

Apr 30 2021

SC Court of Appeals

Hamilton v TRMC Tekayah Hamilton - Direct

5/7/18

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1 MR. TANNER: Nothing on recross, Your Honor.

2 THE COURT: Thank you, ma'am. You may step down.

3 Are you ready to call your next witness, Mr. Krell?

4 MR. KRELL: Tekayah Hamilton.

5 THE COURT: Ms. Hamilton. And Ms. Hamilton, she's
6 got a lot to pick up so don't hurry, okay?

7 MS. HAMILTON: Okay.

8 THE COURT: Okay.

9 MR. KRELL: Your Honor, may Ms. Stobbs be excused?

10 THE COURT: Any objection?

11 MR. TANNER: No objection, Your Honor.

12 THE COURT: Have you got everything, Ms. Stobbs?

13 THE WITNESS: Yes, I do. Thank you.

14 THE COURT: Thank you for coming. You are
15 excused.

16 THE WITNESS: Thank you.

17 THE COURT: Thank you.

18 All right. Ms. Hamilton, you remember you've got to
19 stop right there, put your left hand on the Bible.

20 THE WITNESS: (Complies)

21 THE COURT: Raise your right hand.

22 THE WITNESS: (Complies)

23 THE COURT: The clerk's going to swear you in.

24 THE WITNESS: Okay.

25 (WHEREUPON, Tekayah Hamilton was s

1 duly sworn)

2 THE COURT: All right. Ms. Hamilton, that was
3 very good. That was the right loudness and everything. So
4 you need to keep speaking like that, okay?

5 THE WITNESS: Yes, sir.

6 THE COURT: Okay. Thank you, ma'am.

7 TEKAYAH HAMILTON - DIRECT EXAMINATION

8 BY MR. KRELL:

9 Q Tekayah, where are you from?

10 A Santee.

11 Q And did you go to school in Santee?

12 A No, sir, I went to -- I graduated from Holly Hill-
13 Roberts in Holly Hill.

14 Q What year did you graduate?

15 A In 2003.

16 Q And do you currently work?

17 A Yes, sir, I do.

18 Q All right. And what do you do?

19 A I'm an assistant manager at the Family Dollar in Holly
20 Hill.

21 Q How long have you done that?

22 A I've been the assistant manager for a month, but I was
23 head cashier for five months.

24 Q All right. And do you have any children?

25 A Yes, sir.

1 Q And how many children do you have?

2 A I have six.

3 Q Okay. And you have a child named Robert?

4 A Yes, sir.

5 Q And what does he go by?

6 A R.J.

7 Q How old is R.J.?

8 A He's three.

9 Q And was R.J. in court earlier today?

10 A Yes, sir.

11 Q And did you have to take R.J. after about -- with him
12 being thirty days old at the time to the hospital here in
13 Orangeburg?

14 A Yes, sir, I did.

15 Q Tell us what happened?

16 A He was running a fever off and on that day. And I took
17 him to the Santee Health Clinic and they admitted -- they
18 admitted him into The Regional Medical Center. And upon
19 arriving they checked us in and everything, and then they
20 took us in the other room and put the IV in and brung back.

21 Q And that was on the 25th of October of 2014?

22 A Yes, sir.

23 Q And how did he do during his stay in the hospital?

24 A He was okay. He was off and on. The fever was still
25 running off and on and he was whining and crying.

1 Q Were you with him the whole time?

2 A Yes, sir. I was.

3 Q Any complications prior to October the 28th, 2014?

4 A No, sir.

5 Q On the afternoon of October the 27th, 2014 -- you've
6 heard Nurse Stobbs testify to Mr. Tanner's question, that
7 the nurse had checked his site and it look all right,
8 correct?

9 A Yes, sir.

10 Q That's his IV site? Where it has an infiltration
11 score, as you've heard of zero, correct?

12 A Yes, sir.

13 Q All right. And you heard the phlebitis score was zero,
14 correct?

15 A Yes, sir.

16 Q Now, bring us to and put us in the room, if you can, at
17 4:27 approximately on the 28th. Tell us what happened?

18 A Okay. He was laying in the bed and he was crying, like
19 really crying. I mean, it wasn't not like just crying. And
20 when the nurse finally came back -- the IV beeped and when
21 she did not came, I first pressed the button, the beep on
22 the bed. And when she finally came, she said she was down
23 the hall. And she finally came and she check him and she
24 changed the IV thing and she left out. Then she came back
25 with another lady and they was talking and she say they was

1 -- I was upset because like, I didn't know what was going
2 on. And his hand was just swelled up and so she didn't --
3 the young lady, she didn't remove this thing from his hand.
4 They called the doctor in and a little latter on, I'd say
5 about two or three hours later, that's when the doctor came
6 in and removed it. And his hand was just stuck and it was
7 just big and swell up. And so I got more upset. It look
8 like everybody was just standing around oh, this, that and
9 the other and then they go off and whisper. Meanwhile,
10 while they doing that. So I had called my sister and ask my
11 sister come and -- because she was there at OCT, to come
12 here now because something wrong because my baby hand all
13 swell up, and that. So I asked her to come over, you know,
14 because ain't nobody here want to -- they didn't want to do
15 anything and my baby's sitting in here crying -- I'm sorry -
16 - at the time.

17 Q Do you need a tissue?

18 A Thank you.

19 Q You need a glass of water?

20 A (Witness pauses)

21 Q You want a little water?

22 A No, sir. I'm fine.

23 Q Okay. Let's just go slow, okay, Tekayah?

24 A Okay.

25 Q We'll go at your pace.

1 A Okay.

2 Q Up until 4:27 that morning, R.J. was okay?

3 A Yes, sir.

4 Q He's administered the medication at 4:27, correct?

5 A Yes, sir.

6 Q The medication goes through, correct?

7 A Yes, sir.

8 MR. TANNER: Your Honor, I object to leading the
9 witness.

10 THE COURT: Yeah. Yeah. Just change your
11 question. She can tell it.

12 MR. KRELL: Yes, sir.

13 BY MR. KRELL:

14 Q What happens after the medicine completes?

15 A The machine went off and it buzzed a couple of times.
16 I can't remember exactly how many minutes apart was it, that
17 it just kept going off. She said she was down the hall so
18 she can't hear it, but I did call up there twice and she
19 finally came back and she checked it. And then that's when
20 she left, came back and get another nurse, and they told me
21 they was going to call the doctor then.

22 Q And after they removed the dressing, what did his hand
23 look like?

24 A His whole hand was just swell up and on top was a big
25 black scar and it was a bubble. It was like a big lump

1 sitting on top of his hand full up with fluid. And the
2 whole hand had turned black.

3 MR. KRELL: Your Honor, may I show the witness
4 some documents, please?

5 THE COURT: Sure.

6 BY MR. KRELL:

7 Q I'm going to show you these two documents and ask if
8 you could identify this, please?

9 A Yeah. And it had puss.

10 Q What's that?

11 A That's how his hand looked. The back of his hand.

12 Q Whose hand is this?

13 A R.J.

14 Q And do you know who took that photograph?

15 A His daddy took it.

16 Q Okay. His daddy took it?

17 A Uh-huh. (Affirmative response)

18 MR. KRELL: Your Honor, at this time I move to
19 admit Plaintiff's Exhibit No. 1 into evidence.

20 MR. TANNER: Same objection I made earlier, Your
21 Honor.

22 THE COURT: And I note your objection on the
23 record, but it is in evidence as a true and accurate copy of
24 the hand that day. Your objection is preserved.

25 MR. TANNER: Thank you, Your Honor.

MR. KRELL: Thank you, Your Honor.

(Plaintiff's Exhibit No. 1, photo,

was marked and entered previously)

BY MR. KRELL:

Q And if you could describe that document as well?

A And that was when I was holding him up and they did the picture of a record of it.

Q Whose hand is that?

A It's R.J.'s.

Q And who took the photograph?

A His dad.

MR. KRELL: Your Honor, I've move to put Plaintiff's Exhibit 3 into evidence.

THE COURT: Okay. And again, I'm noting your objection.

(Plaintiff's Exhibit No. 3, photo,
was marked and entered previously)

MR. KRELL: Did we do 2. I'm sorry? It's out of order. I'm sorry.

MR. TANNER: Thank you, Your Honor.

THE COURT: Okay.

BY MR. KRELL:

Q Now, prior to 4/27 he was doing just fine?

A Yes, sir. He was fine.

Q And does this accurately depict what his hand looked

1 like following 4:50 a.m.?

2 A Yes, sir.

3 Q These are all with infiltration scores of zero earlier
4 in the day, right?

5 A Yes, sir.

6 Q And that would be Plaintiff's 3. Does that accurately
7 reflect how R.J. looked?

8 A Yes, sir.

9 Q And when was that taken?

10 A I think it was that picture right there because it bust
11 the following day, so it'd be like the 29th.

12 Q Now, as a result of those injuries did R.J. have
13 follow-up care?

14 A At the wound center, yeah.

15 Q And did he have about fifteen visits?

16 A Yes, sir.

17 Q And when he went to see the wound care specialists,
18 what would they do to the wound?

19 A They unwrap it and they'll clean it and --

20 Q They clean it, right?

21 A Yes, sir.

22 Q And when they clean it they get in there, right?

23 A Yes, sir.

24 Q And how did that make R.J. feel?

25 A He cried every time.

1 MR. TANNER: Objection Your Honor as to how the
2 child felt. Obviously, she's speculating.

3 THE COURT: Well --

4 MR. TANNER: If he rephrases it, possibly.

5 THE COURT: Well, he --

6 BY MR. KRELL:

7 Q Describe R.J. when they cleaned the wound.

8 THE COURT: Okay. Thank you for rephrasing it.
9 How did he react when they cleaned the wound?

10 A He cried.

11 BY MR. KRELL:

12 Q Could you tell -- and as a mother, you gave birth to
13 him. Could you tell if he was in pain?

14 A From the way he cried, yes, sir, I know my baby was in
15 pain.

16 Q And they did that fifteen times?

17 A Yes, sir.

18 Q On different occasions?

19 A Yes, sir.

20 Q I show you another photograph we've marked.

21 THE COURT: This will be 2?

22 MR. KRELL: No, this is actually No. 1, Your
23 Honor.

24 THE COURT: Okay.

25 MR. KRELL: But we just marked them out of

1 chronological order. Excuse me.

2 THE COURT: I think that the --

3 MR. TANNER: I thought --

4 THE COURT: Huh?

5 MR. TANNER: I thought No. 1 is --

6 MR. KRELL: It is. I just --

7 THE COURT: Yeah. The one he just showed you is
8 1, I believe. The last one's going to be --

9 MR. KRELL: 2.

10 MR. TANNER: 2, right?

11 THE COURT: 2.

12 COURT REPORTER: That's in.

13 MR. KRELL: I was showing it to the jury first,
14 Your Honor. I apologize.

15 BY MR. KRELL:

16 Q If you could describe that photograph for us, please?

17 A That's, I think this is his last day at the wound
18 center. I think in the wound center. And it's starting to
19 close up. It's still swelled, but that's how his scaring is
20 on his hand now.

21 Q And whose hand is that?

22 A R.J.'s.

23 MR. KRELL: Your Honor, I'd move to admit
24 Plaintiff's 2 into evidence.

25 THE COURT: Okay.

1 MR. TANNER: Same objection as my --

2 THE COURT: It is in evidence and we're preserving
3 your objection, Mr. Tanner. Thank you, sir.

4 MR. KRELL: Thank you, Your Honor.

5 (Plaintiff's Exhibit No. 2, photo,
6 was marked and entered previously)

7 BY MR. KRELL:

8 Q And that's R.J.'s, what hand, left or right?

9 A The right hand.

10 Q It's the right hand or the left hand?

11 A His right hand.

12 Q Does R.J. have any complications from his scar?

13 A He do. I do a lot of hand motion things with him
14 because his hand does cramped up. And he doesn't complain.
15 Like it's itching, he'll tell you, and I have to massage it.
16 And I got him a little ball that he had for a while that he
17 would do it with his hand because it was. He could not sit
18 still because it hurt, and he'll be like this right here.
19 And then he'll do something like that, and then I massage it
20 and give him his ball so he can exercise his hand because I
21 don't want his hand to get stuck like this. So I do do hand
22 exercises for him. And as I say sometime he do have itching
23 and irritation under the skin. He just say it really itch
24 or he'll say mommy, it hurts.

25 Q How old is he?

1 A Three.

2 Q You've heard Mr. Tanner talk about some injections into
3 this scar during his opening. How do you feel about R.J.
4 having that scar injected?

5 A I don't even want him -- because he done been through
6 so much and I don't want to keep putting him through so much
7 and really, I'm scared that something else might happen. I
8 don't know. And I think he said it's just -- he really did
9 something different. But to me, I don't feel like I should
10 have to do it because I don't know what all it would do.
11 You know, I was scared he'd get it at the time because he
12 done been through so much. I mean, it wouldn't even be a --
13 He may get home with a -- with his hand wrapped up arms
14 wrapped, can't do nothing. But -- he couldn't crawl with
15 his hand out. He always had to have it -- so I'm like this
16 here, constantly watching that he doesn't do nothing or hit
17 it to make it bleed or make the stuff come out. Anyway, he
18 didn't really crawl like he wanted because I constantly had
19 to get him. And there was a whole year I didn't work
20 because I had to make sure he was okay. You can't just
21 leave the child with somebody in that predicament. I didn't
22 trust nobody.

23 Q Is he able to go in the sun?

24 A Sir?

25 Q Is he able to go in the sun with that scar?

1 A I don't let him go out like that. But sometime his
2 hand is -- and how it's tightened up in here. If you
3 missing -- be outside playing, kids on the trampoline, or
4 they're playing basketball too much. And he hit it right,
5 who's to say that something else won't happen. Like, I'm
6 just on -- of just -- I don't know what to do. So my baby's
7 daddy told me he goes, keep a close eye on him. If my mama
8 watch him when I'm at work, you wanting him to go out and
9 she wouldn't want him to go outside. I mean, you got to go
10 outside to make sure you watch him because he couldn't go
11 run and try to follow the other children to climb up on the
12 trampoline or climb a tree per se. It's just a whole lot
13 things so, no, I didn't get it injected because I didn't
14 know.

15 MR. KRELL: Your Honor, with the Court's
16 indulgence, we'd like to bring R.J. in so that the jury can
17 take a look at the --

18 THE COURT: At his hand now?

19 MR. KRELL: Yes. I'm sorry.

20 THE COURT: Any objection, Mr. Tanner?

21 MR. TANNER: No, sir.

22 THE COURT: Okay. Yeah, if you'd bring him on in.

23 (Robert Lee Middleton, Jr., brought
24 into the courtroom)

25 THE COURT: And Mr. Tanner, do you want to see his

1 hand first or do you want the --

2 MR. TANNER: Yeah, we've got a picture of it.

3 THE COURT: Could you let Mr. Tanner see his hand
4 before you show it to them?

5 MR. TANNER: Yes, sir.

6 THE COURT: Okay. All right.

7 MR. KRELL: Do you want me just to walk over to
8 the jury?

9 THE COURT: Yeah. Yeah. If you'd just walk over
10 and let him show the jury.

11 BY MR. KRELL:

12 Q Tekayah, is this R.J.?

13 A Yes, sir.

14 (Mr. Krell presents Robert Lee
15 Middleton, Jr., to the jury)

16 MR. KRELL: Thank you, Your Honor.

17 THE COURT: Okay. Has everybody in the jury,
18 y'all could all see his hand?

19 JURY: (Affirmative response)

20 THE COURT: You could see his hand?

21 JURY: (Affirmative response)

22 THE COURT: Okay. I just wanted to make sure
23 everybody saw it. Okay. All right.

24 (Robert Lee Middleton, Jr., taken
25 out of the courtroom)

1 THE COURT: All right. Anything else, Mr. Krell.

2 MR. KRELL: No, sir.

3 THE COURT: Huh?

4 MR. KRELL: No, sir.

5 THE COURT: All right. Mr. Tanner anything on
6 cross?

7 MR. TANNER: Yes, sir. Just briefly.

8 THE COURT: Yes, sir.

9 TEKAYAH HAMILTON - CROSS-EXAMINATION

10 BY MR. TANNER:

11 Q Thank you for being here, Ms. Hamilton. R.J.'s father
12 is Robert Lee Middleton, Sr.?

13 A Yes, sir.

14 Q And are y'all married?

15 A No, sir.

16 Q R.J. has rickets disease as well?

17 A Yes, sir.

18 Q Can you explain to the jury what that is?

19 A Well, he got fragile bones. And he got the bow-legged
20 -- it's bow-legged syndrome.

21 Q Does he have to get medical treatment for that?

22 A He's just on vitamin D.

23 Q He's seeing some doctors at the medical university for
24 the Rickets disease though, isn't he?

25 A Yes, sir.

1 Q Okay. A couple of different doctors, right?

2 A Yes, sir.

3 Q And you take him from -- you live in Eutawville; is
4 that right? Holly Hill?

5 A No, sir. I live in Santee.

6 Q I'm sorry. Santee. You take him to Santee and
7 Charleston to see the doctors at MUSC?

8 A Yes, sir.

9 Q And that's been going on since, what, 2016?

10 A Yes, sir.

11 Q Okay. And he sees a couple of different doctors at
12 MUSC, right?

13 A He sees two different doctors.

14 Q Okay. Dr. Dawes, does he still see Dr. Dawes?

15 A No, he's gotten released from Dr. Dawes.

16 Q Okay. Does he Dr. Paulo?

17 A Yes, sir.

18 Q And there was a while there that you were taking him to
19 Charleston about every month for the rickets; is that right?

20 A Yes, sir.

21 Q You understand that R.J. first came to the hospital
22 from Santee because of possibility of sepsis, right?

23 A No, I did not know what his diagnosis was at first
24 because nobody knew. They said they was still running test.

25 Q Did they explain to you that they were giving him IV

1 because there was a potential that he could have sepsis?

2 A They didn't say sepsis. They say because he could have
3 some kind of viral infection.

4 Q Have you looked at R.J.'s medical records?

5 A No, sir. I haven't.

6 Q You do recall him spiking a fever of almost a hundred
7 and three degrees?

8 A Yes, sir.

9 Q And do you recall talking to Dr. Bolton in the hospital
10 once you got to Orangeburg from Santee?

11 A Yes, sir.

12 Q And she told you that they were going to do an IV and
13 you would have consented for the IV, correct?

14 A Yes, sir.

15 Q All right. And they started those IV medications
16 around October the 25th; is that right?

17 A Yes, sir.

18 Q And he was discharged from the hospital on October
19 30th, right?

20 A Yes, sir.

21 Q Do you recall this picture being taken?

22 A I can't remember that date. That was after all the
23 visits from the wound center.

24 Q Okay. And that would have been in Orangeburg?

25 A Yes, sir.

1 Q And he was, in fact, released from the Wound Center,
2 right?

3 A Yes, sir.

4 Q Didn't have to have any operation or anything like
5 that, right?

6 A No, sir.

7 Q And who is Dr. Peter DeVito?

8 A He's a plastic surgeon.

9 Q Okay. Where is Dr. DeVito?

10 A He's located in North Charleston.

11 Q And did someone refer you to Dr. DeVito?

12 A Yes, sir.

13 Q Okay. And did you see Dr. DeVito on February 2nd of
14 2015?

15 A Yes, sir.

16 Q And it was Mr. Krell, your lawyer, that referred you to
17 the doctor, right?

18 A Yes, sir.

19 Q None of the doctors at the wound center told you to go
20 see Dr. DeVito, did they?

21 A After they released him they say nothing else they
22 could have done. So --

23 Q And Dr. DeVito saw Robert Lee Middleton again on March
24 2nd, 2015, right?

25 A Yes, sir.

1 Q And at that time he had recommended the steroid
2 injections?

3 A Yes, sir.

4 Q And Dr. DeVito told you that would help flatten out the
5 scar?

6 A Yes, sir.

7 Q Did R.J. receive any of those injections after March
8 2015?

9 A No, sir.

10 Q Did he have any steroid injections in 2016?

11 A No, sir.

12 Q Did he have any steroid injections in 2017?

13 A No, sir.

14 Q Even though that would help his scar?

15 A Maybe it would, but it -- I don't know. Like I say, I
16 wasn't taking a risk because I was scared. I wasn't taking
17 no risk and like you just said about going back and forth
18 with him with the Rickets disease. And I didn't want my
19 baby to be on steroids. And, you know, I didn't got several
20 shots like I said before and maybe it would have helped and
21 maybe it wouldn't. You never know what it -- Yes, I was
22 scared because I never had to went through nothing like
23 that. And so I didn't do it.

24 Q But you saw Dr. DeVito based on the referral from your
25 lawyer, right?

1 A Yes, sir.

2 Q Did you trust what Dr. DeVito was telling you?

3 A I did.

4 Q Okay. And he thought that the steroid injections would
5 be of benefit to your son, right?

6 A Yes, sir.

7 Q And you want your son -- you want his scar heal, don't
8 you, Ms. Hamilton?

9 A Yes, sir.

10 Q Your son saw Dr. Davis in March 2018 in Columbia. Do
11 you remember Dr. Davis?

12 A Yes, sir.

13 Q And Dr. Davis was appointed by this Court to do an
14 independent medical examination; do you recall that?

15 A Yes, sir.

16 Q Okay. And you took him up there and Dr. Davis saw
17 R.J., right?

18 A Yes, sir.

19 Q Okay. And you had an opportunity to speak to Dr.
20 Davis?

21 A Yes, sir.

22 Q Okay. And Dr. Davis issued a report; is that right?

23 A Yes, sir.

24 Q And that report, I believe, was dated March 28th, 2018;
25 is that right?

1 A Yes, sir.

2 Q And Dr. Davis noted in his report that R.J. had a well-
3 healed scar, right?

4 A I'm not sure what his report said.

5 Q All right. Do you remember Dr. Davis telling you at
6 the time that R.J. -- when he saw him that R.J. denied pain,
7 burning or itching with his scar?

8 A R.J. explain to him everything that was bothering him
9 because he can talk.

10 Q So if Dr. Davis noted that R.J. when he saw him denied
11 pain, burning and itching, that would be accurate of what
12 R.J. told Dr. Davis?

13 A He didn't deny it. Because when he asked him if it
14 itched and then Dr. Davis asked who scratch it for you. He
15 said I tell my mama to scratch it like I tell my mama to
16 scratch my back. So, no, R.J. didn't deny it because R.J.
17 the one who brought up the subject about his hand hurting
18 and itching.

