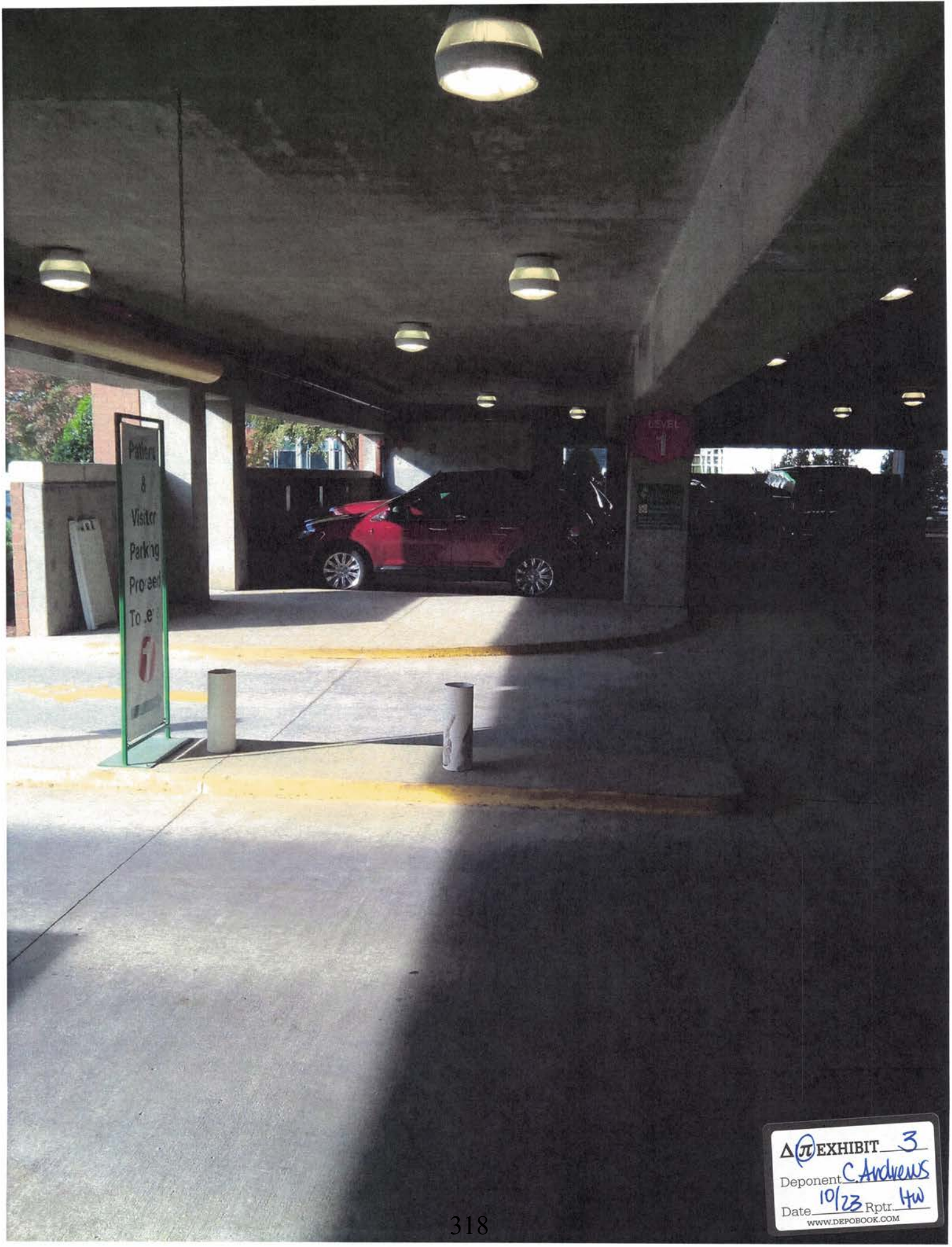

EXHIBIT 3
Deponent C. Andrews
Date 10/23 Rptr. HW
WWW.DEPOBOOK.COM

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	C.A. NO. 2018-CP-32-1750

DIANE CONNELL,	)	
	)	VIDEOTAPE DEPOSITION
PLAINTIFF,	)	
	)	OF
VS.	)	
	)	30(b)(6) DEPOSITION OF
	)	DALE THOMPSON
LEXINGTON COUNTY HEALTH	)	
DISTRICT, INC. D/B/A	)	
LEXINGTON MEDICAL CENTER,	)	
	)	
DEFENDANT.	)	

THE 30(b)(6) VIDEOTAPE DEPOSITION OF DALE THOMPSON, TAKEN BEFORE HOLLY W. WILSON, PROFESSIONAL VERBATIM REPORTER AND NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF 1:46 P.M., WEDNESDAY, THE 23RD DAY OF OCTOBER, 2019, AT GOINGS LAW FIRM, LLC, 1510 CALHOUN STREET, COLUMBIA, SOUTH CAROLINA.

APPEARANCES

FOR THE PLAINTIFF
ROBERT F. GOINGS, ESQUIRE
GOINGS LAW FIRM, LLC
1510 CALHOUN STREET (29201)
POST OFFICE BOX 436
COLUMBIA, SOUTH CAROLINA 29202
rgoings@goingslawfirm.com

FOR THE DEFENDANT
EVAN M. GESSNER, ESQUIRE
DAVIS FRAWLEY, LLC
POST OFFICE BOX 489
LEXINGTON, SOUTH CAROLINA 29071-0489
evan@oldcourthouse.com

ALSO PRESENT
CORY ANDREWS
SEAN STROEHLE, VIDEOGRAPHER

REPORTED BY
HOLLY W. WILSON
BISHOP REPORTING SERVICES, LLC
POST OFFICE BOX 1207
GREENVILLE, SOUTH CAROLINA 29602
864-640-1634
Jill@BishopReporting.com

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PLAINTIFF'S EXHIBIT NUMBER 6, MARKED, PHOTOGRAPH, ATTACHED.....26

*DIGITALLY RECORDED AUDIO RETAINED FOR TWELVE (12) MONTHS FROM DATE OF CERTIFICATION.

STIPULATIONS

IT IS STIPULATED BY AND BETWEEN COUNSEL FOR THE RESPECTIVE PARTIES THAT ALL OBJECTIONS ARE RESERVED UNTIL THE TIME OF TRIAL, EXCEPT AS TO THE FORM OF THE QUESTION.

THIS 30(b)(6) DEPOSITION IS BEING TAKEN PURSUANT TO THE SOUTH CAROLINA RULES OF CIVIL PROCEDURE.

- - - -

THE READING AND SIGNING OF THIS 30(b)(6) DEPOSITION IS RESERVED BY THE DEPONENT AND COUNSEL FOR THE RESPECTIVE PARTIES.

VIDEOGRAPHER: We're going on the record. The time on the monitor is 1:45. This is the 30(b)(6) video deposition of defendant, Lexington County Health Services District, Inc., in the matter of Diane Connell versus Lexington County Health Services District, Inc. d/b/a Lexington Medical Center under the jurisdiction of South Carolina County of Lexington in the court of Common Pleas Eleventh Judicial Circuit, case number 2018-CP-32-1750. This deposition is being held at 1510 Calhoun Street, Columbia, South Carolina on October 23, 2019. Would counsel please state their appearances for the record, and the court reporter will swear in the witness.

MR. GOINGS: Robert Goings for the plaintiff.
MR. GESSNER: Evan Gessner for defendant.
WHEREUPON, DALE THOMPSON BEING DULY SWORN AND CAUTIONED TO SPEAK THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH, TESTIFIED AND DEPOSED AS FOLLOWS:

EXAMINATION

BY MR. GOINGS:

Q Can you state your full name for the record, sir.
A Sure. It's Dale Allen Thompson.
Q Mr. Thompson, you have been designated as a witness on behalf of Lexington Medical Center for purposes of a 30(b)(6) deposition. I'm going to show you what is marked as Exhibit 2, starting on page 3, are the lists of topics R through V that you're going to be the witness most knowledgeable to talk about today. Are those the topics that you're prepared to talk about?
A Yes.
Q All right. Have you ever given a deposition before?
A I have not.
Q Good. Well, so you and your friend, Cory, are doing this together. It's nice when you have company; right?
A Yeah.
Q All right. Well, so you sat in through his deposition. You kind of know exactly what we're doing. If you've

got any questions related to my questions, you need me to clarify, you don't understand my question, direct them to me; okay? If you answer my question, I'm going to assume you understood my question. Okay?

A All right.

Q If you answer the question, make sure you answer audibly and loud enough so that the court reporter can write down what you're saying. Okay?

A Okay.

Q If you respond with a head nod or something like an uh-huh or an uh-uh, I'm going to say, "Is that a yes? Is that a no?" Just to kind of help make sure that the record is clear for everybody. Okay?

A Okay.

Q What is your job duty and job title at Lexington Medical Center?

A I am Director of Facility Services.

Q How long have you been Director of Facility Services?

A I have been director since 2012.

Q Where did you work before 2012?

A I worked at Lexington Medical Center for roughly 35 years, but I did do a stint for a time at Mary Black Hospital in Spartanburg, South Carolina.

Q What years were you at Mary Black?

A I was at Mary Black from 1998 to 2003.

Q That was the hospital in which I was brought into this world. So, it's nice you have a little bit of Spartanburg in you.
A Yeah.
Q Give me your work history at Lexington Medical Center.
A Sure. I started out in high school as a courier in the afternoons, and have progressed through materials management, a brief stint in IS back when I was in college. I worked in environmental services, and did some of the safety -- general safety stuff for them as well. And then since 2012, have been over facilities.
Q Who was responsible for facilities when this parking garage was built?
A That would have been the previous director, Kevin Stanley.
Q How do you spell his last name?
A S-t-a-n-l-e-y.
Q Were you working in the facilities department at that time?
A I was not.
Q Okay. Tell me what you know about this parking garage -- and I understand it's parking garage 3 now, but at the time of Ms. Connell's fall, was parking lot -- parking garage 2; correct?
A That's correct.

Q All right. So, as it relates to parking garage 2 at the time that she fell, tell me what you know about the history of this garage; when it was built, and who built it and who were the contractors.
A Okay. The parking garage was designed by Jumper Carter Sease, the architecture firm. The general contractor that actually did the work was McCrory Construction. I think it went into planning in late 2015 -- excuse me, 2005, and was actually opened in 2008, I believe.
Q Okay.
A Now, as far as our processes that we use with regard to architects and that type thing, we typically hire an architect that is a licensed professional architect to design the building. And then we reach out to a licensed general contractor to handle oversight of the -- all the build. And then we hire the architect firm typically to do the construction management, oversee that the project is actually built as it's drawn.
Q Who performed the oversight?
A With reference to the way it was built would have been the architect as the construction manager.
Q Okay. So, the architect was the construction manager.
A Correct.
Q And what is the name of that architect?
A That's Jumper Carter Sease.

Q That's Jumper Carter Sease. Okay. But the general contractor was what company?
A That was McCrory Construction.
Q All right. And it was completed in 2008?
A I believe that's when it was, yeah.
Q What company designed the garage's painting and marking specifications?
A I do not know that. That is covered under the general contractor's scope. They hire subcontractors to do that.
Q Okay. So, that would be under the responsibility of the general contractor, which would be McCrory.
A That's correct.
Q Okay. So -- but who designed the specifications for the painting and marking?
A That would probably fall under the architect, which is Jumper Carter Sease.
Q Okay. Have you seen the painting or marking specification design?
A I have not.
Q Okay. Do y'all still have the architectural drawings for this?
A I could not find those for this project. That was back when they still had the old paper system in place.
Q All right. Did you look?

A I did.
Q But they're just not available?
A I did not find them.
Q Okay. Were there painting and marking specifications to your knowledge?
A I can only speak to the way it is now. There are requirements as far as painting and striping.
Q All right. If I call it marking, maybe you use the word striping. Are we talking about the same thing?
A Yes.
Q And that is the process of painting curbing and painting parking spaces and ---
A Correct.
Q --- and directional arrows. Is that correct?
A That's correct.
Q All right. You said there are requirements for that now?
A That is correct.
Q What are those requirements, to your knowledge?
A I don't know them off the top of my head.
Q Okay. Have you seen those requirements?
A I have looked at them years ago. They change through time. They're updated as different requirements come into play.
Q What are those -- where would you find those

requirements?
A Typically, they would be in the architect's material that they provide ---
Q Okay.
A --- that was in the package.
Q Has Lexington Medical Center designed and constructed a parking garage since this time?
A We have.
Q Okay. Do you have the plans for that ---
A We do.
Q --- the new parking garage?
A Sure.
Q What is that parking garage called?
A It is parking garage 2 now.
Q Okay. So, the new parking garage is now referred to as parking garage 2.
A That is correct.
Q And where is that located?
A It is on the north side of the campus, between Lexington Medical Park 2 and the hospital, the new tower.
Q Is that near the ER?
A It is -- if you drive past the ER, you'll run into it at the back of the campus.
Q Okay. So, the new garage that was built -- tell me how

I get to the new garage that was built, which is now parking garage 2.
A Correct. There are two ways. The easiest way is to turn off Sunset Boulevard onto East Hospital Drive.
Q Okay.
A Follow East Hospital Drive back to the back of the campus and it'll be on your left-hand side, before you get to Hulon Lane.
Q Okay. And who was the contractor for the newest parking garage, which is parking garage 2?
A That would be Brasfield and Gorrie.
Q Brasfield and Gorrie?
A Uh-huh.
Q When did that get completed?
A It was completed last March, I believe.
Q Okay. And for the new parking garage, who did the painting and the striping for that one?
A Again, it was under the contractor's purvey. So, I couldn't -- I don't know.
Q Okay. And that would be what company?
A Brasfield and Gorrie.
Q And where are they located out of?
A Their home office is out of Alabama.
Q All right. Y'all have the plans for the new ---
A Correct.

Q --- the new parking garage; correct?
A That's correct.
Q All right. Did you review or see any documentation in anticipation for this deposition?
A I saw the video prior to it.
Q Okay. When's the first time you saw the video?
A Several weeks back.
Q All right. In anticipation for this deposition?
A Correct.
Q You haven't seen the video prior to ---
A I don't remember ---
Q --- getting prepared for this deposition?
A I don't remember seeing it. I may have, but I don't remember it.
Q Okay. Other than the video, did you see anything else?
A I did not.
Q All right. So, to the best of your knowledge, the company that would have been, or is responsible or was responsible for painting, marking and striping of the parking garage would have been McCrory; correct?
A That's correct.
Q Okay. Are you familiar with something known as the MUTCD, which is considered the manual on uniform traffic control devices?
A I have heard of it, yes, sir.

Q Okay. Have you ever seen it, reviewed it, as it relates to ---
A I've not spent a lot of time looking at it.
Q You have?
A I have not.
Q You have not. Okay. Are you aware of any codes or standards that would apply to parking lot painting, marking or striping?
A I don't know specific codes that would apply to it, but I'm certain there are.
Q Okay. And I said parking lot. Let me just -- I'm going ---
A Yeah.
Q I meant a parking garage. Are you aware of any codes that do apply?
A Yes, we have handicap striping codes with, you know, different markings for handicap. And there are different, you know, fire codes that we had to reach that goes with that. But as far as the striping on curbing, I am not aware. I'm not an expert. I'm sorry.
Q I know. I'm not saying you're an expert.
A Yeah.
Q I was just saying are you aware of any codes that would apply?

A No.
Q Are you aware of any codes that say that you just have to paint one side of the curb but not the other side?
A I do not.
Q Are you aware of any codes that say you just paint the vertical face of the curb, but not the top of the curb?
A I do not.
Q Okay. Would there be any codes that would even be applicable to your knowledge?
A And if I can, I'll explain how we go about it. We have the architects design to the building codes. Okay? And then as part of the process, once it's built by McCrory, the local building authorities come out and inspect it for all code compliance. And if they find an issue, they don't give us the notice of completion of the project. So, you know, that's who we depend on for our validation.
Q Okay. So, outside of just meeting the local code, is there anything else done to ensure safety?
A The grounds manager and myself will ride the campus monthly looking for different things that we notice that may be unsafe that we can address.
Q If you -- do you routinely ride through the parking garage to try to locate hazards or unsafe conditions?
A I do.

Q Okay. Have you identified the failure to have a yellow stripe marking on the walking surface in the area which Ms. Connell fell to be an unsafe condition that needs to be remedied?
A I did not.
Q Okay. You didn't? You didn't think that anything was wrong there?
A Uh-uh. No.
Q Okay. Why does this parking garage even have yellow paint in it?
A My guess is it's going to be a code requirement.
Q So you think it's painted yellow just because it's a code requirement?
A I do.
Q Do you know what code that you're ---
A I do not. I'm sorry.
Q So you're speculating when you say it's a code requirement?
A Yes. Yes.
Q All right. Let me show you --we're going to continue the exhibit numbers that we already have since this is a 30(b)(6) deposition.
(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 4, PHOTOGRAPH, ATTACHED.)
BY MR. GOINGS:

Q I'm going to show you what -- a new exhibit, which is Exhibit 4, which happens to be the same document that I showed Mr. Andrews. And it's a front and back photograph. Does it have -- can you visibly see yellow paint on curbs?
A I can.
Q What part of the curbs are painted yellow?
A The face and the top.
(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 5, PHOTOGRAPH, ATTACHED.)
BY MR. GOINGS:
Q I'm going to show you what's marked as Exhibit 5 here. Can you visibly see yellow paint?
A I can.
Q And what parts of the curb do you see painted yellow?
A The curbing at the top.
Q So, the top and the side.
A Yes.
Q All right. Let me show you what is marked as Exhibit 2. And this is a photograph that Mr. Andrews saw earlier today, and I just showed you as well. Do you see any yellow paint?
A I do.
Q Where?
A It's on the face of the curb.

Q Do you see any yellow paint in the area which Ms. Connell fell?
A I don't know the area. Can you show me where?
Q Your colleague identified that she fell somewhere in between where those two blue lines are, just for reference.
A Right. I do not see any yellow paint.
Q And you sat in here with his -- in his deposition; correct?
A Correct.
Q You showed -- you saw him show the photograph in the area in which Ms. Connell fell.
A Correct.
Q Where -- those blue lines are approximately where he said; correct?
A Correct.
Q All right. Do you see any yellow paint in that area?
A I do not.
Q Okay. Can you give me an explanation as to why that area does not have any yellow paint?
A I cannot.
Q And this is a curb, isn't it?
A It is a curb, but I don't know if it's anything different based on the lighting close to the entrance, the passageway different than these.

Q Now, not only is this a curb, but this is actually a walking surface, as shown in Exhibit 3, that leads ingress and egress for pedestrian out of the parking garage; correct?
A Correct.
Q All right. So, this is actually not only a walking surface, but a walking path; correct?
A It looks to be.
Q All right. So, if a person is walking from their car out of the parking garage, they're able to see that this is a curb because they could see yellow fluorescent paint at this curb; correct?
A Correct.
Q All right. But if they're walking from outside to going back inside where their car is, there's no yellow paint for this curb for them to visually see, is there?
A Correct.
Q All right. And the reason why curbs are painted yellow is so people can see the curbing; correct?
A There is many reasons they paint curbing.
Q All right. So, let's go through every one of those reasons.
A You've got fire truck -- you know, they're painted red. You've got some of them that are painted white, just so the vehicles can see them as they're pulling in to

parallel park. And then you do have the yellow as a caution for one of those reasons.
Q All right. Yeah, yellow means caution; correct?
A Correct.
Q And the reason there is striping, and painting and marking is to aid in one's vision; correct?
A Yes.
Q All right. And not only does it aid in a pedestrian's vision, it also aids in a driver's vision as well; correct?
A Correct.
Q All right. And there's a good safety reason for marking curbs with yellow paint; correct?
A Yes.
Q All right. It helps to prevent unnecessary falls, doesn't it?
A It does, and visual for -- as you said, the driver's coming through.
Q And pedestrians; correct?
A Uh-huh, yes.
Q And, in fact, not only is this a walking surface, but we're talking about a walkway right here, isn't it?
A That's correct.
Q All right. Nothing prevented Lexington Medical Center from having the face of this curb where Ms. Connell

fell painted yellow, or white or any other color. Is that correct?
A Yes.
MR. GESSNER: Object. Please answer if you can.
BY MR. GOINGS:
Q Right?
A Yes.
Q Nothing prevented that?
A No.
Q You're not aware of any code, or any provision or regulation that prohibits the face of this curb from being painted yellow; correct?
A That is correct.
Q All right. Do you agree with me that if the curb was actually painted yellow on the top, so Ms. Connell could visibly see the curb, that that could have prevented her from falling when she did?
MR. GESSNER: Object. Please answer if you can.
THE WITNESS: If it was painted, I could see it. But also based on the information we had earlier, if all the rest of the curbs are painted with the top, we've had somebody fall on one of these curbs too. So, it's not a guarantee that she wouldn't have fell.
BY MR. GOINGS:
Q Then why paint any curbs then?

A That's a good question. Why aren't all curbs painted in a parking lot or a sidewalk? They're not.
Q So, in your mind, you know, none of these curbs should even painted in the parking lot; right?
MR. GESSNER: Object. Answer if you can.
THE WITNESS: Yeah, I'm not saying that.
BY MR. GOINGS:
Q All right. In fact, it's the right thing to do, to paint curbs in a parking garage, isn't it?
MR. GESSNER: Object. Answer if you can.
THE WITNESS: You're asking me my opinion?
MR. GOINGS: Yeah.
THE WITNESS: I think in traffic areas it's the right thing to do.
BY MR. GOINGS:
Q All right. And this is a traffic area, isn't it?
A I agree, yes.
Q Okay. Not only this is a traffic area, but this is actually a traffic area where vehicular traffic and pedestrian traffic would intersect. Isn't that true?
A Yes.
Q Okay. Because the way this parking garage is designed, the walking path actually intersects vehicular traffic path, doesn't it?
A There are actually a couple of ways into this garage.

Q But the way to enter ---
A This one you just ---
Q --- this garage through this door is that way (indicating); correct?
A Correct.
Q All right. In fact, there's no designated walkway, with paint in the vehicular section, that shows a visitor where to walk as they're crossing over the drive area. Is that fair to say?
A Can you break that one down for me. I'm sorry.
Q Yeah. So, let's look at Exhibit 2.
A Okay.
Q Do you see a walk path painted anywhere in Exhibit 2?
A I do not.
Q All right. In Exhibit 3, do you see a walk path painted anywhere in ---
A I do not.
Q Okay. As you look at Exhibit 2 here -- and you can hold that up to the camera.
A Okay.
Q You agree with me that from the naked eye, it can be hard to see where this walking surface has a change in elevation.

MR. GESSNER: Object. Answer if you can.

THE WITNESS: Based on this photograph, yes.

BY MR. GOINGS:
Q Okay. And are you aware that this is a photograph that was taken by Lexington Medical Center?
A I was not.
Q Huh?
A I was not.
Q Okay. But this photograph does accurately depict the area in which Ms. Connell fell, doesn't it?
A That's correct.
Q Okay. And if this was -- if there was a yellow stripe through this photograph, one would be able to see it a lot better, wouldn't they?
A Yes, they would.
Q Okay. And you don't -- you're not contesting, are you, that it would be a -- from a safety standpoint, it would improve safety in this location to have a yellow stripe on the top of this change in elevation where visitors and patients walk?
MR. GESSNER: Object. Answer if you can.
THE WITNESS: Yeah, no, I'm not arguing that point. I think it would.
BY MR. GOINGS:
Q All right. You can put that down. I'm sorry.
A Oh, you're fine.
Q Have you seen -- and I think you may have already

answered this. Let me make sure I've gotten this clarified in my mind. You've never seen the actual plans for purposes of painting and striping the parking garage, which is now parking garage 3?

A I have not.

Q Okay. You've never seen those. You don't know if the plans called for all of the curbing to be painted or not, do you?

A I do not.

Q Have you reached out to McCrory to ask them?

A I have not.

Q Okay. Have you called anybody that does painting, curbing, markings to get their opinion or understanding about what needs to be painted versus what doesn't need to be painted?

A I have not.

Q Okay. But you would agree with me that throughout the multiple floors of this parking garage, the curbing is actually painted on the side and on the top of the curbs.

A Based on the information you provided, yes, I do.

Q Okay. And I think in the industry that's called the nose of the curb is fully painted; correct? And that would be the side and the top; correct?

A That's correct.

Q All right. Are you aware of any other places within this parking lot that the top of the curb is not painted, other than what you saw in Exhibit 2?
A I'm trying to think if there's a walkway. I do not off memory.
Q Let me show you another picture that's been produced in discovery. I'll mark as Exhibit 3 -- excuse me, Exhibit 6.

(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 6, PHOTOGRAPH, ATTACHED.)

BY MR. GOINGS:
Q This photograph -- you can show it to the camera. Turn it around. This shows the top and the side of the curb painted fluorescent yellow; correct?
A That's correct.
Q Now what's the point of using yellow instead of some other color?
A As a caution.
Q Okay. It means caution; right?
A To me it does, yes.
Q Would you agree with me that curbing can, in certain circumstances, cause a trip hazard?
A Yes.
Q Okay. Would you agree with me that when the curb is the same color concrete as the ground, which is

concrete, that it can have a camouflaging effect to a pedestrian?
A It does blend, yes, I could say.
Q Okay. And when it blends, it can be hard to see where the elevation change actually is located; correct?
A Correct. I agree.
Q And that could result in a trip hazard; correct? Correct?
A Correct.
Q All right. Now the area in which Ms. Connell fell, you would agree that that vertical change is more than a quarter of an inch?
A Yes.
Q Okay. Do you know how much it would cost Lexington Medical Center to paint this curb, which is shown as Exhibit 2?
A I do not.
Q Do you know how much a can of paint cost to paint that?
A It depends on the type of paint, but I would say under a thousand dollars.
Q Under a thousand dollars to paint that area?
A I would say. I would think so.
Q Okay. Do you know how much it cost for Ms. Connell to go through the necessary medical treatment that she had to incur and endure as a result of this?

A I do not.
Q Have you seen the videos of any other falls?
A I've seen one.
Q Okay. Which one would that be?
A It was one of the after falls off the upper floor.
Q Of the upper floor.
A Uh-huh.
Q Was that area painted?
A It was, I believe.
Q Okay. The area on the first level that you saw -- you never saw that one, did you?
A No, not the side one.
Q Okay. Do you have any information about this incident or your scope of knowledge related to this matter that we've not discussed?
A No, but I would like to say, you know, as a person or an organization that is not experts in the exact code requirements for every construction aspect, we do look to the professionals: the architects, the contractors, the compliance -- the county municipalities to be our guide with those. That's...
Q But this parking garage is a facility of Lexington Medical Center; correct?
A That's correct.
Q All right. And it's a piece of property that is

maintained and inspected by Lexington Medical Center; correct?

A That is correct.

Q And it's a piece of property that is under essentially your jurisdiction as the Director of Facility Services; correct?

A That's correct.

Q All right.

A But -- if I may?

Q Yeah.

A One of the things that we do are to address those safety things that are brought to our attention. And prior to this, we had not had a fall or anything like that that -- in the garage or the area that I was aware of. So ---

Q That you were aware of.

A That I was aware of. Yes, sir.

Q Okay. And since this happened in 2017, you -- y'all have known about this, haven't you?

A Sometime afterwards, yes.

Q And nothing's been done to fix this alleged problem, has there?

A No.

MR. GESSNER: Object. Please answer if you can.

BY MR. GOINGS:

Q In fact, there's been a lawsuit filed about this, hasn't there?
A Yes.
Q And not one bit of paint has been painted on this section where she fell, has it?
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: No, not that I'm aware of.
BY MR. GOINGS:
Q All right. Is there anything preventing you from painting this to make it safer?
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: No.
BY MR. GOINGS:
Q You would agree with me that if this curbing was painted like all the curbing in this parking garage, that it would actually improve the safety of this area; correct?
MR. GESSNER: Objection. Please answer if you can.
THE WITNESS: I do believe that.
MR. GOINGS: All right. I believe those are all the questions I have. Let me go consult with my notes, and I will be right back. Okay?

THE WITNESS: Okay.
MR. GOING: In the meantime, please take a ---
VIDEOGRAPHER: We're going off the record. The time on the monitor is 2:15.
(OFF THE RECORD 2:15 PM - 2:19 PM)
VIDEOGRAPHER: We're going back on the record. The time on the monitor is 2:19.
MR. GOINGS: Those are all the questions I have. Do you have any questions?
MR. GESSNER: I have no questions.
MR. GOINGS: All right. We've agreed by consent to hold the deposition open related to any additional discovery that opposing counsel is getting together and will send to me. And we'll proceed accordingly. Sounds good?
VIDEOGRAPHER: We're going off the record. The time on the monitor is 2:20.
(WHEREUPON, THE DEPOSITION CONCLUDED AT 2:20 P.M.)

CERTIFICATE

This is to certify that the foregoing 30(b)(6) deposition of DALE THOMPSON, consisting of 31 pages, is a true and correct transcript of the testimony given by said deponent after first being duly sworn; said deposition was reported by method of Stenomask with digital backup. This transcript may contain quoted material; said material is transcribed as read or quoted by the speaker.

I further certify that I am neither employed by nor related to any of the parties in this matter nor their counsel; nor do I have any interest, financial or otherwise, in the outcome of the same.

IN WITNESS WHEREOF I have hereunto set my hand and seal this 4th day of November, 2019.

_____

Holly W. Wilson
Professional Verbatim Reporter

Notary in and for the State of South Carolina
My Commission Expires: February 22, 2022

ROBERT F. GOINGS, ESQUIRE
GOINGS LAW FIRM, LLC
POST OFFICE BOX 436
COLUMBIA, SOUTH CAROLINA 29202

RE: CONNELL V. LEXINGTON MEDICAL CENTER

Dear Mr. Goings,

Enclosed you will find both the original and copy of the 30(b)(6) deposition of DALE THOMPSON, taken WEDNESDAY, THE 23RD DAY OF OCTOBER, 2019, in the above-referenced action.

As you may recall, the deponent requested to read and sign his/her deposition. Therefore, by copy of this letter, I am forwarding a copy of the transcript to the deponent's counsel, along with the original signature page, errata sheet and instructions for reading and signing.

Upon completion of the signature page and errata sheet, the original of these pages will be sealed under separate cover and forwarded to you with a copy to all counsel. If the said pages are not completed within the thirty-day period or when required in court, the original deposition shall be considered complete with this letter in lieu of the signature page.

It was a pleasure working with you. If we can be of assistance to you in the future, please give us a call.

Very truly yours,

Jill Bishop Edwards, CVR-CM
BISHOP REPORTING SERVICES, LLC

Enclosures
cc: EVAN GESSNER, ESQUIRE
DALE THOMPSON
Original Deposition
Copy of Deposition

SIGNATURE PAGE

Diane Connell v. Lexington County Health Services District, Inc. d/b/a Lexington Medical Center
(C.A. No. 2018-CP-32-1750)
30(b)(6) Deposition of Dale Thompson
Taken Wednesday, October 23, 2019

I do hereby certify that I have read the foregoing deposition given by me before Holly W. Wilson, Notary Public for South Carolina, Spartanburg County, South Carolina.

PLEASE CIRCLE EITHER "A" OR "B".

(A) Said deposition is correct as is and requires no changes.

(B) I desire that the changes attached hereto, described on the "Errata Sheet" be incorporated into said deposition.

_____
DALE THOMPSON

SWORN BEFORE ME THIS _____ DAY OF _____, 20__

_____
NOTARY PUBLIC FOR S.C.
MY COMMISSION EXPIRES:

ERRATA SHEET
FOR THE DEPOSITION
OF DALE THOMPSON
(TAKEN WEDNESDAY, THE 23RD DAY OF OCTOBER, 2019)

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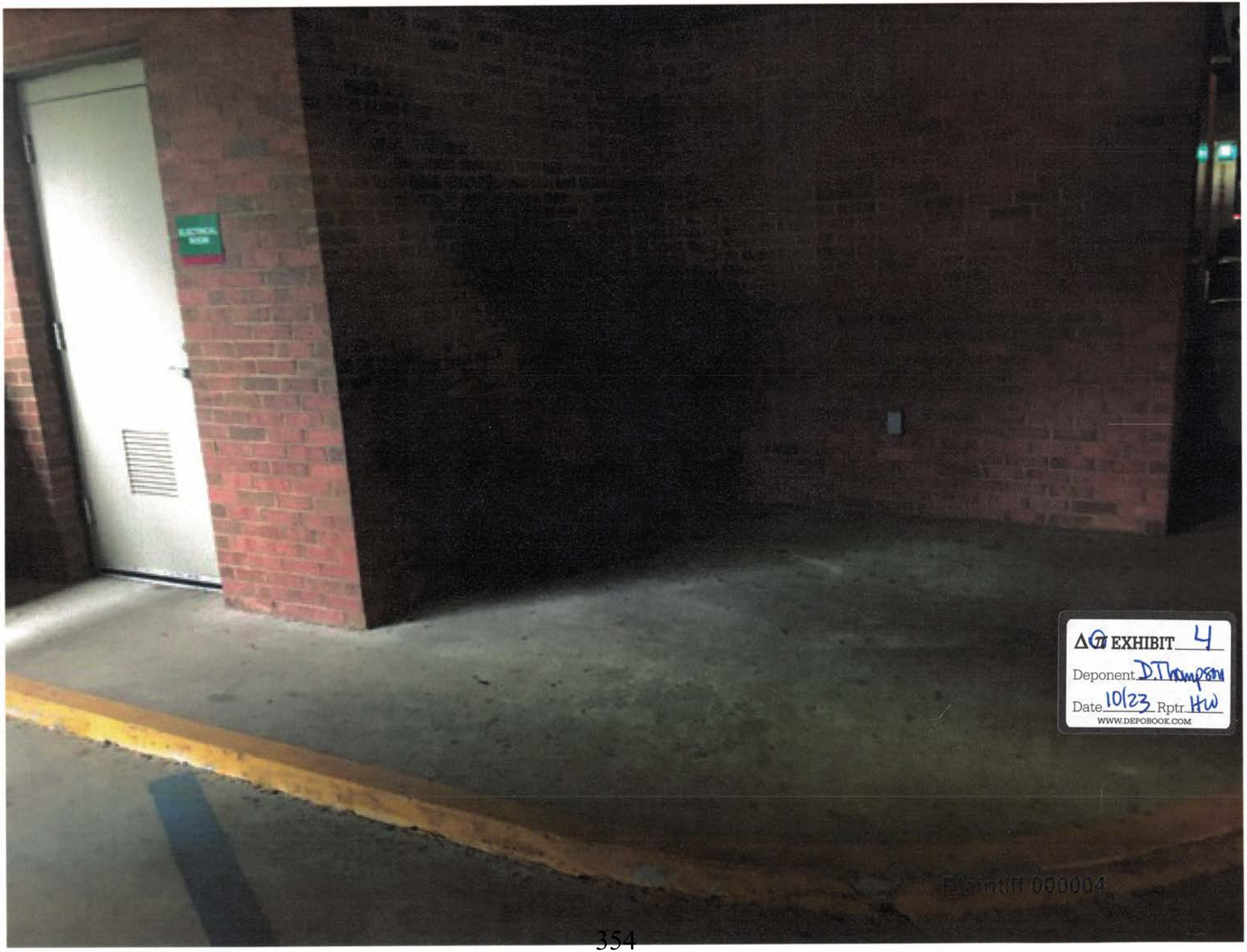
EXHIBIT 4
Deponent D. Thompson
Date 10/23 Rptr. HW
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Plaintiff 000004

PUMP
ROOM
Plaintiff 000003

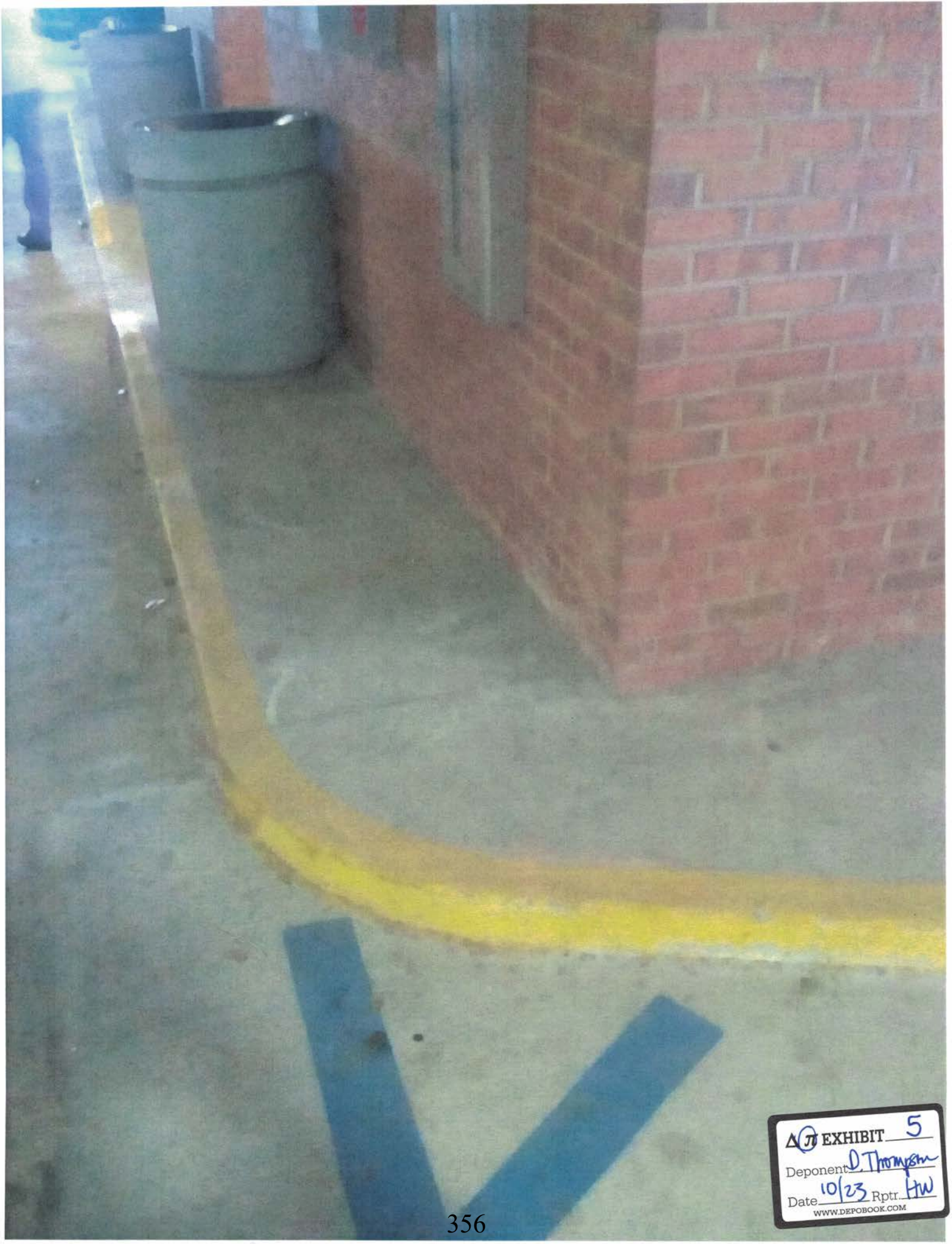
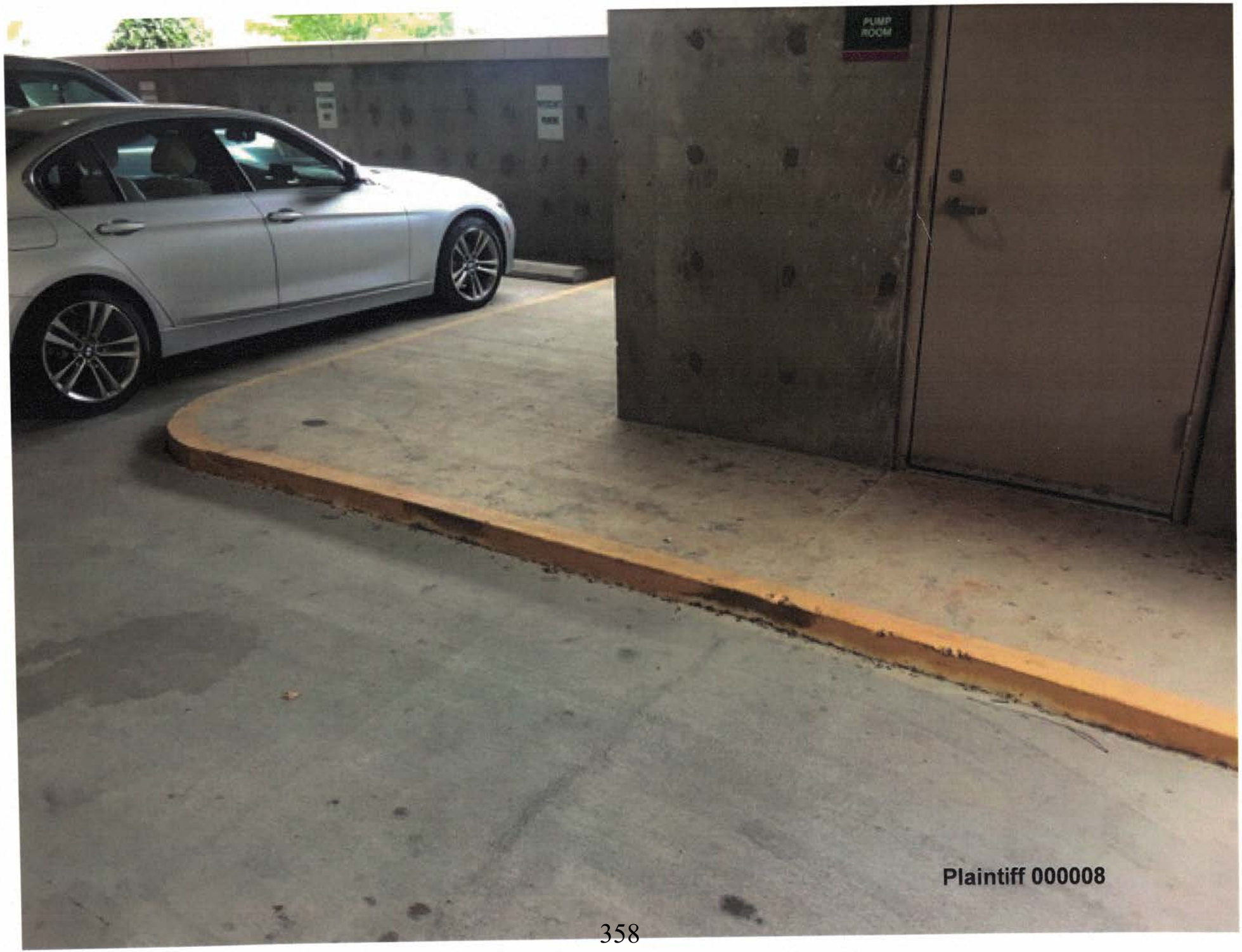


EXHIBIT 5
Deponent D. Thompson
Date 10/23 Rptr. HW
WWW.DEPOBOOK.COM

EXHIBIT 6
Deponent D. Thompson
Date 10/23 Rptr. HW
WWW.DEPOBOOK.COM
Plaintiff 000007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ROOM
Plaintiff 000008

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON	)	C.A. NO. 2018-CP-32-1750
_____		
DIANE CONNELL,	)	
	)	VIDEOTAPED DEPOSITION
PLAINTIFF,	)	
	)	OF
VS.	)	
	)	JAMES LOGING, M.D.
LEXINGTON COUNTY HEALTH SERVICES DISTRICT, INC. D/B/A LEXINGTON MEDICAL CENTER,	)	
DEFENDANT.	)	

THE VIDEOTAPED DEPOSITION OF JAMES LOGING, M.D., TAKEN BEFORE SHELLY M. JONES, PROFESSIONAL VERBATIM REPORTER AND NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF 4:22 P.M., MONDAY, THE 25TH DAY OF NOVEMBER, 2019, AT PALMETTO BONE AND JOINT, P.A., 2605 KINARD STREET, SUITE 105, NEWBERRY, SOUTH CAROLINA.

APPEARANCES

FOR THE PLAINTIFF
JESSICA L. GOODING, ESQUIRE
GOINGS LAW FIRM, L.L.C.
1510 CALHOUN STREET (29201)
POST OFFICE BOX 436
COLUMBIA, SOUTH CAROLINA 29202
jgooding@goingslawfirm.com

FOR THE DEFENDANT
EVAN M. GESSNER, ESQUIRE
DAVIS FRAWLEY, LLC
140 EAST MAIN STREET (29072)
POST OFFICE BOX 489
LEXINGTON, SOUTH CAROLINA 29071
evan@oldcourthouse.com

ALSO ATTENDING
CICI BARR, VIDEOGRAPHER

REPORTED BY
SHELLY M. JONES
BISHOP REPORTING SERVICES, LLC
POST OFFICE BOX 1207
GREENVILLE, SOUTH CAROLINA 29602
864-640-1634
Jill@BishopReporting.com

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*DIGITALLY RECORDED AUDIO RETAINED FOR TWELVE (12) MONTHS FROM DATE OF CERTIFICATION.

STIPULATIONS

IT IS STIPULATED BY AND BETWEEN COUNSEL FOR THE RESPECTIVE PARTIES THAT ALL OBJECTIONS ARE RESERVED UNTIL THE TIME OF TRIAL, EXCEPT AS TO THE FORM OF THE QUESTION.

THIS DEPOSITION IS BEING TAKEN PURSUANT TO THE SOUTH CAROLINA RULES OF CIVIL PROCEDURE.

- - - -

THE READING AND SIGNING OF THIS DEPOSITION IS WAIVED BY THE DEPONENT AND COUNSEL FOR THE RESPECTIVE PARTIES.

WHEREUPON, JAMES LOGING, M.D., BEING DULY SWORN AND CAUTIONED TO SPEAK THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH, TESTIFIED AND DEPOSED AS FOLLOWS:

EXAMINATION

BY MS. GOODING:

Q Hi, Dr. Loging. Thank you for being here today.

A Sure.

Q Will you please tell us about your profession.

A Sure. I'm an orthopedic surgeon with Palmetto Bone and Joint.

Q Can you please tell us about your educational background and training ---

A Sure.

--- to become an orthopedist.
Sure. Undergraduate was with the University of South Carolina in Columbia, med school was at the Medical University of South Carolina in Charleston, and then I did my residency training with the Greenville Hospital System in Greenville, South Carolina.
And do you have any Board certifications?
I do, in orthopedic surgery.
As part of your practice, do you treat patients with traumatic injuries to their extremities such as their knees?
Yes.
And how long have you been in practice?
Fourteen years.
Have you ever been qualified as an expert in your field?
For prior depositions, yes.
Okay.

MS. GOODING: At this time, I would tender Dr. Loging as an expert in the field of orthopedic medicine.

MR. GESSNER: No objection.

BY MS. GOODING:

Dr. Loging, you began treating Ms. Diane Connell for her knee earlier this year; is that correct?

A That is correct.
Q And were you aware when you began treating her that she had fallen on her knee back in 2017?
A I believe, yes, she had had a prior injury. Yes.
Q And were you aware that she had a surgery on that knee within a day or two of the fall?
A Yes.
Q And you have, sitting next to you, over 300 pages of records related to that fall, her emergency room treatment, her admission at the hospital, and her treatment as far as her knee surgery. Did you have an opportunity to review those records in treating her earlier this year?
A Yes, at her prior visit. Yes.
Q And are these the kind of records that you routinely rely on in treating and diagnosing patients?
A Yes.
Q And did you, in fact, rely on those records in treating and diagnosing Ms. Connell?
A Yes.
Q I am going to mark the first 13 pages or so; then I'll have you look at those as Exhibit 1.

(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 1, MEDICAL RECORDS, ATTACHED.)

BY MS. GOODING:

Q And I'm just trying to cut down on the size of the exhibit. And those are the pages I'm going to ask you about.
A Okay.
Q The ER records there, can you tell me the date that are on those.
A I think it's September 26th of 2017.
Q And does that indicate that Ms. Connell fell in the parking garage at Lexington Medical Center?
A Yes.
Q And what was it that she complained that she injured at that time?
A Left knee.
Q And did she also complain of right ankle and left wrist pain, if you look ---
A Yes.
Q --- at Page 2.
A She did.
Q Okay. But it says, (as read) "Unable to bear weight on the left knee"; is that right?
A That is correct.
Q And she also had abrasions on her left knee.
A That's correct.
Q Okay. And then, if you look at Page 6, that record, it shows her diagnosis. Her diagnosis includes, (as

read), “Closed displaced comminuted fracture of left patella.” Is that correct?
A Yes.
Q Can you tell us what that means.
A Basically, that’s a fracture or break of the patella bone. Comminuted means that it’s in multiple pieces. And displaced means the fracture or the fracture fragments are no longer within normal proximity of each other.
Q Okay. And it looks like she was referred to the orthopedic department at that point; one of the orthopedists there.
A Yes.
Q Okay. And on Page 11, there is an operative note from Dr. Barnaby dated 9/27/17; do you see that?
A Yes.
Q And does that operative note show?
A He performed an open reduction internal fixation of the left patella fracture.
Q I am going to hand you a couple of illustrations, and these are going to be marked as Exhibit 2.
(MARKED FOR IDENTIFICATION, PLAINTIFF’S EXHIBIT NUMBER 2, ILLUSTRATIONS, ATTACHED.)
BY MS. GOODING:
Q And I’ll also give you -- these are just boards where

we've made those a little bit larger.
A Okay.
Q Do those look the same to you?
A Yes.
Q Okay. On the first image there, it's labeled "Diane Connell's Left Knee Fracture." On the right-hand side, you see that is an X-ray of Diane Connell's knee. And then, on the left-hand side, there's an illustration of that. Does that illustration accurately depict the injury to Diane Connell's knee?
A It looks pretty accurate, yes.
Q Okay. And can you, kind of, point to the fracture that we were referencing earlier.
A Yeah. So, on the picture, this (indicating) is the patella and then you can see the multiple fracture lines through the patella, which is then broken into several pieces and then displacement of those fragments as the fragments are not within close proximity anymore.
Q Okay. Now, if we could look at the second part of that. This (indicating) depicts the surgery that Ms. Connell underwent just a day after her fall. Does that accurately depict the surgery that she had, based on your review of that operative note?
A Yeah. So this is an open reduction internal fixation

of the patella using a tension band construct where two pins are placed throughout the fragments of the patella and then a wire is used to, kind of, pull those fragments back together. Because there's multiple, small fragments, it's not a type of fracture that you could put, like, a plate or screw on because that would fail. So you use a tension band in order to hold those fragments together until they heal.

Q Okay, thank you.

A Uh-huh.

Q And at this time, I'd also like to move those records you were reviewing in as Exhibit 3. Oh, we already had those. I'm sorry.

Now, Dr. Loging, do you believe most probably to a reasonable degree of medical certainty that Ms. Connell was required to have this surgery because she fell on her knee?

A Yes.

Q And was that surgery reasonable and necessary because of the fall?

A Yes.

Q And following the surgery, she had some follow-up visits and some physical therapy. Is that type of treatment reasonable and necessary after this type of surgery?

A Yes.
Q Okay. I will ask you to look at the follow-up records that are included here. And are these also records that you were able to review in your treatment of Ms. Connell?
A Yes.
Q And are they the type of records that you rely on in your diagnosis and treatment of her?
A Yes.
Q Okay. I'd like to move to have those entered as Exhibit 3.

(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 3, MEDICAL RECORDS, ATTACHED.)

BY MS. GOODING:
Q And these records show follow-up visits on October 12th, November 9th and December 14th of 2017 following the surgery; is that correct?
A That's correct, yes.
Q Okay. If you'd look at Page 2, you see the first follow-up visit there. It looks like Ms. Connell is continuing to take pain medication but that her pain is controlled; is that right?
A Yes, that's correct.
Q And is that the visit where her staples would have been removed?

A Yes.
Q And it says, (as read) “They are transitioned to a hinged knee brace.” Can you tell us, kind of, what that means.
A Yeah. So, with a patella fracture, usually once -- you keep them in a knee immobilizer initially just to limit any mobility. The big problem with any joint is getting mobility and flexibility back in the joint, but we don’t want to bend the joint too much because then we pull those fragments back apart. And, so, we typically will put patients in a hinged knee brace which controls their mobility and we only allow them to bend the knee so much, but then every week, slowly increase the mobility in the knee with therapy until they can get back to full mobility. But, so, it’s to help protect the fracture and prevent having that fracture be displaced.
Q So she would have had her knee completely immobilized for a little while after this surgery and then would have switched to this hinged knee brace, it looks like, on October 12th.
A Correct.
Q Okay. And then, on Page 10, you see the notes from the follow-up visit on November 9th and it says, (as read) “dc brace.” Would that mean discontinue the brace?

A Correct.
Q And it looks like there were some X-rays done to confirm that the fracture remains in good alignment with the hardware.
A Yes.
Q Is that something that needs to be followed up on several times after this type of surgery?
A Yes.
Q Okay. And it looks like she's continuing to do physical therapy in her home; is that correct?
A Yes.
Q And is that reasonable and necessary after an injury like this?
A Yes.
Q Okay. And then, on Page 17, is the note from the visit on December 14, 2017. Looks like she's still controlling her pain with some medication; is that right?
A Yes.
Q And it's noted that she needs to continue to work on her strengthening and range of motion; is that right?
A Yes.
Q So she's being discharged on this day but that's not because she's a hundred percent better; is that a fair assessment?

