+rmc
the Regional Medical Center

Subject:	Intravenous Therapy [Peripheral Access]	TJC Function:	PC
Page:	1 of 9	Manual:	Nursing

PURPOSE:

To effectively initiate, maintain, monitor and discontinue intravenous access for continuous or intermittent fluids and/or medications.

To control the rate of fluid administration.

To prevent infection or other complications during intravenous access maintenance.

POLICY:

The Registered Nurse and the specifically trained Licensed Practical Nurse or Licensed Radiology technologist are to initiate, maintain, monitor and discontinue intravenous access/therapy as prescribed by a physician's order.
NOTE: **Qualified ED RNs may insert external jugular peripheral IVs in adult patients.**

SUPPLIES:

IV Start Kit
Saline flush kit
IV catheter or Butterfly [appropriate size]
Prescribed IV solution and tubing
Buretrol -- if patient 12 years of age and under
Appropriate needleless devices
Infusion Control Device

PROCEDURE

1. Prior to initiating IV access:
   - Check physician's order;
   - Wash hands;
   - Assemble supplies;
   - Identify patient noting name and date of birth;
   - Explain the procedure to the patient;
   - Utilize standard precautions.

2. Considerations for site selection include:
   - Start distally and work up extremity;
   - Avoid areas of flexion and lower extremities to minimize complications;
   - Select vein and appropriately sized catheter on the basis of the intended purpose and duration of use, known complications [e.g., phlebitis and infiltration], and experience of individual catheter operators.
   - Apply a tourniquet 2-6 inches above the proposed site to impede venous flow without arterial occlusion. [A radial pulse should be felt.]

3. Tips to dilate vein include:
   - Apply digital pressure just above selected insertion site;
   - Ask the patient to open and close fist repeatedly;
   - Warm compresses may be used for difficult access;
   - Lower site below level of heart.

4. For children 2 months of age and under the site is to be prepared per protocol:
   - Cleanse with povidone iodine in a circular motion applying friction, starting friction from the center [insertion site] moving outward to the periphery until a 2" diameter has been cleansed.
   - Allow the povidone iodine to air dry.
   - Remove the povidone iodine with alcohol using the same circular motion applying friction.
   - Allow to air dry.

   NOTE: If the patient is allergic to Iodine, prep with alcohol only using two alcohol preps or alternative method ordered by physician.

5. For patients over 2 months of age, the site is to be prepared per protocol:
   - Before skin prep, clip hair as needed [do not shave];
   - Cleanse with Chlorhexidine by pinching the wings on the applicator to break the ampule and release the antiseptic. Do not touch the sponge. Wet the sponge by repeatedly pressing and releasing the sponge against the treatment area until liquid is visible on the skin.
   - Use repeated back and forth strokes of the sponge for approximately 30 seconds. Completely wet the treatment area with antiseptic. Allow the area to air dry for approximately 30 seconds. Do not blot or wipe dry.

   NOTE: If the patient is allergic to Chlorhexidine or isopropyl alcohol, prep with Betadine or alternative method ordered by the physician.

6. The IV protective catheter is to be inserted using sterile technique:
   - Ensure catheter hub and primary push-off tab are fully seated to the needle housing assembly;
   - Hold catheter by ribbed needle housing with the thumb and fingers on opposite sides. The needle bevel and push-off tab should be in the up position;
   - Stabilize dilated vein by anchoring vein with thumb and gently stretching the skin downward;
   - Insert the needle into the skin and vein at an appropriate angle, usually 20-35 degrees;
   - Blood flashback may occur before the catheter tip is fully in the vein, since the catheter is shorter than the needle. Slight advancement of the catheter and needle together will assure full catheter entry into the vein.
   - Hold needle housing stable, thread the desired length of the catheter forward into vein by pushing tab forward. As the catheter is threaded, the needle guard will cover the needle.
   - Do not force if resistance is met.
   - Do not re-insert needle into the catheter at any time as needle could cut catheter causing a catheter embolus.
   - Stabilize device at push-off tab and withdraw needle into needle guard by retracting the ribbed needle housing until securely locked into place. The needle will "click" when locked.
   - Apply digital pressure to the vein just above the tip of the catheter and secure catheter hub.

- Remove needle guard by twisting slightly and pulling it out of the catheter hub.
- Collect blood sample, if applicable. [Withdraw blood prior to flushing catheter with normal saline.]
- Release tourniquet.
- Connect primed **INT**/IV set and luer lock in place, ensuring a secure connection.
- Dispose of secured needle in proper sharps container.