19 Q All right. So it's your testimony that Dr. Davis
20 didn't accurately put that in his report?

21 A I'm not sure what he put in his report because I didn't
22 read his report. I'm telling you what happened when I was
23 there and what happened.

24 Q Okay. Do you remember Dr. Davis doing some muscle test
25 to R.J.?

1 A Dr. Davis told R.J. go stand by the wall, hold his hand
2 up. And he took his light and shine it on R.J.'s hand. And
3 he said hey, buddy can you do this? And R.J. show him his
4 hand. Then he took his hand and do some kind of hand motion
5 out. He took the pen and he went on he say he would have to
6 have surgery and he'd have to do a Z, a Y and X's. I
7 understand XYZ. I don't know how you would have to do
8 surgery on his hand. But he actually took R.J. hand and did
9 the hand motion. No, he didn't. Did he say anything
10 further after he said like what the surgery he would have to
11 do? No, he didn't. He said, all right. I'll get the
12 paperwork to your lawyer. Nice meeting you. Nice meeting
13 you, Mr. Davis and we left.

14 Q And it's your testimony that you haven't read his
15 report?

16 A It's my testimony.

17 Q Did you feel that his report may help R.J.?

18 A I'm not sure because I didn't read his report so I
19 can't say what his testimony would do or won't do.

20 Q I guess it's just interesting that after Dr. Davis'
21 report you then went to see Dr. DeVito again on April 23rd
22 this year. Do you remember seeing Dr. DeVito on April 23rd?

23 A Yes, sir.

24 Q When did you make that appointment, Ms. Hamilton?

25 A I had an appointment with him before but I couldn't get

1 to the appointment because that's when Mr. Krell -- that I
2 was going back and forth with R.J. with his rickets disease.
3 And I couldn't stop that because I had to make sure he was
4 getting his medicine and staying on top of it.

5 Q Do you know when you had that appointment, when you
6 made it?

7 A No.

8 Q Because the last records I have from Dr. DeVito don't
9 show any appointments after March of 2015?

10 A I said I missed an appointment. I can't remember exact
11 what date that was when I missed it. I can --

12 Q You think -- I'm sorry.

13 A I can't --

14 Q I cut you off. I apologize. You can finish.

15 A You're fine. I can't remember. I know I missed the
16 last appointment I had to have with Dr. DeVito. I can't
17 remember when it was or what it was. Like I say, I was
18 doing the back and forth with him.

19 Q Because you were going to Charleston --

20 A Right to see Dr. Dawes and Dr. Paulo.

21 Q And Dr. DeVito is in that Charleston area, isn't he?

22 A Not where Dr. Dawes office is.

23 Q Well, he's in North Charleston you testified to?

24 A Yeah, I think that's North Charleston -- downtown
25 Charleston.

1 Q So the Charleston metropolitan area?

2 A Right.

3 Q Do you think the appointment was from three years ago
4 in 2015?

5 A I'm not sure. I can't say yes or no. I can't
6 remember.

7 Q It just seems a little odd to me that you don't see Dr.
8 DeVito for three years. You see a different doctor that the
9 Court appoints in Columbia that tells you --

10 A It's not odd because like I said I missed an
11 appointment with Dr. DeVito and I explained to Mr. Johnson
12 -- I spoke with Mr. Johnson probably twice about that, but I
13 was also staying in touch with Ms. Debbie and let her know
14 what was going on. And she understood that I had to get
15 that straight and make sure he stay on his medicine.

16 Q Okay. But R.J.'s not on any medicine for his hand,
17 right?

18 A No.

19 Q So the reason you went back to the Dr. DeVito just a
20 few weeks ago wasn't because you got Dr. Davis' report?

21 A I'm pretty sure it wasn't because it's not like he said
22 this and that. He was just doing a follow-up appointment.

23 Q Even though you didn't have any appointments with Dr.
24 DeVito in 2017?

25 THE COURT: Mr. Tanner, we've gone over this

1 enough.

2 BY MR. TANNER:

3 Q You don't have any plans for surgery for R.J., do you?

4 A No.

5 Q Okay. Thank you, Ms. Hamilton.

6 THE COURT: Anything on redirect?

7 MR. KRELL: Yes, sir.

8 THE COURT: Okay. Limited to his cross again.

9 TEKAYAH HAMILTON - REDIRECT EXAMINATION

10 BY MR. KRELL:

11 Q Regarding future surgeries certainly you don't have any
12 plans while he's a baby, do you?

13 A No.

14 Q Maybe when he gets older?

15 A Correct.

16 Q How about if he gets older when he's a teenager?

17 A Yes, when he gets older, yes but not right now because
18 I don't want him to get surgery because he's still young.

19 Q Do you know how Dr. Davis got involved?

20 A No, sir.

21 Q Do you know if he was asked by the Court or asked by
22 the attorneys?

23 A No, I didn't know who he was appointed by.

24 Q He could have been consented to by us and by Mr.
25 Tanner?

1 A Yes, sir. I went in with the intentions thinking that
2 it was somebody else.

3 Q We agreed to it, right?

4 A Yes, sir.

5 Q Thank you.

6 THE COURT: Anything on recross?

7 MR. TANNER: Just briefly.

8 TEKAYAH HAMILTON - RE CROSS EXAMINATION

9 BY MR. TANNER:

10 Q If surgery would be better for R.J. when he's younger,
11 would you be in favor of that?

12 A I wouldn't want to. We can sit down and talk about
13 everything. I wouldn't --

14 Q Okay. Mr. Krell asked you and you said you'd think
15 about it when he's a teenager.

16 A That's what I say we sit down and talk about
17 everything, I would consider it. I didn't just came out and
18 say yes, sir, I'll let him go ahead and get it since he
19 young. I said I would consider it, getting it done if I
20 could sit down and talk over everything and see how it plays
21 out. No, I'm not going to just jump into surgery just
22 because.

23 Q Yes, ma'am. And do you remember in your visits with
24 Dr. DeVito in 2015 any discussions of surgery when R.J.'s
25 younger?

1 A Dr. Devito also -- he say do you want to get surgery
2 done? And I say no, not this early. That's --

3 Q When you saw -- I'm sorry.

4 A Because he just got fresh from the wound center and he
5 done been through so much.

6 Q When you saw Dr. DeVito just a few weeks ago did you
7 discuss having surgery for your son now?

8 A No, I brought it up to Dr. -- Mr. -- Dr. DeVito give
9 me another appointment to come back to him and go into
10 further discussion. So at that morning he just did a scan.
11 He check his hand and wrote on it and asked him to move his
12 hand around and we got an appointment.

13 Q Do you know when R.J. goes back to Dr. DeVito?

14 A It's either June 7th or July the 7th.

15 Q Okay. Thank you, Ms. Hamilton.

16 A Uh-huh.

17 THE COURT: All right.

18 MR. KRELL: Nothing further from Ms. Hamilton.

19 THE COURT: You may step down. Thank you, ma'am.
20 Plaintiff ready to call its next witness.

21 MR. KRELL: Your Honor, this is -- I think Mr.
22 Williams discussed with you, Dr. DeVito's scheduled for
23 tomorrow morning. He will come in tomorrow morning. He
24 couldn't come in this afternoon due to surgery. I think he
25 had surgery with patients, but that's our final witness

1 would be Dr. DeVito.

2 THE COURT: All right. And did y'all do a video?

3 MR. TANNER: It's not a video. It's de bene esse.

4 MR. KRELL: They're going to read the deposition
5 of Dr. Davis.

6 THE COURT: Okay. And that's going to be your
7 witness?

8 MR. TANNER: Yes, sir. I took his deposition. He
9 was appointed to do -- so -- but, yeah. I took his
10 deposition. It's a de bene esse.

11 THE COURT: Well, let me ask the question. Do
12 y'all have any -- how long would it take to read the
13 deposition.

14 MR. TANNER: It's short, Judge. I mean, short. I
15 would think maybe twenty minutes.

16 THE COURT: Would y'all have any problems with
17 taking it out of order? Anybody? Any problems with taking
18 it out of order?

19 MR. TANNER: No, sir.

20 THE COURT: Okay. All right.

21 MR. KRELL: Could we take a very brief recess to
22 discuss this. There's some objections that are in that
23 deposition that maybe we could work out.

24 THE COURT: Okay. Yeah. All right. Ladies and
25 gentlemen, we're going to try and take a brief break. I

1 know the last one lasted a little longer. I had people
2 waiting in my office. They'd been waiting back here for me
3 to do something. This shouldn't last that long. Remember,
4 you can't talk about anything you've heard so far. So if
5 y'all would go back to the jury room. Thank y'all.

6 (Jury out at 4:26 p.m.)

7 THE COURT: Okay. Y'all look it over and work it
8 out.

9 (Court in recess for short break at
10 4:26 p.m.)

11 (Court in session after short break
12 at 4:35 p.m.)

13 THE COURT: Are we ready?

14 MR. TANNER: ??? deposition transcript opening
15 outside the jury.

16 THE COURT: I'm sorry about that. We can do that
17 if you want to wait. One thing I do want to mention is I
18 know we're taking this out of order. And so normally, at
19 the end of the plaintiff's case you make your motion for
20 directed verdict. You're not giving that up or waiving
21 that?

22 MR. TANNER: No, so I'll be making that --

23 THE COURT: Okay.

24 MR. TANNER: -- based on what they said, Dr.
25 DeVito's going tomorrow so I'll make those motions at that

1 time.

2 THE COURT: Okay. And then tomorrow you're going
3 to have Nurse Downing and --

4 MR. TANNER: My expert, Nurse Hurley.

5 THE COURT: Okay. And Dr. DeVito is going to be
6 in here first thing in the morning?

7 MR. KRELL: Yes, sir.

8 THE COURT: What time do you want to be here?

9 MR. KRELL: Whatever time the Judge tells us to be
10 here, we'll be here.

11 THE COURT: Well we'll just do 9:00 in the
12 morning.

13 MR. KRELL: That's fine.

14 THE COURT: Will that be all right?

15 MR. KRELL: That's perfect.

16 THE COURT: Okay. All right.

17 (Off record discussion)

18 (Court's Exhibit No. 2, Dr. Donen
19 Davis deposition, was marked)

20 (Defendant's Exhibit No. 1, Dr.
21 Donen Davis report, was marked for ID previously)

22 (Defendant's Exhibit No. 2,
23 photograph, was marked for I.D previously)

24 THE COURT: And David, Michael, I'm going to
25 explain to the jury that we're taking this doctor's

1 testimony out of order, okay?

2 MR. WILLIAMS: Okay.

3 THE COURT: Okay. Ms. Hamilton's already gone?
4 She'll be back?

5 All right. I'm going to bring the jury back in?

6 MR. KRELL: We've got Ms. Hamilton back in.

7 THE COURT: Okay.

8 Okay. Plaintiff ready?

9 MR. WILLIAMS: Yes, Your Honor.

10 THE COURT: Defense ready?

11 MR. TANNER: Yes, sir.

12 (Off record discussion)

13 THE COURT: Okay. All right. Bring the jury o
14 in.

15 THE BAILIFF: Yes, Your Honor.

16 THE COURT: Thank you, ma'am.

17 (Jury in at 4:35 p.m.)

18 THE COURT: All right. Ladies and gentlemen, what
19 we're going to do next is a deposition was taken by the
20 defendant of Dr. Davis. He's another plastic -- he is a
21 plastic surgeon. And since we still have time today and
22 some of the other witnesses were not available this
23 afternoon, rather than waste time, we're taking witnesses
24 out of order, okay? So this witness, Dr. Davis, is not a
25 plaintiff's witness. He is a defense witness, okay? And

1 we're doing this the old fashioned way. And let me tell you
2 what the old fashioned way is. You go to the doctor's
3 office. You take his deposition. If the doctor can't make
4 it here, somebody else is going to read the deposition as if
5 he were the doctor, okay? And the only thing he can do is
6 read what the doctor said, okay? And so this is as if the
7 doctor's here, the doctor's under oath. And Mr. Tanner, so
8 you're ready to call your first witness?

9 MR. TANNER: Yes, sir. Your Honor, I'd call Dr.
10 Donen Davis, J.D., M.D.

11 THE COURT: Okay. Come on down.

12 MR. SHAKIBANASAB: (Complies)

13 THE COURT: And did they swear him in in that
14 deposition?

15 MR. TANNER: They did. And do you want me to read
16 all of that into the record, Your Honor.

17 THE COURT: Well, put your left hand on the Bible.
18 Raise your right hand. It's going to take me a while to get
19 there.

20 MR. SHAKIBANASAB: (Complies)

21 THE COURT: You swear that you're going to read
22 that deposition accurately?

23 MR. SHAKIBANASAB: Yes.

24 THE COURT: Okay. All right. Thank you, sir.

25 MR. TANNER: May it please the Court?

1 THE COURT: Yes, sir.

2 MR. TANNER: And, Your Honor, for the record, this
3 was a deposition taken of Dr. Davis on April 30th, 2018
4 starting at 3:54 p.m., at Southern Reporting in Columbia,
5 South Carolina.

6 THE COURT: All right.

7 MR. TANNER: And Dr. Davis was duly sworn and
8 cautioned to speak the truth, the whole truth and nothing
9 but the truth.

10 (De bene esse deposition of Dr.
11 Donen Davis taken 4/30/18 read into the record. Questions
12 by Mr. Tanner. Answers by Mr. Shakibanasab)

13 Q Dr. Davis, thank you. We are in Columbia today; is
14 that correct?

15 A Yes, we are.

16 Q All right. My name is Michael Tanner. Again, I
17 represent The Regional Medical Center. I met you briefly
18 before we started the discovery deposition, which just
19 concluded; is that correct?

20 A Yes.

21 Q Okay. Will you please state your full name and
22 professional address for the record, Doctor?

23 A Donen Davis. And my office address is 1850 Laurel
24 Street, Suite B, Columbia, 29201.

25 Q And what is your profession?

1 A Plastic surgery.

2 Q All right. Tell me about your educational background.
3 You grew up in Columbia?

4 A I grew up in Columbia. I graduated from Richland
5 Northeast High School in 1980. Went off to the University
6 of Georgia, but finished undergraduate at the University of
7 South Carolina 1984, then went to the University of South
8 Carolina School of Law graduating in 1987, practiced law
9 here in Columbia, and then went to medical school at MUSC
10 graduating in 1995. Then went and did a full general
11 surgery residency followed by a plastic surgery fellowship.

12 Q Let me stop you there. Where was the general surgery
13 residency?

14 A It was in Atlanta.

15 Q And how long is a general surgery residency?

16 A Five years.

17 Q All right. And you've provided a C.V., which is a
18 fancy Latin term for resume; is that correct?

19 A Yes, sir.

20 Q And I believe that shows you completed your residency
21 from July '95 through June of 2000. Does that sound about
22 right?

23 A Yes.

24 Q All right. And you were the chief resident for your
25 last year; is that right?

1 A Yes.

2 Q Explain to the jury, what's significant about being the
3 chief surgical resident?

4 A Residency is -- you're a doctor when you graduate from
5 medical school, but you're a doctor in the book sense only.
6 And so the way residency programs in the United States work
7 is graduated responsibilities starting from internship all
8 the way through until you graduate. Your final year you can
9 be elevated to the level of chief resident. The chief
10 resident really is somebody, although supervised, more
11 distantly supervised. You're sort of running your own
12 clinic at that point with mild supervision so that you can
13 learn to make those choices properly for patients.

14 Q And that would have been done something you have done
15 at the Atlanta Medical Center your final year?

16 A Yes.

17 Q All right. And then you mentioned that you had a
18 fellowship after your general surgical residency?

19 A I did.

20 Q And was that at the medical university?

21 A In Charleston, yes.

22 Q And that was in plastic and reconstructive surgery?

23 A Correct.

24 Q And that's a two-year program?

25 A It is.

1 Q All right. And what did you learn in your fellowship
2 training?

3 A Well, it's -- so there are two different types of
4 plastic surgery in the United States. I did full-body
5 plastic surgery and reconstruction, so from head to toe.
6 Basically, in that you are trained in burn surgery, cancer
7 surgery, trauma surgery, reconstructive surgery, cosmetic
8 surgery, and the hand surgery.

9 Q And on your C.V. you also state hand and microsurgery?
10 What, is microsurgery a part of hand surgery? Explain that
11 for the jury, please?

12 A It doesn't necessarily have to be hand specific. So,
13 you know, plastic surgeons invented all of those hand
14 transplants, the finger transplants, the face transplants,
15 all of that would be micro. So would some of the other
16 reconstructions we do. Some of the breast reconstructions
17 are micro. Face reconstruction, somebody has cancer of the
18 mandible or the tongue and throat, those would be micro
19 surgeries. So that just means that you're re-approximating
20 and -- things that are so tiny that you would need
21 magnification to do it.

22 Q All right. Any additional formal training after your
23 fellowship?

24 A Not after, but during those two years I did also an
25 extra rhinoplasty mini fellowship and an extra micro mini

1 fellowship.

2 Q And just for jury purposes, rhinoplasty is nose
3 operation?

4 A Nose.

5 Q All right. And then after finishing your fellowship,
6 you went into private practice?

7 A I did.

8 Q And you practiced with associates with Plastic Surgery
9 of the Carolinas for two years; is that right?

10 A Just under two years, yeah.

11 Q All right. And then you mentioned that you had a
12 fellowship after your general surgical residency? I'm
13 sorry. And since June of 2004, you've had your own
14 practice?

15 A Correct.

16 Q And that is the current practice that you're still
17 engaged in today?

18 A I am.

19 Q And you're still also a licensed member of the South
20 Carolina Bar?

21 A Yes.

22 Q Any partners in your practice?

23 A No.

24 Q And your licensed to practice medicine in South
25 Carolina?

1 A I am.

2 Q And are you currently licensed to practice medicine in
3 any other state?

4 A No.

5 Q And have you previously been licensed to practice
6 medicine in any other states?

7 A Yes, I was licensed in Georgia as part of the
8 residency.

9 Q And then when you moved back to South Carolina, you let
10 that license lapse?

11 A I did.

12 Q All right. And are you board certified?

13 A Yes.

14 Q In what specialty?

15 A Plastic and reconstructive surgery.

16 Q Explain to the jury what it means to be board certified
17 in those fields?

18 A So there are only -- The American Board of Medical
19 Specialties, ABMS, defines which specialties are qualifying
20 for certification. And then each one of those specialities
21 has their own requirements once they are a member of the
22 American Board of Medical Specialities. And for plastic
23 surgery in the United States, you have to -- in my area you
24 had to be fully -- already fully trained in one of the three
25 disciplines prior to going. You had to be fully trained in

1 general surgery, (inaudible) or orthopaedic surgery, then
2 apply for plastics, and then complete a certain number of
3 cases at years end and examinations to achieve board
4 certification, the final being an oral examination.

5 Q And you have completed all of the prerequisites to
6 being board certified?

7 A I have, and now we have recertification and I've been
8 re-certified.

9 Q All right. And how long is your certification good
10 for?

11 A Ten years.

12 Q Ten years, and then you're eligible to reapply for
13 recertification?

14 A Every ten years.

15 Q When is your board certification up for renewal in the
16 next time, do you know?

17 A Well, see so you do a little bit every year, but the
18 finality of it is, is in the ninth year, right before the
19 tenth year last, that would be my next one. I think it is
20 2025.

21 Q And as a part of your treatment have you, in your
22 medical career, ever treated patients who have ever had an
23 IV infiltration or extravasation?

24 A Yes.

25 Q And are those terms synonymous and basically differing

1 with a solution involved?

2 A Yes, I think that again those are interchangeable.
3 People would have used them probably, slightly, you know,
4 they would use for the same purposes.

5 Q And have you also in your medical career provided
6 assessment and treatment to patients that have had scaring?

7 A Yes.

8 Q And treated scaring on their hands?

9 A Yes.

10 Q All right. And you were court ordered in this case to
11 perform an independent medical examination on Mr. Robert Lee
12 Middleton, Jr., correct?

13 A Yes.

14 Q Did you prepare such an examination?

15 A I did.

16 Q And that was at what time in this year, do you know?

17 A I think it was -- it was in March of this year, I
18 think.

19 Q And did you issue a report?

20 A I did.

21 Q And that report is dated March 28th, 2018?

22 A Yes.

23 Q All right. And that would have been the report you did
24 after your examination of Mr. Middleton?

25 A Correct.

1 Q All right.

2 MR. TANNER: At this time, Your Honor, I'd move to
3 qualify him as an expert in plastic surgery.

4 THE COURT: Any objection?

5 MR. KRELL: No, sir.

6 THE COURT: Okay. Then he is so qualified as an
7 expert in plastic surgery.

8 And ladies and gentlemen, you remember the earlier
9 statement I made about expert witnesses giving opinion?
10 This applies to Dr. Davis as well.

11 Okay. Thank you.

12 MR. TANNER: Thank you, Your Honor.

13 Q All right. Dr. Davis, you haven't been provided with
14 any of the underlying medical records in this case, have
15 you?

16 A No.

17 Q Let me sort of explain this, what the records indicate
18 and I have a series of questions for you. When you saw Mr.
19 Robert Lee Middleton, Jr., was his mother present?

20 A Yes.

21 Q All right. And did she go over any of the facts that
22 lead to your being court appointed to perform this
23 independent medical examination?

24 A No.

25 Q Did she tell you that when he was approximately thirty

1 days old he had an acute onset fever of a hundred and two
2 point six degrees?

3 A No.

4 Q All right. Did she tell you that he was admitted for a
5 full sepsis work up including empiric antibiotics?

6 A No.

7 Q Can you explain to the jury what is your understanding
8 of sepsis?

9 A Sepsis is when the body is reacting to an infection
10 that is blood-bourne system only.

11 Q All right. And is that a process that can become life
12 threatening and fatal?

13 A Yes.

14 Q And given R.J.'s young age with that fever, would he be
15 at a higher risk for developing sepsis?

16 A Ask me that again?

17 Q Given his young age when he had that temperature spike
18 of a hundred and two point six, would he then be at a higher
19 risk for potentially developing sepsis?

20 A Yes.

21 Q Answer?

22 A Yes, because of at -- at that age you do not have a
23 full immune system.

24 Q And would you agree that the literature reflects that
25 sepsis is best treated with broad-spectrum antibiotics?

1 A Until isolating the particular bacteria, yes.

2 Q Okay. And what is your understanding of claforan and
3 ampicillin, are those considered broad-spectrum antibiotics?

4 A Well, yes. They are different and yet they would cover
5 the majority of the infectious disease.

6 Q And is the use of IV administered antibiotics for a
7 potentially septic patient an appropriate method to
8 administer antibiotics?