A Yes.
Q And then there's also a note on here, (as read) "Discussed with patient and husband a possibility of hardware removal if it is bothersome to her but would wait at least a year." Did I read that correctly?
A Yes, that's correct.
Q And why is it that a doctor might recommend waiting a length of time to discuss a possible hardware removal?
A The main reason is because you want to make sure that those fractures are completely healed, which can take some time, especially in a severely comminuted fracture. The vascularity has been disrupted because of how many fragments it's broken into. So it can take a while, so you don't want to take the hardware out prematurely in order to let the fracture completely heal because once you take the hardware out, if it's not healed, then things will pull back apart. So, it's basically to give it plenty of time to make sure it's completely healed before removing that hardware.
Q And what kind of symptoms or problems might lead you to suggest hardware removal?
A It's usually pain or mechanical symptoms from the irritation. You know, as you can see with the picture, those pins and the wires are pretty prominent and so they're going to irritate people. So, I mean, I find

probably a hundred percent of the time that I do remove hardware after a patella fracture.

Q Okay. So it's a common problem then.

A Yes.

Q Okay. And I'm going to hand you what I've got marked here as Exhibit 4. And these are your records for Ms. Connell. And those are dated April 4, 2019; is that correct?

A That's correct.

Q And do you recognize these records?

A Yes.

Q Were they created at your office?

A Yes.

Q Do they reflect your care and treatment of Ms. Connell?

A Yes.

Q And were they created contemporaneously with that treatment?

A Yes.

Q Okay. I would move them into evidence then as Exhibit 4.

(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 4, MEDICAL RECORDS, ATTACHED.)

BY MS. GOODING:

Q What were Ms. Connell's complaints when she came to see you?

A She had pain and then grinding or mechanical symptoms on the left knee.
Q And is that something that you often see after this kind of injury and surgery?
A Yes.
Q And were you able to determine, kind of, the cause of the symptoms that she was having?
A I think the symptoms were probably twofold. One would be irritation from the hardware. So I think that's one because it had been in there for a good while. So there would be some hardware irritation. But the other issue was the congruity of the joint itself so the patella where the fracture was -- the way that the bone healed -- the patella joint was fairly irregular and had some irregularity to the joint, so that's going to give her some of that grinding and mechanical symptoms that she's experiencing as well.
Q And do you have an opinion most probably to a reasonable degree of medical certainty whether those symptoms were related to the fall that she had back in September of 2017?
A Yes, they're directly related.
Q And based on those symptoms that she's having, do you think that hardware removal would be appropriate?
A Yes.

Q And are you taking steps with Ms. Connell to move towards, in fact, having that hardware removal done?
A Yeah. When I last saw her, I think she was going to let us know, but I think she has an appointment scheduled to follow up, but I haven't seen her back for that yet.
Q Okay. Assuming that she comes in at that appointment and says that she wishes to go forward with the hardware removal, is that something that you would take care of?
A Yes.
Q And you think that that treatment or that removal would be reasonable and necessary based on this injury and surgery she had back in 2017?
A Correct. As mentioned, I typically remove all hardware from patella fractures just because of the superficial nature of the patella and where that hardware and pins are, they usually do cause people problems. So I usually remove it a hundred percent of the time.
Q Okay. And then you mentioned also that the way her bones had healed was also causing grinding and was going to lead to more arthritic changes and increased pain; is that right?
A That's correct.
Q And what treatment do you believe she'll need in the

future to take care of those symptoms.
A So this (indicating) is just an X-ray from our record of her patella. I don't know if the camera can see it. But the backside of the patella is very irregular and there's a big step-off on the backside of the patella. So that joint isn't lined up anymore. And, because of that, while we can see the bone and the step off the stair, what we can't see is the articular cartilage that's been damaged and probably extremely irregular. And so, because of that, she will get post-traumatic arthritis which is some of the grinding that she's experiencing currently. So she will need a knee replacement or at least partial knee replacement as a result of that.
Q And is it your opinion that she will definitely need a knee replacement, or just possibly?
A I think definitely given that trauma that's there. I mean, that's going to progressively get worse to the point where the pain would be intolerable. And, so, she will require a replacement at some point.
Q Okay. And do you know when she would require that replacement?
A No, it's hard to say. I mean...
Q That depends on each individual patient.
A Correct.

Q Okay.

(MARKED FOR IDENTIFICATION, PLAINTIFF'S EXHIBIT NUMBER 5, FUTURE COST ANALYSIS, ATTACHED.)

BY MS. GOODING:

Q This (indicating) is a future cost analysis. This was done by Lindsey Moore, who is a physician's assistant. And this just puts together a projection of what Ms. Connell's future medical costs may be. Have you had an opportunity to review this report?

A Yes.

Q Okay. Taking a look at that, it looks like Scenario A sets forth all of the costs that would be associated with a hardware removal. And then, Scenario B sets forth a cost that would be associated with a partial knee replacement. I believe that your testimony was that you believe she will go forward with the hardware removal and she will need either a partial or a full or potentially both knee replacements; is that correct?

A That's correct.

Q Okay. And in looking over those, are those treatments listed on there what you would expect associated with those operations?

A Yes. I mean, for the most part, with the exception of physical therapy which they do not have listed, as she would need a course of physical therapy after probably

each surgery, those would be all appropriate treatments or necessary tests for those procedures; yes.

Q Okay. So, in addition to those items listed, then, you would also recommend physical therapy.

A Correct.

Q And would that be after both procedures?

A Correct.

Q And one of the things listed with regard to the hardware removal is the Supartz injections, and we have those listed as three to five injections in three to four series over her lifetime. Do you think that that's a reasonable frequency for those?

A Yeah, and it depends on how effective those are for her. I mean, if those did really good -- because you can get those every six months. So it's essentially four injections at six-month intervals would last her about two years. And, so, you know, if she were able to make do with it for five years, then it would be a lot more injections than that. So it all depends on how it progressed. And, so, it would be more, but I think that's probably a reasonable number because, you know, it's hard to know when she would need a replacement. But, obviously, once she had a replacement, then she wouldn't need the Supartz injections anymore; so...

Q Okay. So that's kind of a holdover to try to get as long as she can before she has her knee replaced.
A That is correct.
Q Okay. And then, following a knee replacement, would she have some continued treatments such as physical therapy and follow-up orthopedic visits as well?
A That's correct, yes.
Q Okay. And do you have an opinion to a reasonable degree of medical certainty what is the most probable cause of the pain and symptoms that Ms. Connell is treating for, currently?
A I think it's a combination of both the articular cartilage damage on the back of the kneecap as well as the hardware irritation; so I think it's a combination of both.
Q Okay. And both of those things resulting from the fall back in 2017; is that correct?
A Correct.
Q So do you believe -- this may seem like a silly question, but do you believe to a reasonable degree of medical certainty that Ms. Connell was injured when she fell in September of 2017?
A Yes.
Q And do you believe to a reasonable degree of medical certainty that when she fell that caused Ms. Connell to

suffer pain?
A Yes.
Q Do you believe to a reasonable degree of medical certainty that the fall Ms. Connell received in September of 2017 necessitated the surgery that we have depicted here as well as the two surgeries that you've talked about today?
A Yes.
Q And do you believe that all of that treatment is reasonable and necessary based on that injury?
A Yes.
Q Have all of the opinions that you've given me today been most probable to a reasonable degree of medical certainty?
A Yes.
MS. GOODING: Okay. I don't have anything else.
THE WITNESS: Okay.
EXAMINATION
BY MR. GESSNER:
Q Good evening, my name is Evan Gessner. I'm an attorney with Davis Frawley in Lexington. We represent the defendant, the Lexington County Health Services District. I did have a few quick questions for you.
A Sure.
Q Did you want to take a break before I get started, or?

A No, I'm good.
Q Okay, good. I would venture a guess today that this is not the first deposition you've given. Is that a ---
A That's correct.
Q Okay. How many depositions have you done prior to today?
A I would have no idea.
Q Obviously more than one. More than ten?
A Probably more than ten. I do maybe two or three a year ---
Q Okay.
A --- for over 14 years. So whatever that would average out to.
Q Somewhere getting close to 30.
A Probably.
Q Okay. Have you ever testified in court before?
A No.
Q No. Okay. Now, as best I can recall, Mrs. Connell lives in Northeast Columbia. Where do you primarily see patients?
A Two offices, one in Newberry and one in Chapin.
Q Okay. Do you have any idea why Mrs. Connell came to see you and not some other doctor in Columbia or Lexington that would be a lot closer?
MS. GOODING: Object to the form.

THE WITNESS: I'll tell you, I mean, I have a pretty good reputation and I see a lot of patients who come out of Columbia. So I would say probably 50 percent of my patients are out of the Columbia area ---

MR. GESSNER: Okay.

THE WITNESS: --- because I have a good reputation with hip and knee surgery.

BY MR. GESSNER:

Q You don't have any knowledge if anyone referred Mrs. Connell to see you or anything like that?

A Not that I'm aware of, no.

Q Okay. So, in the prior depositions that we've talked about, I mean, have you -- can you give me a breakdown? How often do you testify for plaintiffs and how often do you testify for defendants?

A I testify for whichever side. I mean, I'm not testifying for one side or the other. I'm giving my accurate assessment of the treatment of this patient. So, I mean, whoever schedules the deposition, I guess you would assume is that's who I'm being -- doing a deposition for, but I'm impartial.

Q Okay.

A I'm giving my deposition based off what's the best, accurate treatment for this patient.

Q Okay. Let me ask that a little differently then.

You're Mrs. Connell's treating physician; correct?
A Correct. She came to see me for this problem, which I have evaluated her and given her my recommendation for.
Q Okay. And, so, your prior depositions, have you always been the treating physician or a treating physician?
A Usually, they are patients that I have seen who have come to see me for a particular problem, yes.
Q Okay. Have you ever been hired by a defense counsel or a defendant?
A I've done IMEs for defense before.
Q You say IME. What is that?
A Independent Medical Evaluation.
Q Okay. All right. Is that something you do frequently? Infrequently? The IMEs?
A I do them intermittently.
Q Okay.
A I'd say it's less than one percent of my practice, though. I mean, my main practice is taking care of patients.
Q Of course. And the injury we've been talking about today, I'm going to say, in layman's terms, would that be a broken kneecap?
A Correct.
Q Over the course of your career, how many times do you think you've seen that in a patient?

A Probably hundreds.
Q Okay. So it's a condition you're pretty familiar with.
A Yes.
Q Okay. You had said that pretty much a hundred percent of the time that results in a hardware removal; correct?
A I usually do recommend removing it because it does irritate people, the hardware.
Q All right.
A I mean, think about your kneecap. It's very superficial. There's no tissue, usually, on most people, over the front of their kneecap. And, so, when those wires are running over it and those pins stick out like they do, that's very irritating to most people.
Q Sure. So anytime somebody walks there's going to be movement in that area and that hardware is going to be rubbing.
A Because the skin is rubbing over the top of that as you move your knee. So I usually do recommend removing it. You know, once -- it's safe to do that once the fracture is healed; so...
Q Okay. And you've talked about the medical records you've reviewed. Can you recall, as you sit here today, if you reviewed any of Mrs. Connell's medical

records dating back prior before the fall?
A I believe I reviewed relating to the injury itself.
Q Okay. But do you have any knowledge as to the condition of Mrs. Connell's knee prior to her fall?
A Not that I'm aware of, no.
Q Okay. You had referred to something earlier, I think you said, was it post-traumatic arthritis?
A Correct.
Q And that's arthritis that would result from the injury; correct?
A Correct.
Q Okay. And is it your opinion based on your review of Mrs. Connell that any arthritis she has in her knee is, in fact, related to her fall and the injury she sustained?
A You know, if you look at her X-ray on her knee, she doesn't have a lot of arthritis currently, but she's going to get it as a result of this injury because of the incongruent joint surface.
Q Okay.
A So, you know, true X-ray forms of arthritis that you would normally see in, you know, degenerative arthritis in most people, she doesn't have that. But what I can tell you is that the irregularities and incongruity of her joint is going to lead to the post-traumatic

arthritis there.
Q Okay. In your experience, can you attach a percentage to the chance that arthritis will develop like that?
A A hundred percent in that injury.
Q Okay. Now, looking back at Exhibit 5, that's the Future Cost Analysis. I did have a few questions. So, within Scenario A, there's the hardware removal, which you've already talked about.
A Uh-huh.
Q And right after that, there's the knee injections. Is that an either/or or would Mrs. Connell get the hardware removal and the injections?
A So the hardware removal is to remove the -- basically, the pain from the hardware irritation that's there. And then the injections are there to treat the irregularity within the joint. So she would get both ---
Q Okay.
A --- because I believe she's having symptoms from both. So we're talking about hardware removal and then also the viscosupplementation or lubricant injections to try to help decrease any of the pain from the irregular joint.
Q Okay. I mean, would that help reduce any arthritis that might develop?

A It can help delay the progression of it, potentially.
Q Okay. Now, while we're on Exhibit 5, in the right-hand columns you see a whole bunch of dollar figures associated. But do you have any knowledge as to -- I think you had talked about earlier the different procedures or different items that would be associated with, say, the hardware removal, the knee injections, the partial knee replacement. But do you have any knowledge as to the cost of those procedures?
A I can know roundabout what my professional fee would be and then a typical facility fee would be. With regard to the fees for bloodwork or those type of things, I wouldn't know those type of ---
Q Right.
A --- fees, but, so, I know some of them but not all of them.
Q Okay. So that's something that your practice handles but not you.
A Correct.
Q All right. So is it fair to say that your testimony about this Future Cost Analysis, you've talked about the different procedures and different items that would be necessary, not necessarily the costs themselves?
A Correct.
Q Okay.

A Because, yeah, all of those costs I don't know the exact answer to.
Q Right.
A Some of them, I would, because I do know professional fees and we own our own surgery center, so I know what a facility fee for that type of procedure would be for those.
Q Okay.
A So I know some, but not all of them.
Q I understand. And now, the second column I noticed on the top it says Diagnostic Code. Or reading down, it looks more like a procedure code. Are you familiar with ICD-10 versus CPT coding and how all that works?
A I'm not sure where you're looking.
Q The second column from the left.
A Okay.
Q It starts out at the top, it says Diagnostic Code.
A Okay.
Q So are you familiar with diagnostic coding?
A Yeah, those are CPT codes and not ICD-10 codes.
Q Correct. My recollection was the CPT codes is more procedure and not the general ---
A That's correct.
Q --- diagnosis.
A Yes.

Q Okay. What's the difference between a partial knee replacement or a full knee replacement?
A So the difference with a partial -- since the majority of her problem is in the patellofemoral compartment, and that's the main joint that was damaged, you could do a patellofemoral replacement where you only replace that portion of the joint. The problem with that is the success rate with patellofemoral replacements is not as high as a full knee replacement. And, so, unless somebody is very young, say 30, I, within that circumstance, probably recommend a partial replacement. But, as some people get older, the newer total knee replacements last a lot longer. It can last over 30 years. And, so, I believe she's 60s, in her 60s. So I would probably recommend a full knee replacement, actually, just because of the longevity and the decreased chance of having to have a revision on that knee in the future and the success rate would be higher.
Q Okay.
A But you could consider a partial since the majority of the problem is in the patellofemoral compartment. But before I would recommend either one, I would probably recommend getting an MRI to evaluate the integrity of the cartilage and meniscus and the rest of the

structures in her knee to fully evaluate that before considering one surgery versus the other.

Q Okay. Of course, we've talked about your recommendations and all that based on a reasonable degree of medical certainty, but do you know whether or not Mrs. Connell's actually going to get any of these procedures?

A Well, I mean, it's up to her whether she's going to have the hardware removed. I mean, she does have an appointment to come back and discuss it, apparently, but, I mean, it's ultimately up to her and when she, you know, would need a replacement. I can only tell you off of standard, the care of patients that I've had with similar issues. I mean, like I said, a hundred percent of the time, I remove the hardware because of the high incidence of hardware irritation and problems from the hardware. And given the incongruity of her joint, her chance of developing post-traumatic arthritis is essentially a hundred percent guaranteed. And, so, I think she will need a replacement, either partial or full, at some point in the future.

MR. GESSNER: Okay. Thank you. That's all the questions I have.

THE WITNESS: Okay.

MR. GESSNER: Thank you for your time.

FURTHER EXAMINATION

BY MS. GOODING:

Q Mr. Gessner asked you about your familiarity with the fees that are on Exhibit 5, the Future Cost Analysis. Did you see anything in this cost analysis that stands out to you as exorbitant or unreasonably high?

A No, actually the exact opposite. So, I mean, like I said, we own our own surgery center, so I know facility fees for an outpatient procedure. Those estimates are extremely low. Knee sleeve or support brace, those costs are extremely low. I think professional fees are probably reasonable, but that -- you know, for a bill fee, that actually may be somewhat low as well. So I think they've erred on the conservative side for most of those just based off, you know, my experience with an outpatient surgery center and those facility fees.

MS. GOODING: Okay. Thank you.

THE WITNESS: Uh-huh.

MS. GOODING: No further questions.

MR. GESSNER: Nothing further.

THE COURT REPORTER: Doctor, do you want to read and sign your deposition?

THE WITNESS: I'll waive.

THE COURT REPORTER: What kind of copy would you like, Mr. Gessner?

MR. GESSNER: Electronic.
THE COURT REPORTER: Okay. What's your email?
MR. GESSNER: It's Evan, E-v-a-n, at oldcourthouse.com.
(WHEREUPON, THE DEPOSITION CONCLUDED AT 4:58 P.M.)

CERTIFICATE

This is to certify that the foregoing deposition of JAMES LOGING, M.D., consisting of 34 pages, is a true and correct transcript of the testimony given by said deponent after first being duly sworn; said deposition was reported by method of Stenomask with digital backup. This transcript may contain quoted material; said material is transcribed as read or quoted by the speaker.

I further certify that I am neither employed by nor related to any of the parties in this matter nor their counsel; nor do I have any interest, financial or otherwise, in the outcome of the same.

IN WITNESS WHEREOF I have hereunto set my hand and seal this 30th day of November, 2019.

_____

SHELLY M. JONES
Professional Verbatim Reporter

Notary in and for the State of South Carolina
My Commission Expires: November 7, 2023

Patient Demographics

Address	Phone	E-mail Address
304 TRENTWOOD DRIVE COLUMBIA SC 29223	803-736-6629 (Home) 803-446-2061 (Mobile)	dianeconnell88@gmail.com

Admission Information - Patient Record Only

Arrival Date/Time:	09/26/2017 1211	Admit Date/Time:	09/26/2017 1230	IP Adm. Date/Time:	
Admission Type:	Emergency	Point of Origin:	Non-healthcare Facility	Admit Category:	
Means of Arrival:	Car	Primary Service:	Orthopedics	Secondary Service:	N/A
Transfer Source:		Service Area:	Lchsd Service Area	Unit:	Lmc 5th Flr Nt
Admit Provider:	Beard, Hoyt R., MD	Attending Provider:	Hensley, Terry G, MD	Referring Provider:	

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/28/2017 1540	Home Or Self Care	None	None	Lmc 5th Flr Nt

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
S82.042A [Principal]	Displaced comminuted fracture of left patella, initial encounter for closed fracture				
S93.401A	Sprain of unspecified ligament of right ankle, initial encounter				
M25.532	Pain in left wrist				
M25.571	Pain in right ankle and joints of right foot				
Z47.89	Encounter for other orthopedic aftercare				

EXHIBIT 1
Deponent Loggins
Date 11/20/19 Rptr. SM
WWW.DEPOBOOKPRODUCTS.COM

ED Provider Notes

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619

Author: Hensley, Terry G, MD | Service: Emergency Medicine | Author Type: Physician
Filed: 09/26/17 1619 | Date of Service: 09/26/17 1247 | Status: Signed
Editor: Hensley, Terry G, MD (Physician)

History

Chief Complaint

Patient presents with:
- Extremity pain/injury
  pt reports falling off of curb, c/o L knee pain, swelling and small abrasions to L knee, also reports hitting head, denies LOC

HPI Comments: Patient was accompanying her husband to an office appointment in the North Tower. Wall walking out of the parking garage she tripped on the entrance and fell landing on her left knee. She suffered the injured left knee, right ankle, left wrist. Unable to bear weight on the left knee. Abrasions to left knee.

No injury to her head or neck. No loss of consciousness.

Patient is a 66 y.o. female.The history is provided by the patient.
Fall
Fall occurred how long ago?: **1 hour**
Height of fall: **From standing**
Cause of fall: **Tripped**
Point of impact: **Other (left knee, right ankle, left wrist, left head)**
Treatment on scene: **No treatment**
Pain Location: **Other (comment) (left knee, right ankle, left wrist)**
Severity of pain: **Moderate**
Relieved by: **Rest**
Exacerbated by: **Activity and palpation**
Associated symptoms: **gait problem (unable to bear weight on left knee), joint swelling, localized swelling** and **wound (left knee abrasions)**
Associated symptoms: **no dizziness** and **no headaches (denies)**

No past medical history on file.

Past Surgical History:

Procedure	Laterality	Date
• ATRIAL ABLATION SURGERY		

No family history on file.

Social History

Social History Narrative:
- No narrative on file

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

Social History
Substance Use Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use No

Review of Systems
Constitutional: Negative for chills and fever.
HENT: Negative for congestion, rhinorrhea and sore throat.
Eyes: Negative for visual disturbance.
Respiratory: Negative for cough and shortness of breath.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for nausea, vomiting, abdominal pain and diarrhea.
Genitourinary: Negative for dysuria.
Musculoskeletal: Positive for arthralgias **(left knee, right ankle, left wrist)**, gait problem **(unable to bear weight on left knee)** and joint swelling. Negative for back pain and neck pain.
Skin: Positive for wound **(left knee abrasions)**. Negative for rash.
Neurological: Negative for dizziness, syncope, weakness, numbness and headaches **(denies)**.
Hematological: Negative for adenopathy.

Physical Exam

Initial ED Vital Signs:
Blood Pressure: 170/79 Heart Rate: 78 Temp: 98.5 °F (36.9 °C) Resp: 20 SpO2: 97 %

Last Documented Vital Signs This Encounter:
Blood Pressure: 128/49
MAP (mmHg): 85
Heart Rate: 75
Temp: 98.5 °F (36.9 °C)
Resp: 20
SpO2: 96 %
Height: 5' 6" (167.6 cm)
Weight: 68 kg (150 lb)

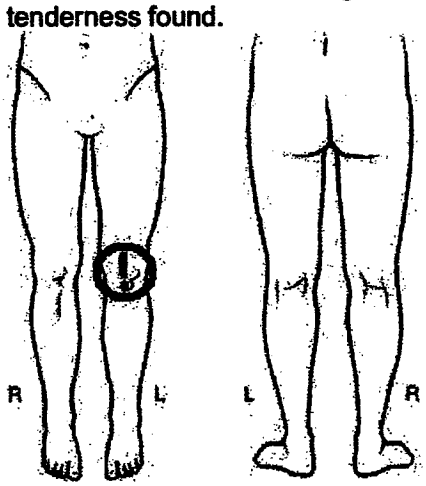
height is 5' 6" (1.676 m) and weight is 68 kg (150 lb). Her temperature is 98.5 °F (36.9 °C). Her blood pressure is 128/49 and her pulse is 75. Her respiration is 20 and oxygen saturation is 96%.

Physical Exam
Constitutional: She appears well-developed and well-nourished. She appears distressed.
Appears to be in pain, but is non-toxic in appearance
HENT:
Head: Normocephalic and atraumatic.
Nose: Nose normal.

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

Mouth/Throat: Oropharynx is clear and moist.
Mild left parietal scalp tenderness. No scalp hematoma. No scalp laceration or abrasion or contusion.
Eyes: Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.
Neck: Normal range of motion. No spinous process tenderness and no muscular tenderness present. No tracheal deviation and normal range of motion present.
Cardiovascular: Normal rate and regular rhythm.
No murmur heard.
Pulmonary/Chest: Effort normal. No respiratory distress.
Musculoskeletal: She exhibits edema and tenderness. She exhibits no deformity.
Right wrist: She exhibits normal range of motion, no tenderness and no bony tenderness.
Left wrist: She exhibits tenderness. She exhibits normal range of motion, no bony tenderness, no swelling and no effusion.
Right hip: She exhibits normal range of motion, no tenderness and no bony tenderness.
Left hip: She exhibits normal range of motion, normal strength and no bony tenderness.
Right knee: She exhibits normal range of motion, no swelling and no effusion. No tenderness found.
Left knee: She exhibits decreased range of motion, swelling, effusion and ecchymosis. Tenderness found.
Right ankle: She exhibits decreased range of motion, swelling and ecchymosis. Tenderness. Lateral malleolus tenderness found. No medial malleolus tenderness found.
Left ankle: She exhibits normal range of motion. No tenderness. No lateral malleolus and no medial malleolus tenderness found.



Legs:
Left knee: Swelling and tenderness over the patella. Overlying skin abrasion but no full-thickness laceration. Some ecchymosis over the patellar surface. Possible small effusion. Full extension left knee but pain limited flexion. Pain limited anterior and posterior drawer testing. Stable to valgus and varus stress. Left foot dorsalis pedis 2+.

Right ankle: Swelling over the lateral malleous. Ankle stable to anterior drawer testing. No open wound or laceration. Right foot dorsalis pedis pulses 2+.

Left wrist: Some ecchymosis on the flexor surface of left wrist. No bony tenderness. No effusion. No open wound or laceration. Flexion and extension left wrist are intact. Left radial pulses 2+.
Lymphadenopathy:
She has no cervical adenopathy.
Neurological: She is alert. She exhibits normal muscle tone. Coordination normal.
Skin: Skin is warm and dry. Abrasion, bruising and ecchymosis noted. She is not diaphoretic. No pallor.

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

Left knee: Swelling and tenderness over the patella. Overlying skin abrasion but no full-thickness laceration. Some ecchymosis over the patellar surface. Possible small effusion. Full extension left knee but pain limited flexion. Pain limited anterior and posterior drawer testing. Stable to valgus and varus stress. Left foot dorsalis pedis 2+.

Right ankle: Swelling over the lateral malleous. Ankle stable to anterior drawer testing. No open wound or laceration. Right foot dorsalis pedis pulses 2+.

Left wrist: Some ecchymosis on the flexor surface of left wrist. No bony tenderness. No effusion. No open wound or laceration. Flexion and extension left wrist are intact. Left radial pulses 2+.
Psychiatric: She has a normal mood and affect. Her behavior is normal.
Nursing note and vitals reviewed.

ED Course

Procedures

XR Wrist Left PA Lateral and Oblique
Final Result
No acute displaced fractures are seen.

XR Knee Left AP Lateral and Both Obliques
Final Result

XR Ankle Right AP Lateral and Oblique
Final Result
Unremarkable right ankle.

No results found for this visit on 09/26/17.

All Medication Administration through 09/26/2017 1619

Date/Time	Order	Dose	Route	Action	Action by
09/26/2017 1256	**HYDROmorphone (DILAUDID) injection 1 mg**	1 mg	Intravenous	Given	Veronee, Jo Ann, RN
09/26/2017 1256	**ondansetron (ZOFRAN) injection 4 mg**	4 mg	Intravenous	Given	Veronee, Jo Ann, RN
09/26/2017 1349	**HYDROmorphone (DILAUDID) injection 0.5 mg**	0.5 mg	Intravenous	Given	Veronee, Jo Ann, RN
09/26/2017 1552	**oxyCODONE-acetaminophen (PERCOCET) 5-325 mg tablet 1 tablet**	1 tablet	Oral	Given	Lukens, Benjamin J, RN

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

ED Discharge Orders

None

ED Prescriptions

Medication	Sig	Dispense	Start Date	End Date	Auth. Provider
oxyCODONE-acetaminophen (PERCOCET) 5-325 mg tablet (Status: Discontinued)	Take 1-2 tablets by mouth every 6 (six) hours as needed for pain.	30 tablet	9/26/2017	9/26/2017	Hensley, Terry G, MD

Diagnosis:

Final diagnoses

Acute pain of left knee
Acute right ankle pain
Wrist pain, acute, left
Closed displaced comminuted fracture of left patella, initial encounter (Primary)
Ankle sprain

Follow Up Instructions:

Dedmond, Barnaby T, MD
146 Hospital Drive N
Suite 140
West Columbia SC 29169
803-936-7230

In 1 day
tomorrow at 10am

Disposition: Admit
Departure Condition: Stable

LMC ED MDM NO CC TIME:
Review of Previous: **Notes**
Notes comment: **Records reviewed: Patient seen and evaluated by cardiology on July 14, 2016**
Interpretation: **X-ray, pulse ox and labs**
Labs comment: **Labs reviewed: Chemistry: Pending. CBC: Pending.**
X-Rray comment: **Left knee films: Comminuted fracture of the patella. Effusion. Right ankle films: No acute fracture. Left wrist films: No acute fracture.**

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

Pulse Ox comment: **Pulse ox symmetry is 97% on room air.**
Consult other physician: **Yes**
Consults: **Orthopedics (Patient discussed with the surgeon on-call, Dr. Beard. Patient is unable to utilize knee immobilizer and crutches in the ED. Her pain is not well controlled. Dr. Beard agrees to admit the patient for further evaluation and treatment.)**
Patient Progress: **Improved**
MDM Comments:
I personally reviewed and interpreted and acted on all labs/ radiology/ urine/ pulse ox/ EKG's ordered on this patient.

ED Course

HENSLEY, TERRY G- was the Primary ED Provider for this patient.

Hensley, Terry G, MD
09/26/17 1619

Electronically Signed by Hensley, Terry G, MD on 09/26/17 1619

Discharge Summaries

Discharge Summaries by Russell, Martha K., NP on 09/28/17 0750

Author: Russell, Martha K., NP | Service: Orthopedics | Author Type: Nurse Practitioner
Filed: 09/28/17 0750 | Date of Service: 09/28/17 0744 | Status: Signed
Editor: Russell, Martha K., NP (Nurse Practitioner) | Cosigner: Dedmond, Barnaby T, MD at 09/28/17 0806

LMC SURGICAL DISCHARGE/TRANSFER SUMMARY NOTE:

PATIENT: Diane M Connell	**DATE OF BIRTH:** 5/31/1951
ACCOUNT NUMBER: 100023195855	**MR#:** M002014739
ADMISSION DATE/TIME: 9/26/2017 12:30 PM	**ADMITTING PROVIDER:** Hoyt R. Beard, MD
DISCHARGE DATE: 9/28/2017	**DISCHARGING PROVIDER:** Russell, Martha K.

ADMISSION DIAGNOSIS: Ankle sprain [S93.409A]

Discharge Summaries (continued)

Discharge Summaries by Russell, Martha K., NP on 09/28/17 0750 (continued)

Closed displaced comminuted fracture of left patella, initial encounter [S82.042A]
Wrist pain, acute, left [M25.532]
Acute pain of left knee [M25.562]
Acute right ankle pain [M25.571]

ACTIVE & RESOLVED PROBLEMS:

Active Hospital Problems

Diagnosis
• Closed displaced comminuted fracture of left patella
• Fracture of left patella

Resolved Hospital Problems

Diagnosis	Date Resolved

No resolved problems to display.

PROCEDURES: Procedure(s) (LRB):
OPEN REDUCTION INTERNAL FIXATION LEFT PATELLA FRACTURE (Left)
No procedure orders placed in the past 24 hours

CONSULTS: CONSULT TO ORTHOPEDIC SURGERY
CONSULT TO SOCIAL WORK

LABS PAST 24 HOURS:

HOSPITAL COURSE:
Diane M Connell is a 66 y.o. female who was admitted on 9/26/2017.

Primary reason for admission was Left Patella fracture
They underwent the following procedures.
Procedure(s) (LRB):
OPEN REDUCTION INTERNAL FIXATION LEFT PATELLA FRACTURE (Left)
Non op management of right ankle sprain

They did work with physical therapy. During their last session, they were able to do the following.

* Pending as of 0745 - has not yet been evaluated by PT. If safe may be discharged to home.

During the hospitalization, there were not additional medical issues.

Discharge diet: Regular
Discharge Pain medication: Norco
Discharge Therapy Instructions:
Weight bearing status: As tolerated to left lower extremity and right lower extremity

Discharge Summaries (continued)

Discharge Summaries by Russell, Martha K., NP on 09/28/17 0750 (continued)

DISCHARGE DISPOSITION: Home or Self Care

DISCHARGE:

Discharge Medications

(Listed on patient's AVS)

amphetamine-dextroamphetamine 20 mg tablet
Take 15 mg by mouth daily.
Commonly known as: ADDERALL

ciclopirox 8% solution
Apply topically daily.
Commonly known as: PENLAC

*** clomiPRAMINE 50 mg capsule**
Last Dose Given: 100 mg on 9/27/2017 9:00 PM
Take 50 mg by mouth nightly.
Commonly known as: ANAFRANIL

*** clomiPRAMINE 25 MG capsule**
Last Dose Given: 100 mg on 9/27/2017 9:00 PM
Take 25 mg by mouth nightly.
Commonly known as: ANAFRANIL

Cranberry 500 MG Chew
Chew 500 mg by mouth daily.

diazePAM 5 mg tablet
Last Dose Given: 5 mg on 9/27/2017 1:22 AM
Take 5 mg by mouth nightly as needed.
Commonly known as: VALIUM

escitalopram 20 mg tablet
Take 20 mg by mouth daily.
Commonly known as: LEXAPRO

*** gabapentin 300 mg capsule**
Last Dose Given: 300 mg on 9/28/2017 6:27 AM
Take 300 mg by mouth 2 (two) times daily. Breakfast and lunch
Commonly known as: NEURONTIN

*** gabapentin 300 mg capsule**
Last Dose Given: 300 mg on 9/28/2017 6:27 AM
Take 600 mg by mouth nightly.
Commonly known as: NEURONTIN

GLUCOSAMINE CHONDROITIN ADV Tabs
Take 2 tablets by mouth daily.

HYDROcodone-acetaminophen 7.5-325 mg tablet
Last Dose Given: 1 tablet on 9/28/2017 2:49 AM
Take 1-2 tablets by mouth every 6 (six) hours as needed.
Commonly known as: NORCO

Discharge Summaries (continued)

Discharge Summaries by Russell, Martha K., NP on 09/28/17 0750 (continued)

pravastatin 40 mg tablet
Last Dose Given: 20 mg on 9/27/2017 5:45 PM
Take 20 mg by mouth daily with dinner.
Commonly known as: PRAVACHOL

vitamin D3 1000 units tablet
Take 2,000 Units by mouth daily.
Commonly known as: CHOLECALCIFEROL

Patient discharged in Stable condition

They should follow up in 2 weeks with
Barnaby Dedmond, MD or Kitty Russell, NP
Lexington Orthopaedics
146 North Hospital Drive, Suite 140
West Columbia, South Carolina 29169
PHONE: 803-936-7230

Russell, Martha K.

Electronically Signed by Dedmond, Barnaby T, MD on 09/28/17 0806

History & Physicals

No notes of this type exist for this encounter.

Encounter-Level H&P Scans:

There are no encounter-level h&p scans.

Operative Notes

Op Note by Dedmond, Barnaby T, MD on 09/27/17 1224

Author: Dedmond, Barnaby T, MD Service: Orthopedics Author Type: Physician
Filed: 09/27/17 1224 Date of Service: 09/27/17 1149 Status: Signed
Editor: Dedmond, Barnaby T, MD (Physician)

OPERATIVE NOTE:

9/27/2017 12:17 PM

PROCEDURE(S): Procedure(s):
OPEN REDUCTION INTERNAL FIXATION LEFT PATELLA FRACTURE

PREOPERATIVE DIAGNOSIS: LEFT PATELLA FRACTURE

POSTOPERATIVE DIAGNOSIS: LEFT PATELLA FRACTURE

SURGEON(S): Surgeon(s) and Role:
* Dedmond, Barnaby T, MD - Primary

ASSISTANT:
* Russell, Martha K, NP - Assisted with maintenance of reduction while I placed the implants as well as retraction, closure, and splint application

ANESTHESIOLOGIST: Richards, Frederick Lee, MD

ANESTHESIA TYPE(S): General

ASA: II

MEDICATIONS:
Intraop Administered Meds from 09/17/2017 1217 to 09/27/2017 1217
None

ESTIMATED BLOOD LOSS: Estimated Blood Loss
In: 2265
Out: - 50cc

DRAINS: none

SPECIMEN(S): * No specimens in log *

IMPLANT(S):

Implant Name	Type	Inv. Item	Serial No.	Manufacturer	Lot No.	LRB	No. Used	Action
SUTURE WIRE	Wire	SUTURE WIRE		JOHNSON AND		Left	1	Implanted

Operative Notes (continued)

Op Note by Dedmond, Barnaby T, MD on 09/27/17 1224 (continued)

STEEL 18G DS-18 - LOG171741		STEEL 18G DS-18		JOHNSON				
ZIMMER 1.6 K- WIRE				ZIMMER		Left	2	Implanted

COMPLICATIONS: There were no complications

OPERATIVE INDICATIONS: Patient sustained a displaced left patella fracture as noted in the preoperative history and physical. Options for treatment of this fracture have been discussed with the patient and their family. They express understanding of the risks, benefits, and alternatives. Specifically we have discussed the options of nonoperative management versus open reduction and internal fixation. They wish to proceed with open reduction and internal fixation, understanding the risks of bleeding, infection, nerve damage, nonunion, malunion, wound complications, need for future surgery including hardware removal, knee stiffness, post-traumatic arthritis, anesthesia complications, deep venous thrombosis, death, and other unforeseen complications.

DESCRIPTION OF PROCEDURE: The patient was identified in the holding area and taken back to the operating room, then placed supine upon the operating table. Anesthesia was administered. After informed consent had been assured and preoperative antibiotics given, the affected lower extremity was prepped and draped in standard sterile fashion. The knee was approached through a midline incision over its subcutaneous border anteriorly. The fracture was exposed and cleared of interposing debris. The fracture was fairly comminuted. NP Russell assisted with the reduction. A tenaculum clamp was placed across the fracture. The fracture was stabilized with a figure of eight tension band wiring technique. Two 1.6 mm guide pins were passed across the fracture site from inferiorly to superiorly in parallel fashion. Position was verified by fluoroscopy and noted to be good. An 18 gauge stainless steel wire was then passed beneath the two wires proximally and distally crossing the fracture site in a figure of eight fashion. The wire was then twisted to tighten it down providing compression across the fracture. This resulted in nice stability of the fracture. The k-wires were then cut and bent over top of the 18 gauge wire and buried in the soft tissues. Fluoroscopic imaging verified good hardware position and fracture reduction. The knee was taken through a range of motion and the fracture noted to be stable.

Wounds were then thoroughly irrigated and closed in layered fashion. First the medial and lateral retinaculum was closed, followed by a deep layer, subcutaneous layer and skin. Sterile dressings were applied followed by a knee immobilizer. The patient tolerated the procedure well and was transported to the recovery room in stable condition.

FOLLOW UP PLANS: The patient will follow up in 2 weeks for wound evaluation. They will be transitioned to a hinged knee brace which is locked in extension when they are walking but allowed to bend to 90 degrees when not weightbearing. They may be weight bearing as tolerated with the brace locked in full extension.

Dedmond, Barnaby T

Electronically Signed by Dedmond, Barnaby T, MD on 09/27/17 1224

Operative Notes (continued)

Procedure Notes

No notes of this type exist for this encounter.

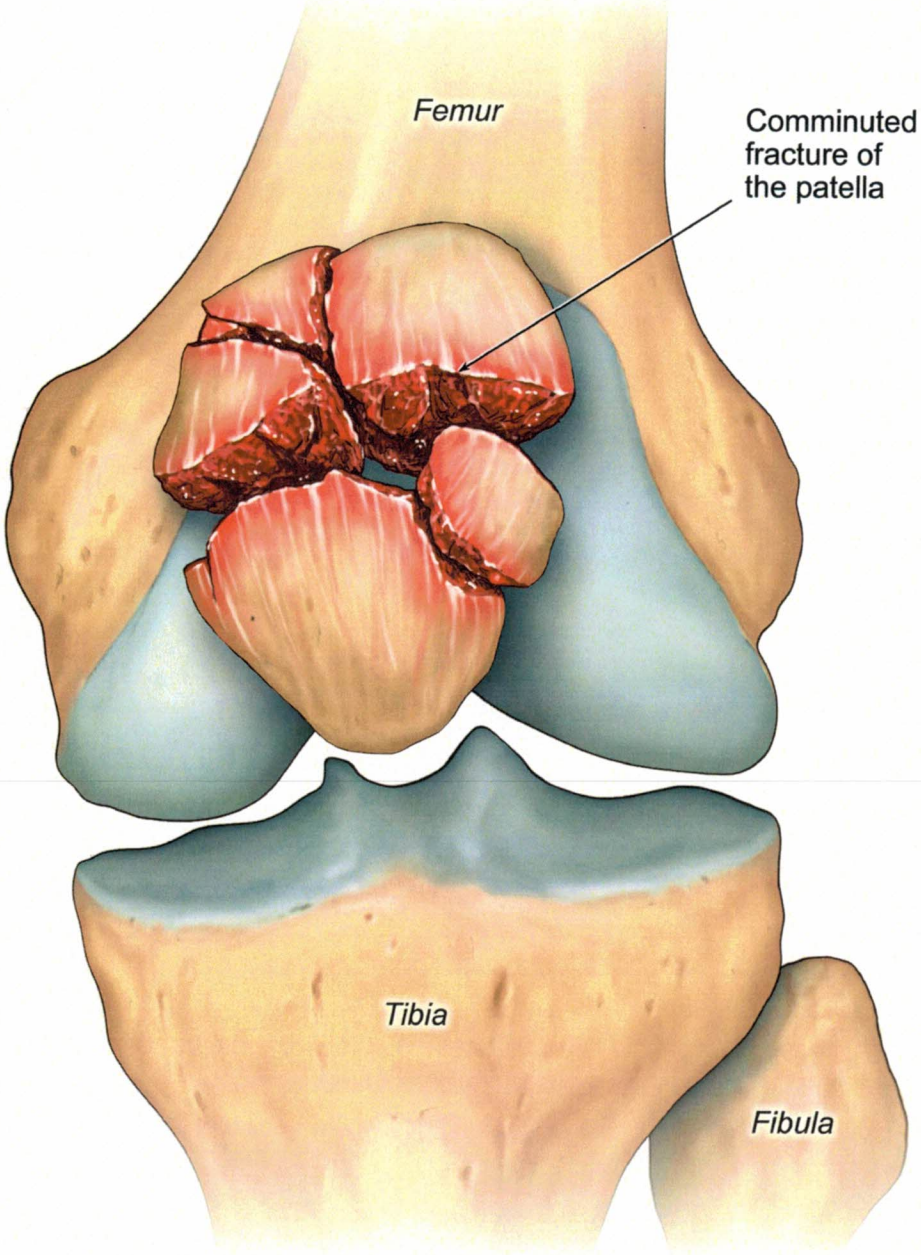
Anesthesia Post-Op Notes

No notes of this type exist for this encounter.

Delivery Notes

No notes of this type exist for this encounter.

Diane Connell's Left Knee Fractures



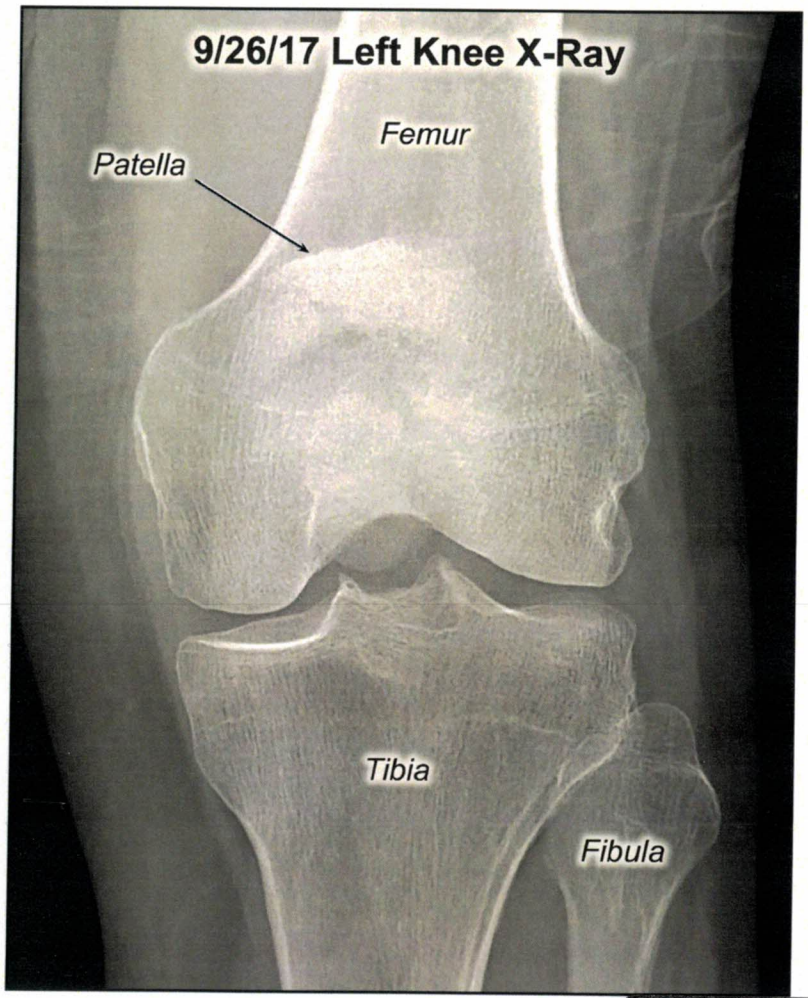
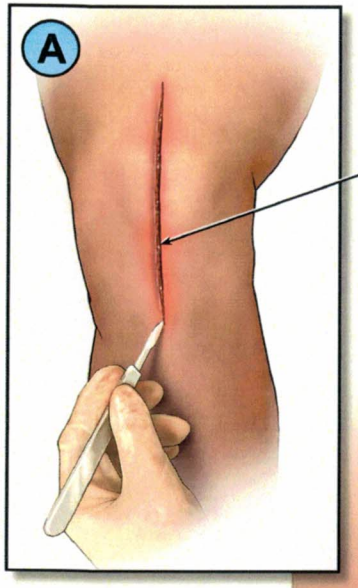
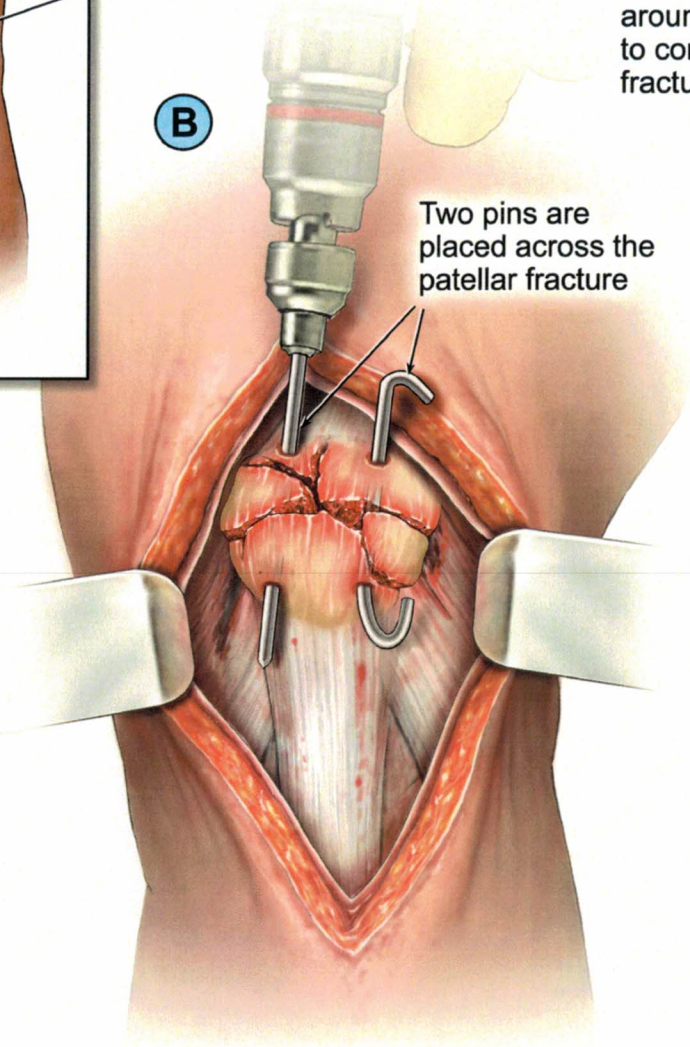


EXHIBIT 2
Deponent Loging
Date 11/25/19 Rptr. SMJ
WWW.DEPOBOOKPRODUCTS.COM

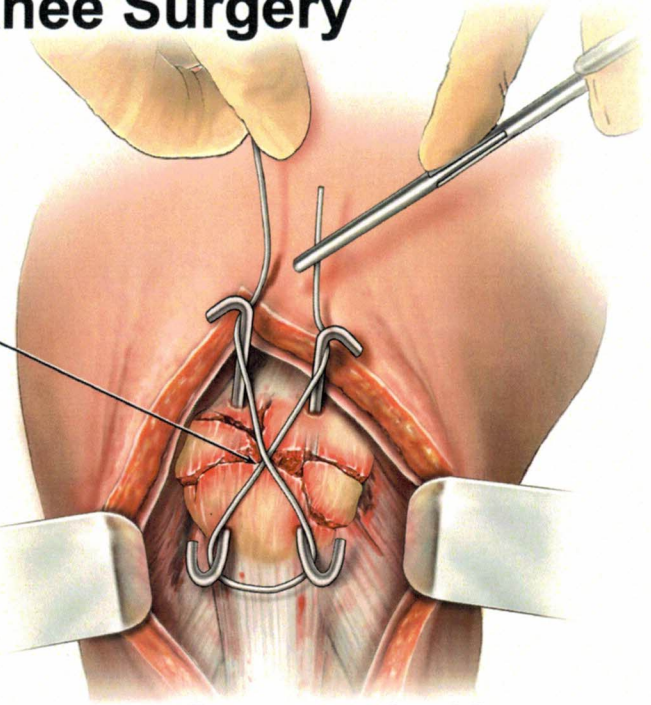
Diane Connell's 9/27/17 Left Knee Surgery



Midline incision over the anterior knee

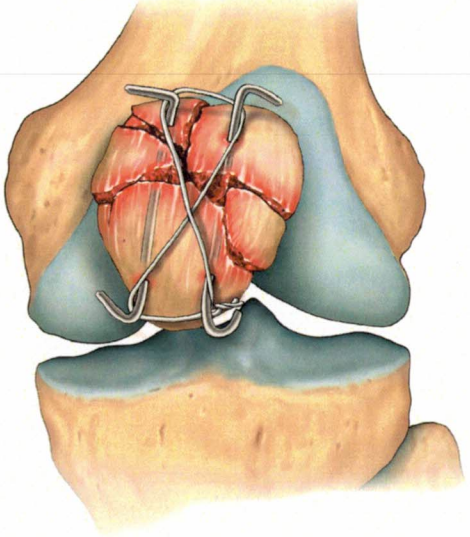


Two pins are placed across the patellar fracture

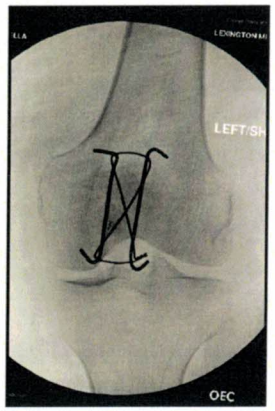


A wire is wrapped around the pins to compress the fracture fragments

Postoperative View



9/27/17 X-Ray



Admission Information - Patient Record Only

Arrival Date/Time:	10/12/2017 0851	Admit Date/Time:	10/12/2017	IP Adm. Date/Time:	
Admission Type:		Point of Origin:		Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:		Unit:	
Admit Provider:	Dedmond, Barnaby T, MD	Attending Provider:		Referring Provider:	

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	LEXINGTON ORTHOPAEDICS WEST COLUMBIA

Allergies as of 10/12/2017

Review Complete On: **9/27/2017** By: **Coleman, Kayla B, RN**

No Known Allergies

Medical as of 10/12/2017

None

Surgical as of 10/12/2017

Past Surgical History	Laterality	Date	Comments
ATRIAL ABLATION SURGERY [SHX560]			
SPINE SURGERY [SHX786]			buldging disc

Problem List

	Noted	Resolved
Closed displaced comminuted fracture of left patella	9/26/2017 by Beard, Hoyt R., MD	No
Fracture of left patella	9/27/2017 by Dedmond, Barnaby T, MD	No

Family History as of 10/12/2017

No family history on file.

ED Records

ED Arrival Information

Patient not seen in ED

Chief Complaint History

User	Date & Time
Bartley, Christin S, MA	**10/12/2017 8:52 AM**

Chief Complaint

Left Knee - Post-op
Comment: 2 weeks s/p ORIF Left patella fracture

ED Notes

No notes of this type exist for this encounter.

Urgent Care Notes

Urgent Care Notes

No notes of this type exist for this encounter.

Encounter Notes

EXHIBIT 3
Deponent Loging
Date 1/25/19 Rptr. SMJ
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Encounter Notes

Progress Notes by Dedmond, Barnaby T, MD on 10/12/17 0931 Version 1 of 1

Author: Dedmond, Barnaby T, MD | Service: (none) | Author Type: Physician
Filed: 10/12/17 0931 | Encounter Date: 10/12/2017 | Status: Signed
Editor: Dedmond, Barnaby T, MD (Physician)

FOLLOW UP VISIT

REASON FOR VISIT

Patient ID: Diane M Connell is a 66 y.o. female.

Reason for visit:
Chief Complaint
Patient presents with
- Left Knee - Post-op
  2 weeks s/p ORIF Left patella fracture[LS1.1]

SUBJECTIVE:

Pain is controlled. Mobilizing with a walker but doing very well. Denies fevers or chills.