7. A butterfly needle is to be inserted utilizing sterile technique:
   - Pinch wings together maintaining sterility of needle.
   - Insert butterfly needle into the skin with bevel upward at a 45 degree angle. Decrease the angle of the needle until almost level with the skin surface, and direct it toward the vein.
   - Proceed carefully until the vein is punctured **indicated by the presence of "flash" directly behind or below the button.**
   - Continue to advance [exerting a gentle lifting pressure to avoid piercing the opposite wall of the vein] until the needle is well within the vein.
   - Release tourniquet;
   - Collect blood sample, if applicable. [Withdraw blood prior to flushing catheter with normal saline.]
   - Connect primed **INT**/IV set and luer lock in place, ensuring a secure connection.

8. Insertion attempts are to be documented:
   - All pertinent data to include date, time, site of insertion, catheter gauge, number of sticks, and staff member initiating IV access is to be documented.
   - If more than 2 attempts to start intravenous access are necessary, assistance is to be obtained from a nurse experienced in starting IV's.
   - After four attempts at initiating IV access, the physician may be notified for further instructions.

9. IV site dressing is to be applied over the IV insertion site to securely anchor the catheter/needle, avoid irritating motion and to avoid transport of cutaneous bacteria to the venipuncture site:
   - Skin prep may be used to secure dressing.
   - Tape is not to be applied under the transparent dressing.
   - Transparent dressing is to be applied over IV site to cover hub only, not junction of tubing and hub, to allow for easier tubing changes;
   - The date, catheter/needle gauge, and initials of staff member initiating access are to be noted and securely attached to the dressing;
   - Transparent dressing does not need to be changed unless integrity of the dressing is disturbed.

10. Protocol for collecting blood sample from IV site:
   - If blood is drawn when IV initiated, blood is to be collected prior to flushing of catheter with normal saline.
   - If blood is drawn from an established IV site, 3 mls of blood is to be discarded prior to collecting blood sample.

11. INT Protocol for Flushing:
   - Swab injection cap with Site Scrub.
   - Instill the saline flush via **endcap** to flush access: ~~maintaining positive pressure on plunger while infusing last ½ ml of saline flush as the clamp is closed.~~

12. Protocols for INT flushes to minimize clot formation: ***[See attached]***
   - Adolescents [13 - 18 years] and adults are to have INT flushed with 3 mls of saline on insertion, after administration of each medication, or a minimum of every 8 hours/PRN;
   - The pediatric [12 years of age and younger and younger] is to have INT flushed with 1 ml of saline [preservation free] on insertion, after administration of each medication, or a minimum of every 4 hours/PRN;
   - Flushing the INT with saline is to be documented on the eMAR.

13. IV Related Monitoring/Care:
    - A buretrol is to be utilized for all patients 12 years of age and under. Fluid volume of buretrol is to be limited to hourly infusion rate.
      [Exception : NBN – volume of buretrol is to equal IV rate for 4 hours]
    - IV site is to be checked hourly and PRN with appropriate documentation.
    - Phlebitis/Infiltration scale [attached] is to be utilized to address IV site condition a minimum of once per shift, unless complications warrant additional evaluations.
    - An Event Record is to be completed when IV complications are identified.
    - IV intake is to be recorded per policy or as ordered with appropriate documentation **in CERNER [right click on IVF on eMAR to enter volume or enter amount manually based on IV pump primary volume.**
    - IV site is to be changed every 3 days unless a physician order is obtained to use for a longer time frame.
    - IV access initiated outside RMC or with poor asepsis is to be restarted within 24 hours.
    - IV tubing is to be changed every 3 days. Exception :
      - EMS tubing – change on admission ;
      - Propofol tubing – change every 12 hours ;
      - TPN/PPN tubing/filter – change every 24 hours.
    - A change sticker is to be applied to the IV tubing to indicate the day tubing is to be changed.
    - With intermittent therapy, cap off end of IV tubing with Dual Luer Lock Cap [~~blue~~ dead end cap]. Use a new cap each time [do not leave tubing open to air].

~~Note : In an emergency, if EMS tubing has to be used prior to changing, a needle lock device is to be attached to the Y port for Clearlink access~~.