9 A Yes.

10 Q And does the placement of an IV have known potential
11 complications?

12 A Yes.

13 Q And can you explain to the jury what the potential
14 complications in an IV would be?

15 A Well, so even though minimally invasive, an IV is
16 anything that breaks the skin, it's somewhat invasive. And
17 so to be able to present a patient with either fluids or
18 medications in a liquid form, that is non-internal, you have
19 to cannulate the blood vessel and we would rather that be a
20 venous blood vessel. And venous blood vessels are sometimes
21 difficult to find and/or fragile.

22 Q Doctor, I believe you testified in your discovery
23 deposition that you have treated patients who have either an
24 infiltration or extravasation in your residency?

25 A Yes.

1 Q All right. And is that similar to what Mr. Robert Lee
2 Middleton, Jr., suffered?

3 A That's what I've been told, yes.

4 Q Okay. And you testified you prepared a report?

5 A Yes.

6 Q Tell me -- explain to the jury what type of physical
7 examination?

8 A This is a standard exam that a surgeon would perform,
9 which is the flex examination based on the complaint. So I
10 was not attempting to interpret whether or not --

11 MR. KRELL: That's a misread. He said flexed.
12 It's fixed.

13 MR. SHAKIBANASAB: Oh, pardon me.

14 THE COURT: Could you reread it?

15 MR. SHAKIBANASAB: May I start?

16 THE COURT: Yeah.

17 A This is a standard exam that a surgeon would perform,
18 which is a fixed focused (sp) examination based on the
19 complaint. So I was not attempting to interpret whether or
20 not he has diabetes or high blood pressure, specifically
21 that he had scaring on the back of his right hand.

22 Q And that would be the nature of your examination?

23 A Yes.

24 Q All right. What sort of testing did you perform on
25 Robert Lee Middleton, Jr.?

1 A So I went through a list of tests that are designed to
2 elicit things that have to do with functionality of the
3 hand.

4 Q And can you explain to the jury what those specific
5 functional tests would entail?

6 A Yes. So the hand is -- it's very -- it is one of the
7 most intrinsically mobile parts of the body. So you want to
8 know if the person has both abduction and adduction of the
9 fingers, that's either bringing them to the middle or
10 spreading them out because that requires different -- both
11 nerves and muscles to do that. You want to know that a
12 person can both press and extend each finger, which is both
13 a muscle and a tendon-ness issue. You want to know if a
14 person has muscular strength. You want to know if the
15 person has range of motion pressability to each one or both
16 -- excuse me -- one of, both of the joints and there are
17 multiple joints to a hand, starting at the wrist and going
18 up to the end of the fingertips. And you want to look at
19 the quality of the soft tissue and the skin and the fat and
20 the muscle that are overlying each of those parts.

21 Q And you performed those various and sundry tests with
22 Robert Lee Middleton?

23 A I did.

24 Q All right. And you prepared a report; is that right?

25 A Yes.

1 Q Do you have a copy there in front of you?

2 A I do.

3 Q Can you tell me your findings from your independent
4 medical exam, please, Dr. Davis?

5 A Well, so he was approximately three years old and the
6 dorsal or the back side of his hand had scar tissue. And
7 that area of the scar tissue is between his wrist and his --
8 what the public would call knuckles. But the
9 metacarpophalangeal joint, the scar tissue was an area that
10 was not consistently one thing. Some areas were thin. Some
11 areas were thick. Also there were portions of the scar
12 tissue that were not the same color as the rest of the back
13 of the hand. Some areas were darker than the parts of the
14 back of the hand. Some areas were lighter in color.

15 Q Let me stop you there for a second?

16 A Yes.

17 Q Real quick. Did you make any comment in your
18 examination about whether Mr. Robert Lee Middleton's scar
19 was healed or not healed?

20 A So based on a conversation that I had with his mother,
21 really about whether or not there have been any break-down
22 to the tissue after the initial healing and time since
23 initial healing, and on my exam I was able to determine that
24 he had, what we would call a well-healed or a mature scar
25 that should be stable from this day forward.

1 Q And is that your opinion to a reasonable degree of
2 medical certainty, most probably?

3 A Yes.

4 Q All right. And can you continue with your report? I'm
5 sorry?

6 A Well, so that -- several other things that I elicited
7 from the exam were devoted to the functionality of each
8 finger and wrist and the strength of his hand and sensation
9 to the hand. And I was not able to find defects --

10 MR. KRELL: That's wrong.

11 MR. TANNER: Deficits.

12 A Deficits to any of those.

13 Q Did you ask him if he had any pain in his hand?

14 A I did.

15 Q And what was his response?

16 A He denied any pain.

17 Q Did you ask him if he had any burning sensation to his
18 hand?

19 A I did.

20 Q And what was his response?

21 A He did not have any burning.

22 Q Did you ask him if he had any itching to his hand?

23 A I did.

24 Q And what was his response?

25 A His response was no, but his mother did tell me that

1 she -- that he would sometimes ask her if it was okay to
2 scratch it.

3 Q And you testified a second ago that you had tested each
4 finger. What was the strength on each finger?

5 A So the way we try to do that in our physical exams is
6 to determine if you have zero ability to contract the
7 muscle, we would call that zero out of five strength. And
8 if you had normal strength it would be five over five.
9 That's not super normal, it's just normal. And people can
10 be the variation between zero to five.

11 Q And what was your finding as to Mr. Robert Lee
12 Middleton, Jr.?

13 A So I could find no diminished grip strength on any of
14 the muscular tests that I performed with him.

15 Q Okay. What is the significance of grip strength of
16 five out of five?

17 A Well, so that implies that he should have normal
18 functionality of the muscle. He also showed normal
19 functionality of the tendons that were -- that's sort of a
20 separate issue.

21 Q And --

22 A But a part of the exam.

23 Q And so in functionality terms, what's the use of his
24 hand?

25 A Right. So the hand generally moves in multiple

1 directions. And so you need to be able to spread your
2 fingers out. You need to be able to pull them in. You need
3 to be able to bring in your fingers. That's called flexion.
4 When you make a fist or extend your fingers, when they're
5 out straight, all of that is a combination of both muscle
6 strength and tendon functionality.

7 Q And did you find any impairment of tendon
8 functionality?

9 A I did not.

10 Q And presuming that Mr. Robert Lee Middleton, Jr.
11 doesn't have any injury to his hand with respect to him, do
12 you have an opinion on whether or not he would have normal
13 functionality throughout the rest of his life?

14 A Based on the exam, he should have normal functionality
15 throughout the rest of his life.

16 Q All right. Your report mentioned no evidence of tendon
17 rod deformities or restrictions. Can you explain what that
18 is in layman's terms for the jury?

19 A Tendons are necessary to manipulate the fingers and we
20 have tendons on other parts of the body. But on this for
21 him particularly, it's the fingers that I was concerned with
22 or being able to full range his wrist. And so if he was to
23 have had some damage that caused the tendon to either adhere
24 to the -- just the external scar itself or the tunnel that
25 each tendon is surround by, the sheath to adhere to the

1 tendon, then he would have not been able to perform some of
2 those tests during the exam.

3 Q And so would it be your opinion that he will, since he
4 was able to perform those tests, that he does not have an
5 insult to the tendon's sheath?

6 A Yes, because of the mature nature of the scaring
7 there's no -- there would be no reason that he would now
8 lose the ability to use the functionality of the tendons.

9 Q Okay. And explain to the jury the significance of the
10 fact that you're of the opinion that he has normal range of
11 motion with his wrist?

12 A So, again, the wrist does not -- it doesn't -- you
13 don't have a hundred and sixty-degree motion both anterior,
14 posterior with the wrist, but he had the normal range, the
15 range in his wrist as any person would. And that range is
16 really not different at his age than it would be for an
17 adult patient.

18 Q And so the scar that he externally does not -- that he
19 has externally does not impact upon his range of motion in
20 his wrist?

21 A He should have no -- nothing inhibiting his full
22 functionality of the wrist.

23 Q All right. And did you recommend some possible
24 treatment options for Robert Lee Middleton, Jr., as a result
25 of this?

1 A Yes. So when you have a scar that is not matching the
2 skin height, texture and the color of the remaining skin on
3 his back of his right hand, then there are techniques that
4 will potentially get it to be more similar.

5 Q All right. What were those techniques.

6 A The non-surgical versions would be a series of steroid
7 injections and silicone and massaging of the scar tissue.
8 And the surgical techniques of those would be to try and
9 remove all of the scar that currently exists and replace it
10 with a scar that would feel -- with more similarity to the
11 height, texture and color as the rest of his hand.

12 Q And if you're implementing a treatment plan on this
13 child, what would be your first course of treatment?

14 A Well, I would try the steroid injection. A three-year-
15 old may not allow you to try that in the office because it
16 could be uncomfortable. If that was not feasible, then it
17 would be a surgical excision and try to create him a new
18 scar.

19 Q All right. A surgical excision would have been done in
20 a hospital setting?

21 A At that age that would be the only appropriate way.

22 Q And that would be under general anesthesia?

23 A Well, the anesthesia department gets the vote on that.
24 But in general, that would be more likely than not at his
25 age. We do -- on hand surgery, again, on a more mature

1 patient we just do a regional block but I would not expect
2 that on a three-year-old.

3 Q And when you envision to have that surgical revision
4 that he would need to undergo an IV during that procedure?

5 A Yes.

6 Q And do you have an opinion as to the cost of the
7 surgical revision and any post-operative follow-up including
8 steroid injections?

9 A I do.

10 Q And what would that cost be?

11 A Based on my twenty-plus years of doing surgery and
12 knowing the costs in the community, it was my estimate is
13 seven thousand five hundred and seventy-six.

14 Q All right. And that would include all the operative
15 and post-operative care?

16 A And steroid -- and steroid injections, yes.

17 Q And that would include the anesthesia component as
18 well?

19 A Yes.

20 Q All right.

21 MR. TANNER: I'll offer your report as Defendant's
22 1 at this time.

23 MR. KRELL: No objection.

24 (Defendant's Exhibit No. 1, Dr.
25 Davis' report, was marked and entered previously)

1 THE COURT: All right. Thank you. You may step
2 down.

3 MR. TANNER: Oh, we're not done.

4 THE COURT: Oh, we're not. Oh, I'm sorry. Excuse
5 me.

6 MR. TANNER: I'm going to publish that to the
7 jury, Your Honor.

8 THE COURT: Y'all tell me what's going on whenever
9 y'all want to, okay? I'm sorry. Go ahead.

10 Q Dr. Davis, earlier in your discovery deposition, we
11 were talking about Dr. Peter DeVito treating Robert
12 Middleton, Jr., in February and March of 2015 and
13 recommending inter-lesional corticosteroids. Do you have an
14 opinion on if whether that treatment plan would have been
15 implemented, what his condition would be like now in 2018?

16 A Definitely. Our research shows that the earlier in the
17 healing process you use steroids as a method to flatten the
18 scar or prevent thickening, then the higher success you
19 would get.

20 Q So would it be -- do you have an opinion to a
21 reasonable degree of medical certainty if those steroids
22 would have been used, if his appearance of the scar would
23 have improved in 2018?

24 A Yes.

25 Q And what would your opinion be?

1 A That would have been the best, the most likely way to
2 have a better appearance.

3 Q And if Dr. DeVito would have implemented the steroid
4 regime, do you have an opinion on whether or not Mr.
5 Middleton's scar would be softer?

6 A If the steroid did what we intended for it to do, it
7 would be softer.

8 Q All right. And do you have an opinion on if Dr. DeVito
9 had implemented the steroid treatment, whether the scar
10 would be as thick as it currently is in 2018?

11 A My opinion would be consistent with my other opinions
12 about steroid use for scar tissue, that it is our number one
13 treatment. It does not always work but it is our number one
14 treatment for just the same thing, for the scar to be less
15 thick and to be softer.

16 Q At this stage if Mr. Robert Lee Middleton, Jr., doesn't
17 avail himself to any of those treatment options, do you have
18 an opinion to a reasonable degree of medical certainty on
19 whether or not the scar will get better or worse?

20 A I do have an opinion.

21 Q And what would that be, sir?

22 A Based on the length of time since injury and healing,
23 it should not get any worse.

24 Q It should sort of remain the same?

25 A Correct.

1 Q All right. And as a part of your examination, did you
2 take photographs of Mr. Robert Lee Middleton, Jr.?

3 A I did.

4 Q All right. I'll pass this photograph to you. Did that
5 photograph accurately and truly represent the condition of
6 Robert Lee Middleton, Jr.'s hand when you performed the IME.

7 A As best as I can tell. I, you know, I'm not a
8 professional photographer and I really take these pictures,
9 in my mind, as a temporary way to make sure that when I do
10 the evaluation I can be complete.

11 Q And you, yourself, took the picture?

12 A I did.

13 Q You didn't put it through any photoshop or digital
14 enhancement process, did you?

15 A No.

16 Q And that's part of your IME that you did on that day?

17 A Yes.

18 MR. TANNER: All right. I'll offer that at this
19 time as Defendant's 2.

20 MR. KRELL: No objection, Your Honor.

21 THE COURT: All right. Defendant's 2 is in
22 without objection.

23 (Defendant's Exhibit No. 2,
24 photograph, was marked and entered previously)

25 Q And Doctor, do you have an opinion to a reasonable

1 degree of medical certainty and most probably whether Mr.
2 Robert Lee Middleton, Jr., will be able to throw a ball?

3 A Based on my exam, he should be able to throw a ball.

4 Q And do you have an opinion most probably whether he'll
5 be able to catch a ball?

6 A Again, based on my exam, I see no reason he could not
7 catch a ball.

8 Q Based on your exam, is there any reason why he couldn't
9 play a piano?

10 A No.

11 Q Any reason why he couldn't hold a fishing pole?

12 A No.

13 Q Any reason why he couldn't write or print his name?

14 A No.

15 Q Any reason why he couldn't grab some crayons and color
16 or draw a picture?

17 A I saw no functional --

18 MR. TANNER: Deficits.

19 A -- deficits.

20 Q Any reason why he wouldn't be able to shoot a
21 basketball if he so desired?

22 A No reason.

23 Q Any reason why he would not be able to drive a car?

24 A He should be able to drive.

25 Q Any reason why he wouldn't be able to pass or catch a

1 football?

2 A I see no reason that he couldn't.

3 Q Any reason why he wouldn't be able to play any type of
4 musical instrument?

5 A None that I can tell.

6 Q And the opinions that you've stated to the jury today,
7 are they your opinions to a reasonable degree of medical
8 certainty, more probable than not?

9 A Yes.

10 Q Thank you for time, sir.

11 THE COURT: Have you got --

12 (Cross examination read by Mr. Krell)

13 Q Doctor, besides functionally that you've just discussed
14 with Mr. Tanner, in your experience as a plastic surgeon,
15 can scars have a psychological effect on people?

16 A Yes.

17 Q Based on your treatment of people with scars, can scars
18 on someone affect their ability or affect how they see
19 themselves?

20 A Yes.

21 Q And how can it?

22 A Well, so all injuries will result in scar tissue.

23 Q All right.

24 A All injures for a healing person. If you're going to
25 heal, you're going to have scar tissue. And people do

1 relate to them differently. You know, there would be no way
2 for me to predict how one person relates to others, but it
3 would not be a surprise that it would be something that
4 someone would not feel good about.

5 Q It's more likely than not to have a negative impact
6 than a positive impact?

7 A Right.

8 Q On someone, correct?

9 A Yes.

10 Q That's to a reasonable degree of medical certainty,
11 correct?

12 A Yes.

13 Q And so just functionality, from shooting a basketball
14 or going fishing, that's one level, but there is a
15 completely different level to having a scar, correct?

16 A Right. So the way the patient feels about the scar
17 would be completely different than whether or not there's a
18 functional component.

19 Q Right. And in your report you described the scar as
20 being itched or being scratched, correct?

21 A The mother wanted me to know that he would sometimes
22 ask her if he can scratch.

23 Q And this was almost four years after the initial
24 infiltration, correct?

25 A Well, at least three. Yeah.

1 Q At least three?

2 A Yeah.

3 Q And he's still having problems?

4 A That's -- yes, she's informed me of that?

5 Q Yeah?

6 A Yeah.

7 Q And having -- wanting it scratched or having it itch,
8 that's a symptom of scaring --

9 A It can be?

10 Q Correct?

11 A Yeah.

12 Q How about in this case, do you have an opinion?

13 A Well, you would -- anybody who has a thick scar tissue
14 that tells you that they itch, you would believe that that
15 is related to the thickness of the scar tissue.

16 Q And in this case for R.J., do you have an opinion
17 regarding --

18 A Well, he does have some thick scar tissue. I don't
19 have an opinion about how he felt about it because he did
20 not answer me when I asked him does it itch?

21 Q But mom, mom did?

22 A Mom did.

23 Q And he is a child of tender age?

24 A Right, yes.

25 Q So?

1 A Yes.

2 Q Okay. And the mom did say that he wants her to scratch
3 it?

4 A Correct. Correct.

5 Q Okay. That's what's in your report, correct?

6 A Correct.

7 Q And that's Exhibit 1 to your testimony, correct?

8 A Yes.

9 Q Okay. We also have a note from Exhibit 1 that the scar
10 felt tight. Did that come out during your direct exam?

11 A I don't know if came out during the exam, but --

12 Q I don't know either. You, during your direct
13 examination?

14 A During my physical findings he told me during all those
15 functionality tests that I gave him that it sometimes felt
16 tight.

17 Q What does that mean to you as a doctor?

18 A Well, I -- the way I would interpret that personally --
19 and he obviously is three, he did not -- he was not as fluid
20 in his discussion. But the human body is sort of fluid
21 until there is an injury and then it is less fluid. And so
22 I would not be -- it would not be a surprise to me if
23 somebody with scaring felt tight, less fluid.

24 Q And he was able to describe it in such a way that you
25 interpreted that it felt tight, the scar?

1 A Right, yes.

2 Q And that tightness is certainly related to the
3 infiltration, correct?

4 A Well, it would be believable that it was due to the
5 scar tissue.

6 Q You believe it, correct?

7 A Yes.

8 Q Okay. And that's given to a reasonable degree of
9 medical certainty?

10 A Yes.

11 Q Okay. Now, with all the treatment you've described,
12 the steroid treatment, getting a three-year-old to take
13 steroid treatments are going to be very difficult, correct?

14 A Well, you would not want to make it scary to them.
15 And, yes, so I think anything that has to be -- we're giving
16 somebody a shot at that age --

17 Q Uh-huh.

18 A -- it is --

19 Q Wouldn't you agree with --

20 A -- intimidating.

21 Q Sorry. Wouldn't you agree with me that in this case
22 that giving R.J. steroid shots is not going to have -- would
23 not be an easy thing to do?

24 A I would totally agree with you that it's not easy.

25 Q Right?

1 A But it is, again, something that I would offer at any
2 age. I would not offer it, as a doctor, based on age.

3 Q All right. You always offer it because that's the
4 correct course of treatment, correct?

5 A That's right.

6 Q But in reality there's not a way to get a three-year-
7 old to take those injections is there?

8 A Oh, well, no. So every -- I can only speak for myself.

9 Q Right.

10 A Not other surgeons. But there would be several ???.
11 If I was with the family and they were agreeable to it.

12 Q Uh-huh. (Affirmative response)

13 A So we might just try to give him benadryl when he came
14 in.

15 Q Right.

16 A We might want to hold him still and do it. But there
17 again -- or we might give him some kind of anesthetic like
18 in an outpatient anesthetic setting. But really that is
19 somewhat dependent on the patient cooperating. Somewhat
20 dependent on parents' own view of that. Obviously, for my
21 own office I would discontinue anything that I thought was
22 too traumatic to the child, but the parent has a lot of --
23 they have some weight in that discussion.

24 Q Right. Do you have an opinion whether or not these
25 type of steroid injections are too traumatic for a three-

1 year-old child?

2 A Without something like a benadryl or something more
3 than that, definitely just doing it, it would be -- it would
4 not be successful at that age. He would not participate.

5 Q Benadryl is a medication for itching, right?

6 A Well, but we use it for sedative reasons too.

7 Q Okay.

8 A On young people, you know. There is the occasional
9 person that has the reverse effects from it, but it is very
10 sedating.

11 Q Okay. So you'd have to sedate the child in order to
12 get these steroid injections?

13 A Yes, right.

14 Q You also said you can physically hold him down?

15 A Definitely. That happens more than probably you're
16 assuming that it would.

17 Q Okay.

18 A It happens almost to everyone when we take the stitches
19 out with a young child. It is more risk than reward to put
20 them to sleep just to take a stitch out.

21 Q Uh-huh. (Affirmative response)

22 A And so there are plenty of times where you do have to
23 physically, you know, restrain a child.

24 Q And when you give this steroid injection for a scar
25 like R.J. has, how do you do it?

1 A Well, so, yeah. So there are different types of
2 corticosteroids. That's not really germane but you want to
3 put it directly into the lesion, which is the fibroblast,
4 cells that are thick cells. So you inject it, you know,
5 with a --

6 Q You take a needle and you stick it in the scar?

7 A And then you inject.

8 Q And then you inject?

9 A Yeah.

10 Q And you just do it one at a time or is it a series of
11 injections around the whole scar?

12 A Well, only into the thick areas.

13 Q Okay.

14 A And so it really depends on -- but, yeah. The length
15 of the needle does not cause pain, it's the, more of the
16 gauge of the needle that does, so --

17 Q Is that the --

18 A It's not --

19 Q -- thickness or --

20 A Yes, the diameter. So you don't need a large diameter
21 needle with the steroids or liquid. And if you had, you
22 know, depending on the person -- so for him at his age if
23 you have a one and half inch needle, you could probably
24 inject the whole area through one entrance, one injection.

25 Q So he would just need to have one stitch?

1 A Probably so, based on the size of his hand, yes.

2 Q All right. Now, you also talked about surgery,
3 correct?

4 A Yes.

5 Q That he probably needs?

6 A Well, so it's not -- it's more about not need, it's the
7 wrong word, but --

8 Q Uh-huh. (Affirmative response)

9 A -- if a person comes to me and would like to improve
10 the look of the scar and not, you know, like we said before
11 not necessarily that there's a functional problem, but the
12 look of it.

13 Q Uh-huh. (Affirmative response)

14 A Then we only have a couple of options available.
15 Whether or not you do stuff externally or remove the scar
16 through an excision.

17 Q And if you do either technique, the steroids or the
18 scar revision, R.J.'s still going to have a scar there for
19 the remainder of his life, correct?