OBJECTIVE:

left Lower Extremity:
Incisions are benign. No signs of infection.
Extensor mechanism is palpably intact. Able to do a straight leg raise with ease.
Foot is perfused.
Some swelling as expected.
Motor and sensory function is intact distally.

ASSESSMENT/PLAN:

Diagnoses and all orders for this visit:

Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter
- Hinged Knee Brace
- XR Knee Left AP and Lateral; Future

Staples are removed today.
They are transitioned to a hinged knee brace.
They are weight bearing as tolerated with the knee braced locked in full extension.
When not walking, the brace will be set at 0 to 90 degrees of flexion and they are instructed to work on knee ROM within this range.
Follow up in 4 weeks for either unlocking of the brace or if quad strength permits discontinuation of the brace altogether. Will obtain new xrays of left knee out of the brace at that visit.
As always, I am happy to see them back sooner if there are concerns.[BD1.1]

Encounter Notes (continued)

Progress Notes by Dedmond, Barnaby T, MD on 10/12/17 0931 (continued) Version 1 of 1

Electronically Signed by Dedmond, Barnaby T, MD on 10/12/17 0931

Revision History

User Key	Date/Time	User	Provider Type	Action
> BD1.1	10/12/17 0931	Dedmond, Barnaby T, MD	Physician	Sign
LS1.1	10/12/17 0900	Skinner, Latasha Q, MOT	Medical Office Technician	Sign at close encounter

Surgery Report

Anesthesia Post-Op Notes

No notes of this type exist for this encounter.

Imaging - Clinical Orders

XR Knee Left AP and Lateral [92308904]

Electronically signed by: **Dedmond, Barnaby T, MD on 10/12/17 0926** Status: **Completed**
Ordering user: Dedmond, Barnaby T, MD 10/12/17 0926 Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD
Frequency: 10/12/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]
Order comments:
After brace removal

Equipment - Other Orders

Hinged Knee Brace [92308903]

Electronically signed by: **Dedmond, Barnaby T, MD on 10/12/17 0926** Status: **Active**
Ordering user: Dedmond, Barnaby T, MD 10/12/17 0926 Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD
Frequency: 10/12/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]

Outpatient Referral - Other Orders

Referral to Home Health [92308905]

Electronically signed by: **Dedmond, Barnaby T, MD on 10/12/17 0939** Status: **Active**
Ordering user: Dedmond, Barnaby T, MD 10/12/17 0939 Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD
Frequency: 10/12/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]
Questions:
Service to evaluate and treat patient: Physical Therapy Comment - WBAT with brace locked in extension, Unlock brace when not walking to work on ROM from 0-90 degrees of flexion

Clinical Lab Results

Lab, Radiology, ECG/EMG and Cardiac Results

No results found

Clinical Lab Results (continued)

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

No education to display

Discharge Instructions

Connell, Diane M (MR # M002014739)

None

Diane M Connell

Oncology

Diane M Connell does not have an active treatment plan of type ONCOLOGY TREATMENT in this episode.

Flowsheet Data

All Flowsheet Data (10/12/17 0000–10/12/17 2359)

Encounter Vitals

	10/12/17 0859
Enc Vitals	
Resp	16 -CB
Weight	68 kg (149 lb 14.6 oz) -CB
Height	5' 6" (1.676 m) -CB
Pain Score	Four -CB

Custom Formula Data

	10/12/17 0859
OTHER	
ABW	62.78 -CB
BSA (Calculated - sq m)	1.78 sq meters -CB
BMI (Calculated)	24.2 -CB
IBW/kg (Calculated) Male	63.8 kg -CB
IBW/kg (Calculated) FEMALE	59.3 kg -CB
Weight in (lb) to have BMI = 25	154.6 -CB
BMI	24.2 -CB
Ideal Body Weight (kg)	58.97 kg -CB
Ideal Body Wgt (lb)	130 lb -CB
Percent of Ideal Body Weight	115.32 Percent -CB
Excess Body Weight (kg)	9.01 kg -CB
Excess Body Wgt (lb)	19.91 lb -CB
Percent Weight Change Since Birth	0 -CB
IBW/kg (Calculated)	59.3 -CB
Low Range Vt 6cc/kg	355.8 mL -CB
Adult Moderate Range Vt 8cc/kg	474.4 mL -CB
Adult High Range Vt 10cc/kg	593 mL -CB
Adult IBW/VT Calculations	
IBW percentage	4044.86 -CB

Pain Assessment

	10/12/17 0859
Pain Assessment	
Pain Score	Four -CB
ED Pain Assessment Timer	
ED Auto Pain Reassessment	Yes -CB

Anthropometrics

	10/12/17 0859
Anthropometrics	
Height	5' 6" (1.676 m) -CB
Weight	68 kg (149 lb 14.6 oz) -CB
Weight Change	0 % -CB
BMI (Calculated)	24.2 -CB

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
CB	Bartley, Christin S, MA	09/14/17 -

Flowsheet Row Details (all recorded)

BMI

BMI (continued)

Effective: 02/03/16

Row Information: BMI=Body Mass Index.(Weight Scale/35.2)/(Height*0.0254)^2Threshold of overweight (BMI>/= 25 Kg/m)source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BMI (Calculated)

Effective: 06/02/06

Row Information: BMI=Body Mass Index.
(Weight Scale/35.2)/(Height*0.0254)^2
Threshold of overweight (BMI>/= 25 Kg/m)
source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BSA (Calculated - sq m)

Effective: 06/02/06

Row Information: BSA=Body Surface Area.
BSA (sq meters) = sqrt([Height (cm) x Weight (kg)]/3600)
.
BSA is calculated using the Mosteller Formula. Mosteller RD: Simplified Calculation of Body Surface Area. N Engl J Med 1987 Oct 22;317(17):1098.

Height

Warning Min/Max	Absolute Min/Max
1' (0.305 m) / 8' (2.438 m)	1.18" (0.03 m) / 9' 10.11" (3 m)

Ideal Body Weight (kg)

Effective: 02/03/16

Row Information: Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Ideal Body Wgt (lb)

Effective: 02/03/16

Row Information: Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Pain Score

Zero = 0-No pain
One = 1
Two = 2
Three = 3
Four = 4
Five = 5
Six = 6
Seven = 7
Eight = 8
Nine = 9
Ten = 10-Worst pain ever

Resp

Warning Min/Max	Absolute Min/Max
8 / 30	0 / 200

Weight

Warning Min/Max	Absolute Min/Max
5 lb (2.268 kg) / 300 lb (136.1 kg)	0.1 oz (0.003 kg) / 1500 lb (680.4 kg)

Weight in (lb) to have BMI = 25

Effective: 09/15/10

Row Information: Uses height to find what their weight would need to be in order to have a BMI of 25.

Flowsheet Notes

No notes of this type exist for this encounter.

Patient-Level E-Signatures:

HIPAA Notice of Privacy - Received on 9/26/2017

Acknowledgement of Receipt of Notice of Privacy Practices

Name: Connell,Diane M

Patient-Level E-Signatures: (continued)

Address: 304 TRENTWOOD DRIVE

City/State/Zip: COLUMBIA SC 29223

Telephone: 803-736-6629 **Account/Chart Number:** M002014739
CSN: 100023195855

I have received a copyof the Notice of Privacy Practices.

Diane Connell
9/26/2017 12:39:12 PM Patient Signature **9/26/2017**
Signature of Patient or Authorized Person Date

Relationship to Individual

Hospital Account-Level E-Signatures:
There are no hospital account-level e-signatures.

Encounter-Level E-Signatures:
There are no encounter-level e-signatures.

All Scans

Encounter-Level Documents:
There are no encounter-level documents.

Order-Level Documents:
There are no order-level documents.

Patient-Level Documents:
PN Auth Lexington Orthopaedics - Scan on 10/12/2017 0903 : Perceptive Content Scan (below)

LeXington ORTHOPAEDICS
A Lexington Medical Center Physician Practice

811 W. Main Street, Suite 101
Lexington, SC 29072
Ph: (803) 936-7230
Fx: (803) 358-6208

7033 St. Andrews Road
Suite 104, Columbia, SC 29212
Ph: (803) 936-7230
Fx: (803) 749-9675

Lexington Medical Park 2
146 North Hospital Drive, Suite 140
West Columbia, SC 29169
Ph: (803) 936-7230 • Fx: (803) 936-8097

Lex-Ortho.com

Lexington Medical Center

Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of **Lexington Orthopaedics** who may attend me, their assistants, including those employed by **Lexington Orthopaedics** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. DMC (*initials*)

I authorize LMC Physician Practices to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose._____ (*initials*)

I consent and give permission to **Lexington Orthopaedics** to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to LMC Physician Practices and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to LMC Physician Practices, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to LMC Physician Practices and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. _____ (*initials*)

Print Patient Name: Diane DOB: _____

Patient Signature: _____ Date: _____

Responsible Party Signature (if different): _____ Date: _____

8338-C33-1 (02/16)

Admission Information - Patient Record Only

Arrival Date/Time:	11/09/2017 0936	Admit Date/Time:	11/09/2017	IP Adm. Date/Time:	
Admission Type:		Point of Origin:		Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:		Unit:	
Admit Provider:	Dedmond, Barnaby T, MD	Attending Provider:		Referring Provider:	Dedmond, Barnaby T, MD

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	LEXINGTON ORTHOPAEDICS WEST COLUMBIA

Allergies as of 11/9/2017 — Review Complete On: 11/9/2017 By: Barber, Tamara L, MA

No Known Allergies

Medical as of 11/9/2017 **None**

Surgical as of 11/9/2017

Past Surgical History	Laterality	Date	Comments
ATRIAL ABLATION SURGERY [SHX560]			
SPINE SURGERY [SHX786]			buldging disc

Problem List

	Noted	Resolved
Closed displaced comminuted fracture of left patella	9/26/2017 by Beard, Hoyt R., MD	No
Fracture of left patella	9/27/2017 by Dedmond, Barnaby T, MD	No

Family History as of 11/9/2017

No family history on file.

ED Records

ED Arrival Information

Patient not seen in ED

Chief Complaint History

User	Date & Time
Barber, Tamara L, MA	11/9/2017 10:35 AM

Chief Complaint

Left Knee - Follow-up

Comment: 6 weeks s/p ORIF left patella

ED Notes

No notes of this type exist for this encounter.

Urgent Care Notes

Urgent Care Notes

No notes of this type exist for this encounter.

Encounter Notes

Encounter Notes

Progress Notes by Dedmond, Barnaby T, MD on 11/09/17 1101 Version 1 of 1

Author: Dedmond, Barnaby T, MD
Filed: 11/09/17 1101
Editor: Dedmond, Barnaby T, MD (Physician)
Service: (none)
Encounter Date: 11/9/2017
Author Type: Physician
Status: Signed

FOLLOW UP VISIT

REASON FOR VISIT

Patient ID:[TB1.1] Diane M Connell[TB1.2] is a[TB1.1] 66 y.o. female[TB1.2].

Reason for visit:[TB1.1]
Chief Complaint
Patient presents with
- Left Knee - Follow-up
  6 weeks s/p ORIF left patella[TB1.2]

Doing very well. Pain controlled.

LLE: incision is benign, good quad strength, ROM 0-100 degrees, NVI

Xr Knee Left Ap And Lateral

Result Date: 11/9/2017
Patella fracture remains in good alignment with hardware in place

D/c brace.
Instructed in ROM exercises. Offered PT but patient prefers to do on her own.
F/u 6 weeks with new xrays left knee[BD1.1]

Dedmond, Barnaby T[BD1.2]

Electronically Signed by Dedmond, Barnaby T, MD on 11/09/17 1101

Revision History

	User Key	Date/Time	User	Provider Type	Action
>	BD1.2	11/09/17 1101	Dedmond, Barnaby T, MD	Physician	Sign
	BD1.1	11/09/17 1100	Dedmond, Barnaby T, MD	Physician	
	TB1.2	11/09/17 1036	Barber, Tamara L, MA	Medical Assistant	Sign at close encounter
	TB1.1	11/09/17 1035	Barber, Tamara L, MA	Medical Assistant	

Surgery Report

Anesthesia Post-Op Notes

No notes of this type exist for this encounter.

Imaging - Clinical Orders

XR Knee Left AP and Lateral [94727371]

Electronically signed by: **Dedmond, Barnaby T, MD on 11/09/17 1059**
Ordering user: Dedmond, Barnaby T, MD 11/09/17 1059
Authorized by: Dedmond, Barnaby T, MD
Ordering provider: Dedmond, Barnaby T, MD
Status: **Completed**

Imaging - Clinical Orders (continued)

XR Knee Left AP and Lateral [94727371] (continued)

Frequency: 11/09/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]

Other Orders

No orders found

Clinical Lab Results

Lab, Radiology, ECG/EMG and Cardiac Results

No results found

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

No education to display

Discharge Instructions

Connell, Diane M (MR # M002014739)

None

Diane M Connell

Oncology

Diane M Connell does not have an active treatment plan of type ONCOLOGY TREATMENT in this episode.

Flowsheet Data

All Flowsheet Data (11/09/17 0000-11/09/17 2359)

Encounter Vitals

	11/09/17 1035
Enc Vitals	
Resp	15 -TB
Weight	68 kg (149 lb 14.6 oz) -TB
Height	5' 6.14" (1.68 m) -TB
Pain Score	Two -TB

Custom Formula Data

	11/09/17 1035
OTHER	
ABW	62.98 -TB
BSA (Calculated - sq m)	1.78 sq meters -TB
BMI (Calculated)	24.1 -TB
IBW/kg (Calculated) Male	64.13 kg -TB
IBW/kg (Calculated) FEMALE	59.63 kg -TB
Weight in (lb) to have BMI = 25	155.2 -TB
BMI	24.1 -TB
Ideal Body Weight (kg)	59.29 kg -TB
Ideal Body Wgt (lb)	130.71 lb -TB
Percent of Ideal Body Weight	114.69 Percent -TB
Excess Body Weight (kg)	8.69 kg -TB
Excess Body Wgt (lb)	19.2 lb -TB
Percent Weight Change Since Birth	0 -TB
IBW/kg (Calculated)	59.63 -TB
Low Range Vt 6cc/kg	357.78 mL -TB
Adult Moderate Range Vt 8cc/kg	477.04 mL -TB
Adult High Range Vt 10cc/kg	596.3 mL -TB
Adult IBW/VT Calculations	
IBW percentage	4022.47 -TB

Pain Assessment

	11/09/17 1035
Pain Assessment	
Pain Score	Two -TB
ED Pain Assessment Timer	
ED Auto Pain Reassessment	Yes -TB

Anthropometrics

	11/09/17 1035
Anthropometrics	
Height	5' 6.14" (1.68 m) -TB
Weight	68 kg (149 lb 14.6 oz) -TB
Weight Change	0 % -TB
BMI (Calculated)	24.1 -TB

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
TB	Barber, Tamara L, MA	09/14/17 -

Flowsheet Row Details (all recorded)

BMI

BMI (continued)

Effective: 02/03/16	
Row Information:	BMI=Body Mass Index.(Weight Scale/35.2)/(Height*0.0254)^2Threshold of overweight (BMI>/= 25 Kg/m)source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BMI (Calculated)

Effective: 06/02/06	
Row Information:	BMI=Body Mass Index. (Weight Scale/35.2)/(Height*0.0254)^2 Threshold of overweight (BMI>/= 25 Kg/m) source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BSA (Calculated - sq m)

Effective: 06/02/06	
Row Information:	BSA=Body Surface Area. BSA (sq meters) = sqrt([Height (cm) x Weight (kg)]/3600) . BSA is calculated using the Mosteller Formula. Mosteller RD: Simplified Calculation of Body Surface Area. N Engl J Med 1987 Oct 22;317(17):1098.

Height

Warning Min/Max	Absolute Min/Max
1' (0.305 m) / 8' (2.438 m)	1.18" (0.03 m) / 9' 10.11" (3 m)

Ideal Body Weight (kg)

Effective: 02/03/16	
Row Information:	Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Ideal Body Wgt (lb)

Effective: 02/03/16	
Row Information:	Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Pain Score

Zero = 0-No pain
One = 1
Two = 2
Three = 3
Four = 4
Five = 5
Six = 6
Seven = 7
Eight = 8
Nine = 9
Ten = 10-Worst pain ever

Resp

Warning Min/Max	Absolute Min/Max
8 / 30	0 / 200

Weight

Warning Min/Max	Absolute Min/Max
5 lb (2.268 kg) / 300 lb (136.1 kg)	0.1 oz (0.003 kg) / 1500 lb (680.4 kg)

Weight in (lb) to have BMI = 25

Effective: 09/15/10	
Row Information:	Uses height to find what their weight would need to be in order to have a BMI of 25.

Flowsheet Notes

No notes of this type exist for this encounter.

Patient-Level E-Signatures:

HIPAA Notice of Privacy - Received on 9/26/2017

Acknowledgement of Receipt of Notice of Privacy Practices

Name: Connell,Diane M

Patient-Level E-Signatures: (continued)

Address: 304 TRENTWOOD DRIVE

City/State/Zip: COLUMBIA SC 29223

Telephone: 803-736-6629 **Account/Chart Number:** M002014739
CSN: 100023195855

I have received a copyof the Notice of Privacy Practices.

Diane Connell
9/26/2017 12:39:12 PM Patient Signature **9/26/2017**
Signature of Patient or Authorized Person Date

Relationship to Individual

Hospital Account-Level E-Signatures:
There are no hospital account-level e-signatures.

Encounter-Level E-Signatures:
There are no encounter-level e-signatures.

All Scans

Encounter-Level Documents:
There are no encounter-level documents.

Order-Level Documents:
There are no order-level documents.

Patient-Level Documents:
PN Auth Lexington Orthopaedics - Scan on 10/12/2017 0903 : Perceptive Content Scan (below)

LeXington ORTHOPAEDICS
A Lexington Medical Center Physician Practice

811 W. Main Street, Suite 101
Lexington, SC 29072
Ph: (803) 936-7230
Fx: (803) 358-6208

7033 St. Andrews Road
Suite 104, Columbia, SC 29212
Ph: (803) 936-7230
Fx: (803) 749-9675

Lexington Medical Park 2
146 North Hospital Drive, Suite 140
West Columbia, SC 29169
Ph: (803) 936-7230 • Fx: (803) 936-8097

Lex-Ortho.com

Lexington Medical Center

Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of **Lexington Orthopaedics** who may attend me, their assistants, including those employed by **Lexington Orthopaedics** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. DMC (*initials*)

I authorize LMC Physician Practices to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose._____ (*initials*)

I consent and give permission to **Lexington Orthopaedics** to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

RELEASE AND ASSIGNMENT OF BENEFITS

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Print Patient Name: Diane C _____ DOB: _____

Patient Signature: _____ Date: _____

Responsible Party Signature (if different): _____ Date: _____

8336-C33-1 (02/16)

Admission Information - Patient Record Only

Arrival Date/Time:	12/14/2017 1046	Admit Date/Time:	12/14/2017	IP Adm. Date/Time:	
Admission Type:		Point of Origin:		Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:		Unit:	
Admit Provider:	Dedmond, Barnaby T, MD	Attending Provider:		Referring Provider:	

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	LEXINGTON ORTHOPAEDICS WEST COLUMBIA

Allergies as of 12/14/2017 — **Review Complete** On: **12/14/2017** By: **Barnes, Andrea R, MA**

No Known Allergies

Medical as of 12/14/2017 ****None****

Surgical as of 12/14/2017

Past Surgical History	Laterality	Date	Comments
ATRIAL ABLATION SURGERY [SHX560]			
SPINE SURGERY [SHX786]			buldging disc

Problem List

	Noted	Resolved
Closed displaced comminuted fracture of left patella	9/26/2017 by Beard, Hoyt R., MD	No
Fracture of left patella	9/27/2017 by Dedmond, Barnaby T, MD	No

Family History as of 12/14/2017

No family history on file.

ED Records

ED Arrival Information

Patient not seen in ED

Chief Complaint History

User	Date & Time
Barnes, Andrea R, MA	12/14/2017 10:55 AM

Chief Complaint

Left Knee - Follow-up
Comment: 3 months s/p ORIF left patella.

ED Notes

No notes of this type exist for this encounter.

Urgent Care Notes

Urgent Care Notes

No notes of this type exist for this encounter.

Encounter Notes

Encounter Notes

Progress Notes by Dedmond, Barnaby T, MD on 12/14/17 1114 Version 1 of 1

Author: Dedmond, Barnaby T, MD
Filed: 12/14/17 1114
Editor: Dedmond, Barnaby T, MD (Physician)
Service: (none)
Encounter Date: 12/14/2017
Author Type: Physician
Status: Signed

FOLLOW UP VISIT

REASON FOR VISIT

Patient ID: Diane M Connell is a 66 y.o. female.

Reason for visit:
Chief Complaint
Patient presents with
- Left Knee - Follow-up
  3 months s/p ORIF left patella.[AB1.1]

DOing very well. Pain well controlled. Some soreness after prolonged activities.

LLE: FROM knee, good quad strength, mild TTP over tip of superolateral pin, NVI[BD1.1]

Xr Knee Left Ap And Lateral

Result Date: 12/14/2017
Healing patella fracture in good alignment with hardware in place[BD1.2]

COntinue to work on strengthening.

D/w patient and husband possibility of HWR if it is bothersome to her but would wait at least a year.

F/u prn.[BD1.1]

Dedmond, Barnaby T[BD1.3]

Electronically Signed by Dedmond, Barnaby T, MD on 12/14/17 1114

Revision History

User Key	Date/Time	User	Provider Type	Action
> BD1.3	12/14/17 1114	Dedmond, Barnaby T, MD	Physician	Sign
BD1.2	12/14/17 1113	Dedmond, Barnaby T, MD	Physician	
BD1.1	12/14/17 1112	Dedmond, Barnaby T, MD	Physician	
AB1.1	12/14/17 1056	Barnes, Andrea R, MA	Medical Assistant	Sign at close encounter

Surgery Report

Anesthesia Post-Op Notes

No notes of this type exist for this encounter.

Surgery Report (continued)

Orders

Clinical Orders

No orders found

Other Orders

No orders found

Clinical Lab Results

Lab, Radiology, ECG/EMG and Cardiac Results

No results found

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

No education to display

Discharge Instructions

Connell, Diane M (MR # M002014739)

None

Diane M Connell

Oncology

Diane M Connell does not have an active treatment plan of type ONCOLOGY TREATMENT in this episode.

Flowsheet Data

All Flowsheet Data (12/14/17 0000-12/14/17 2359)

Encounter Vitals

	12/14/17 1055
Enc Vitals	
Resp	15 -AB
Weight	68 kg (149 lb 14.6 oz) -AB
Height	5' 6.14" (1.68 m) -AB

Custom Formula Data

	12/14/17 1055
OTHER	
ABW	62.98 -AB
BSA (Calculated - sq m)	1.78 sq meters -AB
BMI (Calculated)	24.1 -AB
IBW/kg (Calculated) Male	64.13 kg -AB
IBW/kg (Calculated) FEMALE	59.63 kg -AB
Weight in (lb) to have BMI = 25	155.2 -AB
BMI	24.1 -AB
Ideal Body Weight (kg)	59.29 kg -AB
Ideal Body Wgt (lb)	130.71 lb -AB
Percent of Ideal Body Weight	114.69 Percent -AB
Excess Body Weight (kg)	8.69 kg -AB
Excess Body Wgt (lb)	19.2 lb -AB
Percent Weight Change Since Birth	0 -AB
IBW/kg (Calculated)	59.63 -AB
Low Range Vt 6cc/kg	357.78 mL -AB
Adult Moderate Range Vt 8cc/kg	477.04 mL -AB
Adult High Range Vt 10cc/kg	596.3 mL -AB
Adult IBW/VT Calculations	
IBW percentage	4022.47 -AB

Anthropometrics

	12/14/17 1055
Anthropometrics	
Height	5' 6.14" (1.68 m) -AB
Weight	68 kg (149 lb 14.6 oz) -AB
Weight Change	0 % -AB
BMI (Calculated)	24.1 -AB

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
AB	Barnes, Andrea R, MA	09/14/17 -

Flowsheet Row Details (all recorded)

BMI

Effective: 02/03/16

Row Information: BMI=Body Mass Index.(Weight Scale/35.2)/(Height*0.0254)^2Threshold of overweight (BMI>/= 25 Kg/m)source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BMI (Calculated)

Effective: 06/02/06

Row Information: BMI=Body Mass Index.
(Weight Scale/35.2)/(Height*0.0254)^2
Threshold of overweight (BMI>/= 25 Kg/m)
source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BSA (Calculated - sq m)

BSA (Calculated - sq m) (continued)

Effective: 06/02/06	
Row Information:	BSA=Body Surface Area. BSA (sq meters) = sqrt([Height (cm) x Weight (kg)]/3600) . BSA is calculated using the Mosteller Formula. Mosteller RD: Simplified Calculation of Body Surface Area. N Engl J Med 1987 Oct 22;317(17):1098.

Height

Warning Min/Max	Absolute Min/Max
1' (0.305 m) / 8' (2.438 m)	1.18" (0.03 m) / 9' 10.11" (3 m)

Ideal Body Weight (kg)

Effective: 02/03/16	
Row Information:	Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Ideal Body Wgt (lb)

Effective: 02/03/16	
Row Information:	Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Resp

Warning Min/Max	Absolute Min/Max
8 / 30	0 / 200

Weight

Warning Min/Max	Absolute Min/Max
5 lb (2.268 kg) / 300 lb (136.1 kg)	0.1 oz (0.003 kg) / 1500 lb (680.4 kg)

Weight in (lb) to have BMI = 25

Effective: 09/15/10	
Row Information:	Uses height to find what their weight would need to be in order to have a BMI of 25.

Flowsheet Notes

No notes of this type exist for this encounter.

Patient-Level E-Signatures:

HIPAA Notice of Privacy - Received on 9/26/2017

Acknowledgement of Receipt of Notice of Privacy Practices

Name: Connell,Diane M

Address: 304 TRENTWOOD DRIVE

City/State/Zip: COLUMBIA SC 29223

Telephone: 803-736-6629 **Account/Chart Number:** M002014739
CSN: 100023195855

I have received a copyof the Notice of Privacy Practices.

Diane Connell

9/26/2017 12:39:12 PM Patient Signature **9/26/2017**

Signature of Patient or Authorized Person Date

Patient-Level E-Signatures: (continued)

Relationship to Individual

Hospital Account-Level E-Signatures:

There are no hospital account-level e-signatures.

Encounter-Level E-Signatures:

There are no encounter-level e-signatures.

All Scans

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Patient-Level Documents:

PN Auth Lexington Orthopaedics - Scan on 10/12/2017 0903 : Perceptive Content Scan (below)

All Scans (continued)

Patient-Level Documents: (continued)

LeXington ORTHOPAEDICS
A Lexington Medical Center Physician Practice

811 W. Main Street, Suite 101
Lexington, SC 29072
Ph: (803) 936-7230
Fx: (803) 358-6208

7033 St. Andrews Road
Suite 104, Columbia, SC 29212
Ph: (803) 936-7230
Fx: (803) 749-9675

Lexington Medical Park 2
146 North Hospital Drive, Suite 140
West Columbia, SC 29169
Ph: (803) 936-7230 • Fx: (803) 936-8097

Lex-Ortho.com

Lexington Medical Center

Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of **Lexington Orthopaedics** who may attend me, their assistants, including those employed by **Lexington Orthopaedics** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. DLC (*initials*)

I authorize LMC Physician Practices to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose._____ (*initials*)

I consent and give permission to **Lexington Orthopaedics** to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to LMC Physician Practices and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to LMC Physician Practices, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to LMC Physician Practices and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. _____ (*initials*)

Print Patient Name: Diane C _____ DOB: _____

Patient Signature: _____ Date: _____

Responsible Party Signature (if different): _____ Date: _____

8338-C33-1 (02/16)

Order — **XR Knee Left AP and Lateral [IMG128] (Order 92308907)**

XR Knee Left AP and Lateral [92308906]

Electronically signed by: **Dedmond, Barnaby T, MD on 10/12/17 0926** Status: **Completed**
Ordering user: Dedmond, Barnaby T, MD 10/12/17 0926 Ordering provider: Dedmond, Barnaby T, MD

All Scans (continued)

XR Knee Left AP and Lateral [92308906] (continued)

Authorized by: Dedmond, Barnaby T, MD
Frequency: PRN 11/09/17 1036 - 1 Occurrences
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]
Order comments:
After brace removal

Result — XR Knee Left AP and Lateral (Order 92308907)

Resulted: 11/09/17 1100, Result status: Final result

XR Knee Left AP and Lateral [92308907]

Ordering provider: Dedmond, Barnaby T, MD 11/09/17 1036 | Resulted by: Dedmond, Barnaby T, MD
Performed: 11/09/17 1036 - 11/09/17 1048
Narrative:
Patella fracture remains in good alignment with hardware in place

Order — XR Knee Left AP and Lateral [IMG128] (Order 94727372)

XR Knee Left AP and Lateral [94727371]

Electronically signed by: **Dedmond, Barnaby T, MD on 11/09/17 1059** | Status: **Completed**
Ordering user: Dedmond, Barnaby T, MD 11/09/17 1059 | Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD | Ordered during: Office Visit on 11/09/2017
Frequency: 11/09/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]

Result — XR Knee Left AP and Lateral (Order 94727372)

Resulted: 12/14/17 1113, Result status: Final result

XR Knee Left AP and Lateral [94727372]

Ordering provider: Dedmond, Barnaby T, MD 12/14/17 1053 | Resulted by: Dedmond, Barnaby T, MD
Performed: 12/14/17 1055 - 12/14/17 1102
Narrative:
Healing patella fracture in good alignment with hardware in place

END OF REPORT

Palmetto
Bone & Joint, P.A.

Clinton Office: 22971 Highway 76 East, Clinton SC 29325 Phone: (864) 833-3046 Fax: (864) 833-1711
Newberry Office: 2605 Kinard Street, Suite 105, Newberry SC 29108 Phone: (803) 321-6254 Fax: (803) 321-6259
Chapin Office: 104 Ellett Road, Chapin SC 29036 Phone: (803) 941-8095 Fax: (803) 345-6088

Date of Exam	4/4/2019
Provider	James Loging
Provider NPI	1669490405
Patient Name	DIANE CONNELL
DOB	05/31/1951

History

Chief Complaint (Knee)

Presents with complaints of localized pain and grinding in the left knee that occurs during activities.

History of Present Illness (Knee)

The patient is a 67 year old female who presents with complaints of localized pain and grinding in the left knee that occurs during activities. She had prior ORIF of patella September 2018. The patient's symptoms are aggravated by daily activities, going down stairs, going up stairs. She states she can't do any stooping or squatting.

Allergies

NO KNOWN ALLERGIES

Medications

Lexapro 20mg*
Gabapentin 300mg*

Pravastatin 20mg*
Allerall 15mg*
Diazapam 5m*
Hydrocodone 5mg*

Past History

Medical History	Patient has history of blood thinners and depression.
Surgical History	Knee Surgery
Family History	Mother has history of osteoporosis and osteoarthritis.
Social History	Patient is right handed. Patient reports the use of caffeine. Patient does not use alcohol, illicit drugs or tobacco.

Review of Systems

Constitutional	No fever, fatigue, weakness or sudden weight change
Eyes	Normal visual acuity, no blurred vision or excessive tearing
HEENT	Normal auditory acuity, no nasal discharge or difficulty swallowing
Cardiovascular	No chest pains or palpitations or high blood pressure
Respiratory	No shortness of breath or cough
Gastrointestinal	No abdominal pain, heartburn, hepatitis or bleeding
Genitourinary	No dysuria or hematuria
Musculoskeletal	Patient has history of stiffness.
Skin	No rashes or jaundice
Neurological	No headache, dizziness or memory loss
Psychiatric	Patient has history of depression.

Endocrine	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic	No bruising, swollen glands or anemia
Immunological	No skin rashes, or allergies to food or medication

Vital Signs

Height (in)	66.0
Weight (lbs)	146.0
BMI	23.6

Knee Exam

Gait	The patient walks with a normal, non-antalgic heel to toe gait.
Posture	Shoulders are level, iliac crests are level, normal thoracic kyphosis, normal lumbar lordosis, no lateral curvature.

Inspection	**Right**	**Left**
Alignment		Mild.
Swelling		Negative
Ecchymosis		Negative
Effusion		Mild
Atrophy		Quadriceps femoris

Skin Left	Normal

Palpation

Tenderness	Medial joint line

	Right	**Left**
Patella Position		Neutral

Q Angle	Normal
Tilt	Equal
Crepitus	Absent
Apprehension	Negative
Popliteal Pulse	Normal

Vascular	The peripheral vascular pulses are normal, with normal capillary refill.

ROM Active	**Right**	**Left**
Flexion		135
Extension		0
ROM		Normal pain-free active range of motion.

ROM Passive	**Right**	**Left**
Flexion	135	
Extension	0	

Muscle Testing	**Right**	**Left**
Patella Reflex		2/4

Neurological	The peripheral reflexes are normal with normal distal sensation.

Imaging

Left Knee X-RAY Knee, 4 Views or More

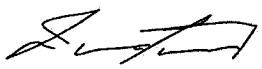
X-rays left knee are reviewed which showed hardware in place from prior ORIF of the patella. There is joint incongruity on the articular side of the patella. Patella fracture appears to be well-healed. Minimal degenerative change of the knee joint.

Diagnosis

M17.12Unilateral primary osteoarthritis, left knee
M25.562Pain in left knee

Plan

Knee I explained the pathology and its natural history of progression. I also explained the treatment options, including the benefits and complications of each of the options. Discussed removing hardware from prior ORIF of patella, these are prominent. Could consider lubricant injections for arthritis after removing hardware. Also discussed with her possible partial replacement later on. She wants to discuss options with husband, will call back when she decides.



James Loging,MD
Electronically signed on 4/5/2019 10:10 AM

Palmetto
Bone & Joint, P.A.

Clinton Office: 22971 Highway 76 East, Clinton SC 29325 Phone: (864) 833-3046 Fax: (864) 833-1711
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Provider James Loging
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ALLERGIES

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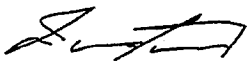

James Loging,MD
Electronically signed on 4/5/2019 10:10 AM

Moore Medical Consulting LLC
1150 Hungryneck Blvd. Ste C-378 Mt. Pleasant, SC 29464
Ph: (843)628-3377 Fax: (843)628-3388

Future Cost Analysis

Regarding:

Diane Connell

Date Completed: 6/20/2019

Lindsay Moore PA-C, CLCP

Lindsay Moore, MSPAS, PA-C, CLCP

Prepared for:

Robert Goings
Goings Law Firm, LLC
Columbia, SC

EXHIBIT 5
Deponent
Date 11/25/19 Rptr
WWW.DEPOBOOKPRODUCTS.COM

**This report is presented in its final form as of the date listed above, however, if new information becomes available Moore Medical Consulting LLC reserves the right to incorporate the additional information into the final cost analysis as needed.*

Future Cost Analysis

Item/Service	Diagnostic Code	Frequency/ Replacement	Item Cost	Total Cost
				Currently 68 yo, Life Exp: 18 (18.3) years
Scenario A:				
Surgical Intervention: Patella ORIF Hardware Removal				
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$101.92 - $137.41
Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$16.88 - $25.48
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$33.32 - $50.05
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$41.14 - $63.70
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$63.20 - $91.91
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$64.78 - $80.99
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$86.90 - $129.22
Hardware Removal: Professional Fee	20680	1x Only	$1,255.80 - $1,637.68	$1,255.80 - $1,637.68
Hardware Removal: Anesthesia Fee	01392	1x Only	$1,936.39	$1,936.39
Hardware Removal: Facility Fee (Hospital Outpatient)	APC 5073	1x Only	$3,765.00 - $9,302.00	$3,765.00 - $9,302.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$46.00 - $71.00
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$4.84 - $11.18
Knee Sleeve/Support	A4667	1x Only	$23.49 - $42.18	$23.49 - $42.18
Medical Intervention: Supartz Knee Injections				
Orthopaedic/Pain Management Visits	99212	3-5 Visits for a total of 3-4 series over her lifetime	$75.53 - $101.92	$679.77 - $2,038.40
Supartz Injections	20610 J7321	3-5 Injections for a total of 3-4 series over her lifetime	$354.05 - $402.28	$3,186.45 - $8,045.60
			Scenario A Total Cost:	**$11,305.88 - $23,663.19**
Scenario B:				
Surgical Intervention: Partial Knee Replacement				
Surgical Consult	99243	1x Only	$232.96 - $313.95	$232.96 - $313.95
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$101.92 - $137.41

Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$16.88 - $25.48
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$33.32 - $50.05
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$41.14 - $63.70
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$63.20 - $91.91
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$64.78 - $80.99
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$86.90 - $129.22
Partial Knee Replacement: Professional Fee	27446	1x Only	$4,401.87 - $5,510.96	$4,401.87 - $5,510.96
Partial Knee Replacement: Anesthesia Fee	01400	1x Only	$2,504.87	$2,504.87
Partial Knee Replacement: Facility Fee (Hospital Outpatient)	APC 5115	1x Only	$7,338.00 - $13,352.00	$7,338.00 - $13,352.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$46.00 - $71.00
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$4.84 - $11.18
Knee Sleeve/Support	A4667	1x Only	$23.49 - $42.18	$23.49 - $42.18
Surgical Intervention: Revision of Partial Knee Replacement				
Surgical Consult	99243	1x Only	$232.96 - $313.95	$232.96 - $313.95
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$101.92 - $137.41
Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$16.88 - $25.48
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$33.32 - $50.05
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$41.14 - $63.70
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$63.20 - $91.91
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$64.78 - $80.99
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$86.90 - $129.22
Revision of Partial Knee Replacement: Professional Fee	27487 -52	1x Only	$4,840.74 - $6,208.02	$4,840.74 - $6,208.02
Partial Knee Replacement: Anesthesia Fee	01400	1x Only	$2,504.87	$2,504.87
Partial Knee Replacement: Facility Fee (Hospital Outpatient)	APC 5115	1x Only	$7,338.00 - $13,352.00	$7,338.00 - $13,352.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$46.00 - $71.00
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$4.84 - $11.18
Knee Sleeve/Support	A4667	1x Only	$23.49 - $42.18	$23.49 - $42.18
			Scenario B Total Cost:	**$30,359.21 - $45,466.86**
			Grand Total of Scenario A + B:	**$41,665.09 - $69,130.05**

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	ELEVENTH JUDICIAL CIRCUIT
Diane Connell,	)	CIVIL ACTION No.: 2018-CP-32-1750
	)	
Plaintiffs,	)	
	)	
vs.	)	**EXHIBIT & DEPOSITION LIST**
	)	
Lexington County Health Services District, Inc. d/b/a Lexington Medical Center,	)	
	)	
Defendant.	)	

1. Parking Garage Surveillance Video
2. Parking Garage Surveillance Photographs
3. Parking Garage Photographs as Existed 9-26-17
4. Parking Garage Photographs Showing Paint — Agree Not Admissible — Object Object
5. Curb Paint Simulation
6. Photographs of Diane Connell's knee
7. Loss Summary and Medical Bills
8. Lexington Medical Center ER Records
9. Lexington Orthopedic Records
10. Palmetto Bone and Joint Records
11. Injury and Surgery Illustrations
12. Curriculum Vitae for Lindsay Moore, PA-C
13. Future Medical Costs Analysis (Lindsay Moore, PA-C) Object in Part
14. Curriculum Vitae for Charles Alford, Ph.D.
15. Present Value Medical Costs (Charles Alford, Ph.D.) Object in Part

- Cory Andrews 30(b)(6) Deposition
  a. Ex 1: 30(b)(6) Deposition Notice Object to excerpts.
  b. Ex 2-6: Photographs
- Dale Thompson 30(b)(6) Deposition Object to excerpts
  a. Ex 1: 30(b)(6) Deposition Notice
  b. Ex 2-6: Photographs
- Dr. Loging Deposition
  a. Ex 1: LMC ER Records
  b. Ex 2: Injury and Surgery Illustrations
  c. Ex 3: Lexington Orthopedic Records
  d. Ex 4: Palmetto Bone and Joint Records
  e. Ex 5: Preliminary Future Medical Costs Analysis (Lindsay Moore)

Respectfully submitted,

By: /s/ Robert F. Goings

Robert F. Goings, Esq. (S.C. Bar # 74855)
Jessica L. Gooding, Esq. (S.C. Bar # 101210)
Goings Law Firm, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
Email: rgoings@goingslawfirm.com
jgooding@goingslawfirm.com
Phone: (803) 350-9230
Fax: (877) 789-6340

December 11, 2019

Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In the Court Appeals

APPEAL FROM LEXINGTON COUNTY
Court of Common Pleas
Walton J. McLeod, IV, Circuit Court Judge

Appellate Case No. 2020-001089

Diane Connell, ……..Respondent,

v.

Lexington County Health Services District, Inc.
d/b/a Lexington Medical Center, ……..……Appellant.

Place Holder for Trial Exhibit 1

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EDT
447
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2017-Sep-26 11:56:33
EDT)
448
PG2 Level 1 Entrance

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PG2 Level 1 Entrance

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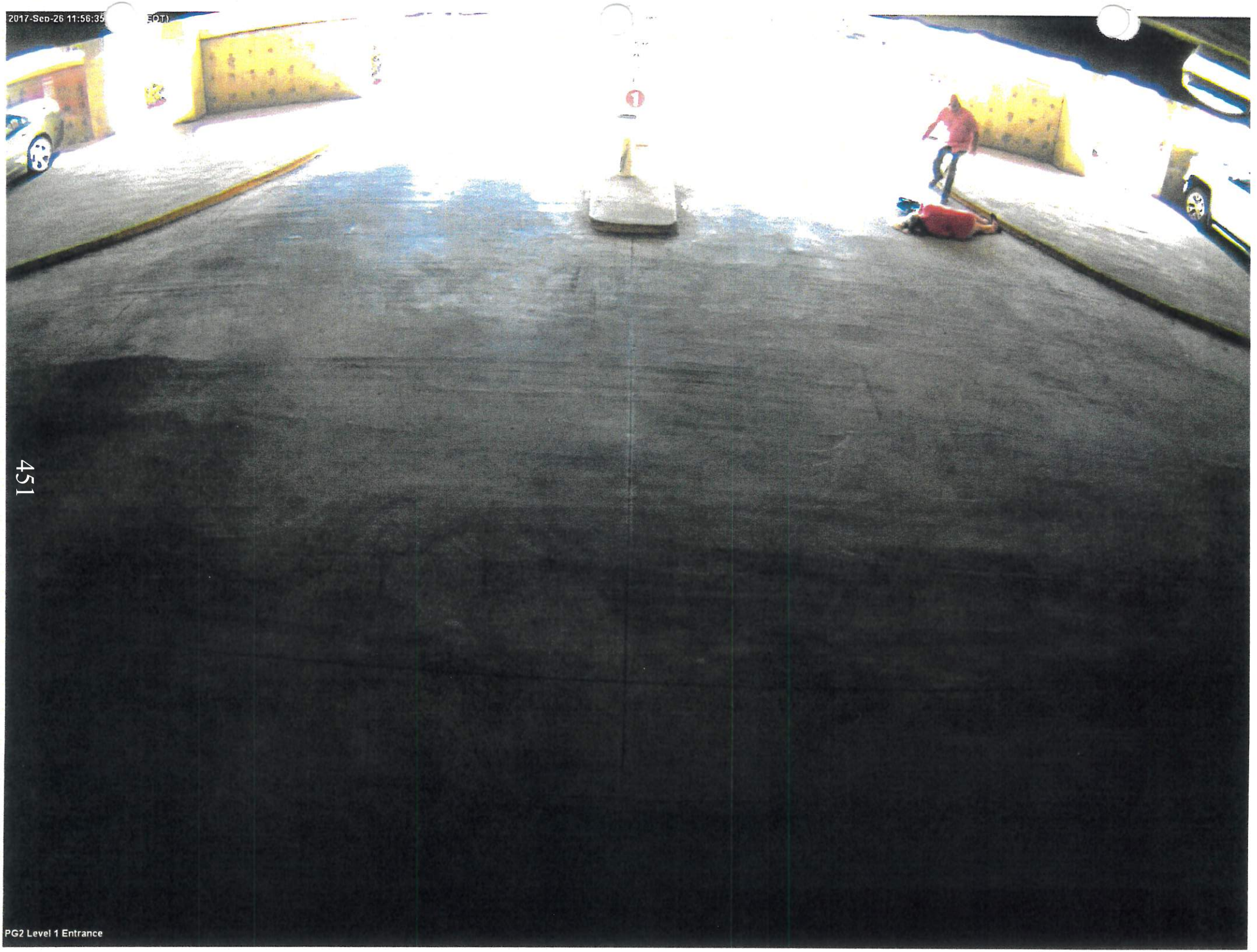
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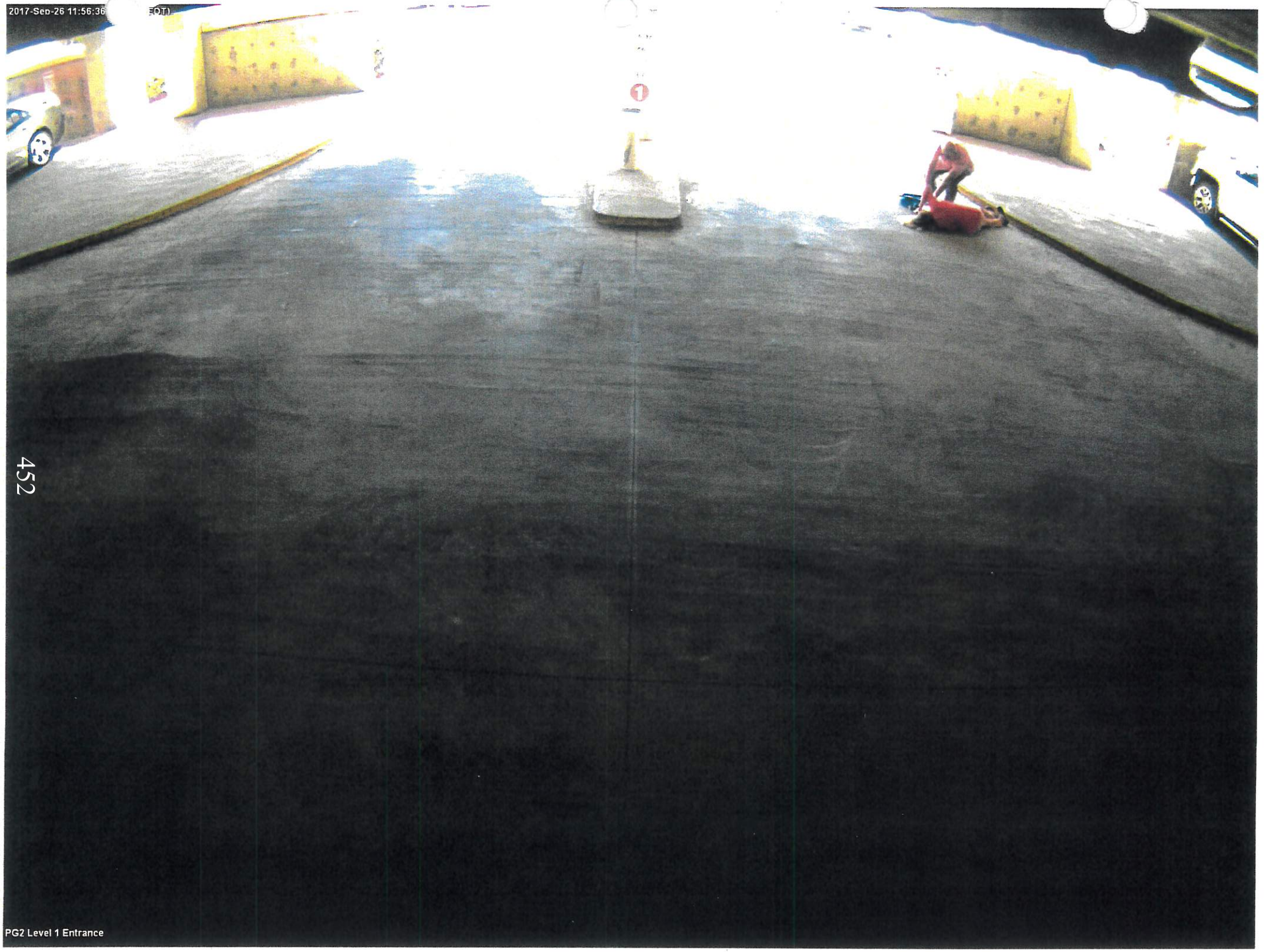
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PG2 Level 1 Entrance

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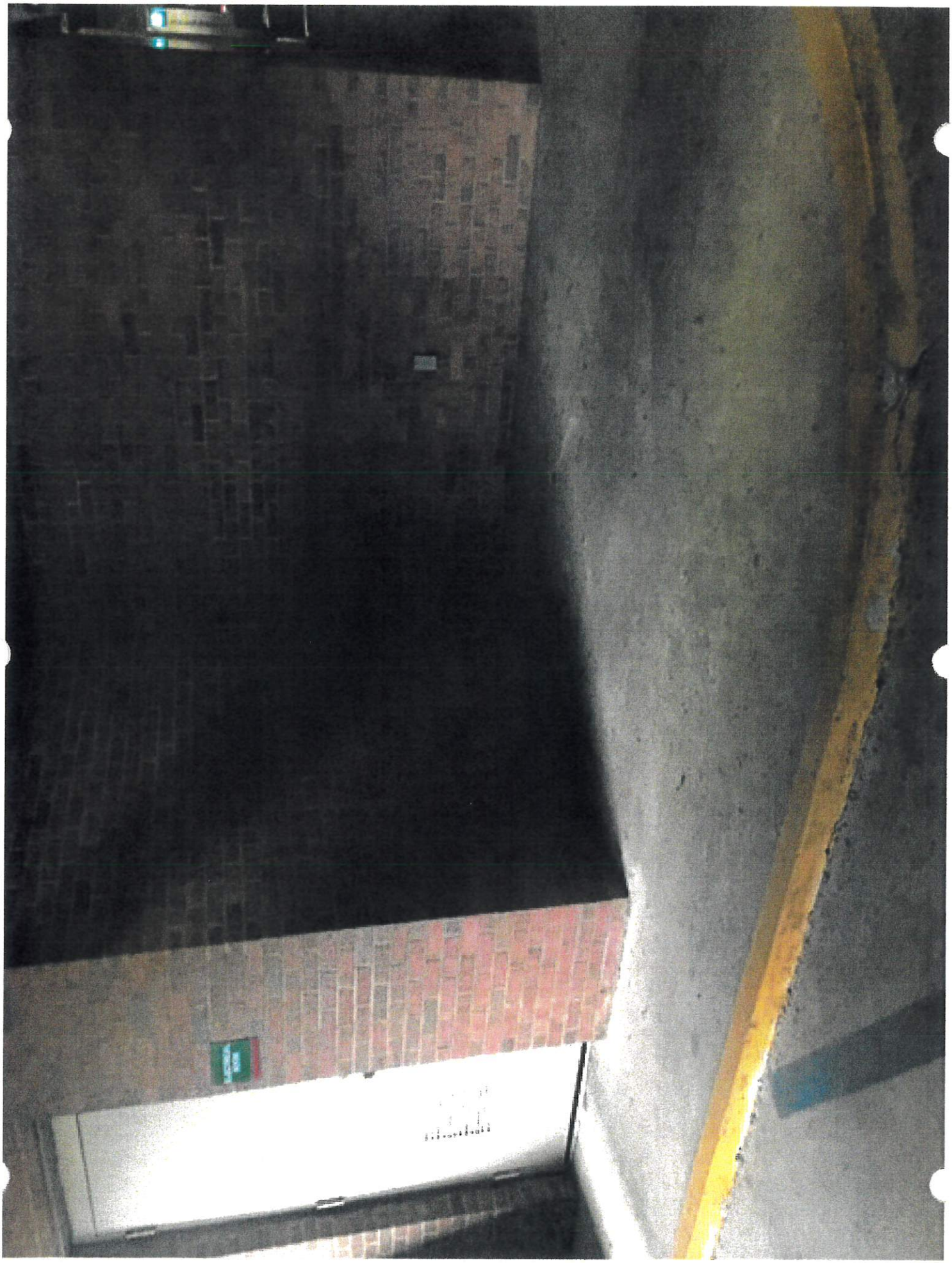
LEVEL
1

Visitor
Parking



PUMP
ROOM

September 26, 2017

Visible if painted

DONJOY

Diane Connell

Past Medical Expenses

DOL: 9/26/2017

PROVIDER	AMOUNT
Lexington Medical Center	$41,398.66
Lexington Orthopeidcs	$3,153.00
Tri County Home Health	$3,728.72
Palmetto Bone and Joint	$613.00
Total Past Medical Expenses*	**$48,893.38**

*Total as of 12/22/2019. Mrs. Connell is still treating with Palmetto Bone and Joint.