14. KVO Rate: [Keep Vein Open]
    - Utilize appropriate size bag to total 24 hours volume [i.e. 500 ml bag of IVF's for adults; 250 ml bag for all others].
    - The KVO rate for an adult patient is not to exceed 25 mls/hour unless specifically ordered otherwise by the physician.
    - The KVO rate for a renal patient is not to exceed 10 mls/hr unless specifically ordered otherwise by the physician.
    - The KVO rate for a pediatric patient is not to exceed 5 mls/hr unless specifically ordered otherwise by the physician.

15. Infusion Control Devices:
    - An infusion control device is to be utilized for all IV infusions. Exceptions:
        - Infusion control device may not be warranted when transporting a patient between nursing units unless the IV solution is medicated.
        - Non-medicated IVF at KVO rate may be regulated by roller clamp.
        - When IVF bolus is required.

16. IV Access Removal:
    - Carefully remove the transparent dressing with alcohol, taking care not to disturb the catheter/needle.
    - A 2 x 2 sterile pad ~~or alcohol swab~~ is to be placed just above the IV site.
    - Without pressure, the device is to be quickly withdrawn pulling straight back to avoid tearing the vein.
    - If butterfly used:
        - **Place a gauze pad over the venipuncture site, covering the body of the device;**
        - **While needle still inside vein, grasp body of device with thumb and middle finger and activate button with tip of index finger [without impeding retraction of the needle at the end of the set].**
        - ~~withdraw by grasping the translucent yellow safety shield grip area with the thumb and index finger with opposite hand, grasp tubing between thumb and index finger, push yellow shield forward until safety shield is locked in place.~~
    - **Confirm that needle is shielded and** dispose of device in approved sharps container.
    - Immediately apply pressure and maintain the pressure to the site with the gauze until bleeding is stopped to prevent hematoma formation or/and blood oozing out of the vein.
    - A band-aid or pressure dressing is to be applied as indicated.
    - **For removal of external jugular [EJ] catheters:**
        - **Apply direct pressure with gauze for at least 5 minutes;**
        - **Apply pressure dressing;**
        - **Instruct patient to continue manual pressure to site for an additional ten minutes to minimize hematoma formation.**

- The venipuncture site is to be assessed for redness, swelling, or formation of a hematoma.
- The intravenous access device is to be assessed for integrity. The physician is to be notified if the integrity of the catheter has been compromised.
- Document the discontinuation of the IV access, site, and access device integrity.

17. Cultures:
    - Cultures of IV catheter and/or fluid may be required if either is the suspected cause of infection in a patient.
    - Each specimen is to be labeled with patient information, noting the type of specimen, date and time of collection, and the **CERNER logon** ~~name~~ of staff member collecting the specimen.
    - If IV fluids is the suspected source of infection:
        - Aseptically withdraw 20 mls of fluid into syringe and place in sterile specimen container.
        - The lot number of IV fluid container is to be recorded on the specimen container label and comment section of computer generated order.
        - Send to lab immediately.
    - If IV cannula is the suspected source of infection:
        - Prep insertion site.
        - Aseptically remove the cannula.
        - Clip cannula tip with sterile scissors and drop tip into a sterile container.
        - Label and send to lab immediately.

Vice President, Patient Care Services/Date

Chairman of Infection Control Comm./Date

References:	
N	• INS Guidelines • CDC Standards for Intravenous Therapy

Written: 1/00, 5/00, 2/03, 3/04, 3/06, 4/13
{IVAccess.Doc}

+rmc
the Regional Medical Center

Subject:	Medication Management: Parenteral Medications	TJC Function: MM
Page:	1 of 4	Manual: Nursing & Pharmacy

PURPOSE: To define a process for parenteral administration of medications.

POLICY: The licensed nursing staff [after completion of appropriate education] is to administer parenteral medications as prescribed by the physician. The RN must administer IV push [bolus] medication and perform IV admixtures per the Nurse Practice Act when permitted per policy.

Only the pharmacy staff compounds or admixes sterile medications, including intravenous admixtures, except in emergencies, when the drug is to be used immediately, when not feasible [i.e. when the product is compounded, it has limited stability] or in ED, OR or other settings where a licensed independent practitioner controls the preparation of the medication.

PROCEDURE:

1. Refer to Medication Administration table [attached] for techniques for intradermal, subcutaneous, intramuscular and Z-track injections.