20 A Yes.

21 Q And that's -- you have an opinion that he'll have a
22 permanent scar for the remainder of his life, correct?

23 A I'm of the opinion that he --

24 Q And what --

25 A -- will have --

1 Q What --

2 A -- a permanent scar.

3 Q Okay. And that opinion's given to a reasonable degree
4 of medical certainty?

5 A Yes.

6 Q So regardless of the steroids, regardless of the
7 surgery, he's going to have a scar for the remainder of his
8 life, correct?

9 A He's going to have a scar but if I do surgery on him,
10 the only goal of that surgery is that it would be a better
11 appearing scar.

12 Q All right.

13 A But he would definitely have the scar still.

14 Q No more questions.

15 MR. TANNER: Nothing further from this witness.

16 (End reading of Dr. Davis De Bene Esse Deposition)

17 (Court's Exhibit No. 2, Dr. Donen
18 Davis De Bene Esse Deposition was marked)

19 THE COURT: All right Thank you. Thank you, Mr.
20 Shakibanasab. You may step down.

21 All right. Ladies and gentlemen, you've heard all the
22 testimony you're going to hear today. I need for y'all to
23 be back in the jury room at 9:00 tomorrow morning and then
24 we'll pick up with the case. And remember you can't talk to
25 anybody about it. You can't talk among yourselves about the

1

2

(Court in session May 8, 2018 at 9:00

3

a.m.)

4

THE COURT: Are y'all ready?

5

MR. KRELL: Yes, sir, Your Honor.

6

THE COURT: Okay.

7

MR. KRELL: We just have one matter to take up.

8

Michael and I spoke and the life expectancy of this child --

9

he's three years old. From the date of trial forward would

10

be 73.76 years and we'd ask that you take judicial notice of

11

that.

12

THE COURT: Yeah. I think that's what we got in

13

the --

14

MR. KRELL: In the charge?

15

THE COURT: -- in the charge. I know it's 73-

16

something.

17

LAW CLERK: .76.

18

THE COURT: Yeah. Okay.

19

Anything else?

20

MR. KRELL: That's it, Your Honor.

21

THE COURT: Okay. Let me just tell y'all what my

22

expectation is. My expectation is we're going to finish up

23

with witnesses this morning and we're going to do the --

24

it'll go to the jury some time this afternoon.

25

MR. KRELL: Nothing from the plaintiff on that.

1 THE COURT: I mean, just so y'all could kind of --

2 MR. KRELL: Yes, sir.

3 THE COURT: I like for y'all to have time to think
4 ahead rather me surprise you, you know, okay?

5 MR. KRELL: Yes, sir. Thank you.

6 THE COURT: All right. Okay. If you'd bring the
7 jury on back out.

8 THE BAILIFF: Yes, Your Honor.

9 THE COURT: Thank you, ma'am.

10 (Jury in at 9:05 a.m.)

11 THE COURT: All right. Ladies and gentlemen, I
12 hope y'all had a good evening. Okay. Today we're going to
13 continue with the plaintiff's part of the case. I don't
14 know if y'all remember, we took one witness out of order
15 yesterday. So right now this morning we're going to
16 continue with the plaintiff's case.

17 And is plaintiff ready to call its next witness?

18 MR. KRELL: We are, Your honor. We call Dr. Peter
19 DeVito.

20 THE COURT: Dr. DeVito. Dr. DeVito, do you see
21 where that Bible is?

22 THE WITNESS: Yes, sir.

23 THE COURT: If you'd stop right there. Put your
24 left hand on the Bible, raise your right hand. The clerk's
25 going to swear you in.

1 THE WITNESS: (Complies)

2 (WHEREUPON, Peter DeVito was sworn
3 to tell the truth.)

4 PETER DEVITO - DIRECT EXAMINATION

5 BY MR. KRELL:

6 Q Good morning, doctor?

7 A Good morning.

8 Q What do you do for a living?

9 A I'm a plastic and reconstructive surgeon.

10 Q And how long have you been a plastic and reconstructive
11 surgeon?

12 A Almost fifty years.

13 Q Where did you go to college?

14 A I graduated from Princeton University. Medical school
15 was Duke University, and I did my internship in general
16 surgery at Yale. And I was one of the two plastic surgery
17 professors at the medical university and ran the residency
18 during the 70s. And I went into private practice in 1980
19 and was chief of plastic surgery at Roper Hospital for
20 fourteen years. And I've been chief at St. Francis
21 Hospital. Those are the two biggest hospitals in
22 Charleston, over twenty-five years now. I'm a senior
23 advisor to the South Carolina Society of Plastic Surgeons.
24 Q Do you typically treat patients with scars?
25 A All the time. My whole life.

1 Q Your entire life. Besides being a plastic surgeon, you
2 also had -- started out in pediatric surgery, correct?

3 A Yes. I had a love for pediatric surgery, came very
4 close to doing pediatric surgery, but I had a hard time
5 dealing with cancer.

6 Q Cancer in children?

7 A That was a killer. And my wife said you can't do this.
8 It's going to kill you. So I went into reconstructive
9 surgery.

10 Q Over the course of your --

11 A Pardon?

12 Q Over the course of your fifty-year medical career in
13 plastic surgery, have you had the opportunity to operate and
14 treat people with scars on their hands?

15 A Absolutely. I was the actual burn reconstruction
16 surgeon at the medical university when we had our own burn
17 unit. Back then, everything did not go to Augusta. In
18 those days, we had our own burn unit and we may get our own
19 burn unit again for Charleston. It was one of the best in
20 the nation?

21 Q And have you ever written any articles or journals
22 regarding plastic surgery?

23 A Yes, sir.

24 Q Regarding surgery, plastic surgery on patients' hands?

25 A Well, I wrote the emergency room manual sections on

1 hand injuries and face injuries. And taught those topics to
2 the medical students.

3 Q You teach as well or you did teach?

4 A I still do.

5 Q Oh, you do?

6 A Yes.

7 Q Are you familiar with Dr. Davis? You taught him?

8 A He was one of my residents, rotated with me.

9 Q And that's the gentleman -- we read his deposition
10 yesterday.

11 A Dr. Donen Davis, right.

12 Q He did rotation with you?

13 A He did. Good -- a very good man. Good surgeon.

14 Q All right.

15 MR. KRELL: At this point, I'd move to introduce
16 Dr. Peter DeVito as an expert in plastic surgery.

17 MR. TANNER: No objection, Your Honor.

18 THE COURT: All right. Ladies and gentlemen,
19 y'all remember yesterday when I told y'all about expert
20 witnesses testimony? I'm not going to read it again but it
21 applies equally to Dr. DeVito today, okay?

22 All right. He's your witness.

23 MR. KRELL: Thank you, Your Honor.

24 BY MR. KRELL:

25 Q Dr. DeVito, did you see R.J. Middleton?

1 A I did.

2 Q Did I set up an independent medical exam with you?

3 A I believe so.

4 Q And were you paid for that?

5 A Yes. We charged the standard fees of the Charleston
6 County Medical Society. We adhere to that suggestion of
7 medical legal fee schedules for reports and appearances and
8 testimonies and --

9 Q So isn't -- the fee is five hundred dollars. Does that
10 seem about right?

11 A I believe that's what it is now. I don't keep up with
12 it. The office up front just deals with that.

13 Q In your chart you have it where it reflects that the
14 independent medical exam fee is five hundred dollars? If
15 you could --

16 A It's probably in here somewhere, Mr. Krell. I don't
17 have the bills.

18 Q Okay.

19 A The only thing I have are the notes that I dictated
20 but there's probably a bill summary. Here it is. It is.
21 Yes. 1/26/15, charged five hundred dollars, credit five
22 hundred dollars, Attorney Krell.

23 Q And when did you see R.J. for this independent exam?

24 A When did I see him the first time?

25 Q Yes, sir.

1 A I saw the little boy on February the 2nd of the year
2 2015.

3 Q How was he doing at that time?

4 A Well, he was four months old and the history on it -- I
5 took the history from the parents, and he had sustained a
6 full thickness skin slough, loss the tissue off the back of
7 his hand, basically a third degree burn. And I thought the
8 scar was very thick. It was definitely what we call
9 hypertrophic and it was bordering on keloid formation. I
10 felt it was a keloid?

11 Q What's a keloid?

12 A That's a good question. The difference between a
13 hypertrophic scar and a keloid, the hypertrophic scar is a
14 very thick scar, a scar that's abnormally thick and angry.
15 Keloid comes from the Greek word meaning crab and it
16 actually scar tissue that invades a little normal
17 surrounding skin. And some of them can become very violent.
18 They're very symptomatic but that is the term for keloid.
19 It's actually a tumor of scar tissue.

20 Q When you say symptomatic, what do you mean symptomatic?

21 A Well, the old French Literature in the 1700s, when
22 these scars were being described, the patients described it
23 as if somebody were putting hot needles to the skin. Those
24 are the symptoms of this type of a scar, a keloid. They
25 burn, they itch. They're very symptomatic.

1 Q I'm going to show you some photographs that we've
2 marked. The first one I'm going to show you is Plaintiff's
3 Exhibit 1. We've got the blow-up. I'll put it up for the
4 jury. Would it be easier if you came down and pointed
5 things out?

6 MR. KRELL: And I'll ask the Judge if that's okay?

7 Q If you'd like to come down and point --

8 THE COURT: Whatever makes it easier for you to
9 explain, Dr. DeVito.

10 A Sure. (Witness steps down)

11 BY MR. KRELL:

12 Q If you would please, describe to the jury what we're
13 seeing in this photograph?

14 A This is a full-thickness slough of tissue. All layers
15 of the skin, sweat glands, hair follicles, everything,
16 straight down to the extensor tendons. And I would imagine
17 that these are extensor tendons where this grumous material,
18 this purulent looking, yellow stuff, which does not have any
19 vascularity or blood supply, is covering these extensor
20 tendons, which you can actually see under the dorsum of your
21 hand. These are the edges of the wound, the different
22 layers that are sloping down. But this is a wide open, full
23 thickness wound on the back of a hand, extending from the
24 metacarpophalangeal joints, the knuckles, all the way to the
25 dorsal flexion crease of the wrist.

1 Q Do you have an opinion, Doctor, whether or not that
2 would be painful?

3 A The actual third degree, where the full thickness loss,
4 the nerves have been damaged. So this central area is not
5 painful. Around the periphery it is painful where there's
6 still neurologic intact. And there is no excess skin on the
7 back of the hand. On the dorsal of the hand, if you take
8 your hand and you pinch the skin above it and you hold it,
9 you think there may be some excess. Then make a fist, you
10 can't hold that skin any more. There is no excess skin on
11 the back of that hand. So this wound, how do you get it to
12 heal. It's too contaminated for a skin graft or a skin
13 flap. So it has to take a lot of wound care, and it takes
14 all kinds of time for a wound to heal by what we call a
15 marginal epithelialization, thin sheets of epithelium, the
16 skin growing in from the sides, then it'll form a thick scar
17 and this scar is symptomatic. This is a rough wound over a
18 mobile extremity in an infant.

19 Q I'm going to show you another photograph doctor and ask
20 you --

21 A And this wouldn't accept a skin graft, so you couldn't
22 get it to heal right away. It's not ready for it, yet. It
23 would have to be prepared.

24 Q I show you what's marked as Plaintiff's Exhibit 3. And
25 If you could describe for the jury what you see in this

1 photograph?

2 A Okay. There's some granulation tissue that's growing
3 over the extensor tendons. So the tendons are not exposed
4 at this time, which is fortunate. Of course, if the wound
5 got infected, the whole thing could break down get
6 tendinitis so -- But right now we have this wide open
7 wound. It doesn't have any skin. It's over the dorsum of
8 the hand, the back of the hand. And the edges are -- it
9 looks like they may be starting to close in. You can tell
10 by the bacterial count within the wound if it's
11 contaminated. When the skin starts growing in from the
12 sides, that means the wound is cleaning up. And that it's
13 not really infected.

14 Q Is that painful?

15 A The whole nature of the wound is painful.

16 Q Thank you. If you want to have a seat, I'll ask you
17 some more questions from the witness stand. You may be more
18 comfortable from the witness stand --

19 A Thank you. (Witness takes stand)

20 Q One the February 2nd, 2015 note, you were talking about
21 the keloid scar.

22 A This is the February 2nd note?

23 Q Yes, sir?

24 A Yes, sir.

25 Q You said there was also hypertrophic scarring bordering

1 on keloid formation?

2 A Yes, sir.

3 Q What did you next find?

4 A Let's see here.

5 Q You talked about steroid injections?

6 A Yes, sir?

7 Q And we talked a lot about that yesterday. Tell us
8 about steroid injections with the age of R.J., and what
9 these injections could do or couldn't do?

10 A That's another excellent question. How do you treat a
11 keloid scar to help get it down. Keloid scars can occur in,
12 really, anybody. Mediterranean people with dark skin,
13 redheads are notorious for forming keloids. It isn't always
14 a black person that will form keloid scars. Keloid scars
15 are a problem, and they're also a problem in certain areas
16 more than others. For instance, on the sternum or on the
17 deltoid area, where there's a lot of motion, people may form
18 hypertrophic scars and keloids when they may not form them
19 on the abdomen or where the tissue tensions are soft. So
20 how do we treat keloid scars. Well, we tried radiation in
21 the past, but that has side effects on a growing child, on
22 bone growth. And well, that can be a problem. We've know
23 that corticosteroids can help soften scar tissue, cortisone
24 type medication, but how do you get it into a hard scar.
25 Trying to penetrate a hard scar with a needle and syringe is

1 very difficult. It's like trying to inject the paint on
2 this wall or something. If you can get the hypodermic
3 needle into the scar and then to try to push the cortisone
4 type medication into the scar, you might not get much in or
5 it may penetrate and go into the deeper soft tissue areas
6 where it's not needed --

7 Q And you're trying to do this with a three-year-old?

8 A Yeah. I'm trying to do it with a three-year-old. I
9 brought to Charleston and actually used it and a lot of
10 people use it now, it's called a derma jet. And it's
11 actually a form of an older bit of an old -- a French
12 vaccination gun where we can actually inject the cortisone
13 under high pressure without a needle. It injects a tenth of
14 a cc and you can get it into the scar. And it'll penetrate
15 the scar itself. And once it gets into the scar over a
16 period of a week or two, it'll start to soften the collagen,
17 the scar tissue in there. And it'll start to make the scar
18 lighter in color, if it's hyper pigmented. And it's really
19 a good way to soften a scar and repair it, but it's painful.

20 Q It's painful?

21 A It's painful. As soon as you inject that scar, it
22 triggers these electrical shocks and the paresthesias and
23 you can't get as much in that scar when it's hard. As it
24 starts to soften, it doesn't hurt as much and you can get
25 more in. It's exactly the opposite from what you might

1 think. But for a child, these are painful sessions. And,
2 you know, as soon a child would walk in and see a white coat
3 they'll start crying, because they associate, you know, the
4 white coat with pain. Oh, he's here. I'm going to -- you
5 know, and they're already crying. We've tried wearing
6 different colored coats or little fun pins and things to
7 make them happy. And if you don't keep doing it every few
8 weeks, you lose the softening effect and it can come back.
9 And they're seasonal too. In heat and humidity, where we
10 live in this humidity here, these things can flare up again.
11 You know, if there's burn scars on the back, kids are
12 scratching their backs on the edge of the door and the wall.
13 They're very symptomatic scars.

14 Q As of February 2nd, 2015, what was your course of
15 treatment for R.J.?

16 A Well, I don't think I ever initiated treatment for the
17 child.

18 Q Well, what are you recommendations?

19 A I felt my recommendations were that this keloid scar
20 was going to need aggressive initial treatment with
21 corticosteroids. Another thing is why don't you excise it
22 when it's thick and angry? Because it's going to come right
23 back again. The same thing is going to happen. Unless you
24 get it under control, then do the surgery, then it's going
25 to come right back. There was one other thing I failed to

1 mention and that's compression. It'll also help. You've
2 seen a lot of burn patients with these masks on where they
3 have a lot of burn scars and just their eyes are exposed.
4 These Jobst elastic supports, which are uncomfortable to
5 wear, exerting pressure on a thick scar can also help to
6 flatten the scar and soften it up. And also silicon
7 sheeting can also help. But they are uncomfortable to wear
8 and they're hot.

9 Q You then saw him a month later in March of 2015,
10 correct?

11 A Yes.

12 Q And how was he doing then?

13 A Well, it was still hyper pigmented, which was dark;
14 hypertrophic, which means thick, contractured. These things
15 never restore skin tones again. They always -- they just
16 don't look right. It's a patch of tissue that doesn't blend
17 in. And at that time, the scar was not softening. So I
18 felt that treatment with intra-lesional corticosteroids was
19 appropriate and probably will continue to be appropriate
20 indefinitely for this wound, for this child.

21 Q When you say appropriate at this point, is it
22 appropriate for R.J. as a three-year-old or is it down the
23 road? What --

24 A Both. Both.

25 Q If his mother doesn't want him to go through the pain

1 of the shots for the corticosteroids, do you have any
2 problems with that?

3 A No. Very understandable.

4 Q Let me show you --

5 A it's a dilemma.

6 Q A painful dilemma?

7 A Yes.

8 Q Let me show you what's been marked as Plaintiff's
9 Exhibit 2. And we've also got a blow up. And I'd like you
10 to just step down if and explain this photograph to the
11 jury?

12 A (Witness steps down)

13 Q And what we're looking at and how does someone either
14 as a plastic surgeon go in there and try to help?

15 A Okay. You remember, we had that big area? Now it's
16 shrunk down and you would think that's healed. But
17 remember, when you're pinching your hand and you thought you
18 had a lot of excess skin there and you made a fist, the skin
19 just disappears. So this is a scar contracture. The hand
20 is kind of dorsal flexed and there's no pliability there.
21 So if you tried to take that scar out of there and hopefully
22 not expose the tendons -- if you try to get the whole scar
23 out you'd probably have to take it off from around the
24 extensor tendons also. You would try to recreate the defect
25 and you would wind up with a big opening again if you were

1 going to put a skin graft on that thing. That's how much
2 skin is missing. So this is contracted down. It's not
3 open. You know, it's not infected, but it's a tight
4 restricting scar and it is limiting his grip.

5 Q Do you have an opinion to a reasonable degree of
6 plastic surgery certainty whether or not that scar is
7 permanent?

8 A Yeah. Once there's a scar there's always a scar.

9 Q How about if you did scar revision surgery?

10 A There's always a scar.

11 Q When was the last time that -- if you would, take the
12 witness stand and refer to your chart again.

13 A (Witness takes stand)

14 Q R.J. didn't return to see you until April 23, 2018,
15 just a couple of weeks ago?

16 A Yes, sir.

17 Q Between March 2nd, 2015 and April 23rd, 2018, would the
18 scar have had time to develop or heal? Is that a proper way
19 to say? It may be an inartful question? Could you explain
20 to us what happened?

21 A Well, the scar would have -- it would have time. It's
22 not going to -- it wouldn't change. The firmness, the
23 thickness, it really wouldn't have a chance to change very
24 much. It might lose some of the erythema, some of the
25 redness.

1 Q Okay. Was the scar symptomatic at that time?

2 A Oh, the same thing with the itching and burning. I
3 couldn't even examine the child. When I went to approach it
4 -- I was trying to check the skin tensions by pulling the
5 skin together and he withdrew and it was really an ordeal.

6 Q What do you mean withdraw?

7 A He just pulled his hand back. It's a source of pain
8 for him.

9 Q How does mother say he was doing at that time?

10 MR. TANNER: Objection, Your Honor. It's hearsay.

11 BY MR. KRELL:

12 Q What does your note reflect?

13 A I don't know.

14 THE COURT: As long as you rephrase the question
15 we're fine.

16 BY MR. KRELL:

17 Q What does your note reflect about whether or not the
18 scar was painful?

19 A His mother has noticed the child scratching at the scar
20 and he does complain to her that it is painful. It's just
21 -- and burns. The overlying epithelium is very thin, prone
22 to breakdown of even slight excoriation. And as I
23 mentioned, it's not normal skin anymore. It doesn't have
24 any roots, reedy ridges. There are no sweat glands. There
25 are no hair follicles, so there's nothing that goes down

1 deep into the skin that gives it pliability. So even
2 slightly bumping the hand on the back of something will
3 cause an excoriation breakdown, a blister, an ulcer.

4 Q And you recommend surgery?

5 A Yes. Surgery is going to have to be involved with this
6 if this scar is going to require release, reorientation.
7 And whether or not to replace tissue or not is another
8 thing, whether it's going to need skin grafting, split
9 thickness grafting, full thickness grafting, a flap or
10 something or whether it can be stage resected, taken out in
11 a couple of stages in an attempt to regain more pliability
12 following the stretching of the skin, but I --

13 Q Do you have an opinion to a reasonable degree of
14 plastic surgery certain that following the surgery the
15 recover is painful or not?

16 A Well, yes. There's pain.

17 Q And we're still talking about a three-year-old child.
18 Whenever you deal with surgery, this is a child of tender
19 years.

20 A Yes, sir.

21 Q Have you had a chance to review Plaintiff's Exhibit 6,
22 which is the wound care records from --

23 A Yes, sir.

24 Q -- the Wound Center. Have you looked at all --

25 THE COURT: That's plaintiff's 6?

1 MR. KRELL: 6, Your Honor.

2 BY MR. KRELL:

3 Q You've had a chance to review those?

4 A Yes, sir.

5 Q Do those seem reasonable and necessary?

6 A Yes, sir. A very good attempt to prevent and keep that
7 wound from getting infected.

8 Q I show you a document and if you could describe that
9 document for us, please?

10 A Yes, sir.

11 Q Is that the bill associated with the wound care?

12 A Yes, sir.

13 Q Does that seem reasonable and necessary?

14 A It seems very reasonable and much better than the
15 Charleston bills. That's very reasonable

16 MR. KRELL: Your Honor, I'd move to move this bill
17 into evidence as Plaintiff's Exhibit 7.

18 MR. TANNER: No objection.

19 THE COURT: Plaintiff's 7 is in evidence without
20 objection.

21 (Plaintiff's Exhibit No. 7, Wound
22 Care bill, was marked and entered.)

23 BY MR. KRELL:

24 Q Doctor, we talked about surgery and treatment, do you
25 have an opinion on the cost of these treatments?

1 A Well, the office did a cost estimate at that time and
2 it's hard for me to keep up with hospital costs. I know
3 what surgeons charge because we have a fee schedule.

4 Q Right?

5 A A lot of people feel that a doctor can charge whatever
6 they want to, but we're kind of locked into a fee schedule.
7 Just like you think we can fly around in an airplane in
8 those friendly skies anywhere you want to, but you're locked
9 into an altitude, in a corridor and a speed, and you're
10 stuck there. And so these fees that are generated from my
11 office come from the relative value fee schedules for the
12 surgeons. And the hospital fees we try to estimate and keep
13 up with them.