Lexington Medical Center
2720 Sunset Boulevard • West Columbia, SC 29169
(803) 791-2000 • www.lexmed.com

1/11/2018

Guarantor Information

Diane M Connell
304 TRENTWOOD DRIVE
COLUMBIA, SC 29223

Guarantor ID: 685644

This is not a bill. This is an itemization of hospital services for:

Patient Name: Diane M. Connell
Hospital Account: 202780591

Admission Date: 09/26/17
Discharge Date: 09/28/17

Charges

Service Date	Rev Code	Procedure Code	Description	Qty	Amount
09/26/2017	0250	22000001	CLOMIPRAMINE 50 MG CAPS	2	109.55
09/26/2017	0260	19000196	HC IV PUSH SAME DRUG EACH ADD	1	234.00
09/26/2017	0270	16070158	HC PS OR SUPPLIES 270 REV CODE W/NO HCPCS	1	141.24
09/26/2017	0270	99005253	HC SLEEVE COMPRESSION SM THIGH	1	183.60
09/26/2017	0300	13000001	HC VENIPUCTURE	1	28.00
09/26/2017	0301	13000010	HC COMPREHENSIVE METABOLIC PANEL	1	390.00
09/26/2017	0305	13000384	HC CBC, AUTOMATED DIFF	1	280.00
09/26/2017	0307	13000043	HC URINALYSIS	1	236.00
09/26/2017	0320	40000124	HC WRIST COMPLETE	1	454.00
09/26/2017	0320	40000148	HC KNEE COMPLETE	1	886.00
09/26/2017	0320	40000153	HC ANKLE	1	454.00
09/26/2017	0450	19000194	HC IV PUSH MED INITIAL	1	254.00
09/26/2017	0450	19000195	HC IV PUSH MED EA ADD	1	336.00
09/26/2017	0450	19000196	HC IV PUSH SAME DRUG EACH ADD	1	234.00
09/26/2017	0450	19000210	HC EMERGENCY ROOM VISIT LEVEL 5	1	1,950.00
09/26/2017	0636	J1170	HYDROMORPHONE PER 4 MG	1	42.00
09/26/2017	0636	J1170	HYDROMORPHONE PER 4 MG	1	42.00
09/26/2017	0636	J1170	HYDROMORPHONE PER 4 MG	0.5	42.00
09/26/2017	0636	J2405	ONDANSETRON 4 MG/2 ML SOLN	1	42.00
09/26/2017	0636	J7040	SODIUM CHLORIDE PER 500 ML	1	65.00
09/26/2017	0637	22000075	GABAPENTIN 300 MG CAPS	2	24.50
09/26/2017	0637	22000075	DOCUSATE SODIUM 100 MG CAPS	1	2.50
09/26/2017	0637	22000075	CELECOXIB 100 MG CAPS	1	12.25
09/26/2017	0637	22000075	OXYCODONE 5 MG TABS	2	24.50
09/26/2017	0637	22000075	OXYCODONE-ACETAMINOPHEN 5-325 MG TABS	1	12.25
09/26/2017	0981	60000329	HC PR EMERGENCY ROOM VISIT LEVEL 5	1	1,503.00
09/27/2017	0250	22000001	HYDROCODONE-ACETAMINOPHEN 7.5-325 MG TABS	2	24.50
09/27/2017	0250	22000001	HYDROCODONE-ACETAMINOPHEN 7.5-325 MG TABS	1	12.25
09/27/2017	0250	22000001	CLOMIPRAMINE 50 MG CAPS	2	109.55
09/27/2017	0250	J2704	PROPOFOL 1000 MG/100ML EMUL 100 ML VIAL	1	138.00

Benefits Assigned to Lexington Medical Center

Service Date	Rev Code	Procedure Code	Description	Qty	Amount
09/27/2017	0260	19000196	HC IV PUSH SAME DRUG; EACH ADD	2	468.00
09/27/2017	0270	16000158	S SC 1000 PB IRR	1	65.00
09/27/2017	0270	16000158	IMMOBILIZER KNEE 20 96510	1	131.10
09/27/2017	0270	16035158	LMA	1	62.10
09/27/2017	0270	90005205	HC SLEEVE COMPRESSION LG THIGH	1	306.00
09/27/2017	0270	90005266	HC OXYGEN SENSOR ADULT	1	52.32
09/27/2017	0272	16000159	CHLORAPREP 26ML 260815	1	36.60
09/27/2017	0272	16000259	STAPLER VISI STAT 35W WECK	1	33.23
09/27/2017	0272	16000259	MODULE ORTHOPAEDIC	1	506.70
09/27/2017	0272	16000359	HC OR SUPPLIES 272 REV CODE W/NO HCPCS 3 OF 3	1	41.86
09/27/2017	0272	16000359	DRAPE C-ARMOR 5523	1	180.00
09/27/2017	0272	16000359	SUTURE WIRE STEEL 18G DS 18	1	51.79
09/27/2017	0272	16070259	K-WIRE 1.6X150 ZIM 4901-16-15	2	69.72
09/27/2017	0272	90005289	HC ANESTHESIA LEVEL III SUPLY CHG	1	393.00
09/27/2017	0320	40000901	HC FLUORO UP TO 1 HOUR	1	1,213.00
09/27/2017	0320	40000914	HC RADIOLOGY EXAM KNEE 1 OR 2 VIEWS	1	688.00
09/27/2017	0360	14000012	HC OR SERVICES CLASS III	1	5,548.00
09/27/2017	0360	14000018	HC OR SERVICE CLASS 3 ADD 30	2	5,610.00
09/27/2017	0370	70000283	HC ANES & MONITORING PER 30 MIN	3	2,196.00
09/27/2017	0636	J0690	CEFAZOLIN PER 500 MG	2	84.00
09/27/2017	0636	J1100	DEXAMETHASONE PER 1 MG	1	42.00
09/27/2017	0636	J1170	HYDROMORPHONE PER 4 MG	0.4	42.00
09/27/2017	0636	J1170	HYDROMORPHONE PER 4 MG	0.3	42.00
09/27/2017	0636	J1170	HYDROMORPHONE PER 4 MG	1	42.00
09/27/2017	0636	J1170	HYDROMORPHONE PER 4 MG	0.4	42.00
09/27/2017	0636	J1170	HYDROMORPHONE PER 4 MG	0.4	42.00
09/27/2017	0636	J2001	LIDOCAINE 2% SOLN	0.3	12.60
09/27/2017	0636	J2001	LIDOCAINE 2% SOLN	0.7	29.40
09/27/2017	0636	J2250	MIDAZOLAM 2 MG/2 ML SOLN 2 ML VIAL	1	42.00
09/27/2017	0636	J2405	ONDANSETRON 4 MG/2 ML SOLN	1	42.00
09/27/2017	0636	J3010	FENTANYL PER 0.1 MG	1	138.00
09/27/2017	0636	J3010	FENTANYL PER 0.1 MG 2	1	138.00
09/27/2017	0636	J3370	VANCOMYCIN 1 G/200 ML SOLN	1	138.00
09/27/2017	0636	J3480	20 MEQ POTASSIUM CHLORIDE IN 0.9% SODIUM CHLORIDE SOLN	1	138.00
09/27/2017	0636	J7040	SODIUM CHLORIDE PER 500 ML	1	65.00
09/27/2017	0636	J7050	SODIUM CHLORIDE PER 500 ML	1	96.00
09/27/2017	0636	J7120	LACATED RINGERS PER 1000 ML	1	65.00
09/27/2017	0636	J7120	LACATED RINGERS PER 1000 ML	1	65.00
09/27/2017	0637	22000075	PRAVASTATIN 20 MG TABS	1	12.25
09/27/2017	0637	22000075	DOCUSATE SODIUM 100 MG CAPS	1	2.50
09/27/2017	0637	22000075	GABAPENTIN 300 MG CAPS	2	24.50
09/27/2017	0637	22000075	CELECOXIB 100 MG CAPS	1	12.25
09/27/2017	0637	22000075	TRAMADOL 50 MG TABS	1	12.25
09/27/2017	0637	22000075	DIAZEPAM 5 MG TABS	1	12.25
09/27/2017	0637	22000075	OXYCODONE 5 MG TABS	2	24.50
09/27/2017	0637	22000075	OXYCODONE 5 MG TABS	2	24.50
09/27/2017	0637	22000075	GABAPENTIN 300 MG CAPS	1	12.25
09/27/2017	0637	22000075	PANTOPRAZOLE 40 MG TBEC	1	12.25
09/27/2017	0710	70000311	HC CLASS II PER 30 MINUTES	5	3,250.00
09/27/2017	0730	18000156	HC EKG ADULT	1	469.00
09/27/2017	0762	10000015	HC OBSERVATION W/TELEMETRY	9	801.00
09/27/2017	0762	30000002	HC OBSERVATION	2	90.00
09/27/2017	0963	60000516	HC PR OPEN UP ENDS TIBIA, FIB	85	2,890.00
09/27/2017	0964	60000516	HC PR OPEN UP ENDS TIBIA, FIB	85	2,380.00
09/27/2017	0985	60000340	HC PR EKG	1	132.00
09/28/2017	0250	22000001	HYDROCODONE-ACETAMINOPHEN 7.5-325 MG TABS	1	12.25
09/28/2017	0250	22000001	ESCITALOPRAM 20 MG TABS	1	12.25
09/28/2017	0250	22000001	VITAMIN D3 1000 UNITS TABS	2	5.00

Benefits Assigned to Lexington Medical Center

Service Date	Rev Code	Procedure Code	Description	Qty	Amount
09/28/2017	0250	22000001	HYDROCODONE-ACETAMINOPHEN 7.5-325 MG TABS	2	24.50
09/28/2017	0260	19000193	HC INJECTION IM/SQ	1	111.00
09/28/2017	0260	19000195	HC IV PUSH MED EA ADD	2	672.00
09/28/2017	0420	12000036	HC GAIT/AMBULATION PER 15 MIN	2	490.00
09/28/2017	0420	12000040	HC THERAPEUTIC ACT DIRECT 15 MIN	1	191.00
09/28/2017	0420	12000140	HC MOBILITY CURRENT STATUS	1	0.01
09/28/2017	0420	12000141	HC MOBILITY GOAL STATUS	1	0.01
09/28/2017	0424	12000210	HC PT EVAL MODERATE COMPLEXITY	1	264.00
09/28/2017	0430	12000040	HC THERAPEUTIC ACT DIRECT 15 MIN	1	191.00
09/28/2017	0430	12000042	HC SELF/HOME MGMT TRAIN (15MIN)	1	246.00
09/28/2017	0430	12000149	HC SELF CARE CURRENT STATUS	1	0.01
09/28/2017	0430	12000150	HC SELF CARE GOAL STATUS	1	0.01
09/28/2017	0430	12000151	HC SELF CARE D/C STATUS	1	0.01
09/28/2017	0434	12000213	HC OT EVAL LOW COMPLEXITY	1	239.00
09/28/2017	0636	J1652	FONDAPARINUX 2.5 MG/0.5 ML SOLN	1	147.00
09/28/2017	0636	J2270	MORPHINE PER 2 MG	1	42.00
09/28/2017	0636	J3370	VANCOMYCIN 1 G/200 ML SOLN	1	198.00
09/28/2017	0637	22000075	GABAPENTIN 300 MG CAPS	1	12.25
09/28/2017	0637	22000075	CELECOXIB 100 MG CAPS	1	12.25
09/28/2017	0637	22000075	DOCUSATE SODIUM 100 MG CAPS	1	2.50
09/28/2017	0637	22000075	GABAPENTIN 300 MG CAPS	1	12.25
09/28/2017	0637	22000075	TRAMADOL 50 MG TABS	1	12.25
09/28/2017	0637	22000075	HYDROCODONE-ACETAMINOPHEN 5-325 MG TABS	2	24.50
09/28/2017	0762	10000015	HC OBSERVATION W/TELEMETRY	15	1,335.00

Total charges: **41,398.66**

Lexington Medical Center
2720 Sunset Boulevard
West Columbia, SC 29169
(803) 791-2300 www.lexmed.com

1/16/2018

CONNELL,DIANE M [685644]	11/03/2017
CONNELL,DIANE M [685644]	11/29/2017
CONNELL,DIANE M [685644]	11/29/2017
CONNELL,DIANE M [685644]	01/04/2018
CONNELL,DIANE M [685644]	01/04/2018

Charge [1] **8**

Account	Svc Dt	Procedure	Orig Amt (Sum)	Department	Diagnosis
CONNELL,DIANE M [685644]	09/27/2017	PR OPEN RX PATELLA FX [27524]	2228.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, initial encounter for closed fracture [S82.042A]

This is not a bill. This is an itemization of professional services.

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1/16/2018

CONNELL,DIANE M [685644]	09/27/2017	PR OPEN RX PATELLA FX [27524]	356.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, initial encounter for closed fracture [S82.042A]
CONNELL,DIANE M [685644]	09/26/2017	PR EMERGENCY DEPT VISIT,LEVEL III [99283]	377.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, initial encounter for closed fracture [S82.042A]
CONNELL,DIANE M [685644]	10/12/2017	PR POST-OP FOLLOW-UP VISIT [99024]	0.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]
CONNELL,DIANE M [685644]	11/09/2017	PR POST-OP FOLLOW-UP VISIT [99024]	0.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]
CONNELL,DIANE M [685644]	11/09/2017	CHG X-RAY KNEE 1 OR 2 VIEW [73560]	96.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]
CONNELL,DIANE M [685644]	12/14/2017	PR POST-OP FOLLOW-UP VISIT [99024]	0.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]

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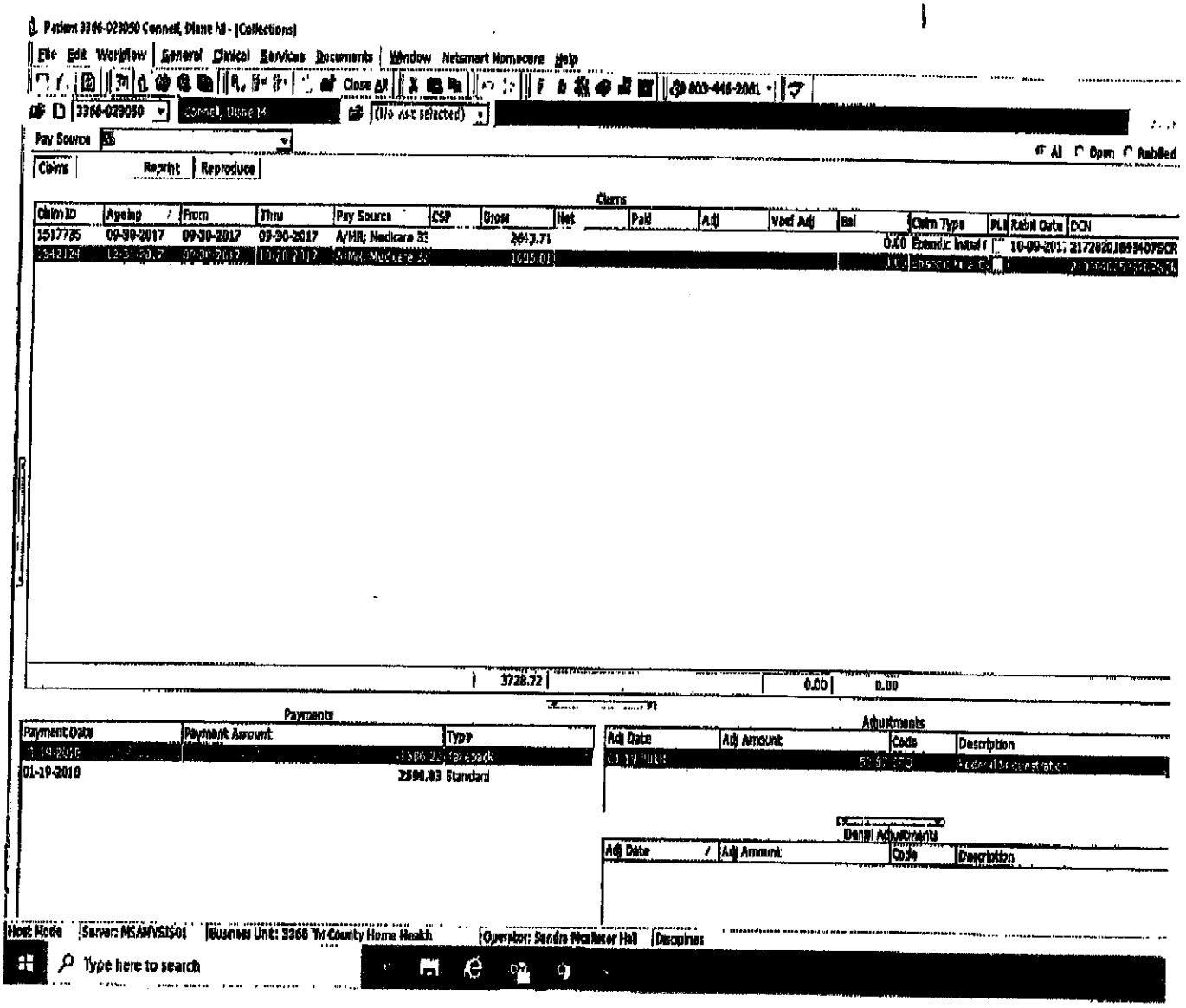
1/16/2018

CONNELL,DIANEM [685644]	12/14/2017	CHG X-RAY KNEE 1 OR 2 VIEW [73560]	96.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]

This is not a bill. This is an itemization of professional services.


Patient 3366-023050 Connell, Diane M - [Collections]
File Edit Workflow General Clinical Services Documents Window Netsmart Homecare Help
Close All
3366-023050
Connell, Diane M
(No Visit Selected)
Pay Source
All Open Rebilled
Claims
Reprint
Reproduce
Claims
Claim ID
Ageing
From
Thru
Pay Source
CSP
Gross
Net
Paid
Adj
Void Adj
Bal
Claim Type
PLI
Rebill Date
ECN
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09-30-2017
09-30-2017
09-30-2017
A/HR; Medicare 3
264.71
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10-09-2017; 2172820;89340750R
3728.72
0.00
0.00
Payments
Payment Date
Payment Amount
Type
01-19-2018
2590.83 Standard
Adjustments
Adj Date
Adj Amount
Code
Description
Detail Adjustments
Adj Date
Adj Amount
Code
Description
Host Mode
Server: MSAPVSIS01
Business Unit: 3366 Tri County Home Health
Operator: Sandra Nicolaou Hall
Disciplines
Type here to search

PALMETTO BONE AND JOINT **Patient Ledger** **12/10/2019 10:34 AM**

Practice : PALMETTO BONE & JOINT, PA
Address : 22971 HIGHWAY 76 E
CLINTON,SC 29325-7529

Phone : (864) 938-0611
Fax :
NPI : 1720295793

Patient Demographics

Name : CONNELL, DIANE M [1008014]
Address : 304 TRENTWOOD DR
COLUMBIA, SC 29223-8417

Provider : LOGING, JAMES A
NPI: 1669490405 TaxId: 570957418

DOB : [redacted]
Home Phone :
Cell Phone : (803) 446-2061
Email : DIANECONNELL66@GMAIL.COM
Employer : RETIRED

Guarantor: CONNELL, DIANE M[90712]
Address: 304 TRENTWOOD DR, COLUMBIA SC, 292238417

Aging

	0-30	31-60	61-90	91-120	121+	TOTAL BALANCE
PATIENT	...	...	...	...	-3.30	-3.30
GRAND TOTAL	...	...	...	...	-3.30	-3.30

Patient Receipts

Receipt	Received	Type	Check Date	Reference	Amount	In Escrow
125618	04/08/19	PP				
175485	11/25/19	PP				

Encounter History

Diagnosis: [M17.12, M25.562, NONE]

Encounter	Line	DOS	Procedure	Charge	Allowed	Adjusted	Write-Offs	Ins Paid	Pat Paid	Col Paid	Ins Bal	Pat Bal	Col Bal
79360	1	04/04/2019	Office out [99203]	286.00									0.00

Posted	Received	Insurance	Transaction	Amount	Diagnosis

Date	Note
04/04/2019	Incomplete Reason: Charge created by interface PhoenixOrtho

109874	1	11/25/2019	Medical le [99075]	1,200.00	0.00	0.00	0.00	0.00	1,200.00	0.00	0.00	0.00	0.00

Practice : PALMETTO BONE & JOINT, PA
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NPI: 1669490405 TaxId: 570957418
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Home Phone :
Cell Phone : (803) 446-2061
Email : DIANECONNELL88@GMAIL.COM
Employer : RETIRED

Guarantor: CONNELL, DIANE M[90712]
Address: 304 TRENTWOOD DR, COLUMBIA SC, 292238417

Encounter History

Diagnosis: [M17.12, M25.362, M25.562]

Encounter	Line	DOS	Procedure	Charge	Allowed	Adjusted	Write-Offs	Pat Paid	Col Paid	Pat Bal	Col Bal
113020	1	12/20/2019	Office out [99214]	245.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Diagnosis:		M25.562 M17.12 M25.362									
113020	2	12/20/2019	Radiologic [73562]	82.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Diagnosis:		M25.562 M17.12 M25.362									

Date	Note
12/20/2019	Incomplete Reason: Charge created by interface PhoenixOrtho

Patient Totals	Charges
TOTAL	327.00

Lexington Medical Center

LCHSD SERVICE AREA

CONNELL,DIANE M
MRN: M002014739
DOB [redacted], Sex: F
Adm: 9/26/2017, D/C: 9/28/2017

Patient Demographics

Address	Phone	E-mail Address
304 TRENTWOOD DRIVE COLUMBIA SC 29223	803-736-6629 (Home) 803-446-2061 (Mobile)	dianeconnell88@gmail.com

Admission Information - Patient Record Only

Arrival Date/Time:	09/26/2017 1211	Admit Date/Time:	09/26/2017 1230	IP Adm. Date/Time:	
Admission Type:	Emergency	Point of Origin:	Non-healthcare Facility	Admit Category:	
Means of Arrival:	Car	Primary Service:	Orthopedics	Secondary Service:	N/A
Transfer Source:		Service Area:	Lchsd Service Area	Unit:	Lmc 5th Flr Nt
Admit Provider:	Beard, Hoyt R., MD	Attending Provider:	Hensley, Terry G, MD	Referring Provider:	

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/28/2017 1540	Home Or Self Care	None	None	Lmc 5th Flr Nt

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
S82.042A [Principal]	Displaced comminuted fracture of left patella, initial encounter for closed fracture				
S93.401A	Sprain of unspecified ligament of right ankle, initial encounter				
M25.532	Pain in left wrist				
M25.571	Pain in right ankle and joints of right foot				
Z47.89	Encounter for other orthopedic aftercare				

ED Provider Notes

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619

Author: Hensley, Terry G, MD | Service: Emergency Medicine | Author Type: Physician
Filed: 09/26/17 1619 | Date of Service: 09/26/17 1247 | Status: Signed
Editor: Hensley, Terry G, MD (Physician)

History

Chief Complaint
Patient presents with
- Extremity pain/injury
  pt reports falling off of curb, c/o L knee pain, swelling and small abrasions to L knee, also reports hitting head, denies LOC

HPI Comments: Patient was accompanying her husband to an office appointment in the North Tower. Wall walking out of the parking garage she tripped on the entrance and fell landing on her left knee. She suffered the injured left knee, right ankle, left wrist. Unable to bear weight on the left knee. Abrasions to left knee.

No injury to her head or neck. No loss of consciousness.

Patient is a 66 y.o. female.The history is provided by the patient.
Fall
Fall occurred how long ago?: **1 hour**
Height of fall: **From standing**
Cause of fall: **Tripped**
Point of impact: **Other (left knee, right ankle, left wrist, left head)**
Treatment on scene: **No treatment**
Pain Location: **Other (comment) (left knee, right ankle, left wrist)**
Severity of pain: **Moderate**
Relieved by: **Rest**
Exacerbated by: **Activity and palpation**
Associated symptoms: **gait problem (unable to bear weight on left knee), joint swelling, localized swelling** and **wound (left knee abrasions)**
Associated symptoms: **no dizziness** and **no headaches (denies)**

No past medical history on file.

Past Surgical History:
Procedure | Laterality | Date
- ATRIAL ABLATION SURGERY

No family history on file.

Social History

Social History Narrative
- No narrative on file

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

Social History
Substance Use Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use No

Review of Systems
Constitutional: Negative for chills and fever.
HENT: Negative for congestion, rhinorrhea and sore throat.
Eyes: Negative for visual disturbance.
Respiratory: Negative for cough and shortness of breath.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for nausea, vomiting, abdominal pain and diarrhea.
Genitourinary: Negative for dysuria.
Musculoskeletal: Positive for arthralgias **(left knee, right ankle, left wrist)**, gait problem **(unable to bear weight on left knee)** and joint swelling. Negative for back pain and neck pain.
Skin: Positive for wound **(left knee abrasions)**. Negative for rash.
Neurological: Negative for dizziness, syncope, weakness, numbness and headaches **(denies).**
Hematological: Negative for adenopathy.

Physical Exam

Initial ED Vital Signs:
Blood Pressure: 170/79 Heart Rate: 78 Temp: 98.5 °F (36.9 °C) Resp: 20 SpO2: 97 %

Last Documented Vital Signs This Encounter:
Blood Pressure: 128/49
MAP (mmHg): 85
Heart Rate: 75
Temp: 98.5 °F (36.9 °C)
Resp: 20
SpO2: 96 %
Height: 5' 6" (167.6 cm)
Weight: 68 kg (150 lb)

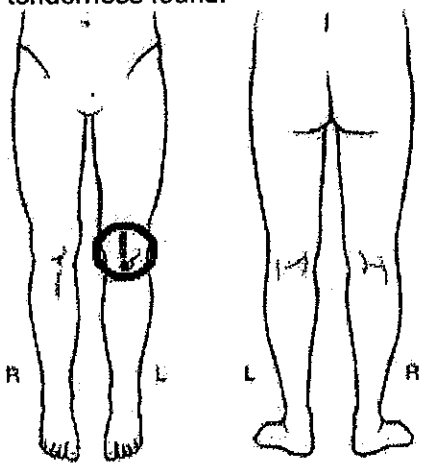
height is 5' 6" (1.676 m) and weight is 68 kg (150 lb). Her temperature is 98.5 °F (36.9 °C). Her blood pressure is 128/49 and her pulse is 75. Her respiration is 20 and oxygen saturation is 96%.

Physical Exam
Constitutional: She appears well-developed and well-nourished. She appears distressed.
Appears to be in pain, but is non-toxic in appearance
HENT:
Head: Normocephalic and atraumatic.
Nose: Nose normal.

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

Mouth/Throat: Oropharynx is clear and moist.
Mild left parietal scalp tenderness. No scalp hematoma. No scalp laceration or abrasion or contusion.
Eyes: Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.
Neck: Normal range of motion. No spinous process tenderness and no muscular tenderness present. No tracheal deviation and normal range of motion present.
Cardiovascular: Normal rate and regular rhythm.
No murmur heard.
Pulmonary/Chest: Effort normal. No respiratory distress.
Musculoskeletal: She exhibits edema and tenderness. She exhibits no deformity.
Right wrist: She exhibits normal range of motion, no tenderness and no bony tenderness.
Left wrist: She exhibits tenderness. She exhibits normal range of motion, no bony tenderness, no swelling and no effusion.
Right hip: She exhibits normal range of motion, no tenderness and no bony tenderness.
Left hip: She exhibits normal range of motion, normal strength and no bony tenderness.
Right knee: She exhibits normal range of motion, no swelling and no effusion. No tenderness found.
Left knee: She exhibits decreased range of motion, swelling, effusion and ecchymosis. Tenderness found.
Right ankle: She exhibits decreased range of motion, swelling and ecchymosis. Tenderness. Lateral malleolus tenderness found. No medial malleolus tenderness found.
Left ankle: She exhibits normal range of motion. No tenderness. No lateral malleolus and no medial malleolus tenderness found.



Legs:
Left knee: Swelling and tenderness over the patella. Overlying skin abrasion but no full-thickness laceration. Some ecchymosis over the patellar surface. Possible small effusion. Full extension left knee but pain limited flexion. Pain limited anterior and posterior drawer testing. Stable to valgus and varus stress. Left foot dorsalis pedis 2+.

Right ankle: Swelling over the lateral malleous. Ankle stable to anterior drawer testing. No open wound or laceration. Right foot dorsalis pedis pulses 2+.

Left wrist: Some ecchymosis on the flexor surface of left wrist. No bony tenderness. No effusion. No open wound or laceration. Flexion and extension left wrist are intact. Left radial pulses 2+.
Lymphadenopathy:
She has no cervical adenopathy.
Neurological: She is alert. She exhibits normal muscle tone. Coordination normal.
Skin: Skin is warm and dry. Abrasion, bruising and ecchymosis noted. She is not diaphoretic. No pallor.

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

Left knee: Swelling and tenderness over the patella. Overlying skin abrasion but no full-thickness laceration. Some ecchymosis over the patellar surface. Possible small effusion. Full extension left knee but pain limited flexion. Pain limited anterior and posterior drawer testing. Stable to valgus and varus stress. Left foot dorsalis pedis 2+.

Right ankle: Swelling over the lateral malleous. Ankle stable to anterior drawer testing. No open wound or laceration. Right foot dorsalis pedis pulses 2+.

Left wrist: Some ecchymosis on the flexor surface of left wrist. No bony tenderness. No effusion. No open wound or laceration. Flexion and extension left wrist are intact. Left radial pulses 2+.
Psychiatric: She has a normal mood and affect. Her behavior is normal.
Nursing note and vitals reviewed.

ED Course

Procedures

XR Wrist Left PA Lateral and Oblique
Final Result
No acute displaced fractures are seen.

XR Knee Left AP Lateral and Both Obliques
Final Result

XR Ankle Right AP Lateral and Oblique
Final Result
Unremarkable right ankle.

No results found for this visit on 09/26/17.

All Medication Administration through 09/26/2017 1619

Date/Time	Order	Dose	Route	Action	Action by
09/26/2017 1256	**HYDROmorphone (DILAUDID) injection 1 mg**	1 mg	Intravenous	Given	Veronee, Jo Ann, RN
09/26/2017 1256	**ondansetron (ZOFRAN) injection 4 mg**	4 mg	Intravenous	Given	Veronee, Jo Ann, RN
09/26/2017 1349	**HYDROmorphone (DILAUDID) injection 0.5 mg**	0.5 mg	Intravenous	Given	Veronee, Jo Ann, RN
09/26/2017 1552	**oxyCODONE-acetaminophen (PERCOCET) 5-325 mg tablet 1 tablet**	1 tablet	Oral	Given	Lukens, Benjamin J, RN

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

ED Discharge Orders
None

ED Prescriptions

Medication	Sig	Dispense	Start Date	End Date	Auth. Provider
oxyCODONE-acetaminophen (PERCOCET) 5-325 mg tablet (Status: Discontinued)	Take 1-2 tablets by mouth every 6 (six) hours as needed for pain.	30 tablet	9/26/2017	9/26/2017	Hensley, Terry G, MD

Diagnosis:
Final diagnoses:
Acute pain of left knee
Acute right ankle pain
Wrist pain, acute, left
Closed displaced comminuted fracture of left patella, initial encounter (Primary)
Ankle sprain

Follow Up Instructions:

Dedmond, Barnaby T, MD
146 Hospital Drive N
Suite 140
West Columbia SC 29169
803-936-7230

In 1 day
tomorrow at 10am

Disposition: Admit
Departure Condition: Stable

LMC ED MDM NO CC TIME:
Review of Previous: **Notes**
Notes comment: **Records reviewed: Patient seen and evaluated by cardiology on July 14, 2016**
Interpretation: **X-ray, pulse ox and labs**
Labs comment: **Labs reviewed: Chemistry: Pending. CBC: Pending.**
X-Rray comment: **Left knee films: Comminuted fracture of the patella. Effusion. Right ankle films: No acute fracture. Left wrist films: No acute fracture.**

ED Provider Notes (continued)

ED Provider Notes by Hensley, Terry G, MD on 09/26/17 1619 (continued)

Pulse Ox comment: **Pulse ox symmetry is 97% on room air.**
Consult other physician: **Yes**
Consults: **Orthopedics (Patient discussed with the surgeon on-call, Dr. Beard. Patient is unable to utilize knee immobilizer and crutches in the ED. Her pain is not well controlled. Dr. Beard agrees to admit the patient for further evaluation and treatment.)**
Patient Progress: **Improved**
MDM Comments:
I personally reviewed and interpreted and acted on all labs/ radiology/ urine/ pulse ox/ EKG's ordered on this patient.

ED Course

HENSLEY, TERRY G- was the Primary ED Provider for this patient.

Hensley, Terry G, MD
09/26/17 1619

Electronically Signed by Hensley, Terry G, MD on 09/26/17 1619

Discharge Summaries

Discharge Summaries by Russell, Martha K., NP on 09/28/17 0750

Author: Russell, Martha K., NP | Service: Orthopedics | Author Type: Nurse Practitioner
Filed: 09/28/17 0750 | Date of Service: 09/28/17 0744 | Status: Signed
Editor: Russell, Martha K., NP (Nurse Practitioner) | Cosigner: Dedmond, Barnaby T, MD at 09/28/17 0806

LMC SURGICAL DISCHARGE/TRANSFER SUMMARY NOTE:

PATIENT: Diane M Connell	**DATE OF BIRTH:** [redacted]
ACCOUNT NUMBER: 100023195855	**MR#:** M002014739
ADMISSION DATE/TIME: 9/26/2017 12:30 PM	**ADMITTING PROVIDER:** Hoyt R. Beard, MD
DISCHARGE DATE: 9/28/2017	**DISCHARGING PROVIDER:** Russell, Martha K.

ADMISSION DIAGNOSIS: Ankle sprain [S93.409A]

Discharge Summaries (continued)

Discharge Summaries by Russell, Martha K., NP on 09/28/17 0750 (continued)

Closed displaced comminuted fracture of left patella, initial encounter [S82.042A]
Wrist pain, acute, left [M25.532]
Acute pain of left knee [M25.562]
Acute right ankle pain [M25.571]

ACTIVE & RESOLVED PROBLEMS:

Active Hospital Problems

Diagnosis
• Closed displaced comminuted fracture of left patella
• Fracture of left patella

Resolved Hospital Problems

Diagnosis	Date Resolved

No resolved problems to display.

PROCEDURES: Procedure(s) (LRB):
OPEN REDUCTION INTERNAL FIXATION LEFT PATELLA FRACTURE (Left)
No procedure orders placed in the past 24 hours

CONSULTS: CONSULT TO ORTHOPEDIC SURGERY
CONSULT TO SOCIAL WORK

LABS PAST 24 HOURS:

HOSPITAL COURSE:
Diane M Connell is a 66 y.o. female who was admitted on 9/26/2017.

Primary reason for admission was Left Patella fracture
They underwent the following procedures.
Procedure(s) (LRB):
OPEN REDUCTION INTERNAL FIXATION LEFT PATELLA FRACTURE (Left)
Non op management of right ankle sprain

They did work with physical therapy. During their last session, they were able to do the following.

* Pending as of 0745 - has not yet been evaluated by PT. If safe may be discharged to home.

During the hospitalization, there were not additional medical issues.

Discharge diet: Regular
Discharge Pain medication: Norco
Discharge Therapy Instructions:
Weight bearing status: As tolerated to left lower extremity and right lower extremity

Discharge Summaries (continued)

Discharge Summaries by Russell, Martha K., NP on 09/28/17 0750 (continued)

DISCHARGE DISPOSITION: Home or Self Care

DISCHARGE:

Discharge Medications

(Listed on patient's AVS)

amphetamine-dextroamphetamine 20 mg tablet
Take 15 mg by mouth daily.
Commonly known as: ADDERALL

ciclopirox 8% solution
Apply topically daily.
Commonly known as: PENLAC

*** clomiPRAMINE 50 mg capsule**
Last Dose Given: 100 mg on 9/27/2017 9:00 PM
Take 50 mg by mouth nightly.
Commonly known as: ANAFRANIL

*** clomiPRAMINE 25 MG capsule**
Last Dose Given: 100 mg on 9/27/2017 9:00 PM
Take 25 mg by mouth nightly.
Commonly known as: ANAFRANIL

Cranberry 500 MG Chew
Chew 500 mg by mouth daily.

diazePAM 5 mg tablet
Last Dose Given: 5 mg on 9/27/2017 1:22 AM
Take 5 mg by mouth nightly as needed.
Commonly known as: VALIUM

escitalopram 20 mg tablet
Take 20 mg by mouth daily.
Commonly known as: LEXAPRO

*** gabapentin 300 mg capsule**
Last Dose Given: 300 mg on 9/28/2017 6:27 AM
Take 300 mg by mouth 2 (two) times daily. Breakfast and lunch
Commonly known as: NEURONTIN

*** gabapentin 300 mg capsule**
Last Dose Given: 300 mg on 9/28/2017 6:27 AM
Take 600 mg by mouth nightly.
Commonly known as: NEURONTIN

GLUCOSAMINE CHONDROITIN ADV Tabs
Take 2 tablets by mouth daily.

HYDROcodone-acetaminophen 7.5-325 mg tablet
Last Dose Given: 1 tablet on 9/28/2017 2:49 AM
Take 1-2 tablets by mouth every 6 (six) hours as needed.
Commonly known as: NORCO

Discharge Summaries (continued)

Discharge Summaries by Russell, Martha K., NP on 09/28/17 0750 (continued)

pravastatin 40 mg tablet
Last Dose Given: 20 mg on 9/27/2017 5:45 PM
Take 20 mg by mouth daily with dinner.
Commonly known as: PRAVACHOL

vitamin D3 1000 units tablet
Take 2,000 Units by mouth daily.
Commonly known as: CHOLECALCIFEROL

Patient discharged in Stable condition

They should follow up in 2 weeks with
Barnaby Dedmond, MD or Kitty Russell, NP
Lexington Orthopaedics
146 North Hospital Drive, Suite 140
West Columbia, South Carolina 29169
PHONE: 803-936-7230

Russell, Martha K.

Electronically Signed by Dedmond, Barnaby T, MD on 09/28/17 0806

History & Physicals

No notes of this type exist for this encounter.

Encounter-Level H&P Scans:

There are no encounter-level h&p scans.

Operative Notes

Op Note by Dedmond, Barnaby T, MD on 09/27/17 1224

Author: Dedmond, Barnaby T, MD | Service: Orthopedics | Author Type: Physician
Filed: 09/27/17 1224 | Date of Service: 09/27/17 1149 | Status: Signed
Editor: Dedmond, Barnaby T, MD (Physician)

OPERATIVE NOTE:

9/27/2017 12:17 PM

PROCEDURE(S): Procedure(s):
OPEN REDUCTION INTERNAL FIXATION LEFT PATELLA FRACTURE

PREOPERATIVE DIAGNOSIS: LEFT PATELLA FRACTURE

POSTOPERATIVE DIAGNOSIS: LEFT PATELLA FRACTURE

SURGEON(S): Surgeon(s) and Role:
* Dedmond, Barnaby T, MD - Primary

ASSISTANT:
* Russell, Martha K, NP - Assisted with maintenance of reduction while I placed the implants as well as retraction, closure, and splint application

ANESTHESIOLOGIST: Richards, Frederick Lee, MD

ANESTHESIA TYPE(S): General

ASA: II

MEDICATIONS:
Intraop Administered Meds from 09/17/2017 1217 to 09/27/2017 1217
None

ESTIMATED BLOOD LOSS: Estimated Blood Loss
In: 2265
Out: - 50cc

DRAINS: none

SPECIMEN(S): * No specimens in log *

IMPLANT(S):

Implant Name	Type	Inv. Item	Serial No.	Manufacturer	Lot No.	LRB	No. Used	Action
SUTURE WIRE	Wire	SUTURE WIRE		JOHNSON AND		Left	1	Implanted

Operative Notes (continued)

Op Note by Dedmond, Barnaby T, MD on 09/27/17 1224 (continued)

STEEL 18G DS-18 - LOG171741		STEEL 18G DS-18		JOHNSON				
ZIMMER 1.6 K- WIRE				ZIMMER		Left	2	Implanted

COMPLICATIONS: There were no complications

OPERATIVE INDICATIONS: Patient sustained a displaced left patella fracture as noted in the preoperative history and physical. Options for treatment of this fracture have been discussed with the patient and their family. They express understanding of the risks, benefits, and alternatives. Specifically we have discussed the options of nonoperative management versus open reduction and internal fixation. They wish to proceed with open reduction and internal fixation, understanding the risks of bleeding, infection, nerve damage, nonunion, malunion, wound complications, need for future surgery including hardware removal, knee stiffness, post-traumatic arthritis, anesthesia complications, deep venous thrombosis, death, and other unforeseen complications.

DESCRIPTION OF PROCEDURE: The patient was identified in the holding area and taken back to the operating room, then placed supine upon the operating table. Anesthesia was administered. After informed consent had been assured and preoperative antibiotics given, the affected lower extremity was prepped and draped in standard sterile fashion. The knee was approached through a midline incision over its subcutaneous border anteriorly. The fracture was exposed and cleared of interposing debris. The fracture was fairly comminuted. NP Russell assisted with the reduction. A tenaculum clamp was placed across the fracture. The fracture was stabilized with a figure of eight tension band wiring technique. Two 1.6 mm guide pins were passed across the fracture site from inferiorly to superiorly in parallel fashion. Position was verified by fluoroscopy and noted to be good. An 18 gauge stainless steel wire was then passed beneath the two wires proximally and distally crossing the fracture site in a figure of eight fashion. The wire was then twisted to tighten it down providing compression across the fracture. This resulted in nice stability of the fracture. The k-wires were then cut and bent over top of the 18 gauge wire and buried in the soft tissues. Fluoroscopic imaging verified good hardware position and fracture reduction. The knee was taken through a range of motion and the fracture noted to be stable.

Wounds were then thoroughly irrigated and closed in layered fashion. First the medial and lateral retinaculum was closed, followed by a deep layer, subcutaneous layer and skin. Sterile dressings were applied followed by a knee immobilizer. The patient tolerated the procedure well and was transported to the recovery room in stable condition.

FOLLOW UP PLANS: The patient will follow up in 2 weeks for wound evaluation. They will be transitioned to a hinged knee brace which is locked in extension when they are walking but allowed to bend to 90 degrees when not weightbearing. They may be weight bearing as tolerated with the brace locked in full extension.

Dedmond, Barnaby T

Electronically Signed by Dedmond, Barnaby T, MD on 09/27/17 1224

Operative Notes (continued)

Procedure Notes
No notes of this type exist for this encounter.

Anesthesia Post-Op Notes
No notes of this type exist for this encounter.

Delivery Notes
No notes of this type exist for this encounter.

Consult Notes

Consults by Beard, Hoyt R., MD on 09/26/17 1722

Author: Beard, Hoyt R., MD | Service: Orthopedics | Author Type: Physician
Filed: 09/26/17 1722 | Date of Service: 09/26/17 1719 | Status: Signed
Editor: Beard, Hoyt R., MD (Physician)

Consult Orders:
1. Consult to Orthopedic Surgery [92236028] ordered by Hensley, Terry G, MD at 09/26/17 1448

9/26/2017, 5:19 PM

SUBJECTIVE:
Patient is a 66 y.o. female who was admitted to the hospital for workup of left knee pain. Orthopaedic surgery was consulted to evaluate left patella fracture.

Patient was at LMC for an appointment with her husband and fell in the parking lot. She had immediate onset of severe left knee pain and was unable to walk. She was evaluated in the ED and diagnosed with a left patella fracture. Pain is in left knee, severe, worse with movement, improved with rest and bracing, no radiation, no associated symptoms. No prior knee surgery. No wound or laceration. When seen in ED, patient is braced and still has pain.

Active Hospital Problems

Diagnosis
• Closed displaced comminuted fracture of left patella

Resolved Hospital Problems

Diagnosis	Date Resolved

No resolved problems to display.

No past medical history on file.

Past Surgical History:

Procedure	Laterality	Date
• ATRIAL ABLATION SURGERY		

(Not in a hospital admission)

No Known Allergies

Social History

Substance Use Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol use	No

Consult Notes (continued)

Consults by Beard, Hoyt R., MD on 09/26/17 1722 (continued)

No family history on file.

REVIEW OF SYSTEMS:

A review of systems was reviewed with the patient and was positive for left knee pain. All other reviewed systems were negative.

OBJECTIVE:
VITAL SIGNS IN LAST 24 HOURS:
Visit Vitals

• BP	128/49 (BP Location: Left arm, Patient Position: Sitting)
• Pulse	75
• Temp	98.5 °F (36.9 °C)
• Resp	20
• Ht	5' 6" (1.676 m)
• Wt	68 kg (150 lb)
• SpO2	96%
• BMI	24.21 kg/m2

Body mass index is 24.21 kg/(m^2).

Constitutional: No acute distress. Well nourished. Well developed.
Psychiatric: Alert, oriented.
Eyes: Extra-ocular movements are grossly intact and sclera are anicteric.
Respiratory: No labored breathing.
Cardiovascular: No edema present other than that documented below
Skin: No skin lesions present other than those documented below
Neurological: No evidence of sensory loss in the affected area.

EXTREMITIES:

LLE
- brace in place
- sensation intact sural / saphenous / deep peroneal / superficial peroneal
- motor intact to EHL / TA / GSC / peroneals
- foot perfused
- 2+ PT pulse

IMAGING:

Independent review of xrays confirms left comminuted patella fracture with step-off on lateral imaging

ASSESSMENT:

Left comminuted patella fracture

Consult Notes (continued)

Consults by Beard, Hoyt R., MD on 09/26/17 1722 (continued)

PLAN:

Discussed options with patient including operative and nonoperative treatment. She is in a fair amount of pain, so we will admit her overnight for pain control. I anticipate that my partner, Dr. Dedmond, will offer her ORIF option tomorrow. Will make NPO after midnight. May be WBAT in brace at all times until surgery.

Beard, Hoyt R., MD

Results

Resulted: 10/06/17 1416, Result status: Edited Result - FINAL

XR Knee Left 2 View Portable [92308902]

Ordering provider:	Dedmond, Barnaby T, MD 09/27/17 1218	Resulted by:	Haynes, John William, MD
Performed:	09/27/17 1130 - 09/27/17 1208	Resulting lab:	PACS

Narrative:
ORIGINAL REPORT
CLINICAL DATA: ORIF left patella

COMPARISON: 9/26/2017

TECHNIQUE: 3 portable views of the right knee were obtained.

FINDINGS: The patient has undergone open reduction and wire fixation of the patella fracture. Fracture fragments are anatomically aligned

Impression:
Satisfactory ORIF left patella
ADDENDUM #
1
TECHNIQUE (CORRECTION): 3 portable views of the left knee were obtained.

Specimen Collection

Type	Source	Collected On
		09/28/17 0742

XR Knee Right 2 View Portable [92255785] Resulted: 10/03/17 0838, Result status: Edited

Ordering provider:	Dedmond, Barnaby T, MD 09/27/17 1218	Resulted by:	Haynes, John William, MD
Performed:	09/27/17 1130 - 09/27/17 1208	Resulting lab:	PACS

Narrative:
CLINICAL DATA: ORIF left patella

Results (continued)

XR Knee Right 2 View Portable [92255785] (continued) Resulted: 10/03/17 0838, Result status: Edited

COMPARISON: 9/26/2017

TECHNIQUE: 3 portable views of the right knee were obtained.

FINDINGS: The patient has undergone open reduction and wire fixation of the patella fracture. Fracture fragments are anatomically aligned

Impression:
Satisfactory ORIF left patella

Specimen Collection

Type	Source	Collected On
		09/28/17 0742

FL Less Than 1 Hour [92255787] Resulted: 09/27/17 1221, Result status: Final result

Ordering provider: Dedmond, Barnaby T, MD 09/27/17 1219 Performed: 09/27/17 1130 - 09/27/17 1208

Narrative:
Fluoroscopy was provided by means of a portable image intensifier. No films were taken.

MRSA Surveillance Screen [92249689] Resulted: 09/27/17 1109, Result status: Final result

Ordering provider: Beard, Hoyt R., MD 09/26/17 1909 Resulting lab: LEXINGTON MEDICAL CENTER

Specimen Collection

Type	Source	Collected On
SWAB		09/26/17 1924

Components

	Value	Reference Range	Flag	Lab
MRSA Surveillance Scn	NEGATIVE	NEGATIVE		LMC

Urinalysis [92236056] (Abnormal) Resulted: 09/26/17 1814, Result status: Final result

Ordering provider: Hensley, Terry G, MD 09/26/17 1613 Resulting lab: LEXINGTON MEDICAL CENTER

Specimen Collection

Type	Source	Collected On
URINE	CLEAN VOIDED URINE	09/26/17 1749

Components

	Value	Reference Range	Flag	Lab
Collect Type, Urine	CLEAN VOIDED URINE			
Color	YELLOW			LMC
Clarity, Urine	CLEAR			LMC
Glucose, Urine	NEGATIVE	NEGATIVE		LMC
Bilirubin, Urine	NEGATIVE	NEGATIVE		LMC

Results (continued)

Resulted: 09/26/17 1814, Result status: Final result

Urinalysis [92236056] (Abnormal) (continued)

Ketones, Urine	NEGATIVE	NEGATIVE		LMC
SG, Urine	1.009	1.003 - 1.030		LMC
Blood, Urine	TRACE	NEGATIVE	A	LMC
pH, Urine	7.0	4.6 - 8.0		LMC
Protein, Urine	NEGATIVE	NEGATIVE		LMC
Urobilinogen, Urine	NORMAL	NORMAL		LMC
Nitrite, Urine	NEGATIVE	NEGATIVE		LMC
Leukocyte Esterase, Urine	NEGATIVE	NEGATIVE		LMC
WBC, Urine	1	<6		LMC
Squamous Epithelial, Urine	1	<6		LMC
Mucous, Urine	PRESENT			LMC
RBC, Urine	2	<4		LMC

Resulted: 09/26/17 1639, Result status: Final result

CMET [92236055]

Ordering provider: Hensley, Terry G, MD 09/26/17 1613 Resulting lab: LEXINGTON MEDICAL CENTER

Specimen Collection

Type	Source	Collected On
SERUM	BLOOD	09/26/17 1228

Components

	Value	Reference Range	Flag	Lab
Glucose	93	70 - 99 mg/dL		LMC
Sodium	139	136 - 145		LMC
Potassium	4.2	3.5 - 5.1		LMC
Chloride	104	98 - 107		LMC
CO2	26	21 - 32		LMC
Anion Gap	9	5 - 16		LMC
BUN	11	7 - 18 mg/dL		LMC
Creatinine	0.7	0.6 - 1.3 mg/dL		LMC
Calcium	9.3	8.5 - 10.1 mg/dL		LMC
Bilirubin Total	0.2	0.2 - 1.0 mg/dL		LMC
Total Protein	7.5	6.4 - 8.2 g/dL		LMC
Albumin	4.0	3.4 - 5.0 g/dL		LMC
AST	17	10 - 37 U/L		LMC
ALT	23	12 - 63 U/L		LMC
Alkaline Phos.	114	45 - 117 U/L		LMC
eGFR	>60	>60 mL/min/1.73 sqm		LMC

Comment: (Multiply result X 1.2 if Afr. Am.)

Resulted: 09/26/17 1623, Result status: Final result

CBC w/ diff [92236054]

Ordering provider: Hensley, Terry G, MD 09/26/17 1613 Resulting lab: LEXINGTON MEDICAL CENTER

Specimen Collection

Type	Source	Collected On
Blood	BLOOD	09/26/17 1228

Components

	Value	Reference	Flag	Lab

Results (continued)

Resulted: 09/26/17 1623, Result status: Final result

CBC w/ diff [92236054] (continued)

		Range	
WBC	4.5	4.0 - 11.0	LMC
RBC	4.32	4.20 - 5.40	LMC
HGB	13.1	12.0 - 16.0 g/dL	LMC
HCT	38.6	36.0 - 48.0 %	LMC
MCV	89.4	80.0 - 98.0	LMC
MCH	30.3	27.0 - 32.0 pg	LMC
MCHC	33.9	32.0 - 36.0 g/dL	LMC
RDW	12.4	11.5 - 14.5 %	LMC
RDW (SD)	40.6	36.4 - 46.3	LMC
PLT	262	130 - 400	LMC
MPV	9.0	7.5 - 10.5	LMC
NRBC,AUTO	<2.0	<2 %	LMC
ABS NRBC,AUTO	NOT APPLICABLE	<1	LMC
% Neutrophils	48	43 - 72 %	LMC
% Lymphocytes	41	17 - 44 %	LMC
% Monocytes	9	0 - 10 %	LMC
% Eosinophils	1	0 - 5 %	LMC
% Basophils	1	0 - 3 %	LMC
% IMMATURE GRANULOCYTES	0	<1 %	LMC
Abs Neutrophils	2.21	1.7 - 8.0	LMC
Abs Lymphocytes	1.84	0.7 - 5.0	LMC
Abs Monocytes	0.41	0.0 - 1.1	LMC
Abs Eosinophils	0.04	0.0 - 0.6	LMC
Abs Basophils	0.03	0.0 - 0.2	LMC
ABS IMMATURE GRANULOCYTES	0.01	<1	LMC

Resulted: 09/26/17 1431, Result status: Final result

XR Wrist Left PA Lateral and Oblique [855398791]

Ordering provider: Hensley, Terry G, MD 09/26/17 1247 Resulted by: McGuire, Keith Alan, MD
Performed: 09/26/17 1405 - 09/26/17 1410 Resulting lab: PACS
Narrative:
CLINICAL DATA: Pain

COMPARISON: None

TECHNIQUE: 4 views of the left wrist were obtained.

FINDINGS: Left wrist shows no traumatic or pathologic changes.
Soft tissues are unremarkable.

Impression:
No acute displaced fractures are seen.

Specimen Collection

Type	Source	Collected On
		09/26/17 1431

Results (continued)

Resulted: 09/26/17 1431, Result status: Final result

XR Knee Left AP Lateral and Both Obliques [85539877]

Ordering provider: Hensley, Terry G, MD 09/26/17 1247 | Resulted by: McGuire, Keith Alan, MD
Performed: 09/26/17 1357 - 09/26/17 1403 | Resulting lab: PACS
Narrative:
CLINICAL DATA: Pain

COMPARISON: None

TECHNIQUE: Four views of the left knee were obtained.