2. Injection site is to be documented using appropriate abbreviations:

RD	-	right deltoid
LD	-	left deltoid
RG	-	right gluteal
LG	-	left gluteal
RT	-	right lateral (lower) thigh
LT	-	left lateral (lower) thigh
LA	-	left arm
RA	-	right arm
ABD	-	abdomen

3. When allowed per policy, the licensed nurse is to prepare the parenteral [IM, subcutaneous, intradermal, etc.] medication immediately prior to administration.

4. The process for reconstituting of powdered medications when allowed per policy:
   - Inject the amount of diluent required per manufacturer into the vial of medication [preservative free sterile water, normal saline or other suitable preservative free diluent is to be utilized for newborns and pediatric patients up to 3 months of age];
   - Mix the solution by shaking gently;
   - Label multidose vial with:
     - time and date of reconstitution
     - amount and type of diluent added
     - equivalent dosage per ml
     - initials of staff reconstituting the medication.
   - Refrigerate when indicated.
   - Discard per policy.

5. To administer IV medications to pediatric patients/newborns:
   - Obtain prepared medication from Pharmacy;
     - Medications for pediatric patients [12 years of age or younger] are to be in a syringe rather than a minibag.
   - For IVF rates greater than 15 ml/hour, add medication to burette and fill with fluid volume to equal hourly infusion rate [medication volume plus fluid volume to equal hourly IV rate]; then infuse at prescribed rate.
   - When monitoring drug levels [i.e. Theophylline, Gentamicin, etc.], the medication is to be administered via a medfusion syringe pump.
   - For IVF rates less than 15 ml/hour and medication volumes less than 2 mls, use syringe pump. If not available:
     - close roller clamp;
     - pinch tubing below lower "y" port;
     - inject medication slowly into lower "y" port;
     - release tubing;
     - restart IV at prescribed rate.

6. To administer IV push medications, the RN is to:
   - Dilute appropriate medications with normal saline or sterile water to promote ease of calculation and accuracy of dosage or obtain premixed diluted medication, if available.
     Ex. [Morphine 10 mg/ml diluted with 9 mls NS = 1 mg/ml]
   - The syringe of diluted medication is to be labeled with dosage of medication, amount of diluent, resultant concentration, date/time and initials of person preparing medication.

- Check compatibility of IV medication and IV solution; if incompatibility noted, flush line with NS before and after medication administration.
- Close roller clamp or pinch IV tubing, wipe lower "y" port injection cap with an alcohol swipe, inject small amount of medication slowly. Open roller clamp and re-adjust flow rate or release IV tubing to flush line.
- If medication requires further dilution, medication may be administered via infusing IV fluids using upper "y" port to administer medication.
- Document medication and dosage administered, duration of administration and drug effect/adverse reactions.

7. When an IV additive is not available in a premixed solution and when permitted per policy, the RN is to compound the admixture:
   - Obtain the required medication dose and type/amount of diluent;
   - Wipe the injection port of the diluent container and add the prescribed dose of medication utilizing aseptic technique
   - Mix the solution thoroughly;
   - Label the solution using a red "medication added" sticker [refer to policy "Medication Management: Labeling"].
   - Refer to policy "Medication Management: Compounding" for additional information.

8. To administer a continuous IV medicated infusion:
   - Utilize the standardized premixed solution or pharmacy staff [or RN in emergency situation] is to prepare the medicated infusion according to the "Red Medication Booklet".
   - Utilize IV pump to deliver the prescribed dose via the specific drug dosing parameters.
   - Document the infusion admixture, to include the type and amount of medication and diluent and the prescribed dose with equivalent ml/hour rate. Also document when the infusion was initiated and ended.

9. Refer to the "Red Medication Booklet" for protocols to titrate or taper the medicated IV infusions.

MD
Chairperson P&T Committee/Date

7/16/12
Pharmacy Director/Date

13 Jul 12
VP – Patient Services/Date

References	
E	• RMC P&T Committee
N	• 2012 Hospital Accreditation Standards

Written: 5/78, 5/81, 11/83, 1/86, 9/86, 11/87, 10/89, 10/93, 2/97, 8/99, 10/02, 2/03, 8/05, 6/12

Techniques for administration of medication by injections:

Reminders for all injections:
- Cleanse site with alcohol prep, wiping from center out to the periphery;
- Express the air bubbles from the syringe leaving 0.1 ml at the tip so that all medication will be expelled;
- After medication is administered, activate safety device and discard in the sharps container.