14 Q After seeing R.J., you know, twice in 2015 and then
15 just several weeks ago, do you have an opinion to a
16 reasonable degree of plastic surgery certainty what your fee
17 would be to -- your surgical fee would be?

18 A The surgery on that scar would be, at that time,
19 twenty-five hundred dollars. That would be just for the one
20 procedure.

21 Q Is there more procedures?

22 A It could be.

23 Q So that twenty-five hundred is on the low end?

24 A Yes. Yes, sir.

25 Q Okay. And then how about the associated costs,

1 hospitalization, anesthesia? You've got a range here of
2 four to twelve thousand?

3 A Yes, sir.

4 Q After seeing R.J. during the course of the past three
5 years, would the twelve thousand dollars be more reasonable?

6 MR. TANNER: Objection, Your Honor. He's leading
7 the witness. He's not --

8 THE COURT: If you'd rephrase the question,
9 please, sir?

10 Q How much is it going to cost to fix R.J.'s hand?

11 A Well, it would depend upon the procedure. If the
12 procedure would be able -- you know, a stage resection with
13 straight suturing and the discharge the following day.
14 However, the wound expanded and needed a skin graft, a full
15 thickness skin graft and then having to take care of the
16 skin graft would require extra days of hospitalization. You
17 have the anaesthesiologist, which is another doctor that's
18 involved in keeping the child asleep, which is not an easy
19 thing to do, and the extra tests that he would want to do
20 it. The hospital charges could absolutely explode.

21 Q It may be more than what's in your estimate?

22 A Absolutely. It's amazing how they can keep going up.
23 I can't keep track of them.

24 Q All right. Let me show you some documents. I think
25 it's Plaintiff's Exhibit 8.

1 A Yes, sir.

2 Q Does that accurately reflect your charge in this
3 matter?

4 A Yeah. This is my initial office note.

5 MR. KRELL: Your Honor, at this time I'd move Dr.
6 DeVito's charge into evidence as Plaintiff's Exhibit 8.

7 MR. TANNER: They've got two copies of the same
8 note.

9 THE COURT: Well, if you'd look it over, Mr.
10 Tanner and make sure we've just got --

11 MR. TANNER: No objection.

12 THE COURT: All right. Plaintiff's 8 is in
13 evidence without objection.

14 (Plaintiff's Exhibit No. 8, Dr.
15 DeVito's initial office note, was marked and entered)

16 BY MR. KRELL:

17 Q Thank you, Doctor. Please answer any questions Mr.
18 Tanner may have.

19 THE COURT: Mr. Tanner.

20 MR. TANNER: Thank you, Judge Dickson. May it
21 please the Court.

22 PETER DEVITO - CROSS-EXAMINATION

23 BY MR. TANNER:

24 Q Thank you, Dr. DeVito. How are you this morning?

25 A I guess I'm doing all right, Mr. Tanner. How are you?

1 Q Thanks for coming to Orangeburg today. You first saw
2 this child based on Mr. Krell asking you to see his client,
3 correct?

4 A Yes, sir.

5 Q And you're good friends with Mr. Krell's dad, right,
6 who's a lawyer in Charleston?

7 A Well, I've been in Charleston for fifty years and
8 everyone knows everyone in Charleston.

9 Q Did you take any photographs when you examined the
10 child?

11 A No.

12 Q So none of these photographs that you've shown and
13 explained to the jury you took?

14 A No.

15 Q Okay. And when the child first came to you in February
16 2015, his hand didn't look like that, did it?

17 A No, sir.

18 Q And this other one where they expose tendons, when he
19 saw you, his hand didn't look like that either, did it?

20 A No, sir.

21 Q And do you know when the picture was taken of this
22 scar?

23 A No..

24 Q Did it look like that when you saw him in February of
25 2015?

1 A It was thick and it was similar.

2 Q Okay. You testified earlier that it was keloid and I
3 think you used the term tumor and it sort of surprised me.
4 And you said it was going to be growing. If that was the
5 case, it hadn't grown much beyond what this -- in this
6 photograph, has it?

7 A The -- I used the term tumor because it's an explosive
8 growth of scar tissue. And I mentioned the word keloid,
9 seeming like crab. And if you look at that picture right
10 there --

11 THE WITNESS: Am I allowed to pick the picture up
12 to show the jury?

13 MR. TANNER: I'm sorry. I'll get it for you.
14 Which one do you want, sir?

15 THE COURT: Yeah. He'll get it for you.

16 I think it's 2. Would you double-check? Is that
17 Plaintiff's Exhibit --

18 MR. TANNER: 2, yes, sir.

19 THE COURT: Okay.

20 THE WITNESS: If they could see that and if I
21 could stand up?

22 THE COURT: Yeah, you want to step back down,
23 yeah.

24 THE WITNESS: Thank you.

25 A (Witness steps down) He also mentioned that -- how

1 this picture, this would have been earlier on and it still
2 had a lot of the dead tissue that was on there. When I saw
3 the child, the scar was healed. There was no open area.

4 BY MR. TANNER:

5 Q That would have been healed by February of 2015,
6 correct?

7 A Yes. I guess so. When I saw him on that day, there
8 was no open area.

9 Q Well, that was the first day you saw him, right?

10 A Yes, sir.

11 Q Okay.

12 A And you can see where these extensions are, the
13 scaring.

14 THE COURT: Ma'am, you can move over if you want
15 to see. You're not stuck in that seat.

16 THE WITNESS: I'm sorry.

17 THE JUROR: Okay.

18 THE COURT: Okay. All right.

19 A And you see those extensions where it looks like this
20 thick scar tissue under there, it's invading normal skin
21 that's right in -- it's going right into what should be
22 normal type skin. And that Greek word, the keloid, crab
23 almost looks like a crab. That's a keloid. And some people
24 feel that it's a tumor of scar tissue because of the way it
25 grows. And some people say gee he feels like a baby. Well,

1 young children and babies may feel more violently than
2 grownups. And certain individuals are more prone to forming
3 scars like these. Not everybody forms a scar like this, but
4 I mentioned certain areas that do form these kinds of scars,
5 the sternum, deltoid, that's a rough start.

6 Q Okay.

7 COURT REPORTER: Mr. Tanner, what is the exhibit
8 number on that photograph that Dr. DeVito used?

9 MR. TANNER: 1.

10 COURT REPORTER: Thank you so much.

11 MR. TANNER: Yes, ma'am.

12 BY MR. TANNER:

13 Q Did you take any pictures when you saw him just
14 recently?

15 A No, I took no pictures.

16 Q But you did an independent medical exam?

17 A Yes.

18 Q All right. I want to show you what's already been
19 admitted as Defendant's Exhibit 2. Is that similar to the
20 child's hand when you saw him back just a few weeks ago?

21 A Yes, sir.

22 Q And that would be the same picture?

23 A Yes, sir.

24 Q But you didn't take any photographs to show how the
25 scaring was?

1 A No.

2 Q When was that appointment made for you to see him on
3 February 23rd, 2018?

4 A I don't know when it was scheduled.

5 Q Because he hadn't been to your office since almost
6 three years, over three years, right?

7 A Correct.

8 Q Were you provided with Dr. Davis' independent medical
9 examination?

10 A I saw it.

11 Q You said he was a good student. He was a good surgeon
12 I believe you testified to, correct?

13 A Yes.

14 Q You mentioned earlier the derma jet. Is there an age
15 limit when a child or person can have the derma jet
16 injection?

17 A No.

18 Q So theoretically he could have had the derma jet back
19 in February of 2015?

20 A Yes.

21 Q At that time, he'd have been four months old, right?

22 A Yes, sir.

23 Q So there probably wouldn't have been the same
24 apprehension of seeing a doctor in a white coat and getting
25 that procedure would you -- is that --

1 A With the derma jet?

2 Q Yes, sir.

3 A The derma jet is as painful as a needle. It's just
4 that it's not a needle. It's injecting the cortisone under
5 high pressure and it helps the physician to get the
6 medication into the scar itself, rather than to try to do it
7 with a needle and syringe.

8 Q Yes, sir. You had mentioned when Mr. Krell was asking
9 you questions though if the child at age three, almost four,
10 come in and see you in the white coat, he can be upset. And
11 so my question is if you'd done this when he was four months
12 old, presumably he wouldn't have had that same apprehension,
13 right?

14 A Oh, no. He could still have apprehension because the
15 derma jet treatments are painful. And, you know, I did it.
16 I gave him the pain and he'd see the white coat and the
17 white coat, pain -- it's emotional scaring that --

18 Q Well, but almost four years later he might not remember
19 it, correct?

20 A No.

21 Q You would agree that it --

22 A He would remember it.

23 Q -- that it was your recommendation back in February of
24 2015 to have steroid injections, correct?

25 A Yes. And I still do.

1 Q And that would have been your recommendation you made
2 to Ms. Hamilton?

3 A To treat the scar, yes.

4 Q You thought that would benefit her son, right?

5 A Yes.

6 Q And to date he hasn't had any injections?

7 A No, not yet.

8 Q And when he came back in March you again recommended
9 him to have the steroid injections, correct?

10 A Yes, sir.

11 Q And you felt at that time that it would benefit,
12 benefit the child?

13 A Yes, sir.

14 Q And you mentioned earlier the jell, the sheeting. And
15 that was what Dr. Davis recommended from his report that you
16 read, right?

17 A Yes, sir.

18 Q I don't see anything in your report that he has any
19 loss of functionality, correct?

20 A I really didn't examine him about that. He wouldn't
21 even let me touch the wound. So I suspect he has some
22 limitation, utilization of that hand compared to a child who
23 doesn't have a hand that's injured like that.

24 Q But you don't have anything in your report --

25 A But I don't have anything in my report about it.

1 Q And were there any appointments scheduled between March
2 2015 and April 2018, right before trying this case?

3 A I don't believe so.

4 Q Thank you, sir. No further questions.

5 THE COURT: Anything on redirect limited to his
6 cross.

7 MR. KRELL: No further questions and we'd ask if
8 Dr. DeVito could be excused.

9 THE COURT: Any problems with that?

10 MR. TANNER: No objection.

11 THE COURT: Thank you, Dr. DeVito.

12 THE WITNESS: Thank you, Your Honor.

13 THE COURT: Yes, sir.

14 All right. Is the plaintiff ready to call its next
15 witness?

16 MR. WILLIAMS: We have one matter. Your Honor,
17 we'd like to read a request for admission in regard to the
18 statute.

19 THE COURT: Okay.

20 (Off record discussion)

21 MR. WILLIAMS: Your Honor, I'd like to publish a
22 request for admission.

23 THE COURT: All right.

24 Do you know what --

25 MR. TANNER: I don't know which. I mean, I know

1 Q And were there any appointments scheduled between March
2 2015 and April 2018, right before trying this case?

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6 cross.

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8 Dr. DeVito could be excused.

9 THE COURT: Any problems with that?

10 MR. TANNER: No objection.

11 THE COURT: Thank you, Dr. DeVito.

12 THE WITNESS: Thank you, Your Honor.

13 THE COURT: Yes, sir.

14 All right. Is the plaintiff ready to call its next
15 witness?

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18 statute.

19 THE COURT: Okay.

20 (Off record discussion)

21 MR. WILLIAMS: Your Honor, I'd like to publish a
22 request for admission.

23 THE COURT: All right.

24 Do you know what --

25 MR. TANNER: I don't know which. I mean, I know

1 -- if he'll refresh my recollection.

2 MR. WILLIAMS: Mr. Tanner sent requests for
3 admissions on December 14th, 2015.

4 THE COURT: Would you show him so that he'll know
5 what we're talking about.

6 (Off record discussion between
7 counsel)

8 MR. TANNER: Yeah. And I think that's probably a
9 matter we need to take up outside the presence of the jury,
10 Your Honor.

11 THE COURT: Okay. All right.

12 All right. Ladies and gentlemen, I'm going to let
13 y'all go back into the jury room for a second. Again,
14 remember, you cannot talk about any of the testimony you've
15 heard so far, okay? I'll get you back out here as soon as
16 we can. Thank you.

17 (Jury out at 9:51 a.m.)

18 THE COURT: All right. Can y'all -- go ahead.
19 You want to show me the request to admit.

20 MR. WILLIAMS: I'm sorry, Your Honor.

21 THE COURT: Thank you, sir. Okay. What do you --
22 you want these -- okay. All right. So Mr. Tanner, you sent
23 these to --

24 MR. TANNER: I sent those. The whole purpose
25 behind those was for the independent medical examination

1 under Rule 35, that's the hundred thousand dollar figure is
2 the trigger that triggers that whole -- I certainly, I don't
3 think that the plaintiff can say well, we think it's worth a
4 hundred thousand dollars and publish that to the jury when
5 that was -- the purpose of that was the independent medical
6 examination, which we subsequently filed a motion on.

7 THE COURT: All right.

8 MR. TANNER: It would certainly also simply
9 confuse the jury based on the medical bills that they've put
10 in, to just try to limit it to those black and white
11 figures.

12 THE COURT: Who's going to speak?

13 MR. WILLIAMS: Your Honor, I will. First, the
14 issue is he's not -- I mean, the rule is clear. The Rule 36
15 says in our state, requests to admit are not -- or that are
16 not sent to the jury. Rather, the proper course of action
17 is to publish the admissions to the jury. The issue that
18 we've got here is he used the request to admit, which
19 creates a stipulation of this court. When we agreed to the
20 stipulation, it is thereby stipulated and it's, according to
21 the rules, to be published to the jury. The request to
22 admit that we wish to publish has nothing to do with the
23 need for an IME. The need to substantiate an IME is a
24 matter of controversies in excess of a hundred thousand
25 dollars. The stipulation was the actual damages exceed one

1 hundred thousand dollars. To have that stipulation entered
2 into this court but then argue something different is a
3 fatal issue, Your Honor, which I don't believe should be
4 allowed. That would be misleading the jury when you've got
5 a stipulation that there's in excess of a hundred thousand
6 dollars in actual damages.

7 THE COURT: All right.

8 Mr. Tanner, anything else?

9 MR. TANNER: It's not a stipulation, Your Honor.
10 It's a discovery tool. And, again, to publish that to the
11 jury I think is highly prejudicial because it's going to
12 confuse them because it -- you know, it's just not -- it is
13 not a stipulation. It's not me agreeing. It is a discovery
14 request and they have answered it, but it's certainly not a
15 stipulation. And I think at this point in time, I think to
16 publish that is just going to lead to a highly prejudicial
17 effect and under Rule 403 any value is going to be
18 outweighed by the prejudice.

19 THE COURT: But, again, the whole purpose of this,
20 I thought the request to admit was to get things --

21 MR. TANNER: To get facts -- I think if it was a
22 factual matter, you know, did he have a scar? Then I think
23 they could use it but damages are subjective. And in order
24 to get to that point -- there's no way to get to the IME, I
25 don't think, unless you have something regarding their view

1 of the case. And all this is, is their view of the case.
2 It's certainly not the hospital's view of the case. So,
3 again, all you're doing is you're, I think, reemphasizing
4 for the jury -- they think the case is worth more than a
5 hundred thousand dollars.

6 THE COURT: Well, just out of curiosity, why
7 wasn't that -- I mean, why wasn't something put in here
8 saying this is limited to the IME or why wasn't that kind of
9 stipulated?

10 MR. TANNER: I guess because, again, it wasn't a
11 stipulation. It was more just a request.

12 THE COURT: All right. Well, I got -- I'm just
13 looking, you know, back through the notes after 36. From
14 one of the cases, Scott versus Greenville Housing says
15 requests to admit are not submitted to the jury, while the
16 proper course of action is to publish these admissions to
17 the jury. And I haven't read that case. I haven't looked
18 at it to see what those admissions were. But if y'all would
19 give me a second, let me -- let me just pull that. I'll be
20 right back out here so we can look at that, okay?

21 I'm assuming nobody's got any other cases that y'all
22 want to show to me, right?

23 (No response from counsel)

24 THE COURT: Okay. I'll be right back. Okay.
25 Thank y'all. We'll stand down for a second.

1 (Court at ease)

2 THE COURT: All right. Going back to publishing
3 these?

4 MR. WILLIAMS: Yes, sir.

5 THE COURT: Here. This is your copy or what you
6 gave me earlier. Oh, y'all can be seated. I'm sorry. I'm
7 sorry. I get -- when I get kind of behind I get really --
8 move faster. It looks -- from my reading of the rules, it
9 appears that the admissions can be published or it should be
10 published. Normally, speaking if you want to make a motion
11 to change the admission or like that, it has to go to the
12 merits and this goes to damages and not the merits. And
13 usually the person that is complaining about the admissions
14 is the person that actually answers. Now, I believe that
15 you, Mr. Tanner, had stated most of your objections onto the
16 record, but if you have any additions to that, I'll be glad
17 to hear them right now.

18 MR. TANNER: May it please the Court, Your Honor?

19 THE COURT: Yes, sir.

20 MR. TANNER: Obviously, under Rule 36, as you
21 alluded to, 36(b), you know, the Rule states that the Court
22 may permit withdrawal or amendment when the presentations of
23 the merits would actually be subverted thereby and the party
24 who obtained the admissions fails to satisfy the Court that
25 withdrawal or amendment will prejudice him in maintaining

1 his action or defense on the merit. And respectfully, I
2 think it does impede my defense on the merits. It's almost
3 like in a sense you're saying to the jury, if you're going
4 to award damages to the plaintiff, you have to give her
5 damages of at least a hundred thousand dollars, which then
6 almost makes it to where you're directing a verdict in
7 liability favor, which is obviously disputed as well as
8 damages. You know, Mr. Williams argued that it was a
9 stipulation. Obviously, the stipulation is under Rule
10 43(k). It's not a stipulation; it's a discovery tool. The
11 request to admit rule says it has to be a statement of fact.
12 I don't believe this is a statement of fact. It has to be
13 an opinion of fact. I don't believe it's an opinion of
14 fact. It is certainly not an admission. It does not say
15 TRMC admits the value of the plaintiff's actual damages
16 exceed a hundred thousand dollars. So I really think that
17 by allowing that with the jury all it's going to do is
18 confuse them. It's certainly going to prejudice them
19 because then they may be under some belief that they have to
20 give a verdict for the plaintiff. And if they give a
21 verdict they have to give a verdict for at least a hundred
22 thousand dollars. And I don't think -- I think the burden
23 is on them to -- the plaintiff to show that by not
24 publishing that, that somehow they'll be prejudiced in
25 maintaining their action. I don't think they can show that

1 because certainly they can argue to the jury to do whatever
2 verdict they want. So there's no prejudicial effect in not
3 allowing the admission to go to the jury, whereas by
4 allowing it to go to the jury, certainly would significantly
5 prejudice to the hospital.

6 THE COURT: And I think those are all good
7 arguments. It's just the way I read the rule. Clearly, I'm
8 going to let them publish it. But I'm going to do
9 everything I can to make sure your objection is preserved,
10 okay?

11 All right. Y'all ready?

12 MR. WILLIAMS: Yes, sir. Your Honor, before I
13 publish this, can I explain to the jury what a request to
14 admit is or would like to just so they understand -- I'm
15 happy to do it in a very brief manner.

16 MR. TANNER: I think all that's going to do is
17 just draw further attention to it.

18 MR. WILLIAMS: Okay. I'll just read it, Judge.

19 THE COURT: Yeah. If you'll just read it. I think
20 that --

21 MR. WILLIAMS: That's fine.

22 THE COURT: That's fine. Okay.

23 Bring the jury on in.

24 THE BAILIFF: Yes, Your Honor.

25 THE COURT: Thank you.

(Jury in at 10:57 a.m.)

THE COURT: All right. Ladies and gentlemen, I apologize for it taking so long, but it took me longer to decide something than it should have, okay? So right now we're going to continue with a portion of the plaintiff's case. Okay.

Yes, sir.

MR. WILLIAMS: May it please the Court.

THE COURT: And just for the record, you are going to read that subject to the defendant's objection?

MR. WILLIAMS: Yes, sir.

THE COURT: Okay. Thank you, sir.

MR. WILLIAMS: Thank you, Your Honor.

Ladies and gentlemen, Michael Tanner sent to Jonathan F. Krell, attorney for plaintiff, pursuant to Rule 36 of the South Carolina Rules of civil Procedure, please admit the follow statements and/or genuineness of the following documents. Request to admit: Admit the value of the amount in controversy in this action is less than one hundred thousand dollars? Answer, denied.

Request to admit number two: Admit the value and amount in controversy in this action is greater than one hundred thousand dollars? Admit.

Admit -- number three: Admit the value of plaintiff's actual damages exceeds one hundred thousand dollars. Admit.

1 (Jury in at 10:57 a.m.)

2 THE COURT: All right. Ladies and gentlemen, I
3 apologize for it taking so long, but it took me longer to
4 decide something than it should have, okay? So right now
5 we're going to continue with a portion of the plaintiff's
6 case. Okay.

7 Yes, sir.

8 MR. WILLIAMS: May it please the Court.

9 THE COURT: And just for the record, you are going
10 to read that subject to the defendant's objection?

11 MR. WILLIAMS: Yes, sir.

12 THE COURT: Okay. Thank you, sir.

13 MR. WILLIAMS: Thank you, Your Honor.

14 Ladies and gentlemen, Michael Tanner sent to Jonathan
15 F. Krell, attorney for plaintiff, pursuant to Rule 36 of the
16 South Carolina Rules of civil Procedure, please admit the
17 follow statements and/or genuineness of the following
18 documents. Request to admit: Admit the value of the amount
19 in controversy in this action is less than one hundred
20 thousand dollars? Answer, denied.

21 Request to admit number two: Admit the value and
22 amount in controversy in this action is greater than one
23 hundred thousand dollars? Admit.

24 Admit -- number three: Admit the value of plaintiff's
25 actual damages exceeds one hundred thousand dollars. Admit.

1 Thank you.

2 THE COURT: Thank you, sir?

3 Any other witnesses on behalf of the plaintiff.

4 MR. WILLIAMS: Your Honor at this time we'd call
5 Jamie Beth Downing.

6 THE COURT: Okay.

7 Where's Ms. Downing.

8 MR. TANNER: I didn't know y'all were going to
9 call her in your case.

10 MR. WILLIAMS: I listed her in our pretrial brief
11 as a witness. Can we have somebody maybe announce for her
12 if she's here. Do we know where she is?