FINDINGS: There is an acute and probably comminuted mildly distracted midpatellar fracture. There is an associated moderate joint effusion with associated soft tissue swelling. No other acute findings identified. Orthopedic consultation recommended.

Specimen Collection

Type	Source	Collected On
		09/26/17 1430

Resulted: 09/26/17 1430, Result status: Final result

XR Ankle Right AP Lateral and Oblique [85539878]

Ordering provider: Hensley, Terry G, MD 09/26/17 1247 | Resulted by: McGuire, Keith Alan, MD
Performed: 09/26/17 1403 - 09/26/17 1408 | Resulting lab: PACS
Narrative:
CLINICAL DATA: Pain

COMPARISON: None

TECHNIQUE: Three views of the right ankle were obtained.

FINDINGS: Right ankle showed no traumatic or pathologic changes. Soft tissues are unremarkable.

Impression:
Unremarkable right ankle.

Specimen Collection

Type	Source	Collected On
		09/26/17 1430

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
17 - LMC	LEXINGTON MEDICAL CENTER	Spalding, Martin John, MD [7409]	2720 Sunset Blvd West Columbia SC 29169	08/29/14 1256 - Present
20 - Unknown	PACS	Unknown	Unknown	10/25/12 1643 - Present

Patient-Level E-Signatures:

HIPAA Notice of Privacy - Received on 9/26/2017

Acknowledgement of Receipt of Notice of Privacy Practices

Patient-Level E-Signatures: (continued)

Name: Connell,Diane M

Address: 304 TRENTWOOD DRIVE

City/State/Zip: COLUMBIA SC 29223

Telephone: 803-736-6629 **Account/Chart Number:** M002014739
CSN: 100023195855

I have received a copyof the Notice of Privacy Practices.

Diane Connell
9/26/2017 12:39:12 PM Patient Signature **9/26/2017**
Signature of Patient or Authorized Person Date

Relationship to Individual

Hospital Account-Level E-Signatures:

Conditions of Admissions - Received on 9/26/2017

Conditions of Admission and General Consent to treat at Lexington Medical Center

AUTHORIZATION FOR TREATMENT: The undersigned consents to any procedure, examination or treatment rendered by the physician. The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physician. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination.

I consent to appropriate test for the presence of infection, such as, but not limited to, infection by the Hepatitis B virus or the human immunodeficiency virus, if deemed necessary for the protection of others, and I authorize withdrawal of blood or other body fluids this purpose. I also understand the organization is required to disclose the results of some communicable diseases, such as HIV, TB, and Viral Meningitis to DHEC and/or the Center for Disease Control Prevention. I understand that if my medical record contains documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable disease, this information will be released as part of my medical record.

I consent to the photographing or televising
of any procedure to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed. I further understand that video cameras may be used in patient rooms for observation purposes.

I consent and give permission to LMC to photograph me in connection with medical identity theft prevention.

I authorize Lexington Medical Center to contact me on any cell phone number provided by me for the purpose of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose.

Hospital Account-Level E-Signatures: (continued)

RELEASE OF INFORMATION: I authorize release of medical records/information to health care providers as deemed necessary for the continuity of care and for the purpose of review, payment and appeal by me or on my behalf or my insurance carrier.

Lexington Medical Center will make our best effort to pre-certify and or pre-authorize treatment with third party payers who conduct Utilization Review as a service to patients. However, Lexington Medical Center does not accept responsibility for the lack of pre-certification and/or pre-authorization and is not responsible for the final payment outcomes or timing restraints.

MEDICARE-MEDICAID PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I authorize and direct my insurers to pay directly to Lexington Medical Center and/or its physicians and and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Lexington Medical Center, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Lexington medical Center and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees.

PROMISE TO PAY ACCOUNT: FOR AND IN CONSIDERATION of service rendered by Lexington Medical Center; I promise to pay all charges incurred for the account on the patient. In the event that I default in the obligation of payment to Lexington Medical Center, I understand that my account(s) can be placed with a collection agency and/or Lexington Medical Center can place my account in the Department of Revenue's Debt Set-Off program and /or a judgment may be secured against any owned property to the extent of the unpaid bill. I further agree to pay reasonable attorney's fees, collection fees, Debt Set-Off administrative fees and court costs if my account is placed for legal or third party collection action.

I understand that I am financially responsible to Lexington medical Center for all charges not covered, approved or considered necessary by my insurance. I will pay at the time of service or have agreeable payment arrangement set up with the Patient

DMC

Accounts Office. 9/26/2017 12:36:25 PM Patient Initials (Patient to initial here).

HOSPITAL PATIENT SAFETY ACT: I acknowledge that I have received information regarding my rights

DMC

under the Hospital Patient Safety Act. 9/26/2017 12:38:32 PM Patient Initials (Patient to initial here).
Or brochure Connell,Diane M
Print Name Relationship

PHYSICIANS AS INDEPENDENT CONTRACTORS: I recognize that some physicians who may be involved in my care, such as radiologists and pathologists, are independent contractors and are not employees or agents of the hospital. Separate bills will be sent for their services. I authorize and direct the named insurers to pay benefits directly to these physicians for services rendered.

RELEASE FROM RESPONSIBILITY FOR PERSONAL PROPERTY: I have been made aware that the hospital provides facilities for the safekeeping of valuables and I hereby release the hospital from liability for loss or damage to any items, which are not given to hospital personnel for safekeeping.

Hospital Account-Level E-Signatures: (continued)

AVAILABILITY OF CLINICAL TRIALS: I am aware that clinical trials (research studies) are available through the hospital or physicians who are members of the medical staff of Lexington Medical Center. If I desire more information about participating in clinical trials, I can request information be provided to me by my physician.

THIS FORM HAS BEEN EXPLAINED TO ME; I HAVE READ AND UNDERSTAND IT.

Diane M. Connell
9/26/2017 12:38:49 PM Pedent Signature

Signature of Patient	9/26/2017 Date	Guarantor (If other than patient)
9/26/2017 If minor, Responsible Party	Date	Relationship to Patient/ Personal Representative
		Connell,Diane M M002014739 100023195855 5/31/1951 Female
Judy M Gantt Witness	9/26/2017 Date	9/26/2017 12:30 PM
9/26/2017 Second Witness Signature	Date	

Notice of Non Covered Services - Received on 9/26/2017

FINANCIAL NOTICE FOR NON-COVERED AND/OR NOT MEDICALLY NECESSARY SERVICES

Patient Name: Connell,Diane M

CSN: 100023195855
DOB: [redacted] Sex: Female
MRN: M002014739 9/26/2017 12:30 PM

Your health insurance company may not pay for certain health care services that they consider non-covered or not medically necessary based on their clinical guidelines. You may be financially responsible for any health care services that your insurance plan deems non-covered or not medically necessary and does not pay.

The purpose of this document is to inform you that YOU MAY BE REQUIRED TO PAY FOR ANY HEALTH CARE ITEM OR SERVICE THAT YOUR INSURANCE PLAN REFUSES TO PAY FOR because it deems the service or items not covered or not medically necessary under it's guidelines.

Please ask us to explain anything that you do not understand. Thank you for allowing us to serve you .

9/26/2017
Date

Diane M. Connell
9/26/2017 12:39:[illegible] Signature of Patient or Guardian

Hospital Account-Level E-Signatures: (continued)

Signature of Patient or Guarantor

Judy M Gantt
Witness

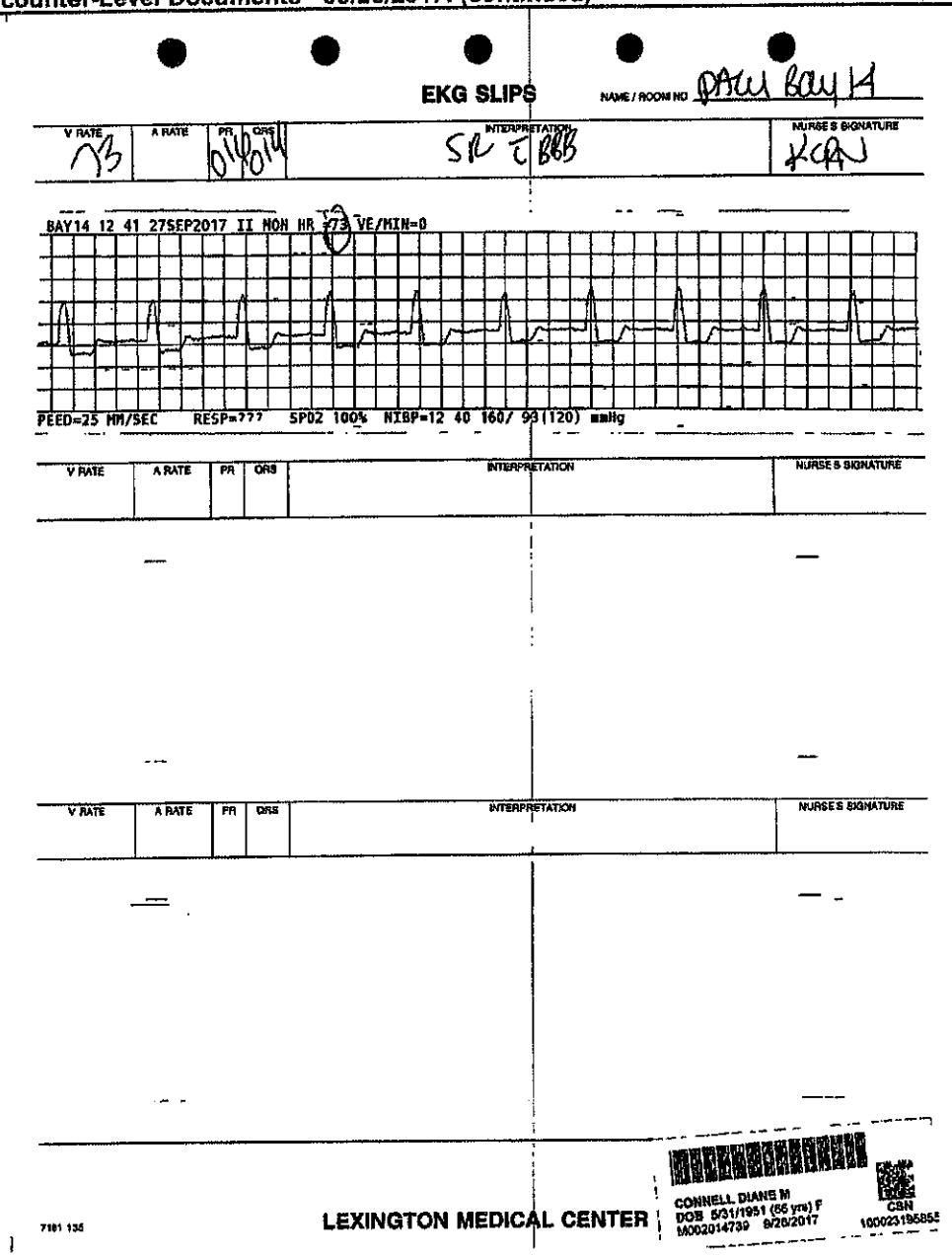
Encounter-Level E-Signatures:

There are no encounter-level e-signatures.

Encounter-Level Documents - 09/26/2017:

EKG and Vital Sign Slips - Scan on 9/29/2017 0947 (below)

Encounter-Level Documents - 09/26/2017: (continued)



EKG SLIPS NAME / ROOM NO PACU Bay 14

V RATE	A RATE	PR	QRS	INTERPRETATION	NURSE'S SIGNATURE
73		0140	14	SR T BBB	KCA

BAY14 12 41 27SEP2017 II MON HR=73 VE/MIN=0

PEED=25 MM/SEC RESP=??? SPO2 100% NIBP=12 40 160/ 93(120) mmHg

V RATE	A RATE	PR	QRS	INTERPRETATION	NURSE'S SIGNATURE

V RATE	A RATE	PR	QRS	INTERPRETATION	NURSE'S SIGNATURE

7181 135

LEXINGTON MEDICAL CENTER

CONNELL, DIANE M
DOB 5/31/1951 (65 yrs) F
M002014739 9/26/2017

CSN
100023195855

EKG and Vital Sign Slips - Scan on 9/27/2017 2106 (below)

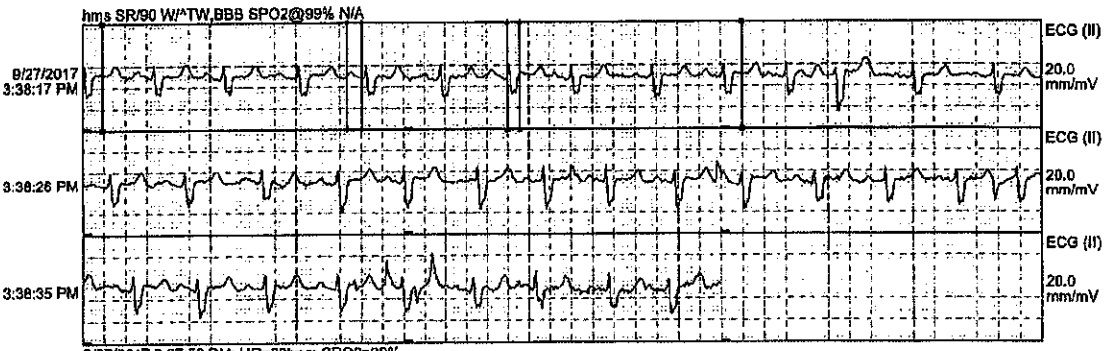
Encounter-Level Documents - 09/26/2017: (continued)

1 Lexington Medical Center

SAVED EVENT REPORT

Page 1
9/27/2017 9:06 PM

Patient Name: 586-CONNELL, DIANE
ID 1: 100023195855
ID 2: M002014739
Unit: NT02
Bed ID: 2134



9/27/2017 3:37:52 PM: HR=93bpm,SPO2=99%
CALIPERS: ▫ Rate 90 bpm (8 intervals) ▵ QRS 0.13 sec ▵ PR 0.15 sec
Comments: Initial Remote Telemetry Strip,Connell,Diane,RM#586, REMOTE#2134, CSN#100023195855. Patients identification completed by Nurse Tya/ emks
Sweep speed: 25.0 mm/s

--END OF REPORT--

Spacelabs Healthcare

END OF REPORT

Admission Information - Patient Record Only

Arrival Date/Time:	10/12/2017 0851	Admit Date/Time:	10/12/2017	IP Adm. Date/Time:	
Admission Type:		Point of Origin:		Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:		Unit:	
Admit Provider:	Dedmond, Barnaby T, MD	Attending Provider:		Referring Provider:	

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	LEXINGTON ORTHOPAEDICS WEST COLUMBIA

Allergies as of 10/12/2017 — Review Complete On: 9/27/2017 By: Coleman, Kayla B, RN

No Known Allergies

Medical as of 10/12/2017 **None**

Surgical as of 10/12/2017

Past Surgical History	Laterality	Date	Comments
ATRIAL ABLATION SURGERY [SHX560]			
SPINE SURGERY [SHX786]			buldging disc

Problem List

	Noted	Resolved
Closed displaced comminuted fracture of left patella	9/26/2017 by Beard, Hoyt R., MD	No
Fracture of left patella	9/27/2017 by Dedmond, Barnaby T, MD	No

Family History as of 10/12/2017

No family history on file.

ED Records

ED Arrival Information

Patient not seen in ED

Chief Complaint History

User	Date & Time
Bartley, Christin S, MA	10/12/2017 8:52 AM

Chief Complaint

Left Knee - Post-op
Comment: 2 weeks s/p ORIF Left patella fracture

ED Notes

No notes of this type exist for this encounter.

Urgent Care Notes

Urgent Care Notes

No notes of this type exist for this encounter.

Encounter Notes

Encounter Notes

Progress Notes by Dedmond, Barnaby T, MD on 10/12/17 0931 Version 1 of 1

Author: Dedmond, Barnaby T, MD | Service: (none) | Author Type: Physician
Filed: 10/12/17 0931 | Encounter Date: 10/12/2017 | Status: Signed
Editor: Dedmond, Barnaby T, MD (Physician)

FOLLOW UP VISIT

REASON FOR VISIT

Patient ID: Diane M Connell is a 66 y.o. female.

Reason for visit:
Chief Complaint
Patient presents with
- Left Knee - Post-op
  2 weeks s/p ORIF Left patella fracture[LS1.1]

SUBJECTIVE:

Pain is controlled. Mobilizing with a walker but doing very well. Denies fevers or chills.

OBJECTIVE:

left Lower Extremity:
Incisions are benign. No signs of infection.
Extensor mechanism is palpably intact. Able to do a straight leg raise with ease.
Foot is perfused.
Some swelling as expected.
Motor and sensory function is intact distally.

ASSESSMENT/PLAN:

Diagnoses and all orders for this visit:

Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter
- Hinged Knee Brace
- XR Knee Left AP and Lateral; Future

Staples are removed today.
They are transitioned to a hinged knee brace.
They are weight bearing as tolerated with the knee braced locked in full extension.
When not walking, the brace will be set at 0 to 90 degrees of flexion and they are instructed to work on knee ROM within this range.
Follow up in 4 weeks for either unlocking of the brace or if quad strength permits discontinuation of the brace altogether. Will obtain new xrays of left knee out of the brace at that visit.
As always, I am happy to see them back sooner if there are concerns.[BD1.1]

Encounter Notes (continued)

Progress Notes by Dedmond, Barnaby T, MD on 10/12/17 0931 (continued) Version 1 of 1

Electronically Signed by Dedmond, Barnaby T, MD on 10/12/17 0931

Revision History

User Key	Date/Time	User	Provider Type	Action
> BD1.1	10/12/17 0931	Dedmond, Barnaby T, MD	Physician	Sign
LS1.1	10/12/17 0900	Skinner, Latasha Q, MOT	Medical Office Technician	Sign at close encounter

Surgery Report

Anesthesia Post-Op Notes

No notes of this type exist for this encounter.

Imaging - Clinical Orders

XR Knee Left AP and Lateral [92308904]

Electronically signed by: **Dedmond, Barnaby T, MD on 10/12/17 0926** Status: **Completed**
Ordering user: Dedmond, Barnaby T, MD 10/12/17 0926 Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD
Frequency: 10/12/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]
Order comments:
After brace removal

Equipment - Other Orders

Hinged Knee Brace [92308903]

Electronically signed by: **Dedmond, Barnaby T, MD on 10/12/17 0926** Status: **Active**
Ordering user: Dedmond, Barnaby T, MD 10/12/17 0926 Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD
Frequency: 10/12/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]

Outpatient Referral - Other Orders

Referral to Home Health [92308905]

Electronically signed by: **Dedmond, Barnaby T, MD on 10/12/17 0939** Status: **Active**
Ordering user: Dedmond, Barnaby T, MD 10/12/17 0939 Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD
Frequency: 10/12/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]
Questions:
Service to evaluate and treat patient: Physical Therapy Comment - WBAT with brace locked in extension. Unlock brace when not walking to work on ROM from 0-90 degrees of flexion

Clinical Lab Results

Lab, Radiology, ECG/EMG and Cardiac Results

No results found

Clinical Lab Results (continued)

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

No education to display

Discharge Instructions Connell, Diane M (MR # M002014739)

None

Diane M Connell

Oncology

Diane M Connell does not have an active treatment plan of type ONCOLOGY TREATMENT in this episode.

Flowsheet Data

All Flowsheet Data (10/12/17 0000-10/12/17 2359)

Encounter Vitals

	10/12/17 0859
Enc Vitals	
Resp	16 -CB
Weight	68 kg (149 lb 14.6 oz) -CB
Height	5' 6" (1.676 m) -CB
Pain Score	Four -CB

Custom Formula Data

	10/12/17 0859
OTHER	
ABW	62.78 -CB
BSA (Calculated - sq m)	1.78 sq meters -CB
BMI (Calculated)	24.2 -CB
IBW/kg (Calculated)	63.6 kg -CB
Male	
IBW/kg (Calculated)	59.3 kg -CB
FEMALE	
Weight in (lb) to have BMI = 25	154.6 -CB
BMI	24.2 -CB
Ideal Body Weight (kg)	58.97 kg -CB
Ideal Body Wgt (lb)	130 lb -CB
Percent of Ideal Body Weight	115.32 Percent -CB
Excess Body Weight (kg)	9.01 kg -CB
Excess Body Wgt (lb)	19.91 lb -CB
Percent Weight Change Since Birth	0 -CB
IBW/kg (Calculated)	59.3 -CB
Low Range Vt 6cc/kg	355.8 mL -CB
Adult Moderate Range Vt 8cc/kg	474.4 mL -CB
Adult High Range Vt 10cc/kg	593 mL -CB
Adult IBW/VT Calculations	
IBW percentage	4044.86 -CB

Pain Assessment

	10/12/17 0859
Pain Assessment	
Pain Score	Four -CB
ED Pain Assessment Timer	
ED Auto Pain Reassessment	Yes -CB

Anthropometrics

	10/12/17 0859
Anthropometrics	
Height	5' 6" (1.676 m) -CB
Weight	68 kg (149 lb 14.6 oz) -CB
Weight Change	0 % -CB
BMI (Calculated)	24.2 -CB

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
CB	Bartley, Christin S, MA	09/14/17 -

Flowsheet Row Details (all recorded)

BMI

BMI (continued)

Effective: 02/09/16

Row Information: BMI=Body Mass Index.(Weight Scale/35.2)/(Height*0.0254)^2Threshold of overweight (BMI>/= 25 Kg/m)source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BMI (Calculated)

Effective: 05/02/06

Row Information: BMI=Body Mass Index.
(Weight Scale/35.2)/(Height*0.0254)^2
Threshold of overweight (BMI>/= 25 Kg/m)
source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BSA (Calculated - sq m)

Effective: 05/02/06

Row Information: BSA=Body Surface Area.
BSA (sq meters) = sqrt((Height (cm) x Weight (kg))/3600)
.
BSA is calculated using the Mosteller Formula. Mosteller RD: Simplified Calculation of Body Surface Area. N Engl J Med 1987 Oct 22;317(17):1098.

Height

Warning Min/Max	Absolute Min/Max
1' (0.305 m) / 8' (2.438 m)	1.18" (0.03 m) / 9' 10.11" (3 m)

Ideal Body Weight (kg)

Effective: 02/09/16

Row Information: Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Ideal Body Wgt (lb)

Effective: 02/09/16

Row Information: Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Pain Score

Zero = 0-No pain
One = 1
Two = 2
Three = 3
Four = 4
Five = 5
Six = 6
Seven = 7
Eight = 8
Nine = 9
Ten = 10-Worst pain ever

Resp

Warning Min/Max	Absolute Min/Max
8 / 30	0 / 200

Weight

Warning Min/Max	Absolute Min/Max
5 lb (2.268 kg) / 300 lb (136.1 kg)	0.1 oz (0.003 kg) / 1500 lb (680.4 kg)

Weight in (lb) to have BMI = 25

Effective: 09/15/10

Row Information: Uses height to find what their weight would need to be in order to have a BMI of 25.

Flowsheet Notes

No notes of this type exist for this encounter.

Patient-Level E-Signatures:

HIPAA Notice of Privacy - Received on 9/26/2017

Acknowledgement of Receipt of Notice of Privacy Practices

Name: Connell,Diane M

Patient-Level E-Signatures: (continued)

Address: 304 TRENTWOOD DRIVE

City/State/Zip: COLUMBIA SC 29223

Telephone: 803-736-6629 **Account/Chart Number:** M002014739
CSN: 100023195855

I have received a copyof the Notice of Privacy Practices.

Diane Connell
9/26/2017 12:30:12 PM Patient Signature **9/26/2017**

Signature of Patient or Authorized Person Date

Relationship to Individual

Hospital Account-Level E-Signatures:
There are no hospital account-level e-signatures.

Encounter-Level E-Signatures:
There are no encounter-level e-signatures.

All Scans

Encounter-Level Documents:
There are no encounter-level documents.

Order-Level Documents:
There are no order-level documents.

Patient-Level Documents:
PN Auth Lexington Orthopaedics - Scan on 10/12/2017 0903 : Perceptive Content Scan (below)

LeXington ORTHOPAEDICS
A Lexington Medical Center Physician Practice

811 W. Main Street, Suite 101
Lexington, SC 29072
Ph: (803) 996-7230
Fx: (803) 359-6208

7033 St. Andrews Road
Suite 104, Columbia, SC 29212
Ph: (803) 936-7230
Fx: (803) 749-9975

Lexington Medical Park 2
148 North Hospital Drive, Suite 140
West Columbia, SC 29169
Ph: (803) 936-7230 • Fx: (803) 936-8097

Lex-Ortho.com

Lexington Medical Center

Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of **Lexington Orthopaedics** who may attend me, their assistants, including those employed by **Lexington Orthopaedics** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. DM (*initials*)

I authorize LMC Physician Practices to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose. _____ (*initials*)

I consent and give permission to **Lexington Orthopaedics** to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to LMC Physician Practices and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to LMC Physician Practices, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to LMC Physician Practices and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. _____ (*initials*)

Print Patient Name: Diane DOB: _____

Patient Signature: _____ Date: _____

Responsible Party Signature (if different): _____ Date: _____

8366-033-1 (02/16)

Admission Information - Patient Record Only

Arrival Date/Time:	11/09/2017 0936	Admit Date/Time:	11/09/2017	IP Adm. Date/Time:	
Admission Type:		Point of Origin:		Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:		Unit:	
Admit Provider:	Dedmond, Barnaby T, MD	Attending Provider:		Referring Provider:	Dedmond, Barnaby T, MD

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	None	None	None	LEXINGTON ORTHOPAEDICS WEST COLUMBIA

Allergies as of 11/9/2017 — Review Complete On: 11/9/2017 By: Barber, Tamara L, MA

No Known Allergies

Medical as of 11/9/2017 **None**

Surgical as of 11/9/2017

Past Surgical History	Laterality	Date	Comments
ATRIAL ABLATION SURGERY [SHX560]			
SPINE SURGERY [SHX786]			buldging disc

Problem List

	Noted	Resolved
Closed displaced comminuted fracture of left patella	9/26/2017 by Beard, Hoyt R., MD	No
Fracture of left patella	9/27/2017 by Dedmond, Barnaby T, MD	No

Family History as of 11/9/2017

No family history on file.

ED Records

ED Arrival Information

Patient not seen in ED

Chief Complaint History

User	Date & Time
Barber, Tamara L, MA	11/9/2017 10:35 AM

Chief Complaint

Left Knee - Follow-up
Comment: 6 weeks s/p ORIF left patella

ED Notes

No notes of this type exist for this encounter.

Urgent Care Notes

Urgent Care Notes

No notes of this type exist for this encounter.

Encounter Notes

Encounter Notes

Progress Notes by Dedmond, Barnaby T, MD on 11/09/17 1101 Version 1 of 1

Author: Dedmond, Barnaby T, MD | Service: (none) | Author Type: Physician
Filed: 11/09/17 1101 | Encounter Date: 11/9/2017 | Status: Signed
Editor: Dedmond, Barnaby T, MD (Physician)

FOLLOW UP VISIT

REASON FOR VISIT

Patient ID:[TB1.1] Diane M Connell[TB1.2] is a[TB1.1] 66 y.o. female[TB1.2],

Reason for visit:[TB1.1]
Chief Complaint
Patient presents with
- Left Knee - Follow-up
  6 weeks s/p ORIF left patella[TB1.2]

Doing very well. Pain controlled.

LLE: incision is benign, good quad strength, ROM 0-100 degrees, NVI

Xr Knee Left Ap And Lateral

Result Date: 11/9/2017
Patella fracture remains in good alignment with hardware in place

D/c brace.
Instructed in ROM exercises. Offered PT but patient prefers to do on her own.
F/u 6 weeks with new xrays left knee[BD1.1]

Dedmond, Barnaby T[BD1.2]

Electronically Signed by Dedmond, Barnaby T, MD on 11/09/17 1101

Revision History

	User Key	Date/Time	User	Provider Type	Action
>	BD1.2	11/09/17 1101	Dedmond, Barnaby T, MD	Physician	Sign
	BD1.1	11/09/17 1100	Dedmond, Barnaby T, MD	Physician	
	TB1.2	11/09/17 1036	Barber, Tamara L, MA	Medical Assistant	Sign at close encounter
	TB1.1	11/09/17 1035	Barber, Tamara L, MA	Medical Assistant	

Surgery Report

Anesthesia Post-Op Notes

No notes of this type exist for this encounter.

Imaging-Clinical Orders

XR Knee Left AP and Lateral [94727371]

Electronically signed by: **Dedmond, Barnaby T, MD on 11/09/17 1059** Status: **Completed**
Ordering user: Dedmond, Barnaby T, MD 11/09/17 1059 | Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD

Imaging - Clinical Orders (continued)

XR Knee Left AP and Lateral [947273711 (continued)

Frequency: 11/09/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]

Other Orders

No orders found

Clinical Lab Results

Lab, Radiology, ECG/EMG and Cardiac Results

No results found

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

No education to display

Discharge Instructions Connell, Diane M (MR # M002014739)

None

Diane M Connell

Oncology

Diane M Connell does not have an active treatment plan of type ONCOLOGY TREATMENT in this episode.

Flowsheet Data

All Flowsheet Data (11/09/17 0000-11/09/17 2359)

Encounter Vitals

	11/09/17 1035
Enc Vitals	
Resp	15 -TB
Weight	68 kg (149 lb 14.6 oz) -TB
Height	5' 6.14" (1.68 m) -TB
Pain Score	Two -TB

Custom Formula Data

	11/09/17 1035
OTHER	
ABW	62.98 -TB
BSA (Calculated - sq m)	1.78 sq meters -TB
BMI (Calculated)	24.1 -TB
IBW/kg (Calculated) Male	64.13 kg -TB
IBW/kg (Calculated) FEMALE	59.63 kg -TB
Weight in (lb) to have BMI = 25	155.2 -TB
BMI	24.1 -TB
Ideal Body Weight (kg)	59.29 kg -TB
Ideal Body Wgt (lb)	130.71 lb -TB
Percent of Ideal Body Weight	114.69 Percent -TB
Excess Body Weight (kg)	8.69 kg -TB
Excess Body Wgt (lb)	19.2 lb -TB
Percent Weight Change Since Birth	0 -TB
IBW/kg (Calculated)	59.63 -TB
Low Range Vt 6cc/kg	357.78 mL -TB
Adult Moderate Range Vt 8cc/kg	477.04 mL -TB
Adult High Range Vt 10cc/kg	596.3 mL -TB
Adult IBW/VT Calculations	
IBW percentage	4022.47 -TB

Pain Assessment

	11/09/17 1035
Pain Assessment	
Pain Score	Two -TB
ED Pain Assessment Timer	
ED Auto Pain Reassessment	Yes -TB

Anthropometrics

	11/09/17 1035
Anthropometrics	
Height	5' 6.14" (1.68 m) -TB
Weight	68 kg (149 lb 14.6 oz) -TB
Weight Change	0 % -TB
BMI (Calculated)	24.1 -TB

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
TB	Barber, Tamara L, MA	09/14/17 -

Flowsheet Row Details (all recorded)

BMI

BMI (continued)

Effective: 02/03/16

Row Information: BMI=Body Mass Index.(Weight Scale/35.2)/(Height*0.0254)^2Threshold of overweight (BMI>/= 25 Kg/m)source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BMI (Calculated)

Effective: 06/02/06

Row Information: BMI=Body Mass Index.
(Weight Scale/35.2)/(Height*0.0254)^2
Threshold of overweight (BMI>/= 25 Kg/m)
source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BSA (Calculated - sq m)

Effective: 06/02/06

Row Information: BSA=Body Surface Area.
BSA (sq meters) = sqrt([Height (cm) x Weight (kg)]/3600)
.
BSA is calculated using the Mosteller Formula. Mosteller RD: Simplified Calculation of Body Surface Area. N Engl J Med 1987 Oct 22;317(17):1098.

Height

Warning Min/Max	Absolute Min/Max
1' (0.305 m) / 8' (2.438 m)	1.18" (0.03 m) / 9' 10.11" (3 m)

Ideal Body Weight (kg)

Effective: 02/03/16

Row Information: Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Ideal Body Wgt (lb)

Effective: 02/03/16

Row Information: Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Pain Score

Zero = 0-No pain
One = 1
Two = 2
Three = 3
Four = 4
Five = 5
Six = 6
Seven = 7
Eight = 8
Nine = 9
Ten = 10-Worst pain ever

Resp

Warning Min/Max	Absolute Min/Max
8 / 30	0 / 200

Weight

Warning Min/Max	Absolute Min/Max
5 lb (2.268 kg) / 300 lb (136.1 kg)	0.1 oz (0.003 kg) / 1500 lb (680.4 kg)

Weight in (lb) to have BMI = 25

Effective: 09/16/10

Row Information: Uses height to find what their weight would need to be in order to have a BMI of 25.

Flowsheet Notes

No notes of this type exist for this encounter.

Patient-Level E-Signatures:

HIPAA Notice of Privacy - Received on 9/26/2017

Acknowledgement of Receipt of Notice of Privacy Practices

Name: Connell,Diane M

Patient-Level E-Signatures: (continued)

Address: 304 TRENTWOOD DRIVE

City/State/Zip: COLUMBIA SC 29223

Telephone: 803-736-6629 **Account/Chart Number:** M002014739
CSN: 100023195855

I have received a copyof the Notice of Privacy Practices.

Diane Connell
9/26/2017 12:30:12 PM Patient Signature **9/26/2017**
Signature of Patient or Authorized Person Date

Relationship to Individual

Hospital Account-Level E-Signatures:
There are no hospital account-level e-signatures.

Encounter-Level E-Signatures:
There are no encounter-level e-signatures.

All Scans

Encounter-Level Documents:
There are no encounter-level documents.

Order-Level Documents:
There are no order-level documents.

Patient-Level Documents:
PN Auth Lexington Orthopaedics - Scan on 10/12/2017 0903 : Perceptive Content Scan (below)

All Scans (continued)

Patient-Level Documents: (continued)

LeXington ORTHOPAEDICS
A Lexington Medical Center Physician Practice

811 W. Main Street, Suite 101
Lexington, SC 29072
Ph: (803) 936-7230
Fx: (803) 359-8208

7093 St. Andrews Road
Suite 104, Columbia, SC 29212
Ph: (803) 936-7230
Fx: (803) 749-9875

Lexington Medical Park 2
146 North Hospital Drive, Suite 140
West Columbia, SC 29169
Ph: (803) 936-7230 • Fx: (803) 936-8097

Lex-Ortho.com

Lexington Medical Center

Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of **Lexington Orthopaedics** who may attend me, their assistants, including those employed by **Lexington Orthopaedics** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. DM (*initials*)

I authorize LMC Physician Practices to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose._____(*initials*)

I consent and give permission to **Lexington Orthopaedics** to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to LMC Physician Practices and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to LMC Physician Practices, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to LMC Physician Practices and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. _____(*initials*)

Print Patient Name: Diane C _____ DOB: _____

Patient Signature: _____ Date: _____

Responsible Party Signature (if different): _____ Date: _____

6338-033-1 (07/16)

Admission Information - Patient Record Only

Arrival Date/Time:	12/14/2017 1046	Admit Date/Time:	12/14/2017	IP Adm. Date/Time:	
Admission Type:		Point of Origin:		Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:		Unit:	
Admit Provider:	Dedmond, Barnaby T, MD	Attending Provider:		Referring Provider:	

Discharge Information - Patient Record Only

Discharge Date/Time:	Discharge Disposition:	Discharge Destination:	Discharge Provider:	Unit:
None	None	None	None	LEXINGTON ORTHOPAEDICS WEST COLUMBIA

Allergies as of 12/14/2017 — Review Complete On: 12/14/2017 By: Barnes, Andrea R, MA

No Known Allergies

Medical as of 12/14/2017 **None**

Surgical as of 12/14/2017

Past Surgical History	Laterality	Date	Comments
ATRIAL ABLATION SURGERY [SHX560]			
SPINE SURGERY [SHX786]			bulging disc

Problem List

	Noted	Resolved
Closed displaced comminuted fracture of left patella	9/26/2017 by Beard, Hoyt R., MD	No
Fracture of left patella	9/27/2017 by Dedmond, Barnaby T, MD	No

Family History as of 12/14/2017

No family history on file.

ED Records

ED Arrival Information

Patient not seen in ED

Chief Complaint History

User:	Date & Time:
Barnes, Andrea R, MA	12/14/2017 10:55 AM

Chief Complaint:

Left Knee - Follow-up

Comment: 3 months s/p ORIF left patella.

ED Notes

No notes of this type exist for this encounter.

Urgent Care Notes

Urgent Care Notes

No notes of this type exist for this encounter.

Encounter Notes

Encounter Notes

Progress Notes by Dedmond, Barnaby T, MD on 12/14/17 1114 Version 1 of 1

Author: Dedmond, Barnaby T, MD | Service: (none) | Author Type: Physician
Filed: 12/14/17 1114 | Encounter Date: 12/14/2017 | Status: Signed
Editor: Dedmond, Barnaby T, MD (Physician)

FOLLOW UP VISIT

REASON FOR VISIT

Patient ID: Diane M Connell is a 66 y.o. female.

Reason for visit:
Chief Complaint
Patient presents with
- Left Knee - Follow-up
  3 months s/p ORIF left patella.[AB1.1]

DOing very well. Pain well controlled. Some soreness after prolonged activities.

LLE: FROM knee, good quad strength, mild TTP over tip of superolateral pin, NVI[BD1.1]

Xr Knee Left Ap And Lateral

Result Date: 12/14/2017
Healing patella fracture in good alignment with hardware in place[BD1.2]

COntinue to work on strengthening.

D/w patient and husband possibility of HWR if it is bothersome to her but would wait at least a year.

F/u prn.[BD1.1]

Dedmond, Barnaby T[BD1.3]

Electronically Signed by Dedmond, Barnaby T, MD on 12/14/17 1114

Revision History

User Key	Date/Time	User	Provider Type	Action
> BD1.3	12/14/17 1114	Dedmond, Barnaby T, MD	Physician	Sign
BD1.2	12/14/17 1113	Dedmond, Barnaby T, MD	Physician	
BD1.1	12/14/17 1112	Dedmond, Barnaby T, MD	Physician	
AB1.1	12/14/17 1056	Barnes, Andrea R, MA	Medical Assistant	Sign at close encounter

Surgery Report

Anesthesia Post-Op Notes

No notes of this type exist for this encounter.

Surgery Report (continued)

Orders

Clinical Orders

No orders found

Other Orders

No orders found

Clinical Lab Results

Lab, Radiology, ECG/EMG and Cardiac Results

No results found

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

No education to display

Discharge Instructions Connell, Diane M (MR # M002014739)

None

Diane M Connell

Oncology

Diane M Connell does not have an active treatment plan of type ONCOLOGY TREATMENT in this episode.

Flowsheet Data

All Flowsheet Data (12/14/17 0000-12/14/17 2359)

Encounter Vitals

	12/14/17 1056
Enc Vitals	
Resp	15 -AB
Weight	68 kg (149 lb 14.6 oz) -AB
Height	5' 6.14" (1.68 m) -AB

Custom Formula Data

	12/14/17 1056
OTHER	
ABW	62.98 -AB
BSA (Calculated - sq m)	1.78 sq meters -AB
BMI (Calculated)	24.1 -AB
IBW/kg (Calculated) Male	64.13 kg -AB
IBW/kg (Calculated) FEMALE	59.63 kg -AB
Weight in (lb) to have BMI = 25	155.2 -AB
BMI	24.1 -AB
Ideal Body Weight (kg)	59.29 kg -AB
Ideal Body Wgt (lb)	130.71 lb -AB
Percent of Ideal Body Weight	114.69 Percent -AB
Excess Body Weight (kg)	8.69 kg -AB
Excess Body Wgt (lb)	19.2 lb -AB
Percent Weight Change Since Birth	0 -AB
IBW/kg (Calculated)	59.63 -AB
Low Range Vt 6cc/kg	357.78 mL -AB
Adult Moderate Range Vt 8cc/kg	477.04 mL -AB
Adult High Range Vt 10cc/kg	596.3 mL -AB
Adult IBW/VT Calculations	
IBW percentage	4022.47 -AB

Anthropometrics

	12/14/17 1056
Anthropometrics	
Height	5' 6.14" (1.68 m) -AB
Weight	68 kg (149 lb 14.6 oz) -AB
Weight Change	0 % -AB
BMI (Calculated)	24.1 -AB

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
AB	Barnes, Andrea R, MA	09/14/17 -

Flowsheet Row Details (all recorded)

BMI

Effective: 02/03/16

Row Information:	BMI=Body Mass Index.(Weight Scale/35.2)/(Height*0.0254)^2Threshold of overweight (BMI>/= 25 Kg/m)source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BMI (Calculated)

Effective: 06/02/06

Row Information:	BMI=Body Mass Index. (Weight Scale/35.2)/(Height*0.0254)^2 Threshold of overweight (BMI>/= 25 Kg/m) source: http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

BSA (Calculated - sq m)

BSA (Calculated - sq m) (continued)

Effective: 06/02/05

Row Information:	BSA=Body Surface Area. BSA (sq meters) = sqrt((Height (cm) x Weight (kg))/3600) . BSA is calculated using the Mosteller Formula. Mosteller RD: Simplified Calculation of Body Surface Area. N Engl J Med 1987 Oct 22;317(17):1098.

Height

Warning Min/Max	Absolute Min/Max
1' (0.305 m) / 8' (2.438 m)	1.18" (0.03 m) / 9' 10.11" (3 m)

Ideal Body Weight (kg)

Effective: 02/03/16

Row Information:	Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Ideal Body Wgt (lb)

Effective: 02/03/16

Row Information:	Female IBW= 100+ (5 x # of inches over 60)Male IBW=106+ (6 x # of inches over 60)

Resp

Warning Min/Max	Absolute Min/Max
8 / 30	0 / 200

Weight

Warning Min/Max	Absolute Min/Max
5 lb (2.268 kg) / 300 lb (136.1 kg)	0.1 oz (0.003 kg) / 1500 lb (680.4 kg)

Weight in (lb) to have BMI = 25

Effective: 09/15/10

Row Information:	Uses height to find what their weight would need to be in order to have a BMI of 25.

Flowsheet Notes

No notes of this type exist for this encounter.

Patient-Level E-Signatures:

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Acknowledgement of Receipt of Notice of Privacy Practices

Name: Connell,Diane M

Address: 304 TRENTWOOD DRIVE

City/State/Zip: COLUMBIA SC 29223

Telephone: 803-736-6629 **Account/Chart Number:** M002014739
CSN: 100023195855

I have received a copyof the Notice of Privacy Practices.

Diane Connell

9/26/2017 12:39:12 PM Patient Signature **9/26/2017**

Signature of Patient or Authorized Person Date

Patient-Level E-Signatures: (continued)

Relationship to Individual

Hospital Account-Level E-Signatures:

There are no hospital account-level e-signatures.

Encounter-Level E-Signatures:

There are no encounter-level e-signatures.

All Scans

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Patient-Level Documents:

PN Auth Lexington Orthopaedics - Scan on 10/12/2017 0903 : Perceptive Content Scan (below)

All Scans (continued)

Patient-Level Documents: (continued)

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Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of **Lexington Orthopaedics** who may attend me, their assistants, including those employed by **Lexington Orthopaedics** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. DM (*initials*)

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RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to LMC Physician Practices and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to LMC Physician Practices, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to LMC Physician Practices and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. _____ (*initials*)

Print Patient Name: Diane DOB: _____

Patient Signature: _____ Date: _____

Responsible Party Signature (if different): _____ Date: _____

938-C39-1 (02/10)

Order — **XR Knee Left AP and Lateral [IMG128] (Order 92308907)**

XR Knee Left AP and Lateral [92308906]

Electronically signed by: **Dedmond, Barnaby T, MD on 10/12/17 0926** Status: **Completed**
Ordering user: Dedmond, Barnaby T, MD 10/12/17 0926 Ordering provider: Dedmond, Barnaby T, MD

All Scans (continued)

XR Knee Left AP and Lateral [92308906] (continued)

Authorized by: Dedmond, Barnaby T, MD
Frequency: PRN 11/09/17 1036 - 1 Occurrences
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]
Order comments:
After brace removal

Result — **XR Knee Left AP and Lateral (Order 92308907)**

Resulted: 11/09/17 1100, Result status: Final result

XR Knee Left AP and Lateral [92308907]

Ordering provider: Dedmond, Barnaby T, MD 11/09/17 1036 | Resulted by: Dedmond, Barnaby T, MD
Performed: 11/09/17 1036 - 11/09/17 1048
Narrative:
Patella fracture remains in good alignment with hardware in place

Order — **XR Knee Left AP and Lateral [IMG128] (Order 94727372)**

XR Knee Left AP and Lateral [94727371]

Electronically signed by: **Dedmond, Barnaby T, MD on 11/09/17 1059** | Status: **Completed**
Ordering user: Dedmond, Barnaby T, MD 11/09/17 1059 | Ordering provider: Dedmond, Barnaby T, MD
Authorized by: Dedmond, Barnaby T, MD | Ordered during: Office Visit on 11/09/2017
Frequency: 11/09/17 -
Diagnoses:
Closed displaced comminuted fracture of left patella with routine healing, subsequent encounter [S82.042D]

Result — **XR Knee Left AP and Lateral (Order 94727372)**

Resulted: 12/14/17 1113, Result status: Final result

XR Knee Left AP and Lateral [94727372]

Ordering provider: Dedmond, Barnaby T, MD 12/14/17 1053 | Resulted by: Dedmond, Barnaby T, MD
Performed: 12/14/17 1055 - 12/14/17 1102
Narrative:
Healing patella fracture in good alignment with hardware in place

END OF REPORT

Lexington Medical Center
2720 Sunset Boulevard
West Columbia, SC 29169
(803) 791-2300 www.lexmed.com

1/16/2018

Itemized Bill

Reporting Period: 01/01/17 - 01/16/18

Grouped by: Tx Type

	Current Balance Due	Total Trans Count
Grand Total	**0.00**	
Adjustment [3]		**10**

Account	Svc Dt	Procedure	Orig Amt (Sum)	Department	Diagnosis
CONNELL,DIANE M [685644]	10/17/2017	CONTRACTUAL WRITE-OFF (INSURANCE) [3000]	-1508.30	LMC PATIENT FINANCIAL SERVICES [100018221]	
CONNELL,DIANE M [685644]	10/17/2017	MEDICARE SEQUESTRATION ADJ [1020]	-11.52	LMC PATIENT FINANCIAL SERVICES [100018221]	
CONNELL,DIANE M [685644]	10/31/2017	CONTRACTUAL WRITE-OFF (INSURANCE) [3000]	-258.12	LMC PATIENT FINANCIAL SERVICES [100018221]	
CONNELL,DIANE M [685644]	10/31/2017	MEDICARE SEQUESTRATION ADJ [1020]	-1.57	LMC PATIENT FINANCIAL SERVICES [100018221]	
CONNELL,DIANE M [685644]	11/03/2017	CONTRACTUAL WRITE-OFF (INSURANCE) [3000]	-316.69	LMC PATIENT FINANCIAL SERVICES [100018221]	

This is not a bill. This is an itemization of professional services.

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1/16/2018

CONNELL,DIANE M [685644]	11/03/2017	MEDICARE SEQUESTRATION ADJ [1020]	-0.97	LMC PATIENT FINANCIAL SERVICES [100018221]
CONNELL,DIANE M [685644]	11/29/2017	CONTRACTUAL WRITE-OFF (INSURANCE) [3000]	-67.22	LMC PATIENT FINANCIAL SERVICES [100018221]
CONNELL,DIANE M [685644]	11/29/2017	MEDICARE SEQUESTRATION ADJ [1020]	-0.46	LMC PATIENT FINANCIAL SERVICES [100018221]
CONNELL,DIANE M [685644]	01/04/2018	CONTRACTUAL WRITE-OFF (INSURANCE) [3000]	-67.22	LMC PATIENT FINANCIAL SERVICES [100018221]
CONNELL,DIANE M [685644]	01/04/2018	MEDICARE SEQUESTRATION ADJ [1020]	-0.46	LMC PATIENT FINANCIAL SERVICES [100018221]

Charge [1] 8

Account	Svc Dt	Procedure	Orig Amt (Sum)	Department	Diagnosis
CONNELL,DIANE M [685644]	09/27/2017	PR OPEN RX PATELLA FX [27524]	2228.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, initial encounter for closed fracture [S82.042A]

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1/16/2018

CONNELL,DIANE M [685644]	09/27/2017	PR OPEN RX PATELLA FX [27524]	356.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, initial encounter for closed fracture [S82.042A]
CONNELL,DIANE M [685644]	09/26/2017	PR EMERGENCY DEPT VISIT,LEVEL III [99283]	377.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, initial encounter for closed fracture [S82.042A]
CONNELL,DIANE M [685644]	10/12/2017	PR POST-OP FOLLOW-UP VISIT [99024]	0.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]
CONNELL,DIANE M [685644]	11/09/2017	PR POST-OP FOLLOW-UP VISIT [99024]	0.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]
CONNELL,DIANE M [685644]	11/09/2017	CHG X-RAY KNEE 1 OR 2 VIEW [73560]	96.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]
CONNELL,DIANE M [685644]	12/14/2017	PR POST-OP FOLLOW-UP VISIT [99024]	0.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]

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1/16/2018

CONNELL,DIANE M [685644]	12/14/2017	CHG X-RAY KNEE 1 OR 2 VIEW [73560]	96.00	LEXINGTON ORTHOPAEDICS WEST COLUMBIA [100458338]	Displaced comminuted fracture of left patella, subsequent encounter for closed fracture with routine healing [S82.042D]

Payment [2] 10

Account	Svc Dt	Procedure	Orig Amt (Sum)	Department	Diagnosis
CONNELL,DIANE M [685644]	10/17/2017	INSURANCE PAYMENT (INSURANCE) [2000]	-564.24	LMC PATIENT FINANCIAL SERVICES [100018221]	
CONNELL,DIANE M [685644]	10/25/2017	INSURANCE PAYMENT (INSURANCE) [2000]	-143.94	LMC PATIENT FINANCIAL SERVICES [100018221]	
CONNELL,DIANE M [685644]	10/31/2017	INSURANCE PAYMENT (INSURANCE) [2000]	-76.73	LMC PATIENT FINANCIAL SERVICES [100018221]	
CONNELL,DIANE M [685644]	11/03/2017	INSURANCE PAYMENT (INSURANCE) [2000]	-47.28	LMC PATIENT FINANCIAL SERVICES [100018221]	
CONNELL,DIANE M [685644]	11/08/2017	INSURANCE PAYMENT (INSURANCE) [2000]	-19.58	LMC PATIENT FINANCIAL SERVICES [100018221]	

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1/16/2018

CONNELL,DIANE M [685644]	11/29/2017	INSURANCE PAYMENT (INSURANCE) [2000]	-22.56	LMC PATIENT FINANCIAL SERVICES [100018221]
CONNELL,DIANE M [685644]	12/06/2017	INSURANCE PAYMENT (INSURANCE) [2000]	-5.76	LMC PATIENT FINANCIAL SERVICES [100018221]
CONNELL,DIANE M [685644]	12/06/2017	INSURANCE PAYMENT (INSURANCE) [2000]	-12.06	LMC PATIENT FINANCIAL SERVICES [100018221]
CONNELL,DIANE M [685644]	01/04/2018	INSURANCE PAYMENT (INSURANCE) [2000]	-22.56	LMC PATIENT FINANCIAL SERVICES [100018221]
CONNELL,DIANE M [685644]	01/10/2018	INSURANCE PAYMENT (INSURANCE) [2000]	-5.76	LMC PATIENT FINANCIAL SERVICES [100018221]

This is not a bill. This is an itemization of professional services.

Palmetto Bone & Joint, P.A.

Clinton Office: 22971 Highway 76 East, Clinton SC 29325 Phone: (864) 833-3046 Fax: (864) 833-1711
Newberry Office: 2605 Kinard Street, Suite 105, Newberry SC 29108 Phone: (803) 321-6254 Fax: (803) 321-6259
Chapin Office: 104 Ellett Road, Chapin SC 29036 Phone: (803) 941-8095 Fax: (803) 345-6088

Date of Exam 4/4/2019
Provider James Loging
Provider NPI 1669490405
Patient Name DIANE CONNELL
DOB [redacted]

History
Chief Complaint (Knee)
Presents with complaints of localized pain and grinding in the left knee that occurs during activities.
History of Present Illness (Knee)
The patient is a 67 year old female who presents with complaints of localized pain and grinding in the left knee that occurs during activities. She had prior ORIF of patella September 2018. The patient's symptoms are aggravated by daily activities, going down stairs, going up stairs. She states she can't do any stooping or squatting.

Allergies
NO KNOWN
ALLERGIES

Medications
Lexapro 20mg*
Gabapentin 300mg*
Pravastatin 20mg*
Allerall 15mg*
Diazapam 5m*
Hydrocodone 5mg*

Past History

Medical History	Patient has history of blood thinners and depression.
Surgical History	Knee Surgery
Family History	Mother has history of osteoporosis and osteoarthritis.
Social History	Patient is right handed. Patient reports the use of caffeine. Patient does not use alcohol, illicit drugs or tobacco.