Type injection: Subcutaneous
Site of injection: Upper lateral aspect of arm, anterior portion of thigh, abdomen
Needle: 25 – 26 gauge, 3/8 - 5/8 inch needle
Fluid Amount: Usually 2 mls or less
Administration:
- Insert needle at a 45 or 90 degree angle depending on patient size;
- Inject medication slowly;
- Withdraw needle quickly and apply pressure unless contraindicated.

Type injection: Intramuscular
Site of injection: Larger muscle masses as deltoid muscle, gluteal muscles and vastus lateralis
Needle: Appropriate size gauge and length for patient [gauges 22 or 23]
Fluid Amount: Usually 2 mls or less
Administration:
- Insert needle at a 90 degree angle
- Pull back on plunger [if blood return noted, discard and prepare another dose of medication]
- Inject medication slowly;
- Withdraw needle at same angle as inserted;
- Apply pressure and/or massage injection site unless contraindicated.

Type injection: Intradermal
Site of injection: Medial forearm [back surfaces for allergy testing]
Needle: 26 gauge, 3/8 inch needle
Fluid Amount: Usually 0.5 mls or less
Administration:
- Pull the patient's skin taut;
- Insert needle at 10 – 15 degree angle with bevel of needle facing up;
- Inject medication slowly, observing for wheals and blanching [normal];
- Withdraw needle, wiping are gently if necessary

Type injection:	Z-track [for administration of irritating medications]
Site of injection:	IM site [preferably in a larger, deeper muscle]
Needle:	▪ Appropriate size gauge and length for patient ▪ Apply new needle to syringe after preparing medication so no solution remains on outside of needle shaft
Fluid Amount:	Usually 2 mls or less
Administration:	▪ Pull overlying skin and subcutaneous tissue approximately 1 – 1 ½ inches laterally to the side ▪ Insert needle at a 90 degree angle ▪ Pull back on plunger [if blood return noted, discard and prepare another dose of medication] ▪ Inject medication slowly; ▪ Leave needle inserted for 10 seconds to allow the medication to disperse evenly; ▪ Release the skin after withdrawing the needle [leaves zigzag path that seals the needle tract].

ITEMIZED BILL PAGE 1

DATE 06/09/2015
TIME 01:10:01 PM

REGIONAL MEDICAL CENTER
3000 ST. MATTHEWS ROAD
ORANGEBURG SC 291181442

PATIENT CONTROL NUMBER
2389182

PATIENT NAME
MIDDLETON JR, ROBERT L

MEDICAL RECORD NUMBER
552507

BEGINNING DATE OF SERVICE
110314

ENDING DATE OF SERVICE
112814

REV CODE	PROCEDURE DESCRIPTION	HCPCS/ RATES	DATE	UNITS	CHARGE AMOUNT	NC CHARGE AMOUNT
0272	WND KLING GAUZE		110514	1	78.00	
0272	WND KLING GAUZE		110614	1	78.00	
0272	WND KLING GAUZE		111114	3	234.00	
0272	DRESSING, MEDIHONEY 2X2	A6196	111114	1	18.00	
0272	WND KLING GAUZE		111314	1	78.00	
0272	DRESSING, MEDIHONEY 2X2	A6196	111814	1	18.00	
0272	DRESSING, MEDIHONEY 2X2	A6196	112814	1	18.00	
0420	WND PT DEBRIDEMENT/SKIN	9759759GP	111914	1	199.00	
0940	WND LOW FREQUENCY ULTRAS	97610	110314	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	110514	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	110614	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	111114	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	111314	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	111414	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	111814	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	9761059	111914	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	112114	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	112414	1	225.00	
0940	WND LOW FREQUENCY ULTRAS	97610	112614	1	225.00	
0001	PAGE 1 OF 1			21	3196.00	
0001	TOTAL			21	3196.00	