13 THE COURT: Do you know where she is?

14 MR. TANNER: I think she should be on her way.
15 Let me go and check if I may have a few minutes.

16 THE COURT: Yeah. Go ahead.

17 MR. TANNER: (Exits courtroom)

18 (Court at ease)

19 MR. WILLIAMS: May I look at the exhibits for a
20 second just to organize them?

21 THE COURT: Sure.

22 (Court at ease)

23 THE COURT: Mr. Shakibanasab?

24 MR. SHAKIBANASAB: Yes, sir.

25 THE COURT: Would you go get Mr. Tanner and tell

1 him to come back in here. I think I want to just let the
2 jury go back to the jury room while we wait. And I want to
3 make sure he's in here while I do that.

4 MR. SHAKIBANASAB: (Exits courtroom)

5 (Court at ease)

6 MR. KRELL: Your Honor, it may be beneficial that
7 we rest and if she's going to be present we can handle our
8 questioning during cross-examination to speed things along.

9 THE COURT: You go get Mr. Tanner and tell him
10 that, that'll be fine.

11 MR. WILLIAMS: Sure.

12 THE COURT: Y'all work it out.

13 MR. WILLIAMS: (Exits the courtroom)

14 (Court at ease)

15 THE COURT: Unfortunately, we don't have
16 commercials when we have down time. That's why we keep
17 y'all back there most of the time while we do this.

18 (Counsel enters courtroom)

19 MR. WILLIAMS: May we approach? I think the
20 witness is here, Your Honor.

21 THE COURT: Oh, okay.

22 (Off the record bench conference with counsel and the
23 Court.)

24 (Court at ease)

25 THE BAILIFF: Your Honor, may they step back? One

1 got to --

2 THE COURT: Huh? Oh, yeah. Somebody's got --

3 THE BAILIFF: Take them back out --

4 THE COURT: Yeah. Yeah.

5 THE BAILIFF: Okay.

6 THE COURT: Yeah. Y'all go on back. We'll be
7 right back out. Right back.

8 (Jury out at 11:04 a.m.)

9 (Court at ease)

10 MR. TANNER: Ms. Downing's here, Your Honor.

11 THE COURT: Okay. The jury had to go back to the
12 -- some people needed to take a break, so y'all bear with
13 them. They're going to be back -- as soon as everybody's
14 through, yeah, if you could get them on back out here.

15 THE BAILIFF: (Affirmative response)

16 (Court at ease)

17 (Jury in at 11:10 a.m.)

18 THE COURT: All right. Ladies and gentlemen, we
19 will get ready to continue with the plaintiff's case. Mr.
20 Williams, you called Ms. Downing?

21 MR. WILLIAMS: Yes, ma'am. Yes, sir. Excuse me.
22 Jamie Beth Downing.

23 THE COURT: Ms. Downing, come on down please,
24 ma'am.

25 THE WITNESS: (Complies)

1 THE COURT: Ms. Downing, you see where that Bible
2 is right there?

3 THE WITNESS: Yes.

4 THE COURT: Okay. If you'd stop right there, put
5 your left hand on the Bible.

6 THE WITNESS: Uh-huh. (Affirmative response)

7 THE COURT: Raise your right hand.

8 THE WITNESS: (Complies)

9 THE COURT: The Clerk's going to swear you in.

10 (WHEREUPON, Jamie Downing, was duly
11 sworn)

12 THE COURT: All right. And Ms. Downing, you might
13 need to talk just a little louder, okay?

14 JAMIE DOWNING - DIRECT EXAMINATION

15 BY MR. WILLIAMS:

16 Q Ms. Downing, my name is David Williams, I'm going to
17 stand over here just so you can more or less speak to the
18 jury in this case. For starters, where do you live now?

19 A I recently relocated to Greensboro, North Carolina.

20 Q Okay. And are you still a nurse?

21 A I am.

22 Q All right. Do you recall treating R.J. at The Regional
23 Medical Center?

24 A Yes. Vaguely.

25 Q Okay. And while you were treating R.J. at TRMC, you

1 had begun working full-time shortly before that?

2 MR. TANNER: Objection, Your Honor. They called
3 her as a witness. They're leading her. He's asking leading
4 questions on direct.

5 MR. WILLIAMS: Your Honor, at this time she's an
6 adverse witness. I'd make a motion to treat her as an
7 adverse witness, and therefore be allowed --

8 THE COURT: Well, right now, she hasn't -- if she
9 starts showing any reluctance to answer like that, I'll
10 address that. Right now, if you'd just ask her regular
11 questions.

12 BY MR. WILLIAMS:

13 Q How many days a week did you work at the time of this
14 incident?

15 A At the time I worked about three twelve-hour shifts,
16 about thirty-six hours a week.

17 Q Okay. So three days a week you'd work. And how many
18 weeks had you been working at The Regional Medical Center?

19 A I can't tell you exact weeks, but I'd started back in
20 August so probably less than two or three months.

21 Q Okay. And when you started, you began a couple week
22 training session?

23 A Yes. And so the way The Regional Medical Center
24 orientation works, you start with a hospital-based
25 orientation, which is about two weeks. And then you do a

1 shift on the floor for about six to eight weeks.

2 Q Okay. So about ten weeks after you started before you
3 became on your own?

4 A Yes, that's correct.

5 Q And you started in August?

6 A Yes.

7 Q So that would be in mid-October you would be on your
8 own?

9 A That sounds about right.

10 Q Do you know about the date that this incident occurred?

11 A I think it was the end of October.

12 Q And that's assuming you started at the beginning of
13 August; is that right?

14 A I believe so. I don't have a calendar in front of me
15 to count weeks.

16 Q And so is it fair to say within a couple of weeks that
17 you would have treated R.J. on your own?

18 A I'd only been there for a few months, so that sounds
19 about accurate, yes.

20 Q And during your two-week training, were you given
21 policies and procedures?

22 A So for the first two weeks it would have been hospital-
23 base training, that is the time you review all the hospital
24 policies.

25 Q And when you did your six to eight week training with

1 another nurse, you went specifically through the policies
2 and procedures?

3 A You specifically care for patients on the floor, and
4 learn the policies in the two weeks prior and implement that
5 into your care of the patient. So you're giving direct
6 patient care.

7 Q So you would expect during that training that they
8 would show you all the policies and procedures?

9 MR. TANNER: Object, Your Honor. Improper form.

10 BY MR. WILLIAMS:

11 Q Did you review all the policies and procedures?

12 A Yes.

13 Q Did you have a nurse tell you how to interpret the
14 policies and procedures?

15 A So the way a hospital policies and procedures are
16 written, they're not -- there's not room for interpretation.
17 They are direct instructions on the way you should perform a
18 procedure.

19 Q Okay. So there's no room for interpretation as you
20 read it as whatever it reads, correct?

21 A Correct. That is the policy of the hospital.

22 Q Whether it's an infant or an adult are you told to
23 assess the IV the same way?

24 A So IV assessment, I don't believe -- it's not a full
25 step by step policy. There are recommendations on when IV's

1 should be assessed, who they should be assessed on, how
2 frequently. But a true nursing assessment of an IV is
3 something that is more for the nursing school, practiced
4 through nursing school and done through the nursing
5 practice. It's not something that is step-by-step taught
6 through a policy. It's something you repetitively do
7 throughout your nursing practice and training.

8 Q Sure. But my question is, in your assessment, is there
9 anything different from with infant as opposed to an adult
10 in the assessment of the IV site?

11 A Yes. Pediatric IV's are very different than adult
12 IV's. With pediatrics, your patients are very small and
13 very mobile, so one factor their veins are very small,
14 they're very mobile. They're very fragile. So in assessing
15 a pediatric IV's you're going to do a more frequent
16 assessment and you're also going to be more understanding of
17 how this patient's probably going to move more. They don't
18 understand what they're doing. Obviously, a baby, pulling
19 at his IV is not intentional or pulling at a site isn't
20 intentional. So you're very aware of that when assessing a
21 pediatric IV, whereas you might have adult patient who's
22 lucid, their veins are more stable. Their veins are bigger.
23 They're able to use bigger catheters, we call them. That's
24 the part of the IV that stays in the vein. So it's very
25 different assessing an adult and a pediatric patient.

1 Q Tell me, what are the steps to assess an IV site?

2 A So to assess an IV sited means to check it. So to
3 assess an IV, kind of eyes, feel, kind of going through
4 everything. So you're first is going to look at the
5 patient. Where is the IV site? So I know with R.J. or Mr.
6 Middleton, it was in his hand. So you're first going to
7 look at that hand. If this is the first time you're coming
8 onto the shift, you're going to do a very thorough
9 assessment, say this is where it is. This is the way it
10 looked when I first saw it. And your assessment throughout
11 the night are going to be kind of based off of that. So
12 you're going to look at the position of the IV. There are
13 little (inaudible) at the bottom of an IV, so especially
14 pediatrics there's a little tiny triangle. So a way to see
15 if it's in the same position is to look at that triangle.
16 And you kind of want it pointed in the same spot. There's
17 going to be a clear dressing over it. You want to make sure
18 that dressing is intact. That there no -- any fluid or
19 anything that looks, other than normal. So you want to make
20 sure that dressing is intact. There's specifically extra
21 tape in a pediatric IV that's going to be moving a lot, and
22 you want to make sure that tape is still there and that it's
23 secure. You're also going to see if there's anything
24 stabilizing it. So a lot of times pediatrics they will have
25 an arm board. So that will cushion, that stabilizes the arm

1 and the hand to keep it straight. So you want to make sure
2 an IV -- it's like a little straw that goes into another
3 little straw and it's very flexible. So sometimes you need
4 to hold that in the same position. So that's what you're
5 going to do when you're looking at it. If there's any
6 tubing hooked up to it, you want to make it's intact,
7 there's nothing changed or abnormal about that IV tubing.
8 You're going to look at it and touch it. You want to feel
9 the top of it and feel around it. It should be consistent
10 with the patient's other extremities. So if this hand was
11 soft and smooth and warm, then it should be soft and smooth
12 and warm. You're going to feel for any kind of swelling,
13 any temperature changes. You're going to keep looking at
14 it, touching. And then you're going to check for something
15 called PEC, so making sure that straw is open so that we're
16 able to flush fluid in and out of it. So you would clean
17 the site and then flush it with normal saline, which is like
18 salt water. So a small amount, about a millimeter, of
19 normal saline just making sure that IV is flowing the way
20 it's supposed to. And so that's going to kind of give you
21 an idea. And you're still going to keep touching and
22 feeling the site as you're flushing it to notice for any
23 changes since that would indicate that the catheter isn't
24 where it's supposed to be. So if you notice any sign and if
25 it's cool to the touch, that means you're touching fluid,

1 you're not touching skin. So you continuously monitor that
2 while assessing the IV. And if all that's good and it looks
3 like it did the first time you saw it, you're not seeing any
4 additional discomfort from the patient, sometimes that salt
5 water can be a little irritating, so you kind of have to
6 assess that, especially in a pediatric patient who can't
7 talk to you. So it can be a little irritating the first
8 time you do it, if the patient initially kind of (inaudible)
9 you'd flush it a little bit more and a lot of times they
10 kind of calm down a little bit after that first irritation
11 because it is salt, so it can be a little irritating, so.
12 You're probably doing a lot of things. You're looking,
13 you're touching, you're feeling, you're seeing, you're
14 flushing. Sometimes those pediatric IVs, especially in the
15 hand, they can become kinked. So sometimes it takes a
16 little manipulating, maybe even to tape the hand a little
17 bit more on the arm board, open that straw back up. And so
18 it's just kind of a give as you go. And you just kind of
19 have to keep reassessing. But that first, initial
20 assessment, you're really going to have a good idea of where
21 that placement is so then throughout the night you can
22 continue to look at that same placement for reference in
23 your assessment.

24 Q Ms. Downing, you had a rather lengthy explanation. Can
25 you tell me any of those steps you don't do for an adult?

1 A So you would do it with an adult. So you typically
2 wouldn't have an arm board with an adult patient if the were
3 lucid. The thing to take out of it with pediatrics is that
4 it is much --

5 MR. WILLIAMS: Your Honor, at this point I'd ask
6 you to instruct her to answer the question yes, no or at
7 least allow me to treat her as a hostile witness.

8 MR. TANNER: I think she's trying to answer his
9 question.

10 THE COURT: Well, I think you were asking her to
11 differentiate -- the difference and I thought she was
12 explaining that. What was she doing --

13 MR. WILLIAMS: Well, she's talking about an arm
14 board. I've asked her about what's different in the
15 assessment of the IV site and what -- I think she's admitted
16 that there's nothing really different about the assessment
17 of the IV site --

18 THE COURT: Well, I don't know --

19 MR. TANNER: Because he interrupted her before we
20 could hear her answer.

21 THE COURT: Well, you just hold on. Ms. Downing.
22 It is Downing, right?

23 THE WITNESS: It is.

24 THE COURT: Okay. Ms. Downing. I'm sorry. When
25 Mr. Williams is asking you the question, if you would just

1 address that specific area. And right now he's asking you
2 about assessments. So if there is a different way that you
3 assess adults rather than children in putting in the IV,
4 that's what -- if you would just address that.

5 THE WITNESS: Absolutely.

6 THE COURT: Okay.

7 THE WITNESS: Sorry.

8 A It's just that it's a little complicated in talking
9 about adults and pediatrics. So adults, you would check an
10 arm board if you an arm board. You don't typically have one,
11 which is why I mentioned it. Also before administering a
12 medication you have to for a check for blood return in an
13 adult patient. You're not able to do that in pediatrics
14 because for risk of collapsing the vein or compromising the
15 site. You wouldn't do that with a pediatric patient like
16 you could do with an adult if you're about to give
17 medication. You could assess a patient differently for
18 pain. And as an adult, you can ask them if they feel tender
19 at the site. Yo can't do that with pediatrics. I think it
20 more comes down to being able assess a pediatric patient
21 versus an adult rather than specific things you do.

22 BY MR. WILLIAMS:

23 Q Sure. But you touch and feel both an adult or a
24 child's hand?

25 A Yes.

1 Q You check for potency?

2 A Patency?

3 Q Patency, excuse me?

4 A Yes. Making sure the IV is flowing well.

5 Q And do you clean the site?

6 A Yes.

7 Q And you always flush before you administer the
8 antibiotic?

9 A You would always flush an IV before administering any
10 medication.

11 Q So you always flush at least four hours?

12 A Yes. And that's the hospital policy. It's either you
13 would flush with the normal saline or if they were getting a
14 medication, it's just making sure the IV is being used every
15 four hours to maintain the site.

16 Q Okay. So is the administration of the ampicillin a
17 suitable flush?

18 A So that's kind of a tricky question. So it would meet
19 the hospital policy that you would need to use the IV every
20 four hours, but you would need to flush it prior to giving
21 the medication to assess the site. So that's kind of
22 considered part of the entire procedure.

23 Q And you're required to note that you flushed the site
24 is that right?

25 A So flushing a site is part of your assessment so it's

1 not -- as -- that is not in the Cerner (sp) data base for
2 that flush to be documented. The four-hour flushes do task,
3 so everything comes up with a flow sheet. So there is no
4 way -- so assessing the IV is part of the procedure of
5 giving the medication, so there is not a specific spot to
6 say, yes, this amount of saline was flushed prior to giving
7 the medication because that's -- it's just part of the
8 procedure.

9 Q Before the time of the incident that we're here today
10 about, had you noted that you flushed the IV before
11 administering ampicillin.

12 A No. So like I said there's no task or flow sheet that
13 pops up for me to document that information in the charting
14 system.

15 Q So The Regional Medical Center mandates in their
16 procedure manual that you're to document when you flush, but
17 there's no way for you to document it?

18 A Okay. The Regional Medical Center policy documents
19 that the IV is flushed every four hours. And that is done
20 through the medical administration record. So the flushes
21 are documented every four hours and they're automatically
22 populate and the medications populate on there as well. So
23 that's where that would be documented. When you're doing a
24 medication and flushing it, -- There's no way to give the
25 medication without flushing the IV first, so it's considered

1 part of that procedure.

2 Q Does your policy and protocol indicate that you're to
3 flush prior to administering medication?

4 A I'm sorry, that I don't know it -- memorized off the
5 top of my head.

6 Q Okay. And does your policy and procedure number twelve
7 say that flushing the INT with the saline is to be
8 documented on the D mark?

9 A (Witness pauses)

10 Q At the very bottom?

11 A Yes. So this section of the policy is referring to INT
12 flushes that are used, those every four-hour flushes if
13 you're not giving a medication. The INT policy protocol for
14 flushing above says to instill the saline flush and doesn't
15 mention documenting. So here at the bottom it's just
16 talking about whether just flushing the IV and you're not
17 actually giving a medication with it, just that that's
18 documented in the MAR, (sp) that's something to be given
19 every four hours.

20 Q So earlier you said there's no room for interpreting
21 these policies; is that right?

22 A Right. This is written and you follow these policies.

23 Q And that policy says flushing the INT with saline is to
24 be documented on the MAR; is that right?

25 A Yes, absolutely for when you are just giving a flush

1 and not giving a medication.

2 Q Okay. Does it say that in that policy?

3 A As a nurse interpreting this policy, as someone who has
4 managed multiple IV's, yes. This is what it means to a
5 nurse.

6 Q As a nurse who's managed multiple IV's for two weeks,
7 three weeks?

8 A So that's not a correct statement. So as a nurse,
9 you're in nursing school for two and a half years. I did
10 multiple IVs. This is not the first time I've ever managed
11 an IV.

12 Q Okay. But do you agree that nothing in the policies
13 and procedures says anything other than it's to be
14 documented on the MAR every time you do a flush?

15 MR. TANNER: Objection, Your Honor. It's been
16 asked and answered at least two or three times.

17 THE COURT: Well, I'll let her finish answering
18 that. Thank you.

19 A Yes. So I understand the spot -- It's in a different
20 section of the policy. It's not referring to when you're
21 administering a medication. This is specifically
22 referencing when you're just flushing an IV, to give the
23 flushing. It's not associated with a medication. So this
24 is saying the saline must be documented in the MAR for these
25 four-hour flushes as they are the only thing I see given at

1 the time. If you're also doing that medication, it's going
2 to be in the MAR, so you are going to see that flush or
3 something being given to that IV every four hours. So this
4 is just making sure if you're just flushing the IV to meet
5 this policy, that it is documented in the MAR. If you're
6 giving medication, it's documented into the electronical
7 medical record as well. So it is included in a different
8 aspect, a different spot in this policy. This section
9 doesn't refer to that.

10 Q Okay. Can you explain to the jury what a vesicant is?

11 A So a vesicant is a solution that can be irritating to
12 the veins.

13 Q If it doesn't make its way into the veins what can it
14 do?

15 A Well, it can go under the skin and it can cause
16 burning.

17 Q So it burns, right?

18 A Yes.

19 Q Would it be more appropriate to document when you flush
20 in preparation for a medication that burns as opposed to
21 just randomly flushing?

22 A No, because it's our policy as a nurse to always flush
23 before any medications. It's consistent throughout your
24 practice. It's not necessary to document on one medication
25 versus another if you're going to do it for everything.

1 Q So it's your testimony you never documented that you
2 flushed prior to administering the medication?

3 A No.

4 Q Is that a no that that's not a correct statement?

5 A No. It's a correct statement, I can't -- There is no
6 reason to do it. I can't say it never got -- happened
7 because there was a flush that was populating at the same
8 time, but I never physically documented a note that said, IV
9 flush prior to administering medication because your
10 assessment is there.

11 Q You had never seen an infiltration before Mr.
12 Middleton's; is that right?

13 A That's an incorrect statement. I'd seen an IV
14 infiltration before. I'd never seen an IV infiltration with
15 ampicillin before.

16 Q Okay. Did you testify in your deposition that you'd
17 never seen an infiltration before?

18 A No, I said I'd never seen an IV infiltrated with
19 ampicillin before.

20 MR. WILLIAMS: I beg the Court's indulgence for
21 one second.

22 THE COURT: Sure.

23 BY MR. WILLIAMS:

24 Q All right. So you've never seen a burn like this
25 before; is that right?

1 A I never had. And I actually never saw Mr. Middleton in
2 person after the event.

3 Q How many infiltrations had you seen prior to this
4 incident?

5 A I couldn't give you an exact number. I would say over
6 ten, probably closer to twenty.

7 Q So twenty. Over what period of time?

8 A Since starting nursing school so probably about two and
9 a half years.

10 Q Okay. And in this case, why did you get the charge
11 nurse?

12 A Because I had never seen an infiltration of the
13 ampicillin before and I knew it was a vesicant. I also saw
14 a small discoloration that looked like bruising and I'd
15 never seen that with an infiltration before. I knew that
16 the catheter had to be removed, but I wanted to make sure
17 that we were following -- in compliance with the hospital
18 policy and I was doing everything that needed to be done.

19 Q Tell me, what's the reason for the need to keep
20 accurate medical records?

21 A So accurate medical records is like taking a picture of
22 a hospital stay. They conform to document what was done and
23 for further treatment. So, you know, like what medications
24 people receive, if that treatment worked or not, how the
25 patients responded to that medication. It's important for

1 the long-term care of patients and treatment in the future.

2 Q And if the record says you did something, would you
3 want people to assume that you did it?

4 A Could you rephrase your question?

5 Q Sure. If the record says you did something, what does
6 that mean in your mind?

7 A Well, it obviously that you documented it and you did
8 it.

9 Q Okay. If a record doesn't say you did something, how
10 do you interpret that?

11 A It'd would be different to say that Jamie did not do
12 this versus it not being in the chart. And so there are
13 some things as a nurse you chart by exception. So it's very
14 important to keep as well as thorough medical records,
15 accurate medical records, also concise medical records, so
16 if a patient's readmitted to the hospital seeking treatment
17 later, they're able to look at these medical records and
18 find the information they're looking for. So you want to
19 make sure you're including information that is helpful for
20 that and that you don't need to be redundant and include the
21 same thing over and over again. Because when you're trying
22 to find that abnormal information, that changing pertinent
23 information, you want it to be easily accessible for the
24 better treatment of the patient.

25 Q Have you ever documented that you failed to flush an

1 IV?

2 A No, because I never would have given a medication
3 without flushing an IV.

4 Q Okay. And if you remembered to document that you
5 didn't flush it, you would just flush it, right?

6 A There's no way to go back, if that makes sense.
7 There's no way to say I didn't flush an IV. I'm going to go
8 do it now. It's part of your medication policy and
9 procedure in my practice as a nurse. You wouldn't give a
10 medication without first flushing the IV.

11 Q Do you remember flushing the IV before administering
12 this ampicillin?

13 A I don't specifically remember the morning. I remember
14 afterwards, day. But I know my practice as a nurse and I
15 know that I flushed that IV. I don't think the medication
16 really would have infused with the extension flaps and the
17 tubing that's used at The Regional Medical Center if that IV
18 hadn't been flushed.