Review of Systems

Constitutional	No fever, fatigue, weakness or sudden weight change
Eyes	Normal visual acuity, no blurred vision or excessive tearing
HEENT	Normal auditory acuity, no nasal discharge or difficulty swallowing
Cardiovascular	No chest pains or palpitations or high blood pressure
Respiratory	No shortness of breath or cough
Gastrointestinal	No abdominal pain, heartburn, hepatitis or bleeding
Genitourinary	No dysuria or hematuria
Musculoskeletal	Patient has history of stiffness.
Skin	No rashes or jaundice
Neurological	No headache, dizziness or memory loss
Psychiatric	Patient has history of depression.
Endocrine	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic	No bruising, swollen glands or anemia
Immunological	No skin rashes, or allergies to food or medication

Vital Signs

Height (in)	66.0
Weight (lbs)	146.0
BMI	23.6

Knee Exam

Gait	The patient walks with a normal, non-antalgic heel to toe gait.
Posture	Shoulders are level, iliac crests are level, normal thoracic kyphosis, normal lumbar lordosis, no lateral curvature.

Inspection	**Right**	**Left**
Alignment		Mild.
Swelling		Negative
Ecchymosis		Negative
Effusion		Mild
Atrophy		Quadriceps femoris

Skin Left	Normal

Palpation

Tenderness	Medial joint line

	Right	Left
Patella Position		Neutral
Q Angle		Normal
Tilt		Equal
Crepitus		Absent
Apprehension		Negative
Popliteal Pulse		Normal

Vascular	The peripheral vascular pulses are normal, with normal capillary refill.

ROM Active	**Right**	**Left**
Flexion		135
Extension		0
ROM		Normal pain-free active range of motion.

ROM Passive	**Right**	**Left**
Flexion	135	
Extension	0	

Muscle Testing	**Right**	**Left**
Patella Reflex		2/4

Neurological	The peripheral reflexes are normal with normal distal sensation.

Imaging

Left **Knee** X-RAY Knee, 4 Views or More

X-rays left knee are reviewed which showed hardware in place from prior ORIF of the patella. There is joint incongruity on the articular side of the patella. Patella fracture appears to be well-healed. Minimal degenerative change of the knee joint.

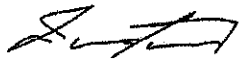
Diagnosis

M17.12Unilateral primary osteoarthritis, left knee
M25.562Pain in left knee

Plan

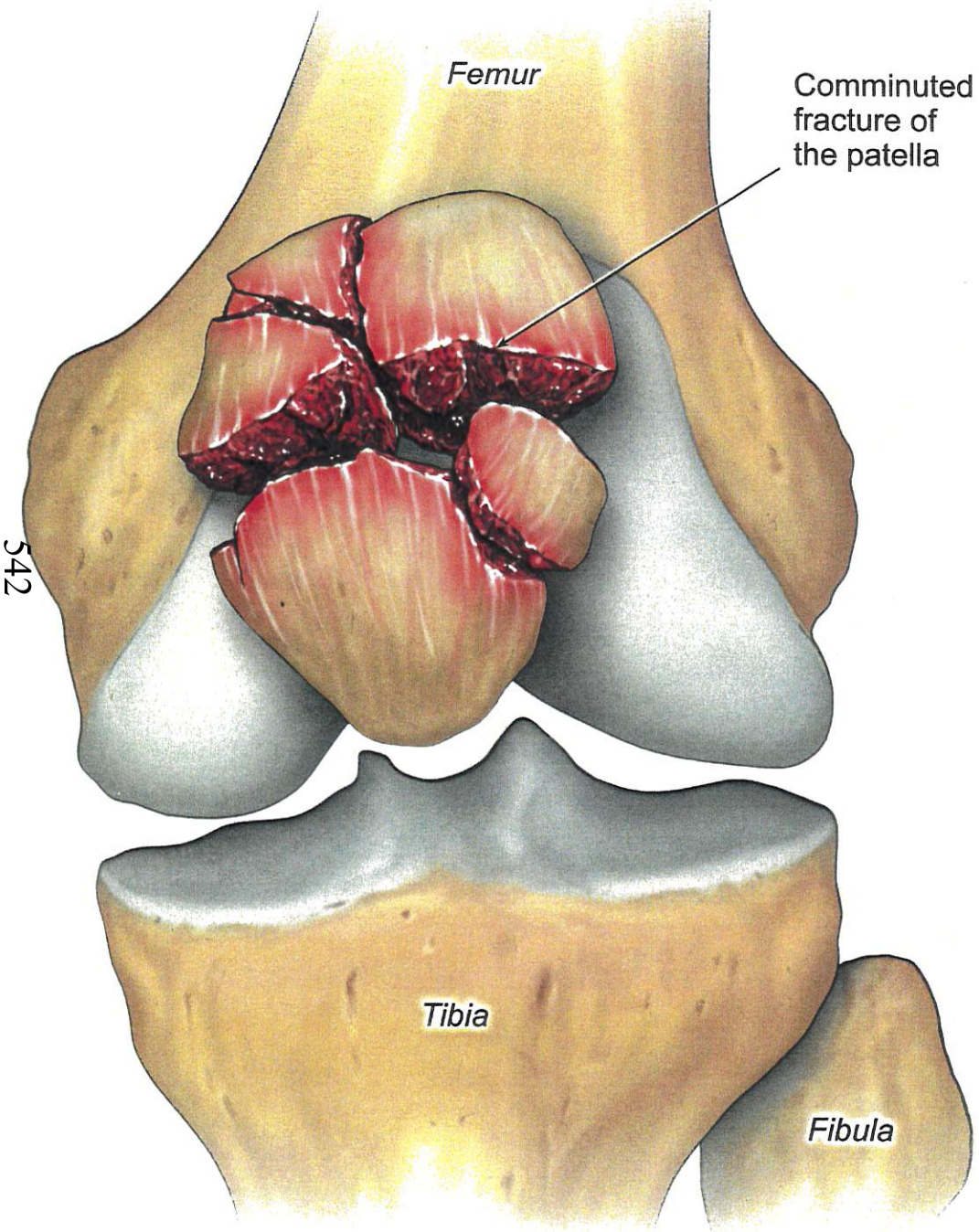
Knee I explained the pathology and its natural history of progression. I also explained the treatment options, including the benefits and complications of each of the options. Discussed removing hardware from prior ORIF of patella, these are prominent. Could consider lubricant injections for arthritis after removing hardware. Also

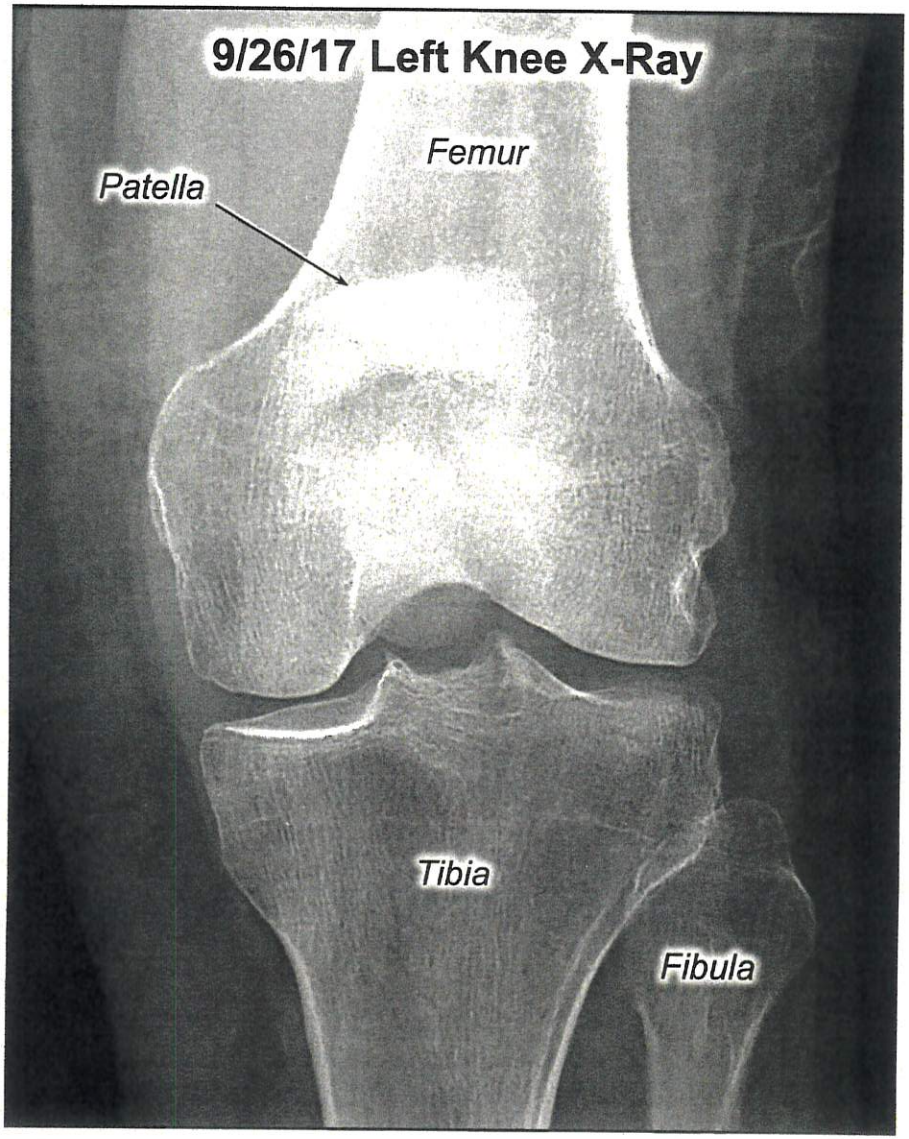
discussed with her possible partial replacement later on. She wants to discuss options with husband, will call back when she decides.



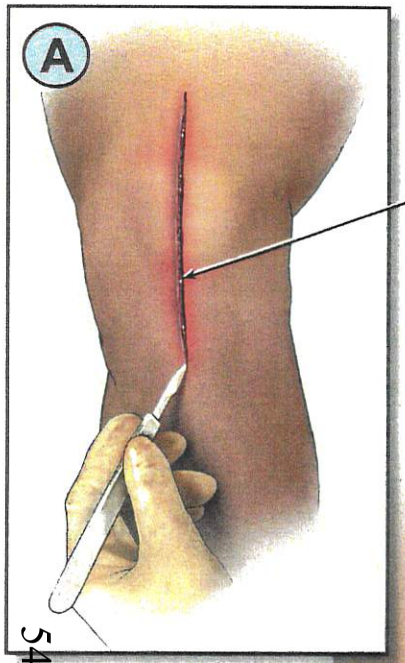
James Loging,MD
Electronically signed on 4/5/2019 10:10 AM

Diane Connell's Left Knee Fractures

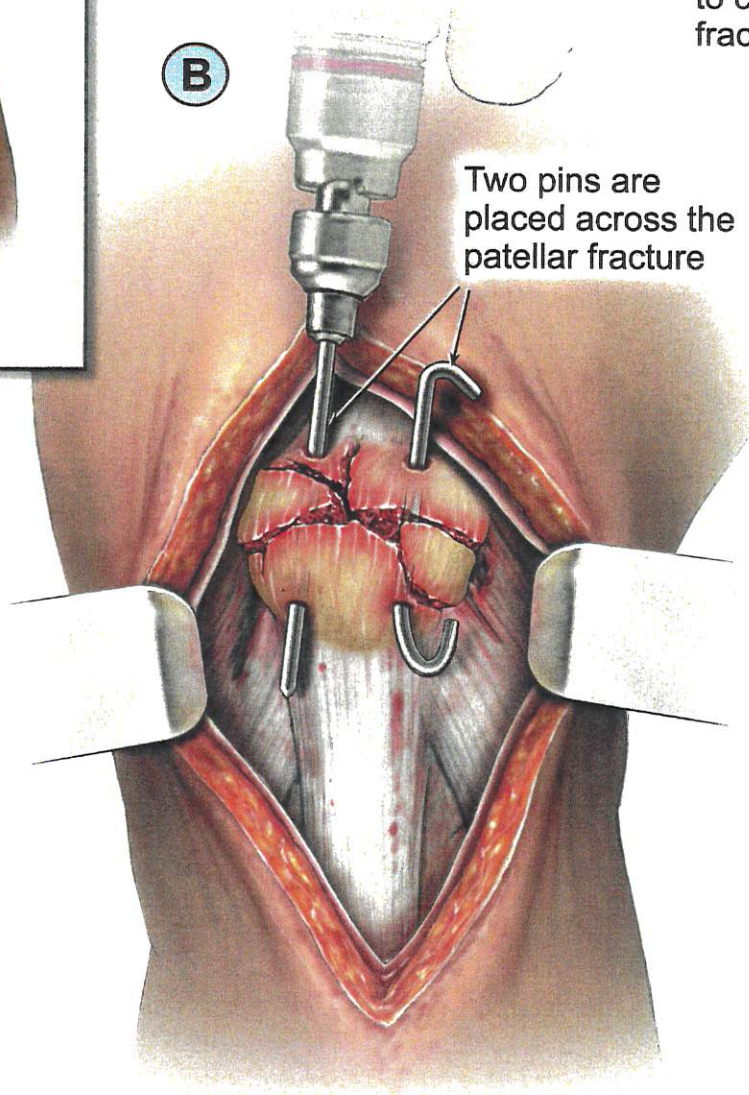




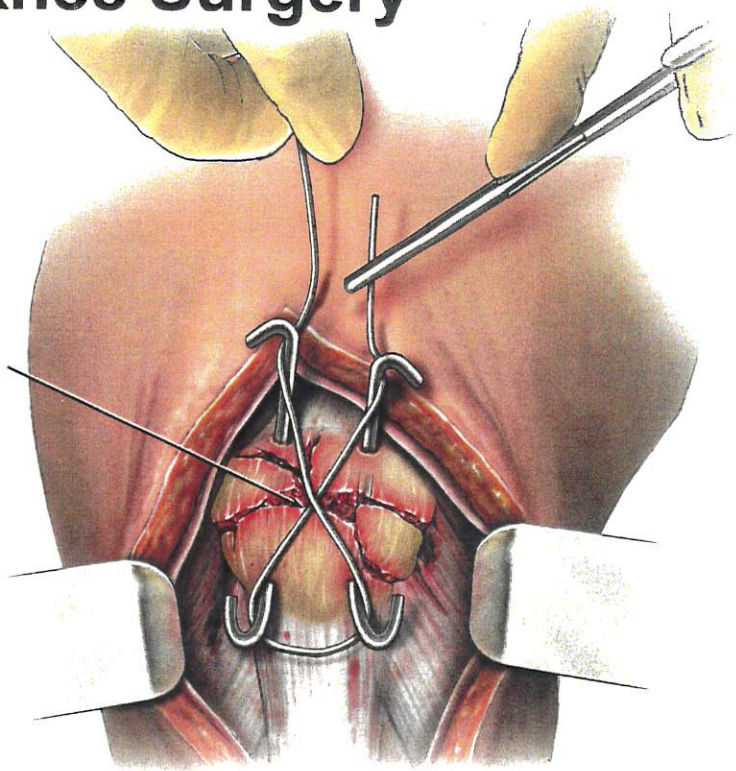
Diane Connell's 9/27/17 Left Knee Surgery



Midline incision over the anterior knee

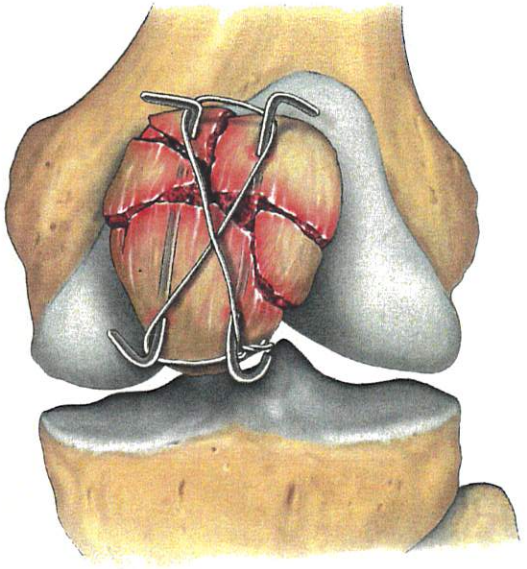


Two pins are placed across the patellar fracture

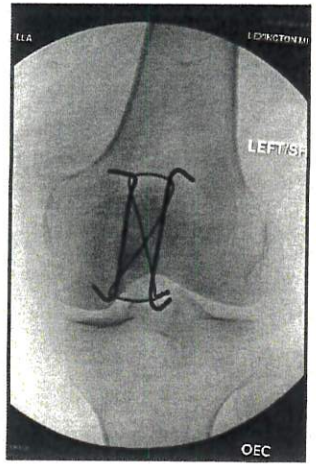


A wire is wrapped around the pins to compress the fracture fragments

Postoperative View



9/27/17 X-Ray



Lindsay W. Moore, MSPAS, PA-C, CLCP

1150 Hungryneck Blvd. Ste C-378 Mt. Pleasant, SC 29464
Phone: 843-628-3377 Fax: 843-628-3388
Email: lmoore@mooremedicalconsulting.com
Website: mooremedicalconsulting.com

Curriculum Vitae

PROFESSIONAL MEDICAL AND CONSULTING EXPERIENCE:

2013 – Present — Moore Medical Consulting LLC — Charleston, SC

Owner, Physician Assistant - Certified, Certified Life Care Planner

Provide medical chart reviews, medical chronologies, and case reviews on the standard of care. Provide Life Care Plans for clients to describe medical conditions and make recommendations regarding the financial needs of patients who have suffered catastrophic injuries, non-catastrophic injuries, or chronic illnesses. Provide expert witness testimony and depositions on LCPs and standard of care.

2014 – Present — Team Health — Charleston, SC

Physician Assistant, Certified
Supervising Physician, Christian Graf, MD
Lead Advanced Practice Clinician (July 2015 – April 2017)

Same position and facility as previous position with Trident Emergency Physicians.

Perform directed medical histories and physical exams, assess patients' medical/surgical conditions, order and interpret necessary lab/radiology studies, develop and implement appropriate treatment plans, advise and counsel patients and families on medical conditions

2008 – 2014 — Trident Emergency Physicians, LLC — Charleston, SC

Physician Assistant, Certified
Supervising Physician, Christian Graf, MD

Perform directed medical histories and physical exams, assess patients' medical/surgical conditions, order and interpret necessary lab/radiology studies, develop and implement appropriate treatment plans, advise and counsel patients and families on medical conditions

2011 – 2012 — Nason Medical Center, Emergency and Urgent Care — Charleston, SC

Physician Assistant, Certified
Supervising Physician, Matthew Blue, MD

Perform directed medical histories and physical exams, assess patients' medical/surgical conditions, order and interpret necessary lab/radiology studies, develop and implement appropriate treatment plans, advise and counsel patients and families on medical conditions

2011 – 2012 — Advanced Medical Weight Management Center — Charleston, SC

Physician Assistant, Certified
Supervising Physician, Rick Slott, MD

Assess patients' medical history, develop appropriate individualized weight loss plans – including diet and exercise, encourage patients to adopt a healthier

lifestyle to reduce their risk of medical complications and life threatening diseases, enhance self-esteem, and improve over-all health

ACADEMIC TEACHING EXPERIENCE:

2011 – 2016 Medical University of South Carolina Charleston, SC
Adjunct Faculty, College of Health Professions
Physician Assistant Program

Instruct Clinical Problem Solving class, facilitate Fundamentals of Clinical Medicine class prn, advise students, evaluate student assignments and comprehensive write-ups, support PA program

EDUCATION:

2013 – 2014 Certificate of Completion of the Life Care Planner Program Columbus, OH
Capital University Law School

2006 – 2008 Master of Science in Physician Assistant Studies (MSPAS) Charleston, SC
The Medical University of South Carolina

2001 – 2005 Bachelor of Science in Education, Exercise and Sport Science Athens, GA
The University of Georgia

CERTIFICATIONS/LICENSURES:

National Commission on Certification of Physician Assistants – Physician Assistant – Certified (PA-C): 2008 - 2024, 10yr certification cycle, must retest every 10yrs and earn 100 hours of CME every 2yrs

International Commission on Health Care Certification – Certified Life Care Planner (CLCP): 2014 – 2019, 5yr certification cycle, must earn 80 hours of CEU every 5yrs

Advanced Cardiac Life Support (ACLS)

Pediatric Advanced Life Support (PALS)

Basic Life Support (BLS)

PROFESSIONAL ORGANIZATIONS:

American Academy of Physician Assistants

American Academy of Physician Assistants in Legal Medicine

Society of Emergency Medicine Physician Assistants

South Carolina Academy of Physician Assistants

RESEARCH:

Rural and Urban Differences in Hypertension in South Carolina. **Lindsay (Woods) Moore**, Amanda Harmon, Lea Buck, Anne Carson, Joseph Coleman, April Logan, Wilfrida Noelsaint, Shaun Nguyen, Brent Egan. MUSC, Charleston, SC. 2007-2008.

Preconception and Interconception Care: An Integrated Approach. **Lindsay (Woods) Moore.** A review of ten recommendations developed by the CDC and Select Panel on Preconception Care (SPPC) to improve preconception health and healthcare by incorporating prevention throughout the lifespan and providing opportunistic care. Reproductive Health Conference 2008.

AWARDS AND HONORS:

National Student Representative for the Association of Physician Assistants in Obstetrics and Gynecology (APAOG), elected by governing APAOG Board, 2007-2009

Elizabeth P. Gouge Memorial Physician Assistant Scholarship Recipient - Based on academic excellence and financial need

Co-founder, Vice-President and President of the Pre-Physician Assistant Club University of Georgia

Moore Medical Consulting LLC
1150 Hungryneck Blvd. Ste C-378 Mt. Pleasant, SC 29464
Ph: (843)628-3377 Fax: (843)628-3388

Future Cost Analysis

Regarding:

Diane Connell

Date Completed: 6/20/2019

Lindsay Moore PA-C, CLCP

Lindsay Moore, MSPAS, PA-C, CLCP

Prepared for:

Robert Goings
Goings Law Firm, LLC
Columbia, SC

**This report is presented in its final form as of the date listed above, however, if new information becomes available Moore Medical Consulting LLC reserves the right to incorporate the additional information into the final cost analysis as needed.*

Future Cost Analysis

Item/Service	Diagnostic Code	Frequency/ Replacement	Item Cost	Total Cost
				Currently 68 yo, Life Exp: 18 (18.8) years
Scenario A:				
Surgical Intervention: Patella ORIF Hardware Removal				
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$101.92 - $137.41
Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$16.88 - $25.48
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$33.32 - $50.05
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$41.14 - $63.70
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$63.20 - $91.91
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$64.78 - $80.99
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$86.90 - $129.22
Hardware Removal: Professional Fee	20680	1x Only	$1,255.80 - $1,637.68	$1,255.80 - $1,637.68
Hardware Removal: Anesthesia Fee	01392	1x Only	$1,936.39	$1,936.39
Hardware Removal: Facility Fee (Hospital Outpatient)	APC 5073	1x Only	$3,765.00 - $9,302.00	$3,765.00 - $9,302.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$46.00 - $71.00
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$4.84 - $11.18
Knee Sleeve/Support	A4667	1x Only	$23.49 - $42.18	$23.49 - $42.18
Medical Intervention: Supartz Knee Injections				
Orthopaedic/Pain Management Visits	99212	3-5 Visits for a total of 3-4 series over her lifetime	$75.53 - $101.92	$679.77 - $2,038.40
Supartz Injections	20610 J7321	3-5 Injections for a total of 3-4 series over her lifetime	$354.05 - $402.28	$3,186.45 - $8,045.60
			Scenario A Total Cost:	**$11,305.88 - $23,668.19**
Scenario B:				
Surgical Intervention: Partial Knee Replacement				
Surgical Consult	99243	1x Only	$232.96 - $313.95	$232.96 - $313.95
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$101.92 - $137.41

Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$16.88 - $25.48
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$33.32 - $50.05
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$41.14 - $63.70
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$63.20 - $91.91
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$64.78 - $80.99
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$86.90 - $129.22
Partial Knee Replacement: Professional Fee	27446	1x Only	$4,401.87 - $5,510.96	$4,401.87 - $5,510.96
Partial Knee Replacement: Anesthesia Fee	01400	1x Only	$2,504.87	$2,504.87
Partial Knee Replacement: Facility Fee (Hospital Outpatient)	APC 5115	1x Only	$7,338.00 - $13,352.00	$7,338.00 - $13,352.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$46.00 - $71.00
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$4.84 - $11.18
Knee Sleeve/Support	A4667	1x Only	$23.49 - $42.18	$23.49 - $42.18
Surgical Intervention: Revision of Partial Knee Replacement				
Surgical Consult	99243	1x Only	$232.96 - $313.95	$232.96 - $313.95
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$101.92 - $137.41
Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$16.88 - $25.48
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$33.32 - $50.05
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$41.14 - $63.70
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$63.20 - $91.91
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$64.78 - $80.99
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$86.90 - $129.22
Revision of Partial Knee Replacement: Professional Fee	27487 -52	1x Only	$4,840.74 - $6,208.02	$4,840.74 - $6,208.02
Partial Knee Replacement: Anesthesia Fee	01400	1x Only	$2,504.87	$2,504.87
Partial Knee Replacement: Facility Fee (Hospital Outpatient)	APC 5115	1x Only	$7,338.00 - $13,352.00	$7,338.00 - $13,352.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$46.00 - $71.00
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$4.84 - $11.18
Knee Sleeve/Support	A4667	1x Only	$23.49 - $42.18	$23.49 - $42.18
			Scenario B Total Cost:	**$30,359.21 - $45,466.86**
			Grand Total of Scenario A + B:	**$41,665.09 - $69,130.05**

Moore Medical Consulting LLC
1150 Hungryneck Blvd. Ste C-378 Mt. Pleasant, SC 29464
Ph: (843)628-3377 Fax: (843)628-3388

Future Cost Analysis

Regarding:

Diane Connell

Date Completed: 12/6/2019

Lindsay Moore PA-C, CLCP

Lindsay Moore, MSPAS, PA-C, CLCP

Prepared for:

Robert Goings
Goings Law Firm, LLC
Columbia, SC

Diane Connell
DOB: 5/31/1951

Primary Disability: Chronic Knee Pain

**This report is presented in its final form as of the date listed above, however, if new information becomes available Moore Medical Consulting LLC reserves the right to incorporate the additional information into the final cost analysis as needed.*

Future Cost Analysis

Item/Service	Diagnostic Code	Frequency/ Replacement	Item Cost	Average Lifetime Cost
				Currently 68 yo, Life Exp: 18 (18.3) years
SCENARIO A: Medical Intervention, Patella Hardware Removal, and Partial Knee Replacement				
Medical Intervention: Supartz Knee Injections				
Orthopaedic/ Pain Management Visits	99212	3-5 Visits for a total of 3-4 series over her lifetime	$75.53 - $101.92	$1,268.03
Supartz Injections	20610 J7321	3-5 Injections for a total of 3-4 series over her lifetime	$354.05 - $402.28	$5,495.94
Surgical Intervention: Patella Hardware Removal				
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$126.87
Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$19.99
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$39.41
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$49.71
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$75.03
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$72.18
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$103.95
Patella Hardware Removal: Professional Fee	20680	1x Only	$1,255.80 - $1,637.68	$1,519.81
Patella Hardware Removal: Anesthesia Fee	01392	1x Only	$1,936.39	$1,936.39
Patella Hardware Removal: Facility Fee	APC 5073	1x Only	$3,887.00	$3,887.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$58.50
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$8.01
Post-Op Hinged Knee Brace	N/A	1x Only	$121.98 - $152.00	$131.99
Post-Op Physical Therapy Eval	97162	1x Only	$151.68 - $258.44	$190.13
Post-Op Physical Therapy Visits	97110 x 2	2x / week for 2-4 weeks Only	$98.28 - $127.40	$701.10
Surgical Intervention: Partial Knee Replacement				
Surgical Consult	99243	1x Only	$232.96 - $313.95	$281.99
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$126.87

Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$19.99
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$39.41
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$49.71
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$75.03
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$72.18
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$103.95
Partial Knee Replacement: Professional Fee	27446	1x Only	$4,401.87 - $5,510.96	$4,708.35
Partial Knee Replacement: Anesthesia Fee	01400	1x Only	$2,504.87	$2,504.87
Partial Knee Replacement: Facility Fee	DRG 467	1x Only	$118,951.00 - $130,986.00	$124,373.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$58.50
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$8.01
Post-Op Hinged Knee Brace	N/A	1x Only	$121.98 - $152.00	$131.99
Post-Op Physical Therapy Eval	97162	1x Only	$151.68 - $258.44	$190.13
Post-Op Physical Therapy Visits	97110 x 2	2x / week for 2-4 weeks Only	$98.28 - $127.40	$701.10
			Total Cost:	**$149,129.12**
SCENARIO B: Medical Intervention, Patella Hardware Removal, and Total Knee Replacement				
Medical Intervention: Supartz Knee Injections				
Orthopaedic/ Pain Management Visits	99212	3-5 Visits for a total of 3-4 series over her lifetime	$75.53 - $101.92	$1,268.03
Supartz Injections	20610 J7321	3-5 Injections for a total of 3-4 series over her lifetime	$354.05 - $402.28	$5,495.94
Surgical Intervention: Patella Hardware Removal				
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$126.87
Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$19.99
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$39.41
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$49.71
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$75.03
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$72.18
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$103.95
Patella Hardware Removal: Professional Fee	20680	1x Only	$1,255.80 - $1,637.68	$1,519.81
Patella Hardware Removal: Anesthesia Fee	01392	1x Only	$1,936.39	$1,936.39
Patella Hardware Removal: Facility Fee	APC 5073	1x Only	$3,887.00	$3,887.00

Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$58.50
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$8.01
Post-Op Hinged Knee Brace	N/A	1x Only	$121.98 - $152.00	$131.99
Post-Op Physical Therapy Eval	97162	1x Only	$151.68 - $258.44	$190.13
Post-Op Physical Therapy Visits	97110 x 2	2x / week for 2-4 weeks Only	$98.28 - $127.40	$701.10
Surgical Intervention: Total Knee Replacement				
Surgical Consult	99243	1x Only	$232.96 - $313.95	$281.99
Pre-Operative Evaluation by Primary Care Physician	99213	1x Only	$101.92 - $137.41	$126.87
Pre-Op Venipuncture	36415	1x Only	$16.88 - $25.48	$19.99
Pre-Op CBC	85025	1x Only	$33.32 - $50.05	$39.41
Pre-Op BMP	80048	1x Only	$41.14 - $63.70	$49.71
Pre-Op EKG	93000	1x Only	$63.20 - $91.91	$75.03
Pre-Op CXR	71045	1x Only	$64.78 - $80.99	$72.18
Pre-Op Knee X-Ray	73560	1x Only	$86.90 - $129.22	$103.95
Total Knee Replacement: Professional Fee	27447	1x Only	$5,371.98 - $7,639.45	$6,256.18
Total Knee Replacement: Anesthesia Fee	01402	1x Only	$3,037.82	$3,037.82
Total Knee Replacement: Facility Fee	DRG 467	1x Only	$118,951.00 - $130,986.00	$124,373.00
Post-Op Pain Control: Norco 7.5mg/325mg #60	N/A	1x Only	$46.00 - $71.00	$58.50
Post-Op Pain Control: Aleve 220mg #100 (OTC)	N/A	1x Only	$4.84 - $11.18	$8.01
Post-Op Hinged Knee Brace	N/A	1x Only	$121.98 - $152.00	$131.99
Post-Op Physical Therapy Eval	97162	1x Only	$151.68 - $258.44	$190.13
Post-Op Physical Therapy Visits	97110 x 2	2x / week for 2-4 weeks Only	$98.28 - $127.40	$701.10
			Total Cost:	**$151,209.90**

**The calculations listed above do not account for inflation or reduction to present day value.*
***The average lifetime cost takes into account all data points for each line item and may be different than the average of the low and high numbers for each item. All data points and resources used to obtain costs are available upon request.*
****For informational purposes, the total range of community costs for Scenario A is $139,768.30 - $160,118.81 and the total range of community costs for Scenario B is $141,217.40 - $162,780.25.*

Charles L. Alford, Ph.D.
Overlook Executive Park
109 Laurens Rd.
Building 2, Suite C
Greenville, SC 29607

Office: (864) 233-8593
Fax: (864) 233-4819
charlie@cla3.com

Education

Ph.D. in Economics and Business Administration; University of Alabama, 1972; Major – marketing; Minors – economics and quantitative methods.

B.A. in Economics; Wofford College, 1968.

Teaching and Administrative Experience

Professor Emeritus (2003), James C. Self Professor of Business Administration (1994), Professor (1983), Associate Professor (1976), Assistant Professor (1971) of Economics and Business Administration, Furman University.

Chair, Department of Economics and Business Administration, Furman University, 1976 – 1985.

Chair, Furman University Faculty, 1993 – 1995.

Faculty Athletic Representative to The Southern Conference and NCAA, 1995 – 2003.

Teaching Assignments at Furman

Economics: macroeconomics, microeconomics, urban economics, personal finance.

Business Administration: principles of marketing, marketing research, marketing problems, marketing management (graduate level), quantitative methods for business, experiential learning in business.

Statistics: graduate and undergraduate.

Director of the Furman Economics and Business Administration Internship Program.

Publications

"The Economist's Role in Wrongful Death Cases," with John G. Fulmer, *South Carolina Trial Lawyers Bulletin*, October, 1974.

"An Investigation into the Effects of Selected Variables Upon Barriers to Entry in Manufacturing Industries," *Southern Marketing Association Proceedings*, 1974.

"New Product Idea Generation: A Case Study of Household Cleaners," with J. Barry Mason, *Journal of Advertising Research*, Spring, 1974.

"The Effects of Oral vs. Written Two-Sided Messages," with J. M. Wilkerson, *Journal of the Academy of Marketing Sciences*, Summer, 1976.

Succeeding in the Free Enterprise System, CORBIA – Council of Resources, 1978. A textbook written for the South Carolina Veterans Administration.

"Business Goodwill in South Carolina," with Katherine Tiffany and Peter C. Tiffany, *South Carolina Lawyer*, May, 2011.

Invited Lectures

"In Defense of Advertising," Wofford College, 1976.

"The Role of Marketing Research in the Business Enterprise," Wofford College, 1977.

"The Changing Marketing Concept," Sales and Marketing Executives Club of Greenville, 1978.

"What Really Matters," L. D. Johnson Memorial Lecture, Furman University, 1983.

Numerous speeches to local service, professional, and business organizations on business strategies and business valuation.

Co-presenter with Peter Tiffany, Timothy Madden, and Thomas Traxler, "2011 Family Law Intensive: Tax Returns, Other Financial Records & Valuation," October 2011.

Professional Affiliations

American Economic Association
Southern Economic Association

Southern Marketing Association
National Association of Forensic Economics

Awards and Honors

Western Electric Fund Award for innovative teaching, presented by the American Assembly of Collegiate Schools of Business, 1982.

Faculty Internship, Henderson Advertising Agency, 1972.

NDEA Fellowship, University of Alabama.

Wall Street Journal Award, Wofford College.

Listed in *Who's Who Among Expert Witnesses.*

Other Professional Activities

Professional Associations – Attended, presented papers, discussed papers, chaired sessions, and judged papers at numerous professional association meetings.

Consulting

Have been recognized in Federal District Courts, state courts in South Carolina, North Carolina, and Tennessee, South Carolina Family Courts, and the South Carolina Public Service Commission as an expert in economic and business affairs, including the following areas.

- valuation of closely held companies
- review of company performance and condition
- forecasting of sales and profits
- consideration of economic consequences of alimony and child support payments
- equitable distribution of marital assets
- application of South Carolina Department of Social Services Child Support Guidelines
- valuation of defined benefit pension plans
- computation of economic loss due to death, disability, and termination
- computation of lost business profits
- unfair trade practices
- antitrust violations

Have been appointed as the court's expert in South Carolina Family Court, South Carolina Circuit Court, and Masters in Equity in Greenville and Anderson counties.

Have been retained by plaintiff's attorneys, defendant's attorneys, United States Department of Justice, and insurance companies in evaluation of economic loss.

Have served as a consultant in valuation of numerous closely held companies outside the context of litigation, including manufacturers, wholesalers, retailers, professional associations, and personal service companies.

Other consulting experience includes market research and analysis, corporate image research, and development and implementation of strategic plans.

Have served on the local advisory boards of a bank, commercial real estate development firm, and travel agency.

Community Activities

Past service on Travelers Rest Area Council, vice chairman, director, chair of Education Committee, co-chair of Economic Development Committee.

Past service on Travelers Rest Home Town Association, director, treasurer.

Charles L. Alford, Ph.D.
Overlook Executive Park
109 Laurens Rd.
Building 2, Suite C
Greenville, SC 29607
Office (864) 233-8593
FAX (864) 233-4819
charlie@cla3.com

December 6, 2019

Jessica Gooding
Attorney at Law
Box 436
Columbia, SC 29202

Re: Diane Connell

Dear Ms. Gooding:

I have computed alternative present value costs of the future medical care needs of Ms. Diane Connell as identified in the December 6, 2019 *Future Cost Analysis* of Lindsay Moore, Certified Life Care Planner. Ms. Moore indicates that Ms. Connell will require either a partial knee replacement or a total knee replacement. Because the total present value costs of these procedures are similar, you have asked me to consider only the cost of the total replacement.

I have discounted all costs to present day dollars as of the estimated trial date of December 11, 2019. However I have assumed that pain management sessions, injections, and hardware removal cannot be scheduled before 2020. Based on your instructions, I have made the following assumptions regarding the scheduling of the procedure as well as needs prior to the procedure.

- The total knee replacement will occur in 2023 (three years from the beginning of 2020), 2025 (five years), or 2030 (ten years).
- Ms. Connell will require an annual series of four pain management visits and injections in each year prior to the surgery, but for a period no longer than five years. Therefore if the replacement is scheduled in 2023, she will require pain management visits and injections in years 2020-2022. If knee replacement occurs in either 2025 or 2030, she will require the pain management visits and injections in years 2020-2024.
- Regardless of the timing of the knee replacement, the hardware removal will occur as quickly as it can be scheduled (2020).

Ms. Moore provides cost estimates in 2019 dollars. I have projected price increases by applying the difference between historical relevant medical item inflation rates and the historical

general inflation rate to the 2.6% long-run rate of general inflation published by the Social Security Administration.[1] These differences are shown below.

Medical Care Category	*Historical Category Inflation Rate minus Historical General Inflation Rate*[2]
Professional Medical Services	0.43%
Physicians' Services	0.29%
Services of Other Medical Professionals	-0.10%
Prescription Drugs	1.14%
Inpatient Hospital Services	3.64%
Over-the-Counter Medications	-1.93%
Medical Equipment and Supplies	-1.48%

Historical price data for the first five items shown above are for the twenty-year period October 1999 – October 2019. Data for the final two items are only available from December 2009.

The total present value cost of Ms. Connell's future medical needs is computed in the range of $179,308 (replacement in 2023) to $237,032 (replacement in 2030). Table 1 enclosed shows the present value costs of the total knee replacement if it occurs in 2023, 2025, or 2030. Tables 2-4 show computed present value costs year by year.

I have discounted future costs to their present values using yields on United States Treasury issues maturing in the middle of each respective future year.

My résumé and a summary of my testimony since 2014 are enclosed. Charges for my work in this matter are at my standard hourly rate, currently $480.

I hope this information is helpful to you. Please let me know if you have questions.

Cordially,

Charles L. Alford

CLA/pc
Enclosures

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[1] Social Security Administration, *2019 OASDI Trustees Report,* Table V.B1, "Principal Economic Assumptions."

[2] U. S. Bureau of Labor Statistics, CPI-All Urban Consumers, "All Items" and various medical care categories.

Table 1

Diane Connell

Total Present Value Medical Costs

Replacement Year		Present Value Cost
2020	Pain Management and Injections	5,814
	Hardware Removal	11,015
	Replacement	162,479
	Total Present Value Cost	**179,308**
2023	Pain Management and Injections	9,854
	Hardware Removal	11,015
	Replacement	177,174
	Total Present Value Cost	**198,044**
2030	Pain Management and Injections	9,854
	Hardware Removal	11,015
	Replacement	216,163
	Total Present Value Cost	**237,032**

Table 2

Diane Connell

Medical Cost Detail -- Pain Management and Injections

Unit cost, 2019 $s	$89	$378			
Year	Pain Management Visits	Injections	Total Cost	Present Value Cost	Cumulative Present Value
2020	365	1,558	1,924	1,906	1,906
2021	376	1,606	1,981	1,938	3,843
2022	387	1,654	2,041	1,971	**5,814**
2023	398	1,704	2,102	2,004	7,818
2024	409	1,756	2,165	2,036	**9,854**

Table 3

Diane Connell

Medical Cost Detail -- Hardware Removal

Year	Pre-op PCP Evaluation	Pre-op Other Professional Services	Professional Fee	Anesthesia Fee	Facility Fee	Post-op Pain Control RX	Post-op Pain Control OTC	Knee Brace	Post-op Therapy Evaluation and Treatment	Total Cost	Present Value Cost
Unit cost, 2019 $s	$127	$360	$1,520	$1,936	$3,887	$59	$8	$132	$2,661		
2020	131	371	1,564	1,995	4,130	61	8	133	2,728	11,120	11,015

Table 4

Diane Connell

Medical Cost Detail -- Total Knee Replacement

Unit cost, 2019 $s	$282	$127	$360	$6,256	$3,038	$124,373	$59	$8	$132	$702		
Replacement Year	Surgical Consult	Pre-op PCP Evaluation	Pre-op Other Professional Services	Professional Fee	Anesthesia Fee	Facility Fee	Post-op Pain Control RX	Post-op Pain Control OTC	Knee Brace	Post-op Therapy Evaluation and Treatment	Total Cost	Present Value Cost
2023	316	142	406	7,011	3,423	158,445	68	8	138	775	170,416	162,479
2025	335	151	431	7,422	3,634	178,836	73	8	141	814	191,510	177,174
2030	386	174	500	8,559	4,219	242,044	88	9	149	921	256,662	216,163

Chapin Orthopedic Surgery Center, LLC.
106 Ellett Road
Chapin, SC 29036
PHONE-803-941-8096
FAX-803-345-6087

Date Of Exam	2/11/2020
Patient Name	DIANE CONNELL
Address	304 TRENTWOOD DR COLUMBIA, SC 292238417
Date of Birth	[redacted]
Patient Age	68

Post Operative Diagnosis	M25.562Pain in left knee
Post Operative Diagnosis	M17.12Unilateral primary osteoarthritis, left knee
Post Operative Diagnosis	M25.362Other instability, left knee

Statement of Procedure

PREOPERATIVE DIAGNOSIS:
Retained hardware left knee

POSTOPERATIVE DIAGNOSIS:
Retained hardware left knee

PROCEDURE:
Removal of Hardware Left Knee, Patella (CPT 20680)

SURGEON:
Dr. James Loging, MD

ANESTHESIA:
General

IMPLANTS: None

ESTIMATED BLOOD LOSS: None

INTRAOPERATIVE COUNTS: Correct

SPECIMENS: None.

COMPLICATIONS: None.

PROPHYLACTIC IV ANTIBIOTICS: None

CONSENT:
After reviewing the risks, benefits, likely outcome and potential complications of the procedure, preoperative verbal and written consents were obtained. The operative procedure and postoperative course were discussed with the patient in detail.

The surgical checklist was performed and correct surgical site was confirmed using written consent and history/physical. Postoperative surgical checklist was also completed.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and transferred to the operating table. After anesthesia was obtained the patient*s left lower extremity was prepped and draped in normal sterile fashion. C-arm imaging was used to visualize the hardware. Incision was reopened. The wire and pins were found and cut. It was then pulled from both sides. There was complete removal of the wires and pins which was confirmed with C-arm image. The wound was irrigated copiously with normal saline. It was then closed with 2-0 Monocryl, 3-0

Monocryl, and Steri-Strips. Incision was injected with Marcaine 0.5% percent. Sterile dressing was applied. She was discharged to recovery room and subsequently discharged home.

POSTOPERATIVE PLAN:
Patient will follow up in 2 weeks for wound check. Weight-bear as tolerated and range of motion as tolerated left knee.

James Loging,MD
Electronically signed on 2/12/2020 1:43 PM

Palmetto Bone & Joint, P.A.

Clinton Office: 22971 Highway 76 East, Clinton SC 29325 Phone: (864) 833-3046 Fax: (864) 833-1711
Newberry Office: 2605 Kinard Street, Suite 105, Newberry SC 29108 Phone: (803) 321-6254 Fax: (803) 321-6259
Chapin Office: 104 Ellett Road, Chapin SC 29036 Phone: (803) 941-8095 Fax: (803) 345-6088

Date of Exam 12/20/2019
Patient Name DIANE CONNELL
DOB [redacted]
Provider James Loging,MD
Provider NPI 1669490405

History
Chief Complaint .
History of Present Illness (Knee)
The patient is a 68 year old female who presents for follow up visit to discuss surgery to remove hardware with complaints of localized pain and grinding in the left knee that occurs during activities. She had prior ORIF of patella September 2017. The patient's symptoms are aggravated by daily activities, going down stairs, going up stairs. She states she can't do any stooping or squatting.
Allergies
NO KNOWN
ALLERGIES
Medications
Hydrocodone 5mg*
Diazapam 5m*
Allerall 15mg*
Pravastatin 20mg*
Gabapentin 300mg*
Lexapro 20mg*
Past History
Medical History Patient has history of blood thinners and depression.
Surgical History Knee Surgery
Family History Mother has history of osteoporosis and osteoarthritis.

Social History	Patient is right handed. Patient reports the use of caffeine. Patient does not use alcohol, illicit drugs or tobacco.

Review of Systems

Constitutional	No fever, fatigue, weakness or sudden weight change
Eyes	Normal visual acuity, no blurred vision or excessive tearing
HEENT	Normal auditory acuity, no nasal discharge or difficulty swallowing
Cardiovascular	No chest pains or palpitations or high blood pressure
Respiratory	No shortness of breath or cough
Gastrointestinal	No abdominal pain, heartburn, hepatitis or bleeding
Genitourinary	No dysuria or hematuria
Musculoskeletal	Patient has history of stiffness.
Skin	No rashes or jaundice
Neurological	No headache, dizziness or memory loss
Psychiatric	Patient has history of depression.
Endocrine	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic	No bruising, swollen glands or anemia
Immunological	No skin rashes, or allergies to food or medication

Vital Signs

Height (in)	66.0
Weight (lbs)	146.0
BMI	23.6

Knee Exam

Inspection	**Right**	**Left**
Gait	The patient walks with a normal, non-antalgic heel to toe gait.	
Posture	Shoulders are level, iliac crests are level, normal thoracic kyphosis, normal lumbar lordosis, no lateral curvature.	
Alignment		Mild.
Swelling		Negative
Ecchymosis		Negative
Effusion		Mild
Atrophy		Quadriceps femoris
Skin		Normal
Palpation	**Right**	**Left**

Tenderness		Medial joint line
Patella Position		Neutral
Q Angle		Normal
Tilt		Equal
Crepitus		Absent
Apprehension		Negative
Popliteal Pulse		Normal
Vascular Normal	The peripheral vascular pulses are normal, with normal capillary refill.	
Active ROM	**Right**	**Left**
Flexion		135
Extension		0
Left Active ROM Description	Normal pain-free active range of motion.	
Passive ROM	**Right**	**Left**
Flexion	135	
Extension	0	
Muscle Testing	**Right**	**Left**
Patella Reflex		2/4
Neurological	The peripheral reflexes are normal with normal distal sensation.	

Imaging

Left **Knee** X-RAY Knee, 3 Views

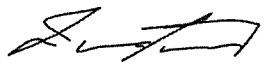
His left knee are reviewed which telwed harhere is posterior medical trac of the patella.regularity of the posterior aspect of the patella.regularity of the posterior aspect of the patella. Fracture appears to be completely healed.

Diagnosis

M25.562	Pain in left knee
M17.12	Unilateral primary osteoarthritis, left knee
M25.362	Other instability, left knee

Plan

Knee	Patient continues to have irritation and issues with knee. I explained the pathology and its natural history of progression. I also explained the treatment options, including the benefits and complications of each of the options. Discussed removing hardware from prior ORIF of patella, these are prominent. Could consider lubricant injections for arthritis after removing hardware. Also discussed with her possible partial replacement later on. She is ready to proceed with surgery, risks and benefits explained. She will be set up for hardware removal.



James Loging,MD
Electronically signed on 12/20/2019 4:31 PM

BCBS FEDERAL
PO BOX 600601

COLUMBIA, SC 29260

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ( ) (Medicare#) MEDICAID ( ) (Medicaid#) TRICARE ( ) (ID#/DoD#) CHAMPVA ( ) (Member ID#) GROUP HEALTH PLAN ( ) (ID#) FECA BLK LUNG ( ) (ID#) OTHER (X) (ID#) R27556292

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CONNELL, DIANE M

3. PATIENT'S BIRTH DATE [redacted] SEX M ( ) X (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CONNELL, DIANE M

5. PATIENT'S ADDRESS (No., Street): 304 TRENTWOOD DR

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street): 304 TRENTWOOD DR

CITY: COLUMBIA STATE: SC

8. RESERVED FOR NUCC USE

CITY: COLUMBIA STATE: SC

ZIP CODE: 29223 TELEPHONE (Include Area Code): ( )

ZIP CODE: 29223 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): CONNELL, DIANE M

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 6E89RH6TG42

a. EMPLOYMENT? (Current or Previous) YES ( ) X NO ( )

a. INSURED'S DATE OF BIRTH [redacted] SEX M ( ) X (X)

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ( ) X NO ( ) PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ( ) X NO ( )

c. INSURANCE PLAN NAME OR PROGRAM NAME: BCBS FEDERAL

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES ( ) NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 04/03/2020

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: LOGING, JAMES

17a.

17b. NPI 1669490405

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z47.2 B. M17.12 C. M25.362 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: NOT REQ'D

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 02 11 20	02 11 20	24		20680		ABC	3887 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN (X): 47-3916029

26. PATIENT'S ACCOUNT NO.: 002421

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES (X) NO ( )

28. TOTAL CHARGE: $ 3887 00

29. AMOUNT PAID: $ 3703 30

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

CHAPIN ORTHOPEDIC SURGERY

SIGNED 04/03/20 DATE

32. SERVICE FACILITY LOCATION INFORMATION

CHAPIN ORTHOPEDIC SURGERY CENTER
106 ELLETT ROAD
CHAPIN, SC 29036

a. 1194233189 b. EI47-3916029

33. BILLING PROVIDER INFO & PH # 803 941-8096

CHAPIN ORTHOPEDIC SURGERY CENTER, L
106 ELLETT ROAD
CHAPIN, SC 29036

a. 1194233189 b. EI47-3916029

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Palmetto Bone & Joint, P.A.

Clinton Office: 22933 Highway 76 East, Clinton SC 29325 Phone: (864) 833-3046 Fax: (864) 833-1711
Newberry Office: 2603 Kinard Street, Suite 105, Newberry SC 29108 Phone: (803) 321-0254 Fax: (803) 321-0259
Chapin Office: 104 Ellett Road, Chapin SC 29036 Phone: (803) 941-8095 Fax: (803) 345-6088

Date of Exam	4/4/2019
Provider	James Loging
Provider NPI	1669490405
Patient Name	DIANE CONNELL
DOB	[redacted]

History

Chief Complaint (Knee)

Presents with complaints of localized pain and grinding in the left knee that occurs during activities.

History of Present Illness (Knee)

The patient is a 67 year old female who presents with complaints of localized pain and grinding in the left knee that occurs during activities. She had prior ORIF of patella September 2018. The patient's symptoms are aggravated by daily activities, going down stairs, going up stairs. She states she can't do any stooping or squatting.

Allergies

NO KNOWN ALLERGIES

Medications

Lexapro 20mg*
Gabapentin 300mg*
Pravastatin 20mg*
Allerall 15mg*

Diazapam 5m*
Hydrocodone 5mg*

Past History

Medical History	Patient has history of blood thinners and depression.
Surgical History	Knee Surgery
Family History	Mother has history of osteoporosis and osteoarthritis.
Social History	Patient is right handed. Patient reports the use of caffeine. Patient does not use alcohol, illicit drugs or tobacco.

Review of Systems

Constitutional	No fever, fatigue, weakness or sudden weight change
Eyes	Normal visual acuity, no blurred vision or excessive tearing
HEENT	Normal auditory acuity, no nasal discharge or difficulty swallowing
Cardiovascular	No chest pains or palpitations or high blood pressure
Respiratory	No shortness of breath or cough
Gastrointestinal	No abdominal pain, heartburn, hepatitis or bleeding
Genitourinary	No dysuria or hematuria
Musculoskeletal	Patient has history of stiffness.
Skin	No rashes or jaundice
Neurological	No headache, dizziness or memory loss
Psychiatric	Patient has history of depression.
Endocrine	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic	No bruising, swollen glands or anemia
Immunological	No skin rashes, or allergies to food or medication

Vital Signs

Height (in)	66.0
Weight (lbs)	146.0
BMI	23.6

Knee Exam

Gait	The patient walks with a normal, non-antalgic heel to toe gait.
Posture	Shoulders are level, iliac crests are level, normal thoracic kyphosis, normal lumbar lordosis, no lateral curvature.

Inspection	**Right**	**Left**
Alignment		Mild.
Swelling		Negative
Ecchymosis		Negative
Effusion		Mild
Atrophy		Quadriceps femoris

Skin Left	Normal

Palpation		
Tenderness		Medial joint line

	Right	**Left**
Patella Position		Neutral
Q Angle		Normal
Tilt		Equal
Crepitus		Absent
Apprehension		Negative
Popliteal Pulse		Normal

Vascular	The peripheral vascular pulses are normal, with normal capillary refill.

ROM Active	**Right**	**Left**
Flexion		135
Extension		0

ROM	Normal pain-free active range of motion.