19 Q Okay. But sitting here today you can't tell the jury
20 that you remember flushing this IV?

21 A That's correct. It was about four years ago and I
22 don't specifically remember flushing the IV. But that is my
23 practice as a nurse and the procedure you have ingrained in
24 you in nursing school. And as a pediatric nurse, you care
25 for your patient. So knowingly not flushing the IV, it

1 makes no sense. It makes no sense not to do that.

2 Q Do you agree that the vesicant, the ampicillin, the
3 medicine that causes the skin to burn, that you administered
4 was what caused this injury?

5 A Yes.

6 Q And sitting here today do you know what happened, other
7 than the vesicant, the burning medication, went somewhere
8 other than where it was supposed to go?

9 A No. There is no way to really know why the medication
10 after starting to infuse then did not go inside the vein.
11 There's no way -- the IV could kink. The IV could move.
12 The medication could irritate the vein. There could then be
13 a tear in the vein. There are just so many things that can
14 happen with a pediatric IV in a very short period of time.
15 There's no way to say why this medication, after the initial
16 assessment went where it wasn't supposed to go.

17 Q Okay. It didn't go to the vein; is that right?

18 A So it initially did. The burn indicates, the
19 infiltration indicates at some point during the infusion the
20 (inaudible) was no longer where it was supposed to be.

21 Q Okay. Are you aware of the nurses' practice act?

22 A Yes.

23 Q What does its rule?

24 A So I'm not familiar with the specific wording but the
25 gist of it, and each state has their own nursing practice

1 act is to provide safe care for your patients and the way
2 they recommend to do that in North Carolina. Not North
3 Carolina, sorry. South Carolina.

4 Q Does it say your duty is to do no harm?

5 A I believe that.

6 Q Are you familiar with Mr. Tanner's articles, the
7 policies and procedures from Infusion Nursing for Pediatric
8 Patients?

9 MR. TANNER: Your Honor, I would object. They're
10 not my articles. I didn't offer them.

11 THE COURT: All right. Okay.

12 A I think --

13 THE COURT: Wait a minute.

14 THE WITNESS: Oh, sorry.

15 THE COURT: No, I was just --

16 THE WITNESS: Okay.

17 THE COURT: -- I will note your objection that
18 they're not your articles. So if you'd just refer to what
19 they were?

20 MR. WILLIAMS: Sure.

21 BY MR. WILLIAMS:

22 Q Are you aware of the articles Mr. Tanner provided such
23 as Assessment of an Infant with Peripheral Intravenous
24 Device?

25 A I had a chance to look them last week, but I haven't

1 read the entire article.

2 Q At the time of this treatment of Mr. Middleton, you
3 hadn't read that article?

4 A No, I hadn't.

5 Q Okay. Have you read the one Intravenous Extravasation
6 Mechanisms Management and Prevention?

7 A No, I haven't.

8 Q Have you read the one Infusion Therapy of the Infusion
9 Nurse's Society?

10 A No, I haven't.

11 Q Okay. Sitting here today, have you read those?

12 A No, I haven't. So reviewing the texts of articles
13 aren't necessarily common practice. I'm sure we'll be
14 having an expert in the field in reviewing literature or
15 doing quality improvement, different settings it would be
16 appropriate to review those articles. Typical nursing
17 practice you're review the policies of the hospital, you
18 have your information you've learned in nursing school how
19 to practice as a nurse, and training and that's the real
20 source of information for IV management.

21 Q Sure. And sitting here today you have some different
22 certifications that you didn't have at the time you were
23 treating Mr. Middleton; is that right?

24 A Right. I'm a certified pediatric nurse and certified
25 nurse educator.

1 Q And at the time of this incident -- that didn't happen
2 until you went and worked at MUSC; is that right?

3 A No. It's not associated with the hospital that you
4 work at. It's the number of hours and the amount of
5 training and studying you've done to take the exam. So I
6 haven't taken the exam yet, no.

7 Q And you did that once you left The Regional Medical
8 Center?

9 A Right. And it's a certification that is -- I wanted to
10 be a pediatric nurse. I wanted to be a pediatric nurse my
11 whole life.

12 Q And sitting here today just to be clear with the jury,
13 you weren't certified as a pediatric nurse at the time you
14 treated Mr. Middleton; is that right?

15 A No, not certified but I had multiple hours of training
16 as a pediatric nurse.

17 Q Tell us about this computer system, would it prompt you
18 indicate to whether you flushed the IV?

19 A No. As we discussed before there's no flow sheet
20 associated with the medication administration for flushing
21 an IV.

22 Q Okay. So explain -- is it my understanding the IV
23 wasn't patent at 4:45?

24 A So I think you're referring to the flush that was
25 charted against. So at that point, I believe in that

1 patient that started right around 4:27 off the top of my
2 head, that that patient ran for about twenty minutes. When
3 those task you have kind of a window of administering those
4 medications, obviously it wouldn't be appropriate to give an
5 IV flush for a medication that's already infusing. At that
6 point, that infusion was done you would give that flush
7 after finishing the medication. The IV was infiltrated and
8 it would not be appropriate to flush the IV out knowing we
9 had a bad site.

10 Q Sure. Is it fair to say the record indicates that the
11 IV wasn't patent at 4:45?

12 A That is not what that documentation says, no. It says
13 that it's not appropriate to give that flush at that time.
14 The assessment later, I think that was documented at 4:50,
15 documented that the IV wasn't patent.

16 Q Okay. The 4:45 number, where would that have come from
17 the record?

18 A So when there's -- when an IV order is placed by a
19 physician, there's saline flushes automatically tasked every
20 four hours. So whenever the IV is initially ordered the
21 saline flushes associated and kind of just a set that's the
22 physician orders. So they would automatically be happening
23 every four hours. So that is that task. So it technically
24 could have been charted against because you already flushed
25 the medication when giving, using this IV or it could be

1 charted after. But it just automatically tasks regardless
2 of what else is ordered or going on with the patient.

3 Q And I earlier asked you if the computer system
4 automatically prompted tasks and you would flush?

5 A It didn't. So that was not a task. That was prior to
6 the medication. That was a task I was tasking every four
7 hours. That was not associated with the medication.

8 Q But again, the computer system prompted that task,
9 correct?

10 A It did. It was for every four hours flush but it was
11 after the medication was administered.

12 Q And that occurred at 4:45, correct?

13 A Correct. That's the time that it tasked.

14 Q And you started this medication twenty minutes prior;
15 is that right?

16 A I believe that was 4:27.

17 Q Okay. So the medication would have run until 4:47; is
18 that right?

19 A Yes.

20 Q Okay. And you didn't enter the room until 4:50; is
21 that right?

22 A No, I would have went in as soon as the alarm sounded.
23 It's documented -- you do the best you can as charting real
24 time. Obviously, at the moment the more pressing
25 circumstance would be to assess the patient and follow proper

1 procedures for removing an IV. The 4:50 documentation would
2 have been documented after, honestly. So I, as a nurse,
3 probably rounded three minutes. And I'll be honest in that.
4 But it -- at the more pressing time I was caring for the
5 patient at 4:47 or it would have been removed (inaudible).

6 Q You agree that the mother was paging you, trying to get
7 you into the room?

8 A I do not recall that. There are multiple nurses on the
9 floor at a time. You're not always sitting at the nursing
10 desk but pretty commonly there's someone is and someone
11 would have gone in there. From my memory, mom was holding
12 the child when I went back in there kind of going back forth
13 with everything you would expect. A new mom with a new baby
14 in a hospital for a couple of days. But if I had been paged
15 in there earlier, someone would have been in there whether
16 it was a nurse or a nursing assistant, or a charge nurse,
17 another nurse if I was with a patient would have been in
18 there.

19 Q Do you recall going in there and the baby's screaming
20 and the mother's upset?

21 MR. TANNER: Your Honor, he's -- I haven't
22 objected every time, but he leading the witness again. He's
23 chosen to call her on his case and he's got to ask open-
24 ended front questions.

25 THE COURT: If you'd just ask her what she

1 remembers about the mother.

2

3 BY MR. WILLIAMS:

4 Q Well, what do you remember about the mother?

5 A Yes, I remember her. And I really in my heart remember
6 mom being agitated and just exhausted. I remember talking
7 to mom, explaining kind of what infiltration is and why
8 we're removing it and why we're putting a compress on it,
9 that we're going to call the doctor, but we're not going to
10 restart the IV and that was mom's question, as well. There
11 was not frequent calling or paging. Someone would have been
12 in there. I remember going in there talking with her about
13 the IV, calling the charge nurse as for removing. Mom very
14 receptive to all the information we were giving her and just
15 kind of going over what this means and that we're going to
16 call the doctor and that this is what this is going to look
17 like. So that is what I remember.

18 Q Okay. You'd been in the room starting this IV
19 medication and you stayed in there for about thirty seconds?

20 A So, I can't tell you exactly how long I was in there.
21 It was long enough to start the medication, I watched the
22 patient, watched the pump, do some documentation on the
23 computer and step out. So I would think it was anywhere
24 from thirty seconds to a minute to a minute and a half.

25 Q Okay. And you weren't here to hear mother's testimony

1 about what she recalled, were you?

2 A No, I wasn't here.

3 Q You just got here a short time ago?

4 A Yes.

5 Q Okay. Did R.J. do anything to cause this?

6 A No.

7 Q Did Ms. Hamilton do anything to cause this?

8 A No. IV infiltration is a known risk of IV therapy.
9 Nobody did anything to make this happen.

10 Q Is it my understanding that this site went from a zero
11 to this?

12 A So a zero describes an IV that is -- I'm assuming
13 you're referring to the infiltration and phlebitis score,
14 which is used in the assessment of the IV. So that is used
15 to assess the IV properly throughout. That's kind of a
16 quick way to say no there's no inflammation, no there's no
17 swelling. There's no sign that this IV is not working
18 properly. So when starting an IV and IV's working well and
19 being used, it's going to be a zero. So it's always going
20 to start at a zero. So, yes. So any sign, like you just
21 discussed about the vesicant. So what happened when a
22 vesicant is -- extravasation, but basically it is an
23 infiltration of a vesicant. So this vesicant goes outside
24 of the vein and under the skin. The initial presentation is
25 going to be the same as just a normal fluid. So it's --

1 it's swollen. It's cool to the touch. There might be some
2 discoloration. There might be a knot. There was like small
3 bruising and the medication is localized. So the longer
4 this medication sits there, it's going to change, which is
5 why we frequently assess these IVs and we assess these site
6 and document them. So, yes. The initial presentation was
7 mild swelling with a dark spot that's been noted. But it
8 changes because of the medication that can burn. So an
9 assessment every thirty minutes is probably going to be
10 different than the one that was done previously before it.
11 So it did start at a zero, the IV was flushing well. It was
12 patent. It was able to be used. It was everything you need
13 an IV to do until it's not and then you notice this swelling
14 and that's when it's removed, but things change
15 progressively, yes.

16 Q What is the scale of the infiltration score?

17 A I would need to see it. So it's on the bottom of the
18 flow sheet in Cerner. I think it's a zero to five,
19 infiltration and phlebitis, which refers to how the
20 irritation of a vein. And it has different kind of
21 categories. I think a one is swelling less than one inch.
22 There is specific criteria that's used that's available to
23 you every time you're rating the site.

24 Q So it's a zero to five. And it was a zero. It went
25 from a zero to this; is that right? A simple yes or no is

1 what I'm asking?

2 A Right. But it's not a simple yes or no question
3 because it progressively changes, it doesn't go from zero to
4 that, no. It takes hours and it takes time.

5 Q In the amount of time from when you administered this
6 medication, it went from a zero to this; is that right?

7 A That is not correct. I did not see his hand that way.

8 Q So you didn't monitor his hand before administering the
9 medication?

10 A Yeah, I did monitor his hand before administering the
11 medication. This picture was taken, I'm not sure when, but
12 hours following the administration -- the medication was
13 administered around 4:27. The IV was removed right around
14 4:50 and then my shift was over at 7:00. So I would've
15 assessed the IV up until reports to the next nurse, which
16 was around 6:45. So the IV continued to change because he
17 still had his medication. That was there.

18 Q Maybe I should ask, did it go from a zero to this?

19 A So my --

20 Q Or --

21 A No. The IV site that I had was documented in the
22 chart. It was mild swelling with a dark spot. A compress
23 was applied and that is the way it looked when I left from
24 my shift.

25 Q Okay. Is what caused this a five plus this or where is

1 this on the chart?

2 A So five plus, it's hard without actually seeing the
3 grid. It is the same injury. It is not that there would be
4 subsequent injury. And the amount of medication went under
5 the skin that damaged tissue and that takes some time. So
6 the IV site changed throughout the next couple of hours and
7 was monitored. So it did start at a zero. I couldn't tell
8 you what a five looks like without seeing a chart.

9 Q But when you administered the medication it's your
10 position it was a zero. But once you gave this medication
11 it continued to do damage to cause this?

12 A So when I initially assessed the IV, it was a zero. So
13 it was flushing well. It was a good IV site. The
14 medication was given. After medication was given in the IV
15 site, as that was assessed, there was a small -- It was, I
16 think mild inflammation is the word I used. And it had a
17 score of a one and a one and that was documented. The IV
18 was removed and then it was documented throughout the next
19 shift, would be another nurse documenting -- would have been
20 assessing of the IV site, of how it changed. So it's the
21 same medication. There's no way to really know what the
22 extent is going to be throughout monitoring and assessing.
23 So it didn't go from zero to this on my shift. I think that
24 this would take time.

25 Q But Mr. Middleton didn't do anything wrong, correct?

1 MR. TANNER: Objection, Your Honor. He's asked
2 and answered this multiple times.

3 THE COURT: She's already said he didn't.

4 MR. WILLIAMS: Okay.

5 BY MR. WILLIAMS:

6 Q And this medication required a flush before you gave
7 it?

8 A It did.

9 Q But you don't specifically remember giving that flush?

10 A So I remember many a times giving -- I do not remember
11 this specific morning, no. I remember many times
12 administering an IV medication via syringe pump and in my
13 practice as a nurse. Like I said, I do not think that --
14 without flushing it first and the medication would have
15 never been given, so common practice as a nurse.

16 MR. WILLIAMS: Nothing further, Your Honor.

17 THE COURT: Okay.

18 Anything on cross?

19 MR. TANNER: Can we have just a comfort break for
20 a couple of minutes?

21 THE COURT: Okay. That probably wouldn't bother
22 anybody, I don't think. All right.

23 Ladies and gentlemen, we're going to take like a five-
24 minute comfort break. And then we'll get y'all back in
25 here, okay? Remember, you cannot talk about any of the

1 testimony you've heard so far. Thank you.

2 (Jury out at 11:46 a.m.)

3 THE COURT: You can stand up.

4 THE WITNESS: Can I stand? All right.

5 THE COURT: No, no, you did good. You can stand
6 up. You can stand up. But you don't go anywhere -- wait
7 one second before you go anywhere, okay?

8 THE WITNESS: Okay.

9 THE COURT: All right. Ms. Downing you're not
10 trapped to the chair. You can get up and walk around.

11 THE WITNESS: Okay.

12 THE COURT: But you can't talk to anybody about
13 your testimony.

14 THE WITNESS: Got it.

15 THE COURT: If you need to go to the restroom to
16 do something like that --

17 THE WITNESS: Okay.

18 THE COURT: -- you can do that but you just can't
19 talk to anybody. Okay.

20 THE WITNESS: Okay.

21 THE COURT: All right. Stretch your legs if you
22 need to.

23 THE WITNESS: I do.

24 THE COURT: Okay. Thank you, ma'am.

25 THE WITNESS: Thank you.

1 THE COURT: Yes, ma'am.

2 (Court in recess for a short break
3 at 11:46 a.m.)

4 (Court in session after short break
5 at 11:53 a.m.)

6 THE COURT: Is the plaintiff ready?

7 MR. WILLIAMS: Yes, Your Honor.

8 THE COURT: Is the Defense ready?

9 MR. TANNER: Yes, sir.

10 THE COURT: If the jury's ready, bring them on
11 out.

12 THE BAILIFF: Yes, Your Honor.

13 THE COURT: Okay.

14 Mr. Tanner, about how long is your -- is --

15 MR. TANNER: I'm not going to have a very long
16 examination of Nurse Downing.

17 THE COURT: Well, yeah. But how about Nurse
18 Hurley?

19 MR. TANNER: Hurley? I don't know, about forty-
20 five minutes, an hour.

21 THE COURT: That'd be your direct?

22 MR. TANNER: I would think she could be done
23 everything in an hour.

24 THE COURT: Oh, okay. Okay. All right. Okay.
25 All right.

1 (Jury in at 11:53 a.m.)

2 THE COURT: All right. Ladies and gentlemen,
3 we're going to continue with the examination of Ms. Downing.
4 Mr. Tanner.

5 MR. TANNER: May it please the Court? Thank you,
6 Judge Dickson.

7 THE COURT: Yes, sir.

8 JAMIE DOWNING - CROSS-EXAMINATION

9 BY MR. TANNER:

10 Q Thank you Nurse Downing, I appreciate you coming back
11 from Greensboro today to be with us. You were explaining to
12 the jury -- Mr. Williams was asking you about this blowup,
13 which I can't remember which Exhibit this is, but this isn't
14 the way the child's hand looked during your shift was it?

15 A No.

16 Q Okay. I'm going to show you this picture right here of
17 a healing wound. That's not what it looked like during your
18 shift, is it?

19 A No. You can see that there's tissue that's healing
20 there. So that would have been --

21 Q This would have been --

22 A -- significantly later.

23 Q -- significantly later in the healing process, correct?

24 A Yeah.

25 Q Where were you born, Nurse Downing?

1 A I was born in (inaudible) Massachusetts.

2 Q Okay. But where did you grow up?

3 A I kind of grew up all of the place. lived in
4 Massachusetts for a while. I lived outside of Fayetteville,
5 North Carolina for a while. I finished High School right
6 outside of Savannah. I went to college in Athens, Georgia.
7 Then Charleston. And several months ago I moved to
8 Greensboro, North Carolina.

9 Q Okay. So you went to high school and spent your
10 formative years in Georgia?

11 A Yes.

12 Q Okay. And did you always want to be a nurse?

13 A I did. So I like many young women. I always want to
14 care for people. That's kind of where you're rooted, and
15 then I good in both math and science so you're edged towards
16 medicine. But I was able to volunteer with a couple of
17 groups in high school, specifically, I was able to volunteer
18 with the Low Country Down Syndrome Society. There's a
19 teacher of mine who was on the board and had a child with
20 down syndrome and was able to attend their events, and there
21 was a bunch of games and interactive participations for the
22 kids to be there and all of their families were there. So
23 walking around and seeing the impact that having this whole
24 community together, but I think that's really what lead me
25 towards nursing versus doing research with science or doing

1 medicine, because I felt like as a nurse you really get to
2 spend time with families. And you get to educate them and
3 really create impact in the community of families and follow
4 them long-term. And so that's kind of what lead me to
5 nursing. It was always kind of in the back of my head, but
6 really lead me towards pediatric nursing, the idea of
7 working with families.

8 Q Okay. And does the practice of pediatric nursing have
9 something called PALS?

10 A It does. PALS is the life saving support during a
11 pediatric emergency.

12 Q And that's a certification you have?

13 A That is a certification I hold. So I am a certified
14 pediatric nurse, like we discussed and I've got that. Which
15 says that you are an expert in the pediatric nursing field,
16 that you have significant hours. I think it's -- I've
17 worked over a thousand clinical hours directly caring for
18 pediatric patients, that you are well-versed in all therapy
19 applications. And so different medicine, different
20 procedures, but that you are widely-versed and It's an
21 awful two-hundred question test that takes you three hours.
22 It's something you keep up with, with continuing education
23 but it's really saying that you've cleared out pediatrics
24 and that you are an expert in that field.

25 Q And you've kept that certification up currently?

1 A Yes.

2 Q And you went to nursing school at Georgia Regions; is
3 that right?

4 A Yes. So the school changed names a couple of times but
5 it was the Medical College of Georgia, the Regions
6 University is where I graduated from.

7 Q And that was my question. Is that the same thing that
8 people know as the former Medical College of Georgia?

9 A Yes. So the curriculum has changed a little bit since
10 I've been there. When I was there it was a five semester
11 program. It's gone down to four. But it's the same
12 administration and faculty.

13 Q Okay. You testified earlier that the cannular that's
14 in the IV site is straw-like; is that right?

15 A Yes.

16 Q And the needle you used was a 24 gauge needle?

17 A Yes.

18 Q Let me show you something Nurse Downing. You testified
19 earlier to an arm board. Is that what this is?

20 A Yes. That's an arm board that would typically be used
21 on a types of patient.

22 Q And would this have been similar to the arm board used
23 on Robert Lee Middleton, Jr.?

24 A Yes.

25 Q And that would be placed under the hand when the IV was

1 started?

2 A Yes. And so it's soft and it allows kind of for that
3 positioning. IVs are -- I like to use straws. When you're
4 working with kids you try to think of things that are
5 relatable. But an IV, cannular, which I think they have
6 here is like a small straw. And then a vein you can kind of
7 think of is a little baby straw. And so the arm board would
8 provide stability to the hand, being able to straighten out
9 that vein, obviously. A small baby can't really keep their
10 hands straight and it helps them from bending frequently and
11 irritating the site as well.

12 Q And what am I holding in my hand now, Nurse Downing?

13 A So that is a 24 gauge three-quarters and five-eighths
14 inch cannular from an IV start. So that yellow piece and
15 then the actual clear small piece is the straw piece that
16 actually stays in the vein. And the second part of that
17 tubing is the extension so that's connected. It helps keep
18 the pressure there so that the site doesn't come compromised
19 with clots and things like that. It's also higher access it
20 to get medication.

21 Q And is that where you would also do the flush?

22 A Yeah.

23 MR. TANNER: Judge, I just want permission -- I'd
24 like Nurse Downing to step down and show the jury the 24
25 gauge needle?

1 THE COURT: Sure.

2 A (Witness steps down)

3 Q Now, again, if you can explain the yellow part. That
4 is the catheter tube, correct?

5 A Okay. The catheter is actually this clear little
6 piece. Earlier when I was describing a triangle, this is
7 what I was talking about. So it would be placed on the hand
8 there. So it would be very -- kind of telling if the vein
9 -- if the catheter is positioned a different way. It kind
10 of has this little trick catheter. If it was straight
11 before and it's twisted that way, there'd be concern that
12 it's not where you left it, and so that means that's a
13 change. And then this would stay there. This would be
14 secured down. But this isn't actually in the vein and as
15 you can see, it's really quite small, which is great when
16 you're inserting it. And it helps you feed it in without
17 damaging the vein, but it can be kinked very easily. It
18 also causes pressure and so over time with frequent
19 movement, it just can bend and sometimes have a mind of its
20 own. So you want to assess it frequently because this is --
21 can be ever changing, because it's not super stable. And
22 then that is the pressured extension (inaudible). And what
23 to make sure is that there is positive pressure. If not,
24 you can have blood coming out the back and then that blood
25 could clot. And so by having this extension back here, it's

1 making sure the pressure is positive. And so you're
2 preventing clotting and then also it's better, comfortable
3 -- from being exposed to infection in the hospital. But
4 this is where you would clean, attach a small syringe that
5 has the normal saline in it and flush. And you're always
6 checking just kind of the integrity of this whole structure
7 when assessing.

8 Q So this would be -- essentially, this would have been
9 in Robert Lee Middleton Jr.'s hand, correct?

10 A Correct.

11 Q And first, there would have been a needle on the other
12 end of this, right?

13 A Correct.

14 Q And then obviously the catheter would go under the
15 skin, correct?

16 A Right.

17 Q All right. And then the extension set you would
18 actually take a syringe with normal saline and do your flush
19 before you administer the medication, correct?

20 A Correct.

21 Q And that was always part of your nursing practice and
22 habit, correct?

23 A Correct. There's no way to really tell if the site is
24 open and flowing without flushing it. And so it would not
25 be (inaudible) to give the medication without flushing it

1 first because you don't know if it's going to go where you
2 want it to.

3 Q And you wouldn't give a medication without flushing it
4 first anyway, right?

5 A No.

6 Q Because that's not how you were taught. That's not how
7 you're a nurse, correct?

8 A Correct.

9 Q All right. So when you administer the flush, you would
10 inherently -- you would be touching his arm to make sure it
11 was still warm, right?

12 A Right.

13 Q You'd be making sure that there's no swelling, no
14 redness?

15 A Correct.

16 Q Okay. And then you would do the flush through there
17 with saline and then you would hook up the IV tubing?

18 A Right.

19 Q And then administer the ampicillin?

20 A Correct.

21 Q And that was 4.25 milliliter; that's correct?

22 A Correct.

23 Q All right. You can have a seat Nurse Downing.

24 A (Witness takes stand)

25 Q At no time during your treatment of R.J. was his

1 infiltration score anything other than a zero, correct?

2 A I believe I charted it after the incident, it was a
3 one. But before that, no.

4 Q I'm sorry. That was a poor question. Before the
5 medication administration, it was never charted at anything
6 other than zero, correct?

7 A Correct.

8 Q And Mr. Williams had asked a number of questions about
9 five. It was never documented as a five, was it?

10 A I haven't reviewed the whole chart as far as what other
11 nurses documented. I do not believe so, but I know on my
12 shift it was zero and then once we noted the inflammation
13 had scored a one.

14 Q And so at no time during your treatment of Robert Lee
15 Middleton, Jr., was the infiltration score a five?

16 A Correct.

17 Q Because if it was, you wouldn't have given medicine,
18 right?

19 A Well, correct.

20 Q And likewise when we're talking about the flush and let
21 me show you this. This would have been your 4:04
22 assessment?

23 A Correct.

24 Q And that would have been when you documented
25 everything, those should be part of your hourly assessing of

1 the IV?

2 A Yes.

3 Q And documented no -- infiltration score of zero,
4 phlebitis score of zero, correct?

5 A Correct.

6 Q And then again when you would have gone in there, just
7 twenty-three minutes later, you would have reassessed the IV
8 as we explained, correct? You would lay hands on it?

9 A Yes. Yes, sir, right. The tubing even connects to Mr.
10 Middleton, what we would call an INT. So it's just saline
11 inserted. The tubing actually, we're going to need him to
12 have that for the medication. So you would need to go in
13 and touch the IV, assess it, and then later hook up the
14 medication.

15 Q And then that's when -- then when you would flush the
16 IV, correct?

17 A Correct.

18 Q And then given the ampicillin.

19 A Yes.

20 Q Thank you so much, Ms. Downing or Nurse Downing for
21 coming back here.

22 THE COURT: All right.

23 MR. WILLIAMS: I want to grab an exhibit, Judge,
24 give me one second.

25 THE COURT: Take your time. I just remind you

1 that your redirect is going to be limited to his cross.

2 MR. WILLIAMS: Yes, sir.

3 THE COURT: Okay. Thank you, sir.

4 MR. WILLIAMS: I'm just going to pull -- is it all
5 right if I pull two documents out of this Exhibit 4?

6 THE COURT: As long as you put them back.

7 MR. WILLIAMS: I'm going to do that. It's TRMC
8 005 and 006.

9 JAMIE DOWNING - REDIRECT EXAMINATION

10 BY MR. WILLIAMS:

11 Q If you would look at those real quick?

12 A (Review documents)

13 Q Prior to this incident what was the last time that it
14 -- you said these flushes were the four-hour flushes on
15 there; is that right?

16 A Correct.

17 Q What was the last time you did a four-hour flush?

18 MR. TANNER: Your Honor, I would object. For the
19 record, I think it was sort of outside of the scope of my
20 cross-examination.

21 MR. WILLIAMS: Well, he asked her if she did a
22 flush before administering medication.

23 MR. TANNER: I asked her if she had flushed before
24 she administered, but I didn't talk about the four-hour
25 flushes that are part of the medication --

1 MR. WILLIAMS: He discussed that, Your Honor.

2 THE COURT: Well, I'll let him ask that question,
3 but we're going to keep it short on this, okay?

4 A (Reviews exhibit) So, there would be a four-hour flush
5 at midnight, flush target and I charted it after I flushed
6 after the Claforan, which was the other antibiotic he was
7 getting. It tasked right after that medication was
8 administered and so it was charted then, flushing out the IV
9 after.

10 BY MR. WILLIAMS:

11 Q And I want to be clear for the jury at midnight is when
12 this flush occurred here and you were supposed to do one
13 four hours later; is that right?

14 A That's right. So in nursing there are --

15 THE COURT: If you'd just answer his question
16 about that part.

17 THE WITNESS: Okay.

18 THE COURT: You want to repeat the question?

19 MR. WILLIAMS: Sure.

20 BY MR. WILLIAMS:

21 Q At midnight, you did a flush and you were supposed to
22 do one four hours later?

23 A Correct, you have an window as a nurse to administer a
24 medication.

25 Q And at 4:00 a.m. would be at four hours after midnight;

1 is that right?

2 A Correct.

3 Q And you administered the medication that caused this
4 injury at 4:27; is that right?

5 A Yes.

6 Q And the system prompted you and said you didn't enter
7 the four-hour flush at 4:47; is that right? Or 4:45?

8 A Do you have the following page with the flush on it?

9 Q Yes, ma'am.

10 THE COURT: Would that be 007?

11 MR. WILLIAMS: Well, I believe it's the backwards
12 way, so that means 004. That could be wrong.

13 THE COURT: I have no idea.

14 Q Is this what you're looking for?

15 A That's it.

16 Q They're in reverse chronological order.

17 A Right. So the next flush was tasking at 4:45. So,
18 yes, that was given at midnight and then the medication was
19 given at 4:27.

20 Q 4:27. But the flush, the four-hour is going to happen
21 at 4:00 a.m.; correct?

22 A So, it's a system based -- I can't tell you when it was
23 supposed to be given. It's incumbent on when the physician
24 ordered the IV. So if the physician might order the IV at
25 8:00 p.m. or 8:45, it would task out a forty-five minute

1 mark with every four hours. So I can't tell you exactly
2 when. I would have to see the original orders.

3 Q And the policy doesn't say an hour limit, does it?

4 MR. TANNER: Your Honor, I think this is far --

5 THE COURT: Okay.

6 MR. TANNER: -- far afield from my questions.

7 THE COURT: And we are going beyond the cross.

8 MR. WILLIAMS: Okay.

9 THE COURT: Okay.

10 MR. WILLIAMS: Nothing further, Your Honor.

11 THE COURT: All right. Thank you.

12 MR. WILLIAMS: Let me put those back real quick so

13 I --

14 THE WITNESS: Here --

15 MR. WILLIAMS: Sure. Thank you.

16 THE COURT: Yeah. Put those back in reverse
17 chronological order.

18 Okay. All right. And anything on recross?

19 MR. TANNER: No, sir.

20 THE COURT: Nothing?

21 MR. TANNER: No, sir.

22 THE COURT: Okay. All right. You may step down.
23 Thank you, ma'am.

24 MR. TANNER: Your Honor, I would ask if Ms.
25 Downing can be excused?

1 THE COURT: Any objection to her being excused,
2 Mr. Williams?

3 MR. WILLIAMS: No objection.

4 THE COURT: Okay. All right. Thank you, ma'am.

5 All right. Ladies and gentlemen, what we're going to
6 do is -- as it's eating time. I don't know if it's eating
7 time for y'all time but it is eating time for me. And the
8 other thing is I've got to take up some matters with the
9 attorneys outside of your present. So I'm going to let
10 y'all go eat lunch. I'll ask y'all to again be back here at
11 1:30 like you were yesterday and we'll get ready to -- I'm
12 anticipating -- so, you know, I didn't say assume, because
13 you know what assume does to, but I'm anticipating that when
14 we come back we've just got one more witness to do, then
15 we'll do closing arguments and my charge to y'all. And
16 hopefully, some time this afternoon, this case is going to
17 go to y'all so y'all can begin your deliberations. Until
18 that time, you cannot talk among -- very good. You cannot
19 talk among yourselves about this and you can't do any
20 independent investigation and you can't talk to anyone else,
21 okay? So y'all go enjoy lunch and come back and we'll be
22 working during the lunch hour while y'all are enjoying
23 yourself, all right.

24 (Jury out at 12:10 p.m.)

25 THE COURT: And I guess y'all should have said

1 y'all rested, shouldn't you?

2 MR. WILLIAMS: We do, Your Honor.

3 THE COURT: Okay. Thanks. Don't get ahead of
4 myself.

5 All right.

6 MR. TANNER: I have a motion.

7 THE COURT: All right, sir. What is your motion?

8 MR. TANNER: I have a motion for a directed
9 verdict.

10 THE COURT: Okay.

11 MR. TANNER: Based on the testimony of all the
12 witnesses, in particular, Nurse Stobbs, plaintiff's expert,
13 I do not feel that the evidence presented to the court and
14 the inferences reasonably derived therefrom have shown that
15 plaintiff has prove gross negligence, which is the standard
16 in this case, given that the hospital is a governmental
17 healthcare facility. There was no question submitted to
18 Nurse Stobbs about gross negligence. I asked her about if
19 an IV infiltrated, does that mean you're negligent and she
20 said, no. Therefore, it's sort of axiomatic that if you're
21 not negligent you certainly can be grossly negligent. They
22 elected to call Nurse Downing in their case in chief. She
23 testified that she flushed the medicine before she gave it
24 to the child. There is an absence of any and all evidence
25 of gross negligence. Nurse Stobbs had no opinions on

1 y'all rested, shouldn't you?

2 MR. WILLIAMS: We do, Your Honor.

3 THE COURT: Okay. Thanks. Don't get ahead of
4 myself.

5 All right.

6 MR. TANNER: I have a motion.

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15 plaintiff has prove gross negligence, which is the standard
16 in this case, given that the hospital is a governmental
17 healthcare facility. There was no question submitted to
18 Nurse Stobbs about gross negligence. I asked her about if
19 an IV infiltrated, does that mean you're negligent and she
20 said, no. Therefore, it's sort of axiomatic that if you're
21 not negligent you certainly can be grossly negligent. They
22 elected to call Nurse Downing in their case in chief. She
23 testified that she flushed the medicine before she gave it
24 to the child. There is an absence of any and all evidence
25 of gross negligence. Nurse Stobbs had no opinions on

1 whether or not Nurse Downing had intentional conduct.
2 Obviously, the gross negligence standard, as the Court
3 knows, doing something intentionally that one knows not to
4 do or the intentional not doing of an act or it is my
5 favorite of her deposition would be the absence of slight
6 care. And clearly all the testimony in this case by the
7 expert, by Nurse Downing, is that she certainly did slight
8 care. She testified at length in front of the jury about
9 all the assessing she did. All the checking for redness,
10 all the documentation, how she managed and monitored this
11 IV. And they -- again, they have nothing sort of even
12 bootstrapping together to get to that gross negligence
13 standard. As a matter of law, I respectfully do not feel
14 that the jury can considered this because of the tort claims
15 definition in 15-78-6025. Clearly, this is a patient in a
16 hospital. The hospital has a duty of due care, with
17 supervising and monitoring. Supervising and monitoring are
18 one in the same. And the case of Ethridge versus Richland
19 School District One certainly leads the court that when
20 there's only one reasonable inference the normal question of
21 law and fact, but in this case when you only have one
22 inference, then it becomes a matter of law for the Court.
23 And I think respectfully, because they didn't get Nurse
24 Stobbs to say that there's evidence of gross negligence,
25 there is nothing for this Court to consider, other than as a

1 matter of law that they have not met their burden of proof
2 and not met their burden for the jury to continue with any
3 sort of submission of this case to the jury.

4 THE COURT: All right. Anything in response from
5 the plaintiff? Whose going to --

6 MR. WILLIAMS: Judge, the first issue I think ir
7 raised is Michael wanted our expert to get on the stand and
8 make a legal conclusion to be able to bind it over to the
9 jury's hands. I don't think that's the requirement. In
10 fact, I think that would be a serious error to allow an
11 expert to testify concerning the law in the case, and it's
12 only Your Honor who can charge the jury on the law. To use
13 a term like gross negligence is a legal conclusion. But the
14 evidence is clear. We've got everything down to a system
15 the first testimony that you can't interpret these rules.
16 And then testify that she interpreted them this way. A
17 system that said you had to do it by this time, the ignore
18 button was pressed. There's nothing more willful, wanton
19 and reckless than to have something that you press ignore
20 when it tells you to do something that your policies and
21 procedures require you to do. I could go one with the
22 testimony, but obviously the plaintiff testified how she was
23 pressing the call button. She was screaming. She was irate
24 that her baby was sitting in her hands burning. And her
25 excuse was she was in another room. I think there's nothing

1 more clear that this is a jury question. I think the law
2 says that the jury gets the case to determine whether or not
3 gross negligence -- and I don't agree with the definition of
4 gross negligence. It doesn't have to be intentional. It
5 can be reckless disregard, reckless disregard of policies
6 and procedures. Reckless disregard of the information you
7 are provided, that causes this kind of damage.

8 So I think we've met certainly our burden of proof to
9 get it in the hands of the jury, but I don't concede that
10 this is a gross negligence standard. It is a negligence
11 standard when it involves the one claim, which is the
12 negligent medical malpractice administration of medication.
13 And I think the case is clear. I think the tort claim act
14 is clear, that their immunity is waived, except for these
15 exceptions. And sure there's some of our claims that fall
16 under subsection 25 and have a gross negligence standard,
17 but I think we have certainly produced a medical malpractice
18 claim, which is separate and apart. And I think the law is
19 clear that medical malpractice is based on negligence. And,
20 you know, should we be a non -- a private entity, we'd be
21 seeking punitive damages would be the only requirement to
22 gross negligence. So I don't think that's accurate, Judge.
23 And I would reserve the right to continue to argue that up
24 until the time the jury charges are --

25 MR. TANNER: If I may reply?

1 THE COURT: Yes, sir.

2 MR. TANNER: Again, Stewart versus Richland
3 Memorial Hospital is the law of this state. And I've yet to
4 hear a case from the plaintiff that says that is not the law
5 of this state. And that says that the standard is gross
6 negligence. The standard in that case was charged to the
7 jury of gross negligence in breaching the professional
8 nursing standard of care. You know, again --

9 THE COURT: I'm aware of that. You don't need to
10 go into that. We mentioned this yesterday. And sort of
11 like we put on the record yesterday, you know, Nurse Stobbs
12 mentioned a lot of different things about not noting it on
13 the computer and not staying there five minutes and things
14 like that. To me, that's all questions of who the jury is
15 going to believe. And since it's a factual question that
16 goes along with the earlier rulings of the Court -- and I'm
17 just looking at (inaudible) versus South Carolina DJJ. It
18 says gross negligence is a factually controlled concept
19 whose determination best rests with the jury. And that's
20 the way I'm going to leave it.

21 MR. TANNER: Yes, sir.

22 THE COURT: All right? And I deny your motion for
23 a directed verdict.

24 MR. WILLIAMS: Could we go over one housekeeping
25 matter, Your Honor.

1 THE COURT: Sure.

2 MR. WILLIAMS: The only issue -- because of his
3 argument I want to be prepared, we would make a motion to
4 prohibit his expert from making any kind of legal
5 conclusions to the jury. I don't think she has the ability
6 to. I think even if she was a lawyer she'd have the ability
7 to get up and offer an opinion as to a legal conclusion.

8 MR. TANNER: An expert can give an opinion on ???
9 issues, Your Honor. I mean, it's in the rules.

10 THE COURT: But I think it just -- I think he's
11 just -- you're going to phrase just in determination of
12 whether there was negligence or not, just like you ask
13 everything else. I'm assuming you're not going to ask.

14 MR. TANNER: I mean, I'd like to ask her were they
15 grossly negligent.

16 THE COURT: Okay.

17 MR. TANNER: I mean, again, I think she can give
18 that opinion under -- I think it's Rule 1001 on experts.

19 THE COURT: Something like that, yeah.

20 MR. TANNER: And certainly negligence and gross
21 negligence.

22 THE COURT: Okay. All right. I'll think about it
23 over lunch. As a general rule the -- you know, an expert
24 can give an opinion as to the ultimate issue in a case, you
25 know? So that's what the rule says, okay? Now, you know,

1 when we left off yesterday I said I still believe that the
2 patient's going to be required to show gross negligence.
3 We've talked about that. So unless y'all -- y'all are going
4 to have to give me a case or something. Have y'all had a
5 chance to look over the charges?

6 MR. WILLIAMS: Very, very briefly, Your Honor. We
7 have a little bit to work on with regard to that.

8 THE COURT: Okay. All right. Well, if y'all will
9 look them over so that we can talk about that. I also need
10 for y'all to give me an idea of how you want the verdict
11 form to look. I generally believe simple is best, but I
12 don't know what y'all going to want, okay?

13 MR. TANNER: Yes, sir.

14 THE COURT: Okay. So, all right. We'll see y'all
15 in about an hour, okay? Thank y'all.

16 (Court in recess for lunch at 12:31
17 p.m.)

18 (Court in session after lunch at
19 1:30 p.m.)

20 THE COURT: One of the last things that happened
21 right before we left is we were talking about the expert
22 talking about the ultimate issue in a case. And I said that
23 yes, they can address the ultimate issue in the case. But
24 Mr. Tanner, you mentioned something to me that you wanted to
25 ask her whether or not she was grossly negligent.

1 MR. TANNER: Yes, sir. And I had asked the
2 plaintiff's expert. You know, we talked about, just
3 colloquialism, about in an infiltration that doesn't mean
4 you're negligent. And so it's my intention to ask my expert
5 was she negligent, and then was she grossly negligent.

6 THE COURT: Okay. And, you know, obviously I was
7 not -- you're asking negligence in some kind of non-legal
8 sense of negligence. See, here's my problem, okay? And I
9 didn't -- your nurse is going to testify to the standard of
10 care of nursing in a pediatric situation, I assume?

11 MR. TANNER: Correct.

12 THE COURT: Okay. And so when you're asking her
13 questions like that, you're going to ask her did she deviate
14 at all from the standard of care?

15 MR. TANNER: Yes, sir.

16 THE COURT: Did she even slightly deviate from the
17 standard of care? Did she do anything wrong whatsoever that
18 you can think of in reviewing the records.

19 MR. TANNER: Yes, sir.

20 THE COURT: Right?

21 MR. TANNER: Yes, sir.

22 THE COURT: Okay. She's not going to be
23 qualified, I don't think -- I mean, she doesn't have -- and,
24 of course, she's not a lawyer, right?

25 MR. TANNER: No, sir. And other than that's how

1 we've always done it is the only reason I know how to tell
2 you.

3 THE COURT: Okay.

4 MR. TANNER: I got your ruling. I'm being
5 respectful of your ruling. I'm not arguing with you about
6 that. The only thing I wanted to do is in recognizing your
7 ruling, I think I need to proffer that just in case we
8 needed to go up --

9 THE COURT: And I want you to do that. And
10 actually, you know, when you asked those questions the
11 plaintiff didn't objection, you know. And I, quite frankly,
12 was, you know, just --

13 MR. TANNER: Doing other judicial matters, right?

14 THE COURT: Well, no. I was listening but I --
15 you know how -- you know how in the Bible it says it's more
16 than just hearing, it's listening or something like that or
17 listening or hearing. I never can figure that out, which
18 shows you how well I do with my Bible reading. But I don't
19 think -- if he asked a question like that, I think you can
20 get into it on redirect. But as far as direct, I think you
21 go over everything, that she didn't do anything wrong and
22 don't do that. Because I think you can ask whether or not
23 she was negligent without asking that.

24 MR. TANNER: Like I said, whether or not I could
25 properly do it before, I just did it. I would always ask

1 did they breach the standard of care? Were they grossly
2 negligent. So I'll just ask the negligence questions on the
3 proffer. That way, it's not heard.

4 THE COURT: Yeah. If you don't mind just to
5 protect the record that way.

6 MR. TANNER: Yes, sir.

7 THE COURT: But I think -- my own take on it is
8 the jury is going to listen more, did she do anything wrong?
9 Did she break anything -- negligence is a --

10 MR. TANNER: Foreign concept?

11 THE COURT: Yeah. Uh-huh. Okay? All right. So
12 are the plaintiff's ready to go?

13 MR. WILLIAMS: Yes, sir.

14 THE COURT: Defendant ready to go?

15 MR. TANNER: Yes, sir.

16 THE COURT: Okay. Yes, ma'am. Is the jury ready?

17 THE BAILIFF: Yes, Your Honor.

18 THE COURT: Okay. Bring them on in.

19 THE BAILIFF: Yes, sir.

20 THE COURT: Yes, ma'am.

21 And, Mr. Tanner, thank you for being so accommodating,
22 you know.

23 MR. TANNER: Glad to help you, Judge.

24 THE COURT: A Judge needs all the help he can get.
25 Okay. You said you think it'll take about an hour, an hour