ROM Passive	**Right**	**Left**
Flexion	135	
Extension	0	

Muscle Testing	**Right**	**Left**
Patella Reflex		2/4

Neurological	The peripheral reflexes are normal with normal distal sensation.

Imaging

Left Knee X-RAY Knee, 4 Views or More

X-rays left knee are reviewed which showed hardware in place from prior ORIF of the patella. There is joint incongruity on the articular side of the patella. Patella fracture appears to be well-healed. Minimal degenerative change of the knee joint.

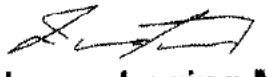
Diagnosis

M17.12Unilateral primary osteoarthritis, left knee

M25.562Pain in left knee

Plan

Knee I explained the pathology and its natural history of progression. I also explained the treatment options, including the benefits and complications of each of the options. Discussed removing hardware from prior ORIF of patella, these are prominent. Could consider lubricant injections for arthritis after removing hardware. Also discussed with her possible partial replacement later on. She wants to discuss options with husband, will call back when she decides.



James Loging,MD

Electronically signed on 4/5/2019 10:10 AM

Palmetto Bone & Joint, P.A.

Clinton Office: 22071 Highway 76 East, Clinton SC 29325 Phone: (864) 833-3046 Fax: (864) 833-1711
Newberry Office: 3609 Kinard Street, Suite 103, Newberry SC 29108 Phone: (803) 321-6254 Fax: (803) 321-6259
Chapin Office: 104 Ellett Road, Chapin SC 29036 Phone: (803) 941-9093 Fax: (803) 345-6088

Date of Exam 12/20/2019
Patient Name DIANE CONNELL
DOB [redacted]
Provider James Loging,MD
Provider NPI 1669490405

History
Chief Complaint .
History of Present Illness (Knee)
The patient is a 68 year old female who presents for follow up visit to discuss surgery to remove hardware with complaints of localized pain and grinding in the left knee that occurs during activities. She had prior ORIF of patella September 2017. The patient's symptoms are aggravated by daily activities, going down stairs, going up stairs. She states she can't do any stooping or squatting.
Allergies
NO KNOWN
ALLERGIES
Medications
Hydrocodone 5mg*
Diazapam 5m*
Allerall 15mg*
Pravastatin 20mg*
Gabapentin 300mg*
Lexapro 20mg*
Past History
Medical History Patient has history of blood thinners and depression.
Surgical History Knee Surgery
Family History Mother has history of osteoporosis and osteoarthritis.

Social History	Patient is right handed. Patient reports the use of caffeine. Patient does not use alcohol, illicit drugs or tobacco.

Review of Systems

Constitutional	No fever, fatigue, weakness or sudden weight change
Eyes	Normal visual acuity, no blurred vision or excessive tearing
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Musculoskeletal	Patient has history of stiffness.
Skin	No rashes or jaundice
Neurological	No headache, dizziness or memory loss
Psychiatric	Patient has history of depression.
Endocrine	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic	No bruising, swollen glands or anemia
Immunological	No skin rashes, or allergies to food or medication

Vital Signs

Height (in)	66.0
Weight (lbs)	146.0
BMI	23.6

Knee Exam

Inspection	**Right**	**Left**
Gait	The patient walks with a normal, non-antalgic heel to toe gait.	
Posture	Shoulders are level, iliac crests are level, normal thoracic kyphosis, normal lumbar lordosis, no lateral curvature.	
Alignment		Mild.
Swelling		Negative
Ecchymosis		Negative
Effusion		Mild
Atrophy		Quadriceps femoris
Skin		Normal
Palpation	**Right**	**Left**

Tenderness		Medial joint line
Patella Position		Neutral
Q Angle		Normal
Tilt		Equal
Crepitus		Absent
Apprehension		Negative
Popliteal Pulse		Normal
Vascular Normal	The peripheral vascular pulses are normal, with normal capillary refill.	
Active ROM	**Right**	**Left**
Flexion		135
Extension		0
Left Active ROM Description	Normal pain-free active range of motion.	
Passive ROM	**Right**	**Left**
Flexion	135	
Extension	0	
Muscle Testing	**Right**	**Left**
Patella Reflex		2/4
Neurological	The peripheral reflexes are normal with normal distal sensation.	

Imaging

Left Knee X-RAY Knee, 3 Views

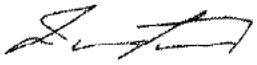
His left knee are reviewed which telwed harhere is posterior medical trac of the patella.regularity of the posterior aspect of the patella.regularity of the posterior aspect of the patella. Fracture appears to be completely healed.

Diagnosis

M25.562	Pain in left knee
M17.12	Unilateral primary osteoarthritis, left knee
M25.362	Other instability, left knee

Plan

Knee Patient continues to have irritation and issues with knee. I explained the pathology and its natural history of progression. I also explained the treatment options, including the benefits and complications of each of the options. Discussed removing hardware from prior ORIF of patella, these are prominent. Could consider lubricant injections for arthritis after removing hardware. Also discussed with her possible partial replacement later on. She is ready to proceed with surgery, risks and benefits explained. She will be set up for hardware removal.



James Loging,MD
Electronically signed on 12/20/2019 4:31 PM

Chapin Orthopedic Surgery Center, LLC.

106 Ellett Road
Chapin, SC 29036

PHONE-803-941-8096
FAX-803-345-6087

Date Of Exam	2/11/2020
Patient Name	DIANE CONNELL
Address	304 TRENTWOOD DR COLUMBIA, SC 292238417
Date of Birth	[redacted]
Patient Age	68

Post Operative Diagnosis	M25.562Pain in left knee
Post Operative Diagnosis	M17.12Unilateral primary osteoarthritis, left knee
Post Operative Diagnosis	M25.362Other instability, left knee

Statement of Procedure

PREOPERATIVE DIAGNOSIS:
Retained hardware left knee

POSTOPERATIVE DIAGNOSIS:
Retained hardware left knee

PROCEDURE:
Removal of Hardware Left Knee, Patella (CPT 20680)

SURGEON:
Dr. James Loging, MD

ANESTHESIA:
General

IMPLANTS: None

ESTIMATED BLOOD LOSS: None

INTRAOPERATIVE COUNTS: Correct

SPECIMENS: None.

COMPLICATIONS: None.

PROPHYLACTIC IV ANTIBIOTICS: None

CONSENT:
After reviewing the risks, benefits, likely outcome and potential complications of the procedure, preoperative verbal and written consents were obtained. The operative procedure and postoperative course were discussed with the patient in detail.

The surgical checklist was performed and correct surgical site was confirmed using written consent and history/physical. Postoperative surgical checklist was also completed.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and transferred to the operating table. After anesthesia was obtained the patient*s left lower extremity was prepped and draped in normal sterile fashion. C-arm imaging was used to visualize the hardware. Incision was reopened. The wire and pins were found and cut. It was then pulled from both sides. There was complete removal of the wires and pins which was confirmed with C-arm image. The wound was irrigated copiously with normal saline. It was then closed with 2-0 Monocryl, 3-0

Monocryl, and Steri-Strips. Incision was injected with Marcaine 0.5% percent. Sterile dressing was applied. She was discharged to recovery room and subsequently discharged home.

POSTOPERATIVE PLAN:

Patient will follow up in 2 weeks for wound check. Weight-bear as tolerated and range of motion as tolerated left knee.

James Loging,MD

Electronically signed on 2/24/2020 11:17 AM

Palmetto Bone & Joint, P.A.

Clinton Office: 22971 Highway 76 East, Clinton SC 29325 Phone: (864) 833-3044 Fax: (864) 833-1711
Newberry Office: 2605 Kinard Street, Suite 105, Newberry SC 29108 Phone: (803) 321-6254 Fax: (803) 321-6259
Chapin Office: 104 Ellett Road, Chapin SC 29036 Phone: (803) 941-8095 Fax: (803) 345-6088

Date of Exam 2/28/2020
Patient Name DIANE CONNELL
DOB [redacted]
Provider James Loging,MD
History
Chief Complaint .
History of Present Illness (Knee)
The patient is a 68 year old female who presents for two week post op visit, status post removal of hardware from left knee. This doing well, states she can notice some difference since surgery.
Allergies
NO KNOWN
ALLERGIES
Medications
promethazine 25 mg tablet 1 every six to eight hours 15 0 y
Norco 7.5-325 mg tablet 1-2 every four hours 30 0 y
Hydrocodone 5mg*
Diazapam 5m*
Allerall 15mg*
Pravastatin 20mg*
Gabapentin 300mg*
Lexapro 20mg*
Past History
Medical History Patient has history of blood thinners and depression.
Surgical History Knee Surgery
Family History Mother has history of osteoporosis and osteoarthritis.
Social History Patient is right handed. Patient reports the use of caffeine. Patient does not use alcohol, illicit drugs or tobacco.
Review of Systems
Constitutional No fever, fatigue, weakness or sudden weight change

Eyes	Normal visual acuity, no blurred vision or excessive tearing
HEENT	Normal auditory acuity, no nasal discharge or difficulty swallowing
Cardiovascular	No chest pains or palpitations or high blood pressure
Respiratory	No shortness of breath or cough
Gastrointestinal	No abdominal pain, heartburn, hepatitis or bleeding
Genitourinary	No dysuria or hematuria
Musculoskeletal	Patient has history of stiffness.
Skin	No rashes or jaundice
Neurological	No headache, dizziness or memory loss
Psychiatric	Patient has history of depression.
Endocrine	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic	No bruising, swollen glands or anemia
Immunological	No skin rashes, or allergies to food or medication

Vital Signs

Height (in)	66.0
Weight (lbs)	146.0
BMI	23.6

Imaging

Left Knee X-RAY Knee, 3 Views

X-rays left knee are reviewed which show a staple placed from prior hardware removal left knee. Hardware is been completely removed. Placement arthritis and patellofemoral compartment.

Diagnosis

M25.562	Pain in left knee
M17.12	Unilateral primary osteoarthritis, left knee
M25.362	Other instability, left knee

Plan

Knee Patient is status post removal of hardware from left knee. She is doing well. Will remove staples today. She can use vitamin E on incision for healing. She is interested in doing exercises on her own. Slowly increase activity. Follow up in 4 weeks with xrays.

James Loging,MD
Electronically signed on 3/2/2020 8:43 AM

PALMETTO BONE AND JOINT **Patient Ledger** 03/02/2020 08:44 AM

Patient Totals	Charges	Allowances	Adjustments	Write-Offs	Collections	Balance
TOTAL	3,059.00	0.00	0.00	0.00		0.00

Patient ID=1008014;Facility=;Address=PALMETTO BONE & JOINT, PA 2297 HIGHWAY 76 E CLINTON SC, 29325-7529;Pay to NPI=PALMETTO BONE AND JOINT[1720295793];Date Span=Date Range:From=:To=:Rendering=:Billing=:Referring=:Supervising=:Select Case=ALL CASES;Practice=on;Demographics=on;Guarantor=on;Aging=on;Encounter

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	OF THE ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON	)	
	)	
Diane Connell,	)	Civil Action No. 2018-CP-32-1750
Plaintiff,	)	
vs.	)	
	)	
Lexington County Health Services District, Inc., d/b/a/ Lexington Medical Center,	)	**ORDER GRANTING DEFENDANT'S MOTION FOR DIRECTED VERDICT**
	)	
Defendant.	)	
	)	

This matter came before the Court for a bench trial on March 2, 2020. Representing the parties were Robert Goings and Jessica Gooding of the Goings Law Firm, LLC, for the Plaintiff Diane Connell and Evan M. Gessner of Davis Frawley, LLC, for the Defendant Lexington County Health Services District. At the close of Plaintiff's case, Defendant moved for directed verdict.

FACTS PRESENTED BY PLAINTIFF

The Plaintiff, Diane Connell, and her husband Stephen Connell visited the Defendant's medical center on September 26, 2017 for a medical appointment. Mr. Connell dropped Plaintiff off at the doctor's office then parked the car in a nearby parking garage. After the appointment, the pair were walking back to their car and, as they entered the parking garage, Plaintiff stepped halfway off a curb causing her to fall. Several witnesses testified that the curb on which Plaintiff fell had yellow paint on the front of the curb, but not on the top of the curb. No yellow paint would have been visible from Plaintiff's vantage point. The sidewalk on which Plaintiff was walking, the curb, and the adjacent roadway were all concrete.

Shortly after her fall, Plaintiff was brought the Lexington Medical Center emergency department where she was diagnosed with a fractured patella and a sprained ankle. Plaintiff was

admitted to the hospital for pain management and because she could not be moved back to her home. Plaintiff had surgery the next day to repair the fractured patella, which involved metal wire being driven through the patella and pulled back together to reshape the patella. Plaintiff was later discharged home where she began her recovery. Plaintiff testified that she continued to have pain in her injured knee and later had a second surgery to remove the metal hardware. Plaintiff's treating physician, Dr. Loging, testified that Plaintiff will likely develop post-traumatic arthritis in her knee, requiring injections to delay the onset, and will eventually need a full knee replacement.

STANDARD OF REVIEW

A trial court, in deciding a motion for a directed verdict, must view the evidence in the light most favorable to the nonmoving party. *See Burnett v. Family Kingdom, Inc.*, 387 S.C. 183, 188, 691 S.E.2d 170, 173 (Ct. App. 2010). When considering a directed verdict motion, the trial court may not decide credibility issues or resolve conflicts in the testimony or the evidence. *See id.* at 188-89; 691 S.E.2d at 173. "When the evidence yields only one inference, a directed verdict in favor of the moving party is proper." *Wright v. Craft*, 372 S.C. 1, 22, 640 S.E.2d 486, 498 (Ct. App. 2006).

ANALYSIS

Plaintiff's sole cause of action for negligence sounds in premises liability. To prove her cause of action, Plaintiff must show (1) a duty of care owed by Defendant to Plaintiff; (2) a breach of that duty by a negligent act or omission; and (3) damages proximately resulting from that breach. *Crolley v. Hutchins*, 300 S.C. 355, 387 S.E.2d 716 (Ct. App. 1989). It is not contested that at the time of the incident, Plaintiff was an invitee on Defendant's premises and Defendant owed Plaintiff a duty of care to warn of unsafe conditions of which Defendant knew

or should have known and of which Plaintiff was reasonably unaware. *See Wilson v. Duke Power Co.*, 273 S.C. 610, 258 S.E.2d 101 (1979). In any negligence action, the plaintiff must show that the defendant did not use the amount of care one ordinarily would have under the circumstances. Negligence cannot be presumed from injury because South Carolina does not recognize the doctrine of *res ipsa loquitur*. *See Fletcher v. Med. Univ.*, 390 S.C. 458, 702 S.E.2d 372 (Ct. App. 2010). Defendant is not the insurer of Plaintiff's safety and "had no duty to make the parking lot accident proof". *See Wimberly v. Winn Dixie Greenville, Inc.*, 252 S.C. 117, 120, 165 S.E.2d 627, 628 (1969); *Nelson v. Piggly Wiggly Central, Inc.*, 390 S.C. 382, 391, 701 S.E.2d 776, 781 (Ct. App. 2010). As a result, whether Defendant could have made the premises "more safe" is irrelevant. Plaintiff must establish the standard of care and prove that Defendant breached that standard. Further, because *res ipsa loquitur* is not the law of this state, Plaintiff must prove that her injury was the result of some bad act on the part of Defendant.

Plaintiff argued that as she was walking into Defendant's parking garage, the similarly colored concrete surfaces blended together, creating a "camouflage effect" that concealed the change in elevation. Plaintiff further argued that had the top of the curb been painted yellow, the change in elevation would have been more noticeable and she would not have fallen. In other words, Plaintiff alleges that Defendant was negligent in failing to paint the top of the curb yellow.

Generally, industry standards are used to establish the standard of care in a negligence action. *See Elledge v. Richland/Lexington Sch. Dist. Five*, 352 S.C. 179, 186, 573 S.E.2d 789, 793 (2002). In *Nelson v. Piggly Wiggly Central, Inc.*, the plaintiff sustained injuries in a grocery store parking lot when a vehicle drove over a concrete wheel stop and pinned the plaintiff between one of the store walls and the vehicle. 390 S.C. at 386, 701 S.E.2d at 778. The plaintiff

in *Nelson* argued that the defendant should have installed curbing in the parking lot instead of wheel stops, and relied on an engineering expert's testimony that curbing would have prevented the accident. *Id.* However, plaintiff's engineering expert "could not point to any recognized safety standard or building code that required [defendant] to modify the parking lot [when it was constructed] or subsequently." *Id.* at 393, 701 S.E.2d at 782. Instead, plaintiff's expert testified "only to his own preferences rather than requirements of any law, ordinance, or recognized industry standard." *Id.* The question in *Nelson* was "not whether [the defendant] owed [plaintiff] a duty of care, but whether the scope of the acknowledged duty of reasonable care extends to the particular risk that led to her injury." *Id.* at 392, 701 S.E.2d at 781. The Court of Appeals upheld the dismissal of the complaint and emphasized the plaintiff's obligation to "identify a duty that the defendant has to protect her from a particular harm to merit consideration of her claim by a jury." *Id.* Absent some evidence that the defendant owed a specific, articulable standard of care, plaintiff's injury fell "beyond the realm of any duty [defendant] owed to [plaintiff]." *Id.* at 394, 701 S.E.2d at 782.

Here, Plaintiff did not present any evidence establishing the painting of the tops of curbs as an industry standard. There was no evidence of any building code or ordinance and no testimony by any expert witness regarding industry standards. Consequently, Plaintiff has failed to establish the painting of the tops of curbs as a standard of care. Instead, Plaintiff relies more on the general duty all property owners owe to an invitee and argues that Defendant should have known that the two concrete surfaces would blend together and failed to correct this condition by painting the top of the curb to warn pedestrians of the change in elevation. In other words, Plaintiff argues that Defendant failed to fix or warn her of a latent defect.

"[W]here a dangerous condition in premises is latent and of which the owner knew or should have known, and is unknown to invitees, the owner is required to give proper warning in order to relieve himself from liability for injuries incurred by reason thereof." *Bruno v. Pendleton Realty*, 240 S.C. 46, 51-52, 124 S.E.2d 580, 582-83 (1962). A latent defect "is one which a reasonably careful inspection will not reveal." *See Meadows v. Heritage Vill. Church & Missionary Fellowship*, 305 S.C. 375, 378, 409 S.E.2d 349 (1991). To prove liability relating to the failure to discover and fix or warn of a latent defect, Plaintiff must show that Defendant was on notice of the latent defect. Ultimately, the burden is on Plaintiff to show that Defendant, or its agents, knew or should have known of the hazardous condition. "This notice may be actual or constructive." *Wimberly v. Winn-Dixie Greenville, Inc.*, 252 S.C. 117, 122, 165 S.E.2d 627, 629 (1969).

> Constructive notice is a legal inference which substitutes for actual notice. It is notice imputed to a person whose knowledge of facts is sufficient to put him on inquiry; if these facts were pursued with due diligence, they would lead to other undisclosed facts. Therefore this person is presumed to have actual knowledge of the disclosed facts.

Strother v. Lexington County Recreation Comm'n, 332 S.C. 54, 63 n. 6 (1998). To show constructive notice, Plaintiff must present actual evidence indicating that Defendant was on "inquiry", meaning that Plaintiff must show evidence that something alerted or should have alerted Defendant that there might be an issue with that particular area, requiring further investigation.

Plaintiff did not provide any evidence that Defendant had any notice or was on "inquiry". Instead, relying on *Wimberly*, Plaintiff argued that the curb had existed in much the same condition for sufficient time that Defendant should have known it was hazardous. Plaintiff's reliance on *Wimberly* is misplaced. *Wimberly* did not involve a latent defect and instead involved

a slip and fall caused by a foreign substance, in that case rice spilled on a grocery store floor. *See* 252 S.C. at 119. The Court held that if plaintiff could show that the rice had been on the floor long enough that the defendant should have discovered it and cleaned it up, plaintiff could show constructive notice. *See id.* at 122. However, this case does not involve a foreign substance. This Court is not aware of any South Carolina authority which states that the existence of a latent defect for any length of time can suffice to prove constructive notice. As a result, to the extent that Plaintiff argues constructive notice can be inferred by the length of time the curb has been in existence, she is mistaken.

Additionally, the existence of a latent defect for any length of time is irrelevant because our Supreme Court has held that a latent defect is one that cannot be found, even with a reasonably careful inspection. *See Meadows*, 305 S.C. at 378. As a result, a premises owner cannot be expected to find every latent defect that may exist on the premises. To succeed on her claim, Plaintiff must show evidence that Defendant was put on inquiry and failed to correct or warn of the defect. Plaintiff was unable to show any such evidence and has therefore failed to carry her burden. *Cf. Bruno*, 240 S.C. at 53 (finding a property owner liable when evidence was presented showing that prior to the plaintiff's fall, the property owner had actual knowledge that vegetation had grown to the extent it covered the edge of a curb, concealing a change in elevation).

Plaintiff also argued that Defendant built the parking garage, creating the hazardous condition and, as a result, is liable regardless of notice. *See Smith v. Wal-Mart Stores*, 314 S.C. 248, 250, 442 S.E.2d 606, 607 (1994) ("To avoid a directed verdict in a slip and fall case, the plaintiff has the burden of presenting evidence . . . that the storekeeper was responsible for creating the hazard which caused the fall or had actual or constructive knowledge of the

existence of the hazard."). It was established at trial that Defendant hired independent contractors to design and build the parking garage. Plaintiff argued that Defendant owed Plaintiff a nondelegable duty and could not be absolved of liability simply because it hired independent contractors. However, because Defendant is a governmental entity subject to the provisions of the South Carolina Tort Claims Act, it is not liable for a loss resulting from "an act or omission of a person other than an employee including but not limited to the criminal actions of third persons." *See* S.C. Code Ann. §§ 15-78-20(b), 60(20); *see also Smith v. Reg'l Med. Ctr.*, 394 S.C. 110, 114-16, 713 S.E.2d 656, 658-59 (Ct. App. 2010); *Lexington County Health Servs. Dist. v. S.C. Dep't of Revenue*, 384 S.C. 647, 649, 682 S.E.2d 508 (Ct. App. 2009) ("Lexington Medical is an incorporated health services district created in 1988 pursuant to section 44-7-2010 of the South Carolina Code (2002)"); S.C. Code Ann. § 15-78-30(j) ("'Governmental health care facility' . . . includes any facility as defined in Title 44, S.C. Code Ann. for the provision of mental or physical care to individuals, whether or not it is required to be licensed under those provisions."). Independent contractors are specifically excluded from the Act's definition of "employee". *See* S.C. Code Ann. § 15-78-30(c) ("'Employee' . . . does not include an independent contractor doing business with the State or a political subdivision of the State.") Consequently, to the extent Plaintiff alleges that the curb was negligently designed or constructed, Defendant cannot be held liable for the acts or omissions of the independent contractors that designed and built the parking garage.

Plaintiff failed to present evidence of any negligent act of the Defendant that lead to her injury.

CONCLUSION

Based on the foregoing, Defendant Lexington County's Motion for a Directed Verdict is **GRANTED**. Plaintiff's Complaint against Defendant is hereby dismissed with prejudice.

AND IT IS SO ORDERED.

_____
The Honorable Walton J. McLeod

Dated: April ____, 2020

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	ELEVENTH JUDICIAL CIRCUIT
Diane Connell,	)	CIVIL ACTION No.: 2018-CP-32-1750
	)	
Plaintiffs,	)	
	)	
vs.	)	**ORDER AND ENTRY OF JUDGMENT**
	)	
Lexington County Health Services District, Inc. d/b/a Lexington Medical Center,	)	
	)	
Defendant.	)	

This matter comes before the Court for a bench trial on March 2, 2020. Robert Goings, Esquire and Jessica Gooding, Esquire appeared on behalf of Plaintiff Diane Connell. Evan Gessner, Esquire appeared on behalf of Defendant Lexington County Health Services District, Inc. d/b/a Lexington Medical Center ("LMC").

Plaintiff Diane Connell ("Mrs. Connell") brought this action seeking to recover for damages she sustained when she fell entering an LMC parking garage. Mrs. Connell asserts that she fell as a result of LMC leaving an elevation change or curb in a concrete pedestrian walkway unpainted, which had a camouflaging effect, and prevented Mrs. Connell from seeing the elevation change. This fall resulted in painful injuries, medical bills, and other damages. The undersigned received 14 Exhibits into evidence and heard testimony from: Diane Connell; Steven Connell; Christopher Brewer; James Loging, M.D. (by video); Lindsay Moore, PA-C; Charles Alford, Ph.D.; Dale Thompson (live and by deposition); and Cory Andrews (by deposition). Having considered the evidence and arguments presented, this Court finds in favor of Mrs. Connell and awards her $300,000.00 in actual damages.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

PARTIES & JURISDICTION

Mrs. Connell is a citizen and resident of Lexington County, South Carolina, and she is 68 years old. LMC is a hospital district in Lexington County, South Carolina, and the facts and circumstances surrounding this action occurred on its premises in Lexington County. Accordingly, the Court has specific and general jurisdiction over the parties and venue is proper.

FACTS

On September 26, 2017, Mrs. Connell accompanied her husband to a doctor's appointment on the LMC campus. It was a sunny day. Mr. Connell dropped Mrs. Connell off at the entrance to the doctor's office building and went to park the car. After the appointment, Mr. & Mrs. Connell followed the sidewalk into Parking Garage 3, where their vehicle was parked. Not far from the pedestrian entrance to the garage, there is a curb and a greater-than-six-inch elevation drop to the driveway utilized by vehicles leaving the garage. However, both the sidewalk and the driveway are gray concrete, and there was no paint or other demarcation on the top of the curb signaling the sudden elevation change. Mrs. Connell was unable to see the curb or visually recognize the change in elevation. As a result, her heal caught the curb, causing her to fall forward and strike her left knee and head on the concrete. She immediately had severe pain in her left knee. Mr. Connell, who was walking just behind Mrs. Connell, testified that his wife was screaming in agony, and he was unable to get her to her feet. Others in the parking lot came to assist the couple, and they were able to get Mrs. Connell to a seated position on the curb.

Chris Brewer, an off duty officer with Allen University who testified at trial, arrived on the scene shortly after Mrs. Connell was seated on the curb. He stopped to render aid and to assess the scene. Mr. Brewer testified that he could see that Mrs. Connell had fallen off the curb, which

was very difficult to discern from the direction where she was walking. Mr. Brewer also testified that other curbs were painted yellow, except for the curb that resulted in Mrs. Connell's fall. He recalled that she was clearly suffering and needed immediate medical attention. One of the passersby called for a security golf cart to come to the scene and transport Mrs. Connell to the LMC Emergency Room, as she was totally unable to ambulate. Mr. Brewer assisted Mrs. Connell onto the golf cart, being careful to keep her leg straight on the back seat. Mrs. Connell testified that bending her knee in any way was very painful.

In the LMC Emergency Room, Mrs. Connell was diagnosed with a right ankle sprain and displaced comminuted fracture of the left patella. She was required to spend two nights in the hospital and undergo an open reduction internal fixation surgery, where screws and metal wire were used to repair her kneecap.

After discharge, Mrs. Connell followed up with Lexington Orthopedic and went through in-home rehabilitation. Thereafter, in order to have an orthopedist not associated with LMC, Mrs. Connell sought continued treatment with Dr. James Loging of Palmetto Bone and Joint, PA. She treats regularly with Dr. Loging for ongoing pain and discomfort in her left knee. In his deposition, Dr. Loging opined that the hardware in Mrs. Connell's kneecap was irritating the joint and contributing to her discomfort. For this type of injury, he testified that almost "hundred percent of the time" a hardware removal is needed "because of the high incidence of hardware irritation and problems from the hardware." Dr. Loging performed a hardware removal surgery on Mrs. Connell on February 11, 2020.[1] While Dr. Loging expressed hope that this surgery would reduce Mrs. Connell's discomfort, he also testified that the incongruity of her joint where the patella

[1] Dr. Loging's *de benne esse* deposition was taken November 25, 2019, prior to Dr. Loging performing the hardware removal surgery.

fracture healed would cause "grinding" and "mechanical symptoms." Over time, Mrs. Connell will develop post-traumatic arthritis, which will "progressively get worse to the point where the pain would be intolerable," and she will require a knee replacement surgery. He testified that "given the incongruity of her joint, her chance of developing post-traumatic arthritis is essentially a hundred percent guaranteed," and he was confident that she will undergo a knee replacement surgery in the future. Dr. Loging was unable to say definitively whether Mrs. Connell's knee replacement would be a partial or a total knee replacement, but he testified that she would "definitely" need a knee replacement "because of the that trauma that's there." To a reasonable degree of medical certainty, however, Dr. Loging testified that he would "recommend a full knee replacement, actually, just because the longevity and the decreased chance of having to have a revision of that knee in the future and the success rate [of a total knee replacement] would be higher [than a partial knee replacement]." In the meantime, Dr. Loging recommends that she undergo Supartz injections in her knee every six months until her condition deteriorates enough to require the knee replacement.

Mrs. Connell has incurred $55,839.38 bills to date, and she is continuing to incur medical bills in her treatment with Palmetto Bone and Joint, PA. Dr. Loging has also indicated that Mrs. Connell will most probably need pain management injections and physical therapy. Based on Dr. Loging's recommendations, Lindsay Moore, PA-C, a Certified Nurse Lifecare Planner, put together a report estimating Mrs. Connell's future medical cost needs. The report includes two scenarios: one in which Mrs. Connell has a partial knee replacement and one in which she has a full knee replacement. Ms. Moore testified that Mrs. Connell's knee replacement surgery, whether it is a partial or full replacement, would most likely be an inpatient procedure, especially due to Mrs. Connell's comorbidities. Mrs. Connell further testified that she would rather have the

procedure in the hospital setting since it would require general anesthesia. Charles Alford, PhD took Ms. Moore's report and, accounting for inflation, provided the present value of Mrs. Connell's future medical costs.[2] Assuming Mrs. Connell does not have a knee replacement in the next three years, the present value of the pain management injections she will most probably need is $9,854.00. The present value of the knee replacement surgery ranges from $162,479.00 to $216,163.00 depending on when it takes place.[3]

In addition to the medical expenses Mrs. Connell has incurred and will continue to incur, she has suffered immense pain and been very limited by her injuries. Mrs. Connell and her husband testified that she was essentially bedridden for the first week after being discharged from LMC. She was unable to shower and used a bedside commode with assistance. After the first week, she began in-home rehabilitation, which consisted of frequent painful exercises to regain the use of her knee. She was required to use a walker for months and continued to rely upon her husband to prepare her meals, help her from the bed into a chair, assist her with bathing, handle the housework and laundry, take care of the grocery shopping, etc. The pain and discomfort limited her ability to spend time with her family and her grandchildren, as well as caused a significant loss of enjoyment of her life. She had a second open knee surgery to remove the hardware in her knee more than two years following the injury because she continued to have pain

[2] Because Ms. Moore's report is based on the recommendations Dr. Loging made in his deposition in November 2019, both Ms. Moore's report and Dr. Alford's report include the hardware removal surgery as a future cost. As trial was delayed and took place after the hardware removal was completed, those costs are now included in the past medical costs, and the Court has removed those expenses from the future costs projections for the purpose of determining damages in this case.

[3] Although Ms. Moore's report included alternate scenarios depending on whether Mrs. Connell had a full or partial knee replacement, the expenses in the two scenarios were very similar. Therefore, Dr. Alford's report assumed that Mrs. Connell will have a full knee replacement in the future.

whenever she attempted to walk on an uneven surface or incline, go up and down stairs, stoop or kneel. Her limitations have forced Mrs. Connell to miss out on family holidays, time with her grandchildren, and gardening, which is her favorite hobby. Even at the time of trial, Mrs. Connell was still doing her exercises daily to attempt to continue her slow progress with mobility.

Mrs. Connell asserts that the curb where she fell was a hazard to pedestrians, and LMC breached its duty to remedy or warn of the hazard. The curb was painted on its face (i.e. the rise), so it could be seen by vehicular traffic or pedestrians exiting the garage, but it was not painted on top (i.e the run). Importantly, the remainder of the curbing throughout the parking garage is painted yellow on the top and the side. The top side painting was left off in the location where Mrs. Connell fell. There was no demarcation of the change in elevation that could be seen by a person walking in the direction Mrs. Connell was walking.

Cory Andrews, LMC's Director of Risk Management, testified that LMC is responsible for the upkeep and maintenance of their facilities, such as parking garages. Mr. Andrews recognized the purpose of painting curbs in parking garages is to make them visible and admitted that Diane Connell would not have been able to see any yellow paint on the curb where she fell from the direction she was walking. He testified that he believed yellow paint being on the side and tops of the curbs was prevalent throughout the garage and the yellow paint is used to make elevation changes visible to the human eye. He agreed that elevation changes on concrete are hard to see without demarcations such as paint and that Diane Connell would not have been able to see any paint on the curb where she fell from the direction she was walking. Mr. Andrews also admitted that Mrs. Connell appeared to be walking normally and at an acceptable speed, and he could not identify anything that she did wrong that contributed to her fall.

Dale Thompson, LMC's Director of Facility Services, also agreed that curbing can cause a trip hazard and that when the concrete curb is the same color as the concrete ground, it has a "camouflaging effect," making it hard to see where there is a change in elevation. Neither party has identified any regulatory code or rule that designates when and how a curb in a parking garage must be painted, but Mr. Thompson testified that he believed the paint markings or "striping" on the curbing was required by code. He recognized that LMC is responsible for maintaining and inspecting the premise to address any safety concerns, but prior to this incident, LMC had done nothing to call pedestrians' attention to the sudden change in elevation where invitees were expected to walk. Although Mr. Thompson testified that he was not aware of anyone else having fallen on that curb prior to Mrs. Connell's fall, he conceded that there may have been other falls where the injuries were just not severe enough to cause someone to report them. Mr. Thompson also conceded on cross-examination at trial that the condition of the parking garage as depicted in the photographs constituted a "trip hazard" because it was hard to see the curb or its change in elevation. Finally, Mr. Thompson conceded that the curb and its change it elevation would be more visible and safer to pedestrians if the top was painted yellow in a similar manner that curbs were found painted elsewhere in the parking garage.

LIABILITY

Mrs. Connell has asserted a claim of negligence, and more specifically, premises liability, against LMC. "To prove a cause of action for negligence, a plaintiff must show: (1) the defendant owes a duty of care to the plaintiff; (2) the defendant breached that duty by a negligent act or omission; (3) the defendant's breach was the actual and proximate cause of the plaintiff's injury; and (4) the plaintiff suffered an injury or damages." *Roddey v. Wal-Mart Stores E., LP*, 415 S.C. 580, 589, 784 S.E.2d 670, 675 (2016). Thus, the Court must first determine, "as a matter of law,

whether the defendant owed a duty of care to the plaintiff." *Huggins v. Citibank, N.A.*, 355 S.C. 329, 332, 585 S.E.2d 275, 276 (2003).

The duty of care a landowner owes to a person upon its premises depends upon the classification of the individual; she may be an invitee, licensee, adult trespasser, or child. *Larimore v. Carolina Power & Light*, 340 S.C. 438, 444, 531 S.E.2d 535, 538 (Ct. App. 2000). "An invitee is a person who enters onto the property of another at the express or implied invitation of the property owner." *Goode v. St. Stephens United Methodist Church*, 329 S.C. 433, 441, 494 S.E.2d 827, 831 (Ct.App.1997). "[A] person is an invitee on the land of another if he enters by express or implied invitation, his entry is connected with the owner's business or with an activity the owner conducts or permits to be conducted on his land, and there is a mutuality of benefit or a benefit to the owner." *Sims v. Giles*, 343 S.C. 708, 716–17, 541 S.E.2d 857, 862 (Ct. App. 2001). "Invitees include . . . patients in a physician's office . . . ." *Id*. As she was accompanying her husband to a doctor's appointment on LMC's premises, Mrs. Connell was undeniably an invitee. LMC does not dispute her status as an invitee.

"[T]he invitee is offered the utmost duty of care by the landowner." *Id.* at 715, 541 S.E.2d at 861. "[A]lthough the operator of a parking lot is not an insurer of the safety of those who use the lot, reasonable care must be used by the operator to keep the premises used by invitees in a reasonably safe condition." *Hancock v. Mid-S. Mgmt. Co.*, 381 S.C. 326, 331, 673 S.E.2d 801, 803 (2009). A property owner "owes the customers the duty of exercising ordinary care to keep the passageways, sidewalks and such other parts of the premises as are ordinarily used by the customers in transacting business in a reasonably safe condition." *Bruno v. Pendleton Realty Co.*, 240 S.C. 46, 51, 124 S.E.2d 580, 582 (1962). "A landowner owes an invitee a duty of due care to discover risks and to warn of or eliminate foreseeable unreasonable risks." *Landry v. Hilton Head*

Plantation Prop. Owners Ass'n, Inc., 317 S.C. 200, 203, 452 S.E.2d 619, 621 (Ct. App. 1994). If a risk of injury is "reasonably foreseeable," the landowner must take action to prevent the injury. *Nelson v. Piggly Wiggly Central, Inc.*, 390 S.C. 382, 392, 701 S.E.2d 776, 781 (2010).

In this case, LMC admits that Mrs. Connell was an invitee on its premises and that it owes her the duty above described. LMC further admits that Mrs. Connell sustained a patella fracture when she fell in the LMC parking lot. The issue in this case is whether the scope of the acknowledged duty of reasonable care extends to the particular risk that led to Mrs. Connell's injuries. Thus, Mrs. Connell prevails by showing that it was reasonably foreseeable that someone might fall as a result of the unpainted curb and LMC either (1) created the hazard or (2) had actual or constructive knowledge of the hazard and failed to remedy it. *Garvin v. Bi-Lo, Inc.*, 343 S.C. 625, 628, 541 S.E.2d 831, 832 (2001). Constructive notice may be proven by showing that the dangerous condition existed long enough that the defendant should have discovered it. *Wimberly v. Winn Dixie Greenville Inc.*, 252 S.C. 117, 121, 165 S.E.2d 627, 629 (1969). Based on the totality of evidence before this Court, in particular the photographs of the parking garage and the unpainted curb where Mrs. Connell fell and the testimony of LMC's witnesses Dale Thompson and Cory Andrews, Mrs. Connell has carried this burden.

This case is similar to *Bruno v. Pendleton Realty*, where our supreme court upheld a verdict in favor of a store patron who fell "as a result of stepping on the edge of a curbing, which was concealed by a heavy growth of grass." *Id.* at 48, 124 S.E.2d at 581. In that case, there was a sidewalk and a walkway that intersected in the parking lot, and grass had grown in the crack at the intersection, which "gave the appearance that the walkway and sidewalk were on the same level." *Id.* at 52, 124 S.E.2d at 583. Testimony established that the patron had not used that particular walkway before, the patron had the impression that the sidewalk and the walkway were the same

height, and the walkway and the sidewalk were the same color, "giving the impression that it was one continuous walk." *Id.* at 52-53, 124 S.E.2d at 583. Although evidence showed the property owner inspected the premises two or three times per week, the condition had existed for a month or more at the time the patron fell. The court held, "[t]he mere fact that there is a difference between the levels in the different parts of the premises does not, in itself, indicate negligence unless, owing to the character, location and surrounding condition of the change of level, a reasonably careful person would not be likely to expect or see it." *Bruno v. Pendleton Realty Co.*, 240 S.C. 46, 51, 124 S.E.2d 580, 582 (1962). Further, the court pointed out that where a property owner knew or should have known of a dangerous condition that is unknown to an invitee, "the owner is required to give proper warning in order to relieve himself from liability for injuries incurred by reason thereof." *Id.* at 52, 124 S.E.2d at 583. The *Bruno* court found that the evidence was sufficient to find that the property owner, "in the exercise of ordinary care to make its premises reasonably safe, . . . should have given warning of the situation, or taken other precautions to guard against injury to the [patron]." *Id.* at 54, 124 S.E.2d at 584.

Like the patron who fell in *Bruno*, Mrs. Connell was unfamiliar with the pedestrian walkway leading into the parking garage at LMC. She testified that she was looking ahead of her as she walked but was unable to see any curb or change in elevation and believed the surface before her to be flat. In addition, Mr. Connell and Mr. Brewer testified that both the walkway and the driveway were concrete, and it gave the appearance that they were one level. It is foreseeable that a reasonably prudent person walking into the garage, as Mrs. Connell was, would not expect or observe the curb or elevation change of the walking surface. LMC completed construction this parking garage in or around 2008 and regularly inspected the premises. Nine years is certainly sufficient time for LMC to have realized that the lack of paint on a curb between two levels of

concrete had a camouflaging effect, but more than that, LMC created this hazard by failing to paint the curbs when it built the garage in 2008. The fact that LMC painted both the top and side of the curbing/elevation changes on walking surfaces through the parking garage, but failed to ensure that the top of the curb was painted where Mrs. Connell fell, is evidence that LMC created the hazardous condition, or at the very least, knew or should have known this condition existed. In spite of its knowledge that the concrete pedestrian walkway suddenly dropped down to the concrete driveway, with no color change or other distinguishing characteristics, LMC did nothing to alert pedestrians to this change in elevation. This failure is a breach of the duty of care LMC owes invitees on its premises.

LMC argues that *Bruno* actually supports its position on the theory that there can be no liability where there is no new defect. Essentially, LMC argues that its failure to paint the curb on the top side, which would make it visible to pedestrians walking into the garage, cannot make LMC liable for Mrs. Connell's injury because the curb has been in that state since construction, and there is no grass hiding the curb or other defect that has developed to make this area more hazardous. This argument is not persuasive. The court in *Bruno* found sufficient evidence of negligence to uphold the verdict based on the invitee's inability to see the change in elevation and the landowner's failure to make the elevation change visible or warn of its existence. The grass that had grown in the crack between the walkway and the sidewalk contributed to the inability to see the curb in that instance, but there is nothing to say that a curb cannot be difficult to see, and thus, hazardous, to an invitee unfamiliar with the parking area without the growth of grass or some other obstacle. This is especially true here, where there is clear evidence that the curb or change in elevation is not visibly apparent. The photographs and testimony of the witnesses, including LMC representatives, present strong evidence of a trip hazard due to the inability to readily

visualize the change in elevation. In this case, just like in *Bruno*, it should have been obvious to the property owner that a pedestrian using the appropriate walkway might be unable to see the change in elevation, thereby making it unreasonably hazardous. Thus, LMC's failure to remedy or warn of the potential danger is a breach of its duty to Mrs. Connell.

In addition to its argument based on *Bruno*, LMC argued at trial that it cannot be liable for Mrs. Connell's injuries because (1) Plaintiff has not identified a statute or code that LMC violated; (2) there is no evidence that it had constructive notice of this hazardous condition; (3) no one ever reported being injured by falling on this curb prior to Mrs. Connell's fall; and (4) even if LMC was negligent, Mrs. Connell was also negligent, and her negligence outweighs that of LMC, barring her claim. Each of these arguments is addressed in turn below.

First, relying on *Nelson v. Piggly Wiggly*, LMC argues that it cannot be liable because Mrs. Connell has not pointed to a statue or code regulation that requires the curb be painted on both sides. In *Nelson*, a store customer was injured when her grandmother's car drove over the wheel stop in the Piggly Wiggly parking lot and pinned her to the exterior store wall. *Id.* at 386, 701 S.E.2d 776, 778. The customer argued that the wheel stops were installed too close to the building because "there was no room for a pedestrian to escape injury if a car crossed a wheel stop" and the improper installation of the wheel stops "created hazards." *Id.* at 387, 701 S.E.2d at 778. The customer's expert witness testified to the hazardous design but could not identify any specific code violations. *Id.* at 386-87, 701 S.E.2d at 778. The court held that Piggly Wiggly did not have a duty to protect the customer from this injury because it was "legally unforeseeable." It explained that "the injury resulted not from the condition or placement of the wheel stops but from the operation of Grandmother's vehicle," and the grandmother's car accelerating over a wheel stop after stopping in a parking space was "unexpected and unusual." *Id.* at 394, 701 S.E.2d at 782. The

court also held that the expert witness's opinion did not "as a matter of law, establish a duty on [Piggly Wiggly] to guard against the possibility that an improperly operated vehicle would injure [its customer]." *Id.* at 393, 701 S.E.2d at 781-82. In essence, the *Nelson* court found that Piggly Wiggly was not required to protect this customer from her grandmother's negligence. *Id.* at 394, 701 S.E.2d at 782.

LMC's interpretation of this case to say that a plaintiff cannot recover unless she is able to identify a code violation is flawed. A code violation is not required to prove negligence. The lack of liability in *Piggly Wiggly* was not based on the failure to point to a code violation, but based upon the unforeseeability of the intervening cause of injury to its customer. A violation of statue or code is relevant because if a violation is found, it may establish that there was a duty as a matter of law. Indeed, it would constitute negligence *per se*. However, the absence of a code violation does not rule out the possibility of negligence. LMC has an obligation to use due care to keep its parking garage in a reasonably safe condition. Regardless of whether there is any regulatory code that required the tops of the curbs to be painted, doing so is clearly standard practice in the industry. Visible yellow painting on the top and side of the curbs is prevalent throughout the remainder of the garage, and Dale Thompson testified that he believed this striping was required by code. Further, Corey Andrews testified that curbs were generally painted in order to make changes in elevation visible to the human eye. Painting the top of the curbs, where pedestrians are intended to walk, clearly falls within what should be performed to eliminate foreseeable risks and to keep the parking garage reasonably safe whether or not it is specifically required by a code.

Next, LMC argues that there is no evidence that it had notice of the condition of the curb, and therefore, it cannot be held liable for Mrs. Connell's injuries. First, this argument is without merit because it ignores the fact that LMC created this hazard. LMC's own witnesses testified that

LMC built the parking lot and had it "striped" (painted) in or around 2008 and thereafter would routinely inspect the garage for hazards. However, there is nonetheless evidence that LMC should have known of this condition because it had existed for years in a parking garage it maintains and is regularly accessed and utilized by its employees. Constructive notice may be proven by showing that the dangerous condition existed long enough that the defendant should reasonably have discovered it. *Wimberly v. Winn Dixie Greenville Inc.*, 252 S.C. 117, 121, 165 S.E.2d 627, 629 (1969). Defendant argues, without reliance on any authority, that the time a hazard existed may only provide evidence of constructive notice in foreign substance cases, such as where a store customer slips on something spilled on a floor. However, *Bruno*, discussed above, and *LeFont v. City of Myrtle Beach Convention Center*, App. Case No. 2017-001258, Opinion No. 5175 (S.C. Ct. App. Mar. 11, 2020), are both parking lot cases where an invitee tripped on an uneven surface, not a foreign substance, and the respective courts found evidence of notice based on the amount of time the hazards existed. [4] In *LeFont*, the invitee tripped in a pothole in the defendant's parking lot. *Id.* at slip op. *2. The trial court held that there was no evidence the defendant had constructive notice of the pothole, but the court of appeals reversed, citing testimony that the pothole contained dirt and debris, which would allow a fact finder to infer that the hole had existed long enough for the defendant's employees to discover it. *Id.* at slip op. *8. Thus, it is appropriate to impute knowledge of the hazardous curb on LMC based on its opportunity to observe the hazard over the nine years since construction.

LMC also argues that it did not have notice of the hazardous condition because no one reported any injuries resulting from a fall in that location prior to Mrs. Connell falling. To hold

[4] The *Bruno* court cited testimony indicating that the walkway and sidewalk had been in the same condition for at least a month before the patron fell there. *Id.* at 52, 124 S.E.2d at 583.

that this lack of report was proof that there was no constructive notice of the hazard that existed would be to grant property owners a "one free fall" rule, excusing them from liability the first time a hazardous condition on their property caused an injury. This idea is inconsistent with the law of this state. In South Carolina, if it is "reasonably foreseeable" that the property poses a risk to an invitee, the landowner must take action to prevent the injury. *See Nelson v. Piggly Wiggly Central, Inc.*, 390 S.C. 382, 392, 701 S.E.2d 776, 781 (2010). "The mere fact that a particular kind of an accident has not happened before does not . . . show that such accident is one which might not reasonably have been anticipated." *Bass v. Gopal, Inc.*, 395 S.C. 129, 136-37, 716 S.E.2d 910, 914 (2011). A defendant is not excused from liability based on "the fortuitous absence of prior injury." *Id.* LMC's own witnesses agreed that elevation changes could create trip and fall hazards and that the lack of paint on the top portion of the curb where Mrs. Connell fell created a "camouflaging effect" on the elevation change, such that a reasonably prudent person is likely not to see it. This creates a foreseeable risk of falling and sustaining injury, and LMC had a duty to protect against that risk.

Finally, there is no evidence that Mrs. Connell's conduct contributed to her fall. The security camera footage corroborates Mrs. Connell's testimony that she was walking straight and looking ahead when she fell. There is no evidence that she was distracted, not looking where she was walking, or behaving unreasonably. LMC's own witness admitted that upon reviewing the video, he did not observe any action on her part that contributed to her fall. Therefore, this court holds that there was no contributory negligence on her part.

INJURIES AND DAMAGES

Because the Court has concluded that LMC is liable for the injuries and damages Mrs. Connell sustained when she fell in its parking garage, it is necessary to determine the amount of

Mrs. Connell's damages. "Actual damages are awarded to a litigant in compensation for his actual loss or injury." *Austin v. Specialty Transp. Servs., Inc.*, 358 S.C. 298, 594 S.E.2d 867, 874 (Ct. App. 2004). Such damages "include compensation for all injuries which are naturally the proximate result of the alleged wrongful conduct of the defendant." *Id*. The elements that are properly considered in determining the amount of actual damages for personal injury include medical expenses, pain and suffering, loss of income and earning power, and loss of enjoyment of life. *See Schumacher v. Cooper*, 850 F. Supp. 438, 453 (D.S.C. 1994) (citing *Watson v. Wilkinson Trucking Co.*, 244 S.C. 217, 136 S.E.2d 286 (1964)).

"In a personal injury action, the plaintiff must recover for all injuries, past and prospective, which arose and will arise from the defendant's tortious activity." *Haltiwanger v. Barr*, 258 S.C. 27, 32, 186 S.E.2d 819, 821 (1972). "Thus, recovery must be had for future pain and suffering, and for the reasonable value of medical services and impaired earning capacity, to the extent that these injuries are reasonably certain to result in the future from the injury complained of." *Id*.; *see also Watson v. Wilkinson Trucking Co.*, 244 S.C. 217, 228, 136 S.E.2d 286, 291 (1964) (stating a plaintiff is "entitled to recover all damages proximately resulting from the negligent acts of the defendant," including "pain and suffering, and medical expenses, including any future damages resulting from permanent injuries"). "An award for pain and suffering compensates the injured person for the physical discomfort and the emotional response to the sensation of pain caused by the injury itself." *Boan v. Blackwell*, 343 S.C. 498, 501–02, 541 S.E.2d 242, 244 (2001). "Pain and suffering have no market price. They are not capable of being exactly and accurately determined, and there is no fixed rule or standard whereby damages for them can be measured." *Harper v. Bolton*, 239 S.C. 541, 548, 124 S.E.2d 54, 57 (1962). "Separate damages are given for mental anguish where the evidence shows, for example, that the injured person suffered shock, fright,

emotional upset, and/or humiliation as the result of the defendant's negligence." *Boan*, 343 S.C. at 501–02, 541 S.E.2d at 244. "[D]amages for 'loss of enjoyment of life' compensate for the limitations, resulting from the defendant's negligence, on the injured person's ability to participate in and derive pleasure from the normal activities of daily life, or for the individual's inability to pursue [her] talents, recreational interests, hobbies, or avocations." *Boan*, 343 S.C. at 502, 541 S.E.2d at 244. A plaintiff may also recover damages for permanent physical scarring. *Howle v. PYA/Monarch, Inc.*, 288 S.C. 586, 601, 344 S.E.2d 157, 165 (Ct. App. 1986). The monetary value to assign a plaintiff's damages is "a matter resting within the sound judgment of the" fact-finder. *Id*.

Mrs. Connell suffered significant injuries when she fell in the LMC garage. Her husband, Steven Connell, testified that as soon as she fell, she started screaming in agony. He was unable to get Mrs. Connell to her feet, but with the assistance of some passersby, they were able to get her to a seated position on the curb. She was taken immediately to the Emergency Room at LMC, where she was admitted and had surgery the next day. She testified that bending her knee at all caused her excruciating pain. Following surgery, which left a large scar on her knee, Mrs. Connell was discharged from the hospital but had very limited mobility. She was not able to shower for the first week she was home, and she required assistance to use a bedside commode. Mrs. Connell relied on her husband to prepare her meals, assist her with personal hygiene, and handle all household tasks such as grocery shopping, housework, and laundry, for weeks. Even after regaining some mobility, she has been very limited in her ability to squat or kneel, which has resulted in her being unable to return to gardening, which she loves. Mr. Connell still accompanies her to the grocery store so he can assist with reaching things on lower shelves because stooping causes her such pain. At the time of trial, Mrs. Connell had just recently undergone a hardware

removal surgery with Dr. James Loging, which she hoped would alleviate some of her pain. Still, Dr. Loging made it clear that Mrs. Connell would develop post-traumatic arthritis in her knee because of the way her injury healed, which will lead to more pain and, ultimately, a knee replacement surgery.

LMC did not present any expert testimony or other evidence to refute that Mrs. Connell's medical treatment was reasonable and necessary or to present alternative figures for the costs of her future treatment. LMC also does not dispute Dr. Loging's testimony that Mrs. Connell will require a third knee surgery in the future. LMC's only contest to any element of the damages Mrs. Connell presented was to challenge Ms. Moore's determination that Mrs. Connell would most likely have the recommended knee replacement surgery inpatient. LMC argues that she is not qualified to give this opinion because she does not have hospital admitting privileges. The Court disagrees. The Court found that Ms. Moore properly based her opinion on her clinical experience, training she has received regarding common practices, and research on this subject. As a Certified Nurse Life Care Planner, Ms. Moore has been trained on common practices amongst physicians in various treatment scenarios. As a Physician's Assistant practicing in the Emergency Room, Ms. Moore evaluates patient risks and makes recommendations regarding when patients should be admitted. Ms. Moore's testimony and the evidence before the court supports the fact that Mrs. Connell's knee replacement surgery would be in a hospital setting due to existing cardiovascular condition and the need for general anesthesia. It is not necessary that Ms. Moore be able to make the final determination on whether Mrs. Connell should be admitted to the hospital because future damages need not be proven to absolute certainty. *See Pearson v. Bridges,* 344 S.C. 366, 371, 544 S.E.2d 617, 619 (2001) (holding that plaintiffs must prove that their future damages are

"reasonably certain to occur"). The evidence Mrs. Connell presented is sufficient to show that a future inpatient surgery is reasonably certain to occur.

Mrs. Connell has proven by a preponderance of the evidence that she incurred causally-related health care expenses of $55,839.38 and that she will incur additional medical expenses of approximately $193,870.33,[5] all of which are reasonable and necessary as a direct and proximate result of injuries she suffered from the September 26, 2017 fall. In addition, Mrs. Connell has shown by a preponderance of the evidence that she has suffered significant pain, mental anguish, inability to care for herself, and loss of enjoyment of her life, and that she will suffer these damages into the future.

Mrs. Connell has proven by a preponderance of the evidence that her actual damages, to include past and future medical costs, past and future pain and suffering, mental anguish, anxiety, and loss of enjoyment of life, together exceed $300,000.00. However, because LMC is a political subdivision of the State of South Carolina, the South Carolina Tort Claims Act limits the award in this case to no more than $300,000.00. *See* S.C. Code § 15-78-120. Therefore, the award shall be $300,000.00.

[5] This figure is an average of the present value costs of pain management and the knee replacement surgery in the three scenarios Dr. Alford presented. The cost of the hardware removal surgery is included in the past medical expenses.

CONCLUSION

Based on the foregoing, the Court hereby awards Mrs. Connell $300,000 in actual damages and enters judgment against Defendant Lexington County Health Services District, Inc. d/b/a Lexington Medical Center for same.

IT IS SO ORDERED

_____

Walton J. McLeod
Circuit Court Judge, SC Court of Common Pleas

Lexington, South Carolina

_____, 2020

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	OF THE ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON	)	
	)	
Diane Connell,	)	Civil Action No. 2018-CP-32-1750
Plaintiff,	)	
vs.	)	
	)	
Lexington County Health Services District, Inc., d/b/a/ Lexington Medical Center,	)	**ORDER GRANTING DEFENDANT'S MOTION TO LIMIT TESTIMONY OF EXPERT WITNESS**
	)	
Defendant.	)	
	)	

This matter came before this Court for a bench trial on March 2, 2020. During the presentation of her case, Plaintiff called Lindsay Moore to testify as an expert witness in the field of life care planning. Defendant moved to limit Ms. Moore's testimony. Having taken the matter under consideration the Court makes the following determination.

Ms. Moore testified as to the likely costs of several anticipated future medical procedures that Plaintiff may require. Ms. Moore had generated two reports, a June 20, 2019 report, and a December 6, 2019 report. Ms. Moore explained that she generated the second report to better reflect the future medical needs as outlined by Dr. Loging in his deposition. Defendant took issue with one aspect of Ms. Moore's second report, which changed an outpatient facility fee of $7,338.00 to $13,352.00 in her first report to a $124,373.00 inpatient hospital fee in her second report. Defendant argued that there was insufficient evidence in the record to show that Plaintiff would need to have surgery in the inpatient setting and that Ms. Moore was not qualified to testify that Plaintiff would require inpatient surgery.

There is no South Carolina case law that specifically addresses the scope of admissible testimony of a life care planner. However, a survey of other jurisdictions reveals that generally, to be admitted as an expert to present a life care plan, one must be generally qualified in the area

of life care planning, and must also be qualified to substantiate the need for each element of care included in the plan to the degree required by the jurisdiction. *See Oram v. deCholnoky*, No. X05CV0540055135, 2008 WL 4984752 (Conn. Super. Nov. 3, 2008) (Connecticut court finding that testimony of a certified life care planner was admissible even though he was not a medical doctor because he reviewed his report with medical doctors and sought the approval of patient's health care providers); *Dan Cristiani Excavating Co., Inc. v. Money*, 941 N.E.2d 1072 (Ind. Ct. App. 2011) (Indiana court allowed a certified nurse to testify to what rehabilitation expert told her when she prepared the life care plan in question because as a life care planner, it is expected to rely on experts in preparing their plans); *Donaldson v. Ryder Truck Rental & Leasing*, 737 N.Y.S.2d 783 (Sup. Ct. N.Y. 2001) (New York court found a vocational rehabilitation specialist retained to prepare life care plan for claimant was not qualified to make an information assessment for cost of future medical procedures when treating physician testified only as to existing medical expenses and not future medical needs); *Mitchem v. Gabbert*, 31 S.W.3d 538 (Mo. App. 2000) (In Missouri, an expert witness who was a doctor, board certified in physical medicine and rehabilitation, sub-board certified in spinal cord injury medicine, was a wound care specialist, and certified by disability evaluation commission as a life care planner was qualified to testify that the life care plan in question was based upon a reasonable degree of medical certainty). In other words, a life care planner can testify as to the projected costs of future medical care when properly qualified experts opine that such services are necessary. When the life care planner lacks the qualifications to testify whether a particular service is necessary, he or she must rely on the testimony of other properly qualified experts. This is in line with the plain meaning of our Rule 702, SCRE, which states that an expert witness can testify if "qualified as an expert by knowledge, skill, experience, training, or education".

Applying that standard to this case, Plaintiff moved to qualify Ms. Moore, a certified life care planner, as an expert witness. Defendant did not object to the qualification of Ms. Moore in totality, but instead sought to limit Ms. Moore's testimony. Counsel for Defendant admitted that Ms. Moore was qualified to testify as to the projected costs for Plaintiff's anticipated future medical needs, but argued that Ms. Moore could not make any diagnosis or testify that any specific service would be necessary if such a determination would be outside the scope of her underlying profession. Counsel pointed out that Ms. Moore, as a Physician's Assistant, cannot admit patients to any hospital, and that function is restricted to physicians. Ms. Moore attempted to evade Defense Counsel's questioning regarding her ability to admit patients by stating that she is a part of an admitting team. Ms. Moore did not testify that as a physician's assistant she is qualified to admit patients to a hospital. Ms. Moore did testify that a physician must decide whether to admit a patient.

The decision as to whether Plaintiff should be admitted as inpatient for an anticipated future surgery is outside the scope of Ms. Moore's profession. As a result, Ms. Moore cannot testify that Plaintiff would need to be admitted to a hospital for inpatient treatment without a qualified expert opining such would be necessary. Had Plaintiff's treating physician, Dr. Loging, testified that Plaintiff would require inpatient surgery for the knee replacement, Ms. Moore could then testify as to the projected cost of the inpatient surgery. However, Dr. Loging did not testify that Plaintiff would require inpatient surgery. Dr. Loging reviewed Ms. Moore's first report and reviewed the services listed therein. Dr. Loging approved of Ms. Moore's first report, testifying that the services listed by Ms. Moore were reasonable and are typically associated with the procedures he recommended. Dr. Loging even commented on the outpatient facility fee and did not state any objection to Plaintiff having a knee replacement done in the outpatient setting. It is

reasonable to expect that if Plaintiff would require an inpatient hospital stay for a knee replacement, her treating physician would so testify while he is discussing a line item in a report that indicates Plaintiff would have the surgery outpatient.

Ms. Moore also testified at trial that she reviewed data regarding the incidents of full knee replacement surgeries and further testified that the data revealed that more often than not, full knee replacements are conducted in the inpatient setting. However, on cross-exam, Ms. Moore admitted that she was uncertain as to the exact percentage between inpatient and outpatient and further admitted that she was not certain what the driving factors were behind the difference or whether Plaintiff would fit into one category or the other. Consequently, Ms. Moore's testimony regarding Plaintiff requiring inpatient admission for a full knee replacement is speculative and exceeded the scope of her knowledge, skill, experience, training, and education and, as a result, is inadmissible pursuant to Rule 702, SCRE, and must be excluded.

Plaintiff's expert in economics, Charles L. Alford, Ph.D, testified as to the present value of Plaintiff's projected future medical needs. Dr. Alford testified that his calculations included Ms. Moore's estimation of an inpatient hospital stay, and that to adjust his present values to remove the cost of an inpatient hospital stay and replace with the estimated cost of an outpatient facility fee, simply discount his figures by the same percentage in reduction between the inpatient and outpatient facility fees.[1] Dr. Alford's present value of Plaintiff's anticipated full knee replacement would then equate to $28,099.80 if done in 2023 and $34,283.45 if done in 2030.

[1] ***I recall Dr. Alford testifying about a percentage reduction and he then did a few calculations on the fly which resulted in numbers that are obviously incorrect. By my math, replacing the inpatient fee with the midpoint between the estimated outpatient fee ($10,345) results in a reduction of 84.14%. In the interest of fundamental fairness, I recalculated Dr. Alford's figures with the 84.14% reduction. - EMG

Defendant's Motion to Limit the testimony of Lindsay Moore is **GRANTED**. Any testimony by Ms. Moore that Plaintiff will require surgery for a full knee replacement in the inpatient setting, and the increased cost associated with an inpatient hospital stay, is excluded.

AND IT IS SO ORDERED.

_____
The Honorable Walton J. McLeod

Dated: April ____, 2020

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STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	OF THE ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON)	
)	
Diane Connell,)	Civil Action No. 2018-CP-32-1750
Plaintiff,)	
vs.)	
)	
Lexington County Health Services)	**MEMORANDUM OF LAW IN SUPPORT**
District, Inc., d/b/a/ Lexington Medical)	**OF DEFENDANT'S MOTION**
Center,)	**FOR DIRECTED VERDICT**
)	
Defendant.)	
)	

The Defendant, Lexington County Health Services District, by and through its undersigned attorneys of record, respectfully submits this Memorandum of Law in support of its Motion for Directed Verdict pursuant to Rule 50(a), SCRCP.

STANDARD OF REVIEW

A trial court, in deciding a motion for a directed verdict, must view the evidence in the light most favorable to the nonmoving party. *See Burnett v. Family Kingdom, Inc.*, 387 S.C. 183, 188, 691 S.E.2d 170, 173 (Ct. App. 2010). When considering a directed verdict motion, the trial court may not decide credibility issues or resolve conflicts in the testimony or the evidence. *See id.* at 188-89; 691 S.E.2d at 173. "When the evidence yields only one inference, a directed verdict in favor of the moving party is proper." *Wright v. Craft*, 372 S.C. 1, 22, 640 S.E.2d 486, 498 (Ct. App. 2006).

LAW/ARGUMENT

Plaintiff's sole cause of action for negligence sounds in premises liability. To prove her cause of action, Plaintiff must show (1) a duty of care owed by Defendant to Plaintiff; (2) a breach of that duty by a negligent act or omission; and (3) damages proximately resulting from that breach. *Crolley v. Hutchins*, 300 S.C. 355, 387 S.E.2d 716 (Ct. App. 1989). It is not

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contested that at the time of the incident, Plaintiff was an invitee on Defendant's premises and Defendant owed Plaintiff a duty of care to warn of unsafe conditions of which Defendant knew or should have known and of which Plaintiff was reasonably unaware. *See Wilson v. Duke Power Co.*, 273 S.C. 610, 258 S.E.2d 101 (1979).

However, Plaintiff has failed to show that Defendant breached a standard of care; that there was a dangerous or defective condition on the premises; that Defendant was on notice of any defect or dangerous condition; and that Defendant was comparatively more negligent than Plaintiff herself. For these reasons, Defendant respectfully moves this Court to grant Defendant's Motion for Directed Verdict and dismiss Plaintiff's Complaint, with prejudice, as a matter of law.

I. PLAINTIFF HAS FAILED TO SHOW THAT DEFENDANT BREACHED A STANDARD OF CARE

In any negligence action, the plaintiff must show that the defendant did not use the amount of care one ordinarily would have under the circumstances. Negligence cannot be presumed from injury because South Carolina does not recognize the doctrine of *res ipsa loquitur*. *See Fletcher v. Med. Univ.*, 390 S.C. 458, 702 S.E.2d 372 (Ct. App. 2010).

While it is uncontested that Defendant owed Plaintiff a duty to exercise ordinary care to keep its premises in a reasonably safe condition, Plaintiff has failed to show that Defendant violated any standard of care. Plaintiff's Complaint is centered on the idea that Defendant should have painted the top of the curb where Plaintiff fell. Plaintiff assumes that the change in elevation would have been more readily visible if the top of the curb was painted yellow. However, Plaintiff is confusing the issues. Defendant is not the insurer of Plaintiff's safety and "had no duty to make the parking lot accident proof". *See Wimberly v. Winn Dixie Greenville, Inc.*, 252 S.C. 117, 120, 165 S.E.2d 627, 628 (1969); *Nelson v. Piggly Wiggly Central, Inc.*, 390 S.C. 382, 391, 701 S.E.2d 776, 781 (Ct. App. 2010). As a result, whether Defendant could have

made the premises "more safe" is irrelevant. Plaintiff has failed to provide any evidence of any standard establishing the painting of the top of a curb as a standard of care. Plaintiff has not presented any statute, regulation, county ordinance, or building code addressing this issue. *See Elledge v. Richland/Lexington Sch. Dist. Five*, 352 S.C. 179, 186, 573 S.E.2d 789, 793 (2002) (stating the general rule that evidence of industry standards is relevant to establishing the standard of care in a negligence action).

In *Nelson v. Piggly Wiggly Central, Inc.*, the plaintiff sustained injuries in a grocery store parking lot when a vehicle pinned the plaintiff between one of the store walls and the vehicle. 390 S.C. at 386, 701 S.E.2d at 778. The plaintiff in *Nelson* argued that the defendant should have installed curbing in the parking lot instead of wheel stops, but plaintiff's engineering expert "could not point to any recognized safety standard or building code that required [defendant] to modify the parking lot [when it was constructed] or subsequently." *Id.* at 393, 701 S.E.2d at 782. Instead, plaintiff's expert testified "only to his own preferences rather than requirements of any law, ordinance, or recognized industry standard." *Id.* The question in *Nelson* was "not whether [the defendant] owed [plaintiff] a duty of care, but whether the scope of the acknowledged duty of reasonable care extends to the particular risk that led to her injury." *Id.* at 392, 701 S.E.2d at 781. The Court of Appeals emphasized the plaintiff's obligation to "identify a duty that the defendant has to protect her from a particular harm to merit consideration of her claim by a jury." *Id.* Absent some evidence that the defendant owed a specific, articulable standard of care, plaintiff's injury fell "beyond the realm of any duty [defendant] owed to [plaintiff]." *Id.* at 394, 701 S.E.2d at 782.

Here, Plaintiff has, without pointing to any building code or industry standard, alleged that Defendant should have painted the top of the curb yellow to alert individuals as to the

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presence of a change in elevation. This is very similar to the *Nelson* case where the plaintiff alleged that a curb would have prevented the injury without any indication of any industry standard to place a curb in that location as opposed to a wheel stop. Consequently, this Court is bound by the Court of Appeals holding in *Nelson*, that summary judgment is proper where fails to support an alleged standard of care with building codes or industry standards and this Court must grant Defendant's Motion for Directed Verdict and dismiss Plaintiff's Complaint, with prejudice, as a matter of law.

II. PLAINTIFF HAS FAILED TO SHOW EVIDENCE SUFFICIENT TO PROVE THE EXISTANCE OF A DEFECTIVE OR DANGEROUS CONDITION ON DEFENDANT'S PREMISES

In a premises liability case, the burden is on the plaintiff to show that the defendant, or its agents, knew or should have known of a hazardous condition. *See id.* at 122. Here, Plaintiff has offered no evidence indicating that curb was defective or hazardous.

The South Carolina Supreme Court has held that the owner of a parking lot that was in a state of disrepair knew or should have known that a dangerous condition existed on the premises. *See Hancock v. Mid-South Mgmt. Co.*, 381 S.C. 326, 331, 673 S.E.2d 801, 803 (2009). Here, there is no evidence that the parking garage was in a state of disrepair. Plaintiff relies solely on the fact that there was a change in elevation not marked with yellow paint to establish negligence. However,

> [g]enerally, it is not negligence to maintain under appropriate circumstances, different levels in approaches to places of business. The mere fact that there is a difference between the levels in the different parts of the premises does not, in and of itself, indicate negligence unless, owing to the character, location and surrounding condition of the change of level, a reasonably careful person would not be likely to expect or see it . . . So, a step-down or step-up upon premises does not, in and of itself, constitute negligence.

Bruno v. Pendleton Realty Co., 240 S.C. 46, 51, 124 S.E.2d 580, 582 (1962)(internal citations

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omitted). Similar to our case here, *Bruno* involved a change in elevation between a concrete sidewalk and a concrete walkway of the same color; however, unlike our case, the property owner in *Bruno* had allowed grass to grow in a crack between the sidewalk and the walkway, to the extent that the grass concealed the change in elevation. *Id.* at 49, 124 S.E.2d at 581. In upholding the jury verdict, the Court in *Bruno* pointed to testimony showing that the property owner was aware that the grass had grown to the extent it concealed the change in elevation and had failed to remove or even trim the grass. *Id.* at 52, 124 S.E.2d 583.

Here, there is no evidence that the curb in question was in a state of disrepair, that the parking garage itself was in a state of disrepair, or that there was any foreign substance concealing the change in elevation. Consequently there is no evidence indicating the presence of a dangerous condition on the premises and, as a result, this Court must grant Defendant's Motion for Directed Verdict and dismiss Plaintiff's Complaint, with prejudice, as a matter of law.

III. PLAINTIFF HAS FAILED TO PRESENT EVIDENCE THAT DEFENDANT WAS ON NOTICE OF A DEFECT OR DANGEROUS CONDITION ON ITS PREMISES

Ultimately, the burden is on Plaintiff to show that Defendant, or its agents, knew or should have known of the hazardous condition. *Wimberly v. Winn-Dixie Greenville, Inc.*, 252 S.C. 117, 122 (1969). Plaintiff must therefore show that the Defendant had notice of the hazardous condition. *Id.* at 121. "This notice may be actual or constructive." *Id.*

> Constructive notice is a legal inference which substitutes for actual notice. It is notice imputed to a person whose knowledge of facts is sufficient to put him on inquiry; if these facts were pursued with due diligence, they would lead to other undisclosed facts. Therefore this person is presumed to have actual knowledge of the disclosed facts.

Strother v. Lexington County Recreation Comm'n, 332 S.C. 54, 63 n. 6 (1998).

The issue in *Wimberly* was whether the plaintiff had submitted evidence that the

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defendant was on constructive notice that a foreign substance, rice, was on the floor of its grocery store causing a hazardous condition. The Court held that plaintiff could show constructive notice by submitting evidence that the rice had been there "sufficiently long that the defendant should have discovered it." *Id.* *Wimberly* is not applicable here because this case does not involve a foreign substance. Rice should not be on a grocery store floor and it is reasonable to expect that an entity operating a grocery store clean up spilled rice. It is also reasonable to expect that an entity operating a grocery store be mindful to keep a lookout for foreign substances and to clean them up when discovered. *Wimberly* does not support Plaintiff's argument that because the curb existed in much the same condition for approximately nine years that Defendant is on constructive notice.

To the extent that Plaintiff argues constructive notice can be inferred, she is mistaken. An "inferential leap does not create a genuine issue of material fact." *Nelson*, 390 S.C. at 390, 701 S.E.2d at 780 (*citing McKnight v. S.C. Dep't of Corr.*, 358 S.C. 380, 389-90, 684 S.E.2d 566, 570-71 (Ct. App. 2009)). To show constructive notice, Plaintiff must present actual evidence indicating that Defendant was on "inquiry", meaning that Plaintiff must show evidence that something alerted or should have alerted Defendant that there might be an issue with that particular area, requiring further investigation. Plaintiff has failed to provide any evidence that Defendant had any notice or was on "inquiry".

Consequently, Plaintiff has failed to provide evidence sufficient to show that Defendant was on actual or constructive notice that the unpainted curb was a hazardous condition and, as a result, this Court must grant Defendant's Motion for Directed Verdict and dismiss Plaintiff's Complaint, with prejudice, as a matter of law.

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IV. PLAINTIFF WAS HERSELF NEGLIGENT TO A DEGREE SUFFICIENT FOR THIS COURT TO DIRECT A VERDICT UNDER THE DOCTRINE OF COMPARATIVE NEGLIGENCE

Under the doctrine of Comparative Negligence, Plaintiff may only recover damages if her own negligence is not greater than that of Defendant. *Nelson v. Concrete Supply Co.*, 303 S.C. 243, 399 S.E.2d 783 (1991). Ordinarily, the comparison of the plaintiff's negligence with that of the defendant is a question of fact; however, if the sole reasonable inference which may be drawn from the evidence is that the plaintiff's negligence exceeded fifty percent, no jury issue is created and a directed verdict is properly granted. *See Bloom v. Ravoria*, 339 S.C. 417, 422, 529 S.E.2d 710, 713 (2000).

In *Denton v. Winn-Dixie Greenville*, the court held that "speed bumps, curbing, or concrete dividers . . . all of which are commonly found in or along public streets and places to park . . . are common structures that a person taking reasonable care for his own safety would likely expect and see while on the premises." 312 S.C. 119, 121, 439 S.E.2d 292, 294 (Ct. App. 1993).

It is therefore established that Plaintiff should have expected to encounter a curb and other similar features in Defendant's parking garage. Plaintiff's failure to see the curb, and resulting change in elevation, was comparatively negligent to a greater extent that any negligence of Defendant, which is expressly denied and presented here solely for the purpose of this argument. Plaintiff has alleged that Defendant was negligent in failing to paint the top of a curb yellow to increase visibility. However, the evidence in the record reflects that Defendant was not aware of any building code requiring the top of the curbs to be painted. The evidence further reflects that Defendant conducted routine safety inspections and did not believe the curb in question was in a dangerous or defective condition. The evidence also shows that the parking

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garage stood in the same condition for roughly nine years with no prior reported falls in that location. In other words, there was no reason for Defendant to believe that the top of the curb should be painted yellow.

Consequently, to the extent this Court might find that Defendant's failure to paint the top of the curb yellow was in any way negligent, Plaintiff herself was negligent to a greater degree by failing to keep a proper lookout in a parking garage, where changes in elevation should be expected. As a result, this Court must direct a verdict in favor of Defendant and dismiss Plaintiff's Complaint with prejudice.

CONCLUSION

Consequently, and for the reasons stated herein and at the hearing on this Motion, Defendant respectfully requests this honorable Court to enter an order granting Defendant's Motion for a Directed Verdict and dismissing Plaintiff's Complaint, with prejudice, as a matter of law.

Respectfully submitted,

DAVIS | FRAWLEY, LLC

Patrick J. Frawley
Evan M. Gessner
140 East Main Street (29072)
PO Box 489, Lexington SC 29071-0489
(803) 359-2512; F: (803) 359-7478
pat@oldcourthouse.com
evan@oldcourthouse.com

ATTORNEYS FOR DEFENDANT
LEXINGTON COUNTY HEALTH
SERVICES DISTRICT

Lexington, South Carolina
March 2, 2020

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	ELEVENTH JUDICIAL CIRCUIT
Diane Connell,	)	CIVIL ACTION No.: 2018-CP-32-1750
	)	
Plaintiff,	)	
	)	
vs.	)	**PLAINTIFF'S TRIAL BRIEF**
	)	
Lexington County Health Services District, Inc. d/b/a Lexington Medical Center,	)	
	)	
Defendant.	)	

Plaintiff Diane Connell is seeking recovery for injuries and damages she sustained when she fell in the parking garage at Lexington Medical Center. She fell over a curb, and there was no yellow paint delineating the change in elevation for pedestrians in the garage. Lexington Medical Center admits that Mrs. Connell fell in a parking garage that it built and was responsible for inspecting and maintaining. LMC also admits that the unpainted curb was a trip hazard that had existed for more than ten years. Because Lexington Medical Center created a trip hazard, had knowledge of its existence, and failed to remedy or warn against it, Mrs. Connell is entitled to recover for her injuries resulting from the fall.

1. FACTS

On September 26, 2017, Plaintiff Diane Connell accompanied her husband to a doctor's appointment on the Lexington Medical Center campus. After the appointment, Mr. & Mrs. Connell followed the sidewalk into Parking Garage 3, where their vehicle was parked, and Mrs. Connell tripped on a curb.[1] There was no yellow paint on the top side of the curb where she fell. Mrs. Connell fell forward, striking her left knee and head on the concrete, and immediately had severe pain in her left knee. In the LMC Emergency Room, she was diagnosed with a right ankle sprain and displaced comminuted fracture of the left patella. She was required to spend two nights in the hospital and undergo an open reduction internal fixation surgery, where screws and metal wire were used to hold the pieces of her kneecap together. She followed up with Lexington Orthopedic and went through in-home rehabilitation, and is currently treating with Dr. James Loging. Dr. Loging performed a hardware removal surgery on February 11, 2020. Mrs. Connell incurred $48,280.38 in medical bills in 2017, and is continuing to incur medical bills in her treatment with Dr. Loging, who has testified that Mrs. Connell will need a knee replacement in addition to the hardware removal surgery.[2]

Mrs. Connell asserts that the curb where she fell was a hazard to pedestrians, and Lexington Medical Center breached its duty to remedy or warn of the hazard. The curb was painted on its

[1] The garage was known as Parking Garage 2 at the time of the fall but has since been renumbered.
[2] Mrs. Connell's medical bills total $48,893.38 through the end of 2019. Her bills from the hardware removal surgery and related appointments are not yet available.

face, so it could be seen by traffic or pedestrians exiting the garage, but it was not painted on top. Importantly, the remainder of the curbing throughout the parking garage is painted yellow on the top and the side. The top side painting was left off in the location where Mrs. Connell fell. There was no demarcation of the change in elevation that could be seen by a person walking in the direction Mrs. Connell was walking. Below are photos of the location of Mrs. Connell's fall, with and without yellow paint on the top of the curb.

Condition on Date of Fall – September 26, 2017

Visible if Curb Painted (Simulation/Computerized)

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Present Condition of Curbing

2. LAW ON PREMISES LIABILITY

Under South Carolina law, the standard of care applied in this type of action depends on whether the visitor (the injured party) is an invitee, licensee, trespasser, or child. *Sims v. Giles*, 343 S.C. 708, 716, 541 S.E.2d 857, 862 (Ct. App. 2001).

Diane Connell was an invitee. "[A] person is an invitee on the land of another if he enters by express or implied invitation, his entry is connected with the owner's business or with an activity the owner conducts or permits to be conducted on his land, and there is a mutuality of benefit or a benefit to the owner." *Sims v. Giles*, 343 S.C. 708, 716–17, 541 S.E.2d 857, 862 (Ct. App. 2001). "Invitees include . . . patients in a physician's office . . . ." *Id.*

Duty owed to invitees: "[T]he invitee is offered the utmost duty of care by the landowner." *Id.* at 715, 541 S.E.2d at 861. "[A]n invitee enters the premises with the implied assurance of preparation and reasonable care for his protection and safety while he is there." *Singleton v. Sherer*, 377 S.C. 185, 202, 659 S.E.2d 196, 205 (Ct. App. 2008). **"A landowner owes an invitee a duty of due care to discover risks and to warn of or eliminate foreseeable unreasonable risks."** *Landry v. Hilton Head Plantation Prop. Owners Ass'n, Inc.*, 317 S.C. 200, 203, 452 S.E.2d 619, 621 (Ct. App. 1994).

Proving breach: To prove that this duty was breached, a plaintiff must show either (1) the landowner **created the hazard** or dangerous condition that caused the plaintiff's injury **or** (2) the landowner had **actual or constructive knowledge** of the hazard or dangerous condition and failed

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to remedy it. *Garvin v. Bi-Lo, Inc.*, 343 S.C. 625, 628, 541 S.E.2d 831, 832 (2001) (emphasis added). Constructive notice may be proven by showing that the dangerous condition existed long enough that the defendant should have discovered it. *Wimberly v. Winn Dixie Greenville Inc.*, 252 S.C. 117, 121, 165 S.E.2d 627, 629 (1969).

3. Witnesses & Evidence

a) **Surveillance Video** shows that Mrs. Connell tripped on the Parking Garage 3 curb, was helped to a sitting position, and sat, supported, on the floor of the parking garage for about ten minutes. At that point, a golf cart arrived, and Mr. Connell, Mr. Brewer, and others helped Mrs. Connell onto the golf cart, which transported her to the Lexington Medical Center Emergency Room.

b) **Diane Connell** is the Plaintiff and will testify that she could not see the change in elevation in the parking garage because it was not marked. The painted curbs in the garage are much more visible. She will also testify that she has suffered significant pain and made many lifestyle changes because of this injury, and she is currently recovering from her hardware removal surgery, which was performed a few weeks ago. Further, she intends to have a knee replacement surgery in the future.

c) **Steve Connell** is Mrs. Connell's husband and will testify regarding her fall and the impact Mrs. Connell's injury had on her life.

d) **Chris Brewer** rendered aid to Mrs. Connell after her fall and will provide testimony regarding his observations of the scene and what happened immediately following Mrs. Connell's fall.

e) **Cory Andrews** testified on behalf of Lexington Medical Center that Lexington Medical Center is "responsible for the upkeep and maintenance of their facilities, such as parking garages." (p. 31, ll.12-15). He was asked if yellow paint on the top and the side of curbs was prevalent in the parking garage. He testified that it was. (p. 26, ll. 17-25):

Q Okay. And the condition that I'm showing you in this document, that has painting on the top and the side of the curb, is that prevalent throughout the parking garage?

MR. GESSNER: Objection. Please answer if you can.

THE WITNESS: I believe that it is. I have not parked over there in quite some time. So, I couldn't say with a hundred percent.

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He further testified that the purpose of painting curbs in parking garages is to make them visible and admitted that Diane Connell would not have been able to see any yellow paint on the curb where she fell from the direction she was walking (p. 29-30):

Q Okay. And from her vantage point, she's not able to see any yellow paint on the curb that she would eventually step on or step off of; correct?
MR. GESSNER: Object. Please answer if you can.
THE WITNESS: She would not see yellow paint on the curb that she was actually on.
BY MR. GOINGS:
Q That's correct.
A Yes, sir.
Q All right. Because only the front face of that curb is painted yellow; correct?
A Yes, sir.
Q The top of the curb, which would allow her to see that it would be a change in elevation, was not painted yellow; correct?
A That's correct.

BY MR. GOINGS:
Q Well, let me ask you this. Why are curbs painted at all in a parking garage?
MR. GESSNER: Object. Please answer if you can.
THE WITNESS: I would assume that they would have paint, such as this, to make it easier to see.
BY MR. GOINGS:
Q For -- to make the change in elevation visible to the human eye; correct?
A Yes, sir.
Q Okay. Because oftentimes, it can be hard to see changes of elevation without demarcations through pain or other type of signage; correct?
A Yes, sir.

f) **Dale Thompson** testified on behalf of Lexington Medical Center that the unpainted curb created a trip hazard and that painting the curb would improve safety in this location:

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Pages 26-27:

Q Would you agree with me that curbing can, in certain circumstances, cause a trip hazard?
A Yes.
Q Okay. Would you agree with me that when the curb is the same color concrete as the ground, which is

concrete, that it can have a camouflaging effect to a pedestrian?
A It does blend, yes, I could say.
Q Okay. And when it blends, it can be hard to see where the elevation change actually is located; correct?
A Correct. I agree.
Q And that could result in a trip hazard; correct? Correct?
A Correct.

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Q Okay. And if this was -- if there was a yellow stripe through this photograph, one would be able to see it a lot better, wouldn't they?
A Yes, they would.
Q Okay. And you don't -- you're not contesting, are you, that it would be a -- from a safety standpoint, it would improve safety in this location to have a yellow stripe on the top of this change in elevation where visitors and patients walk?

MR. GESSNER: Object. Answer if you can.

THE WITNESS: Yeah, no, I'm not arguing that point. I think it would.

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BY MR. GOINGS:

Q You would agree with me that if this curbing was painted like all the curbing in this parking garage, that it would actually improve the safety of this area; correct?

MR. GESSNER: Objection. Please answer if you can.

THE WITNESS: I do believe that.

g) Dr. Loging testified by video that Mrs. Connell's ongoing symptoms were directly related to her fall and that she would require additional treatment (p. 16):

A I think the symptoms were probably twofold. One would be irritation from the hardware. So I think that's one because it had been in there for a good while. So there would be some hardware irritation. But the other issue was the congruity of the joint itself so the patella where the fracture was -- the way that the bone healed -- the patella joint was fairly irregular and had some irregularity to the joint, so that's going to give her some of that grinding and mechanical symptoms that she's experiencing as well.

Q And do you have an opinion most probably to a reasonable degree of medical certainty whether those symptoms were related to the fall that she had back in September of 2017?

A Yes, they're directly related.

Q And based on those symptoms that she's having, do you think that hardware removal would be appropriate?

A Yes.

Dr. Loging also testified that Mrs. Connell would require a knee replacement surgery (p. 18):

But the backside of the patella is very irregular and there's a big step-off on the backside of the patella. So that joint isn't lined up anymore. And, because of that, while we can see the bone and the step off the stair, what we can't see is the articular cartilage that's been damaged and probably extremely irregular. And so, because of that, she will get post-traumatic arthritis which is some of the grinding that she's experiencing currently. So she will need a knee replacement or at least partial knee replacement as a result of that.

Q And is it your opinion that she will definitely need a knee replacement, or just possibly?

A I think definitely given that trauma that's there. I mean, that's going to progressively get worse to the point where the pain would be intolerable. And, so, she will require a replacement at some point.

According to Dr. Loging, it is most probable to a reasonable degree of medical certainty that Mrs. Connell's knee will continue to get worse, and she will require a knee replacement surgery:

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A You know, if you look at her X-ray on her knee, she doesn't have a lot of arthritis currently, but she's going to get it as a result of this injury because of the incongruent joint surface.

Q Okay.

A So, you know, true X-ray forms of arthritis that you would normally see in, you know, degenerative arthritis in most people, she doesn't have that. But what I can tell you is that the irregularities and incongruity of her joint is going to lead to the post-traumatic

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arthritis there.
Q Okay. In your experience, can you attach a percentage to the chance that arthritis will develop like that?
A A hundred percent in that injury.

Page 32:

Q Okay. Of course, we've talked about your recommendations and all that based on a reasonable degree of medical certainty, but do you know whether or not Mrs. Connell's actually going to get any of these procedures?
A Well, I mean, it's up to her whether she's going to have the hardware removed. I mean, she does have an appointment to come back and discuss it, apparently, but, I mean, it's ultimately up to her and when she, you know, would need a replacement. I can only tell you off of standard, the care of patients that I've had with similar issues. I mean, like I said, a hundred percent of the time, I remove the hardware because of the high incidence of hardware irritation and problems from the hardware. And given the incongruity of her joint, her chance of developing post-traumatic arthritis is essentially a hundred percent guaranteed. And, so, I think she will need a replacement, either partial or full, at some point in the future.

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h) **Lindsay Moore** provided a **Future Medical Costs Analysis**, which shows that Mrs. Connell's likely future medical costs will total $151,209.90.[3]

i) **Dr. Charles Alford** provided a **Present Value Medical Costs Report**, which shows the present value of the future medical costs Mrs. Connell will most likely need, accounting for inflation, will range from $179,308 to $237,032,[4] depending on when she has the knee replacement surgery.

4. DAMAGES

In a personal injury case, a plaintiff may recover for all past, present and future aspects of the injury, which include physical pain and suffering endured, mental distress or anguish, expenses incurred for necessary medical treatment, and the loss of enjoyment of life suffered as a result of the injury. *Boan v. Blackwell*, 343 S.C. 498, 500, 541 S.E.2d 242, 243 (2001). A plaintiff may recover for such future damages as it is reasonably certain will of necessity result from the injury received, including future pain and suffering. *Id.* at 500, 541 S.E.2d 243-244.

Thus, Mrs. Connell's damages include the following:

Past Medical Expenses	$48,893.38
Future Medical Expenses	$179,308 to $237,032
Past Pain and Suffering	$ (amount to be determined by court)
Future Pain and Suffering	$ (amount to be determined by court)
Past Mental Distress	$ (amount to be determined by court)
Future Mental Distress	$ (amount to be determined by court)
Past Loss of Enjoyment of Life	$ (amount to be determined by court)
Future Loss of Enjoyment of Life	$ (amount to be determined by court)

5. CONCLUSION

Lexington Medical Center admits that a hazardous condition has existed in parking garage it built, manages, and maintains for more than ten years. The unrefuted evidence shows that Mrs. Connell will undergo at least two surgeries, rounds of injections and physical therapy, significant pain and suffering, and a loss of enjoyment of life as a result of falling on the unpainted curb in LMC's garage. Because LMC failed to remedy or warn of the hazard that existed on its property, Mrs. Connell is entitled to recover for the injures she sustained as a result of that hazard.

[3] This number does not account for inflation or discount future costs to present value. This number includes hardware removal, injections, and pain management, and a full knee replacement surgery. Ms. Moore's report also provides a scenario where Mrs. Connell receives a partial knee replacement surgery, as opposed to a full knee replacement.

[4] These numbers account for inflation and reduce future costs to present value. *Grimsley v. Atlantic Coast Line R. Co.*, 189 S.C. 251, 1 S.E.2d 157 (1939).

Respectfully submitted,

By: /s/ Robert F. Goings

Robert F. Goings, Esq. (S.C. Bar # 74855)
Jessica L. Gooding, Esq. (S.C. Bar # 101210)
Goings Law Firm, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
Email: rgoings@goingslawfirm.com
jgooding@goingslawfirm.com
Phone: (803) 350-9230
Fax: (877) 789-6340

March 2, 2020
Columbia, South Carolina

ELECTRONICALLY FILED - 2020 Mar 06 10:15 AM - LEXINGTON - COMMON PLEAS - CASE#2018CP3201750

ELECTRONICALLY FILED - 2020 Jul 16 2:46 PM - LEXINGTON - COMMON PLEAS - CASE#2018CP3201750

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	OF THE ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON	)	
	)	
Diane Connell,	)	Civil Action No. 2018-CP-32-1750
Plaintiff,	)	
vs.	)	
	)	
Lexington County Health Services District, Inc., d/b/a/ Lexington Medical Center,	)	**NOTICE OF MOTION AND MOTION FOR LEAVE TO DEPOSIT IN COURT**
	)	
Defendant.	)	
	)	

The Defendant, Lexington County Health Services District, Inc., by and through its undersigned attorney of record, hereby moves this Court, pursuant to Rule 67, SCRCP, for leave to deposit with the court an amount equal to the judgment entered against Defendant in this case. Defendant intends to appeal this Court's decision and respectfully requests direction as to the deposit of funds to remain on deposit with the Court until such time as this Court directs the clerk to disperse the deposited funds.

Respectfully requested,

DAVIS | FRAWLEY, LLC

s/ Evan M. Gessner

Evan M. Gessner, S.C. Bar #77704
140 East Main Street (29072)
PO Box 489
Lexington SC 29071-0489
803-359-2512
evan@oldcourthouse.com

ATTORNEY FOR DEFENDANT

July 16,2020
Lexington, South Carolina

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	ELEVENTH JUDICIAL CIRCUIT
Diane Connell,	)	CIVIL ACTION No.: 2018-CP-32-1750
	)	
Plaintiffs,	)	
	)	
vs.	)	**PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANT'S MOTION FOR LEAVE TO DEPOSIT IN COURT**
	)	
Lexington County Health Services District, Inc. d/b/a Lexington Medical Center,	)	
	)	
Defendant.	)	

COMES NOW, Plaintiff Diane Connell (hereinafter "Mrs. Connell"), by and through her undersigned attorneys, opposing Defendant Lexington County Health Services District, Inc. d/b/a Lexington Medical Center's (hereinafter, "Lexington Medical") Motion for Leave to Deposit the judgment awarded in Mrs. Connell's favor against Lexington Medical into the Court. For the reasons stated herein, the Court should deny Lexington Medical's motion.

The court should not grant the Defendant's request to deposit the judgment funds into the court. This motion is **discretionary** and can be denied at the discretion of the court. South Carolina Civil Procedure Rule 67 allows a party to deposit the amount of a judgment only "with leave of the court." *Id.* "The granting of leave to deposit money with the court pursuant to Rule 67, SCRCP is a matter within the discretion of the trial court and will not be overturned absent an abuse of that discretion." *S.C. Dep't of Transp. v. First Carolina Corp. of S.C.*, 369 S.C. 150, 153, 631 S.E.2d 533, 535 (2006). The court is not required to grant such a motion. *See Brown v. Buttz*, 15 S.C. 488, 492 (1881) (holding that a statute permitting a party to take a certain action with leave of the court does not require a court to grant such a request); *Hentges v. Hentges*, No. 2011-UP-513, 2011 WL 11735805, at *2 (S.C. Ct. App. Nov. 28, 2011) (affirming a court's refusal to allow funds awarded to be deposited into the court because there was no "question of entitlement to the

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funds" under the applicable order(s)). Rather, the Court is permitted to consider all the facts and circumstances of the case before it and determine what is most fair and just under those circumstances. *See Griffin v. Owens*, 171 S.C. 276, 172 S.E. 221, 222 (1934). The Court's discretion will not be interfered with absent the complaining party proving that the judge's decision "was so opposed to a sound discretion as to amount to a deprivation of [its] legal rights." *Wade v. S. Ry. Co*., 186 S.C. 265, 195 S.E. 560, 560–61 (1938).

In this case, the Court has awarded Mrs. Connell Two Hundred Twenty-Five Thousand and 0/100 Dollars ($225,000.00) to compensate her for the injuries she sustained and the pain she suffered when she fell due to Lexington Medical's negligence on September 26, 2017. A sum of that size would draw interest if invested in the market or deposited in some investment tool. This truth is recognized by the South Carolina Legislature's decision to grant parties such as Mrs. Connell post-judgment interest on verdicts awarded "at the rate of eight and three-fourths percent per annum." S.C. Code Ann. § 34-31-20. Now, after Mrs. Connell has waited nearly four years for just compensation, Lexington Medical seeks to deny her the benefit of investing the sum properly awarded to her in this action while it embarks on a likely years-long appeal process.

Lexington Medical is not guaranteed a legal right to deposit these funds into the Court and avoid the interest obligation associated with an appeal, and therefore, it is within the sound discretion of this Court to deny Lexington Medical's motion. Further, permitting this Defendant, with the benefit of an insurance company, to save rightfully accruing interest at Mrs. Connell's expense would cut against all notions of fairness and justice. Mrs. Connell should receive the benefit of interest accruing while Lexington Medical pursues an appeal, and it would be patently unfair to allow an appeal to proceed for several years and for her to be penalized by not receiving any monetary compensation or the benefit of interest during this period of time. For these reasons,

Mrs. Connell respectfully requests that this Court deny Lexington Medical's motion to deposit funds with the Court.

Respectfully submitted,

By: /s/ Robert F. Goings
Robert F. Goings, Esq. (S.C. Bar # 74855)
Jessica L. Gooding, Esq. (S.C. Bar # 101210)
Goings Law Firm, LLC
1510 Calhoun Street
Post Office Box 436 (29202)
Columbia, South Carolina 29201
Email: rgoings@goingslawfirm.com
jgooding@goingslawfirm.com
Phone: (803) 350-9230
Fax: (877) 789-6340

July 20, 2020

Columbia, South Carolina

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ELECTRONICALLY FILED - 2020 Jul 27 1:05 PM - LEXINGTON - COMMON PLEAS - CASE#2018CP3201750

STATE OF SOUTH CAROLINA COUNTY OF LEXINGTON Diane Connell, Plaintiff, vs. Lexington County Health Services District, Inc., d/b/a/ Lexington Medical Center, Defendant.	IN THE COURT OF COMMON PLEAS OF THE ELEVENTH JUDICIAL CIRCUIT Civil Action No. 2018-CP-32-1750 **DEFENDANT'S REPLY TO PLAITNIFF'S RESPONSEIN OPPOSITION TO DEFENDANT'S MOTION TO DEPOSIT IN COURT**

The Defendant, Lexington County Health Services District, by and through its undersigned counsel, submits the following Reply to Plaintiff's Response in Opposition to Defendant's Motion to Deposit in Court. In her Response, Plaintiff correctly states that Defendant's motion is discretionary and would not be disturbed on appeal absent an abuse of discretion. However, Plaintiff has failed to articulate a compelling reason why this Court should deny Defendant's motion.

Rule 67, SCRCP, requires only two things: (1) notice to all parties and (2) leave of court. Motions for Leave to Deposit are routinely granted. *See, e.g., Small v. Pioneer Mach., Inc.*, 330 S.C. 62, 64, 496 S.E.2d 884 (Ct. App. 1998) (when the moving party complied with the terms of Rule 67, it would be an abuse of discretion to refuse to allow the funds to be deposited). The sole case Plaintiff cites stating that a deposit into the court should not be allowed, *Hentges v. Hentges*, No. 2011-UP-513, 2011 WL 11735805 (Ct. App. Nov. 28, 2011), is an unpublished case with no precedential value and Plaintiff cannot cite to that case here. *See* Rule 268(d)(2), SCACR. Nevertheless, even if the *Hentges* case did hold precedential value, it would not support Plaintiff's position. The Court of Appeals held that deposit into the court was not proper when there was no question of entitlement to the funds. *See Hentges*, 2011 WL 11735805 at *5.

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The Court of Appeals then cited Rule 67, SCRCP, at stated that Rule "allow[s] a judgment debtor to avoid further accrual of post judgment interest pending the resolution of an appeal from the judgment". *Id.* Because Defendant will be filing an appeal of this Court's Order and Entry of Judgment in this case, there is a question as to whether Plaintiff is entitled to the funds. As a result, based on the authorities cited in the *Hentges* opinion, deposit with the Court is proper.

The rationale behind the awarding of post judgment interest is to disincentivize defendants from drawing out proceedings to benefit from interest earned on funds while an appeal is pending. By depositing the judgment amount with the Court, Defendant will not get the benefit of collecting interest on the judgment amount during the pendency of the anticipated appeal. While there does not appear to be any precedent in this jurisdiction that specifically addresses this issue, Federal Courts, applying a nearly identical Federal Rule, deny additional interest to a prevailing party when the funds were deposited with the court because the non-prevailing party did not receive any interest or other benefit. *See, e.g., Reliable Marine Boiler Repair, Inc. v. Mastan Co.*, 325 F. Supp. 58 (S.D.N.Y. 1971).

The only reason to deny Defendant's Motion would be to subject Defendant to an award of post judgment interest at the statutorily mandated interest rate[1], which may exceed the interest Defendant is actually able to earn on the judgment amount during the pendency of an appeal. While Rule 67, SCRCP, does not specify that the funds are to be deposited in an interest bearing account, there are references in the applicable case law indicating that this practice is common. *See, e.g., Duval b. Heritage Life Ins. Co.*, 339 S.C. 616, 618-19, 529 S.E.2d 566, 568 (Ct. App. 2000) (funds deposited into an interest bearing Merrill Lynch account). To the extent that the

[1] Plaintiff's reference to eight and three-fourths percent interest is incorrect. Plaintiff quotes section 34-31-20(A), which applies to prejudgment interest and is inapplicable to Defendant. *See Lee v. Thermal Eng'g Corp.*, 352 S.C.81, 87-88; 572 S.E.2d 298, 301-02 (Ct. App. 2002); S.C. Code Ann. § 15-78-120(b). Code section 34-31-20(B) applies to post judgment interest. *See Hunting v. Elders*, 359 S.C. 217, 229, 597 S.E.2d 803, 809 (Ct. App. 2004).

judgment amount would collect interest while on deposit with the Court, the undersigned is under the impression that said interest may be awarded to whichever party ultimately prevails on appeal. For that reason alone, Plaintiff's arguments in opposition to Defendant Motion to Deposit are without merit.

Defendant would further point out that Plaintiff's mention of possible insurance coverage and intimation that Defendant should be denied the ability to deposit funds as a result violates Rule 411, SCRE, and is entirely irrelevant.

Consequently, and for the reasons stated herein, Defendant respectfully requests this Court grant its Motion to Deposit in Court.

Respectfully submitted,

DAVIS | FRAWLEY, LLC

s/ Evan M. Gessner

Evan M. Gessner, S.C. Bar No. 77704
140 East Main Street (29072)
PO Box 489, Lexington SC 29071-0489
(803) 359-2512; Fax: (803) 359-7478
pat@oldcourthouse.com
evan@oldcourthouse.com

ATTORNEYS FOR LEXINGTON COUNTY HEALTH SERVICES DISTRICT, INC. D/B/A LEXINGTON MEDICAL CENTER

Lexington, South Carolina
July 27, 2020

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM LEXINGTON COUNTY
Court of Common Pleas
Walton J. McLeod, IV, Circuit Court Judge

Case No. 2018-CP-32-01750

RECEIVED
Aug 10 2020
SC Court of Appeals

Diane Connell.....Respondent,

v.

Lexington County Health
Services District, Inc., d/b/a
Lexington Medical Center .....Appellant.

NOTICE OF APPEAL

Appellant Lexington County Health Services District, Inc., appeals from the Order and Entry of Judgment of the Honorable Walton J. McLeod, IV finding in favor of Respondent and awarding her damages on July 10, 2020; and from an Order denying leave to deposit entered on July 31, 2020.

Respectfully submitted,

s/ Evan M. Gessner
Patrick J. Frawley
Evan M. Gessner
DAVIS FRAWLEY, LLC
140 East Main Street (29072)
PO Box 489
Lexington, SC 29071
(803) 359-2512
evan@oldcourthouse.com

Attorneys for Lexington County Health Services District, Inc.

Other attorneys of record:

Robert Goings
Jessica Gooding
GOINGS LAW FIRM
1510 Calhoun Street
Columbia, SC 29201
(803) 350-9230
rgoings@goingslawfirm.com
jgooding@goingslawfirm.com

Attorneys for the Respondent Diane Connell

August 10, 2020
Lexington, South Carolina

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM LEXINGTON COUNTY
Court of Common Pleas

Walton J. McLeod, IV, Circuit Court Judge

Case No. 2018-CP-32-01750

RECEIVED
Aug 10 2020
SC Court of Appeals

Diane Connell,

Respondent,

v.

Lexington County Health Services District, Inc., d/b/a Lexington Medical Center,

Appellant.

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on Diane Connell by depositing a copy of it in the United States Mail, postage prepaid, on August 10, 2020, addressed to her attorney of record, Robert Goings, Post Office Box 436, Columbia, South Carolina 29202.

August 10, 2020

s/ Evan M. Gessner
Evan M. Gessner
Davis Frawley Law Firm
140 East Main Street (29072)
PO Box 489
Lexington, SC 29071
803-359-2512
evan@oldcourthouse.com

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM LEXINGTON COUNTY
Court of Common Pleas
Walton J. McLeod, IV, Circuit Court Judge

Case No. 2018-CP-32-01750

Diane Connell.....Respondent,

v.

Lexington County Health Services District, Inc., d/b/a Lexington Medical Center .....Appellant.

RECEIVED
Aug 18 2020
SC Court of Appeals

AMENDED NOTICE OF APPEAL

Appellant Lexington County Health Services District, Inc., appeals from the Order and Entry of Judgment of the Honorable Walton J. McLeod, IV finding in favor of Respondent and awarding her damages on July 10, 2020 and served on Appellant the same day. Appellant further appeals from an Order denying leave to deposit entered by Judge McLeod on July 31, 2020, and served on Appellant on the same day.

[SIGNATURE BLOCK APPEARS ON FOLLOWING PAGE]

Respectfully submitted,

s/ Evan M. Gessner
Patrick J. Frawley
Evan M. Gessner
DAVIS FRAWLEY, LLC
140 East Main Street (29072)
PO Box 489
Lexington, SC 29071
(803) 359-2512
evan@oldcourthouse.com

Attorneys for Lexington County Health Services District, Inc.

Other attorneys of record:

Robert Goings
Jessica Gooding
GOINGS LAW FIRM
1510 Calhoun Street
Columbia, SC 29201
(803) 350-9230
rgoings@goingslawfirm.com
jgooding@goingslawfirm.com

Attorneys for the Respondent Diane Connell

August 18, 2020
Lexington, South Carolina

THE STATE OF SOUTH CAROLINA
In the Court Appeals

APPEAL FROM LEXINGTON COUNTY
Court of Common Pleas
Walton J. McLeod, IV, Circuit Court Judge

Appellate Case No. 2020-001089

Diane Connell, ……..Respondent,

v.

Lexington County Health Services District, Inc.
d/b/a Lexington Medical Center, ……..……Appellant.

CERTIFICATE OF COUNSEL

I hereby certify that this Final Brief of Appellant complies with Rule 210 of the South Carolina Appellate Court Rules.

BY:*s/ Evan M. Gessner*____
Evan M. Gessner
140 East Main Street
Lexington, SC 29072
Ph: 803-359-2512
Fax: 803-359-7478
evan@oldcourthouse.com
ATTORNEY FOR Appellant, LEXINGTON COUNTY HEALTH SERVICES DISTRICT, INC D/B/A LEXINGTON MEDICAL CENTER

Lexington, SC
January 19, 2021