ITEMIZED BILL

PAGE 1

DATE 06/09/2015
TIME 10:19:59 AM

REGIONAL MEDICAL CENTER
3000 ST. MATTHEWS ROAD
ORANGEBURG SC 291181442

PATIENT CONTROL NUMBER
2389183

PATIENT NAME
MIDDLETON JR, ROBERT L

MEDICAL RECORD NUMBER
552507

BEGINNING DATE OF SERVICE
111114

ENDING DATE OF SERVICE
112814

REV CODE	PROCEDURE DESCRIPTION	HCPCS/ RATES	DATE	UNITS	CHARGE AMOUNT	NC CHARGE AMOUNT
0510	WND OP FACILITY FEE LEVE	99213	111114	1	237.00	
0510	WND OP FACILITY FEE LEVE	9921325	111914	1	237.00	
0510	WND OP FACILITY FEE LEVE	9921325	112114	1	237.00	
0510	WND OP FACILITY FEE LEVE	99213	112814	1	237.00	
0001	PAGE 1 OF 1			4	948.00	
0001	TOTAL			4	948.00	

Statement of Account Page 1

From 10/01/14 To 06/09/15

TRMC HOSPITALIST WOUND CENTER
3000 ST MATTHEWS RD
ORANGEBURG SC 29118-1442

Account 1719

[redacted]

Statement Date 06/09/15

Business Phone 803-395-4566
Registration Phone

Federal ID No. 576008010

BC 10 TIKAYAH JEWEL HAMILTON
FC 198 SWEET BAY LN
NC P O BOX 276
SANTEE SC 29142-8791

- - Patient Name - -
ROBERT LEE MIDDLETON

- - Misc Remarks - -
0000552507

Date	Patient	Code	PL	Mods	Description	Units	Doctor	Amount
11/19/14	ROBERT	99213		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	89.00
11/26/14	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	29.35-
11/26/14	ROBERT	99912			[redacted]		Gehling,Ma	59.65-
12/05/14	ROBERT	99212		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	65.00
01/09/15	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	14.93-
01/09/15	ROBERT	99912			[redacted]		Gehling,Ma	50.07-
10/31/14	ROBERT	99214		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	140.00
02/25/15	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	45.39-
02/25/15	ROBERT	99912			[redacted]		Gehling,Ma	94.61-
11/21/14	ROBERT	99213		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	89.00
03/18/15	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	58.70-
03/18/15	ROBERT	99912			[redacted]		Gehling,Ma	119.30-
11/28/14	ROBERT	99213		22	OFFICE/OUTPATIE	1.000	Gehling,Ma	89.00
03/02/15	ROBERT	99212		22	VISIT EST OFFICE/OUTPATIE	1.000	Gehling,Ma	65.00
04/06/15	ROBERT	12			VISIT EST [redacted]		Gehling,Ma	14.93-

04/06/15 ROBERT 99912 [redacted] Gehling,Ma
50.07-

Total Listed:	.00
Total Not Listed:	.00
Balance Due:	.00

Peter C. de Vito, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
1050 ST. ANDREWS BLVD.
CHARLESTON, SOUTH CAROLINA 29407

TELEPHONE (843) 571-2350

02/03/15

Jonathan Krell, Esquire
P O Box 399,
Charleston SC, 29401

RE: Robert Middleton

Dear Mr. Krell

This letter is regarding the future medical treatment required to assist Robert Middleton; these are a direct result of the accident which occurred on October 2014, when my patient sustained injuries. The following treatments and fees would be recommended:

Intralesional injections with cortico-steroids at a fee of $85.00 per injection. The patient will need these treatments at monthly intervals for an indefinite period, to obtain the desired softening.

The surgical fee for scar revision with possible skin grafs of the right hand would be-$2,500.00. The hospital, operating room, and anesthesia fees could range from $4,000.00 to $12,000.00 or more depending upon the length of stay, etc.

It should be understood, however, that while these procedures will improve the scarring, the patient will still be left with noticeable scars due to the nature of the injury.

If further information is needed to assist my patient, please do not hesitate to contact my office.

Very truly yours,

Peter C. de Vito, M.D.

Peter C. de Vito, M.D., F.A.C.S.
DBNR

PCD:pdv

PLAINTIFF'S EXHIBIT

Peter C. deVito, M.D.
1050 St. Andrews Boulevard
Charleston, SC 29407

(843)571-2350

THIS IS A STATEMENT OF YOUR ACCOUNT ON THE FOLLOW DATE. ANY CHARGES OR PAYMENTS MADE AFTER THIS DATE WILL APPEAR ON NEXT MONTHS STATEMENT

6121-G	4/23/18

FINANCE CHARGE	equal to	ANNUAL PERCENTAGE RATE
at % PER MONTH		at % PER ANNUM

will be added to the unpaid balance of Days or more past due as of the billing date appearing on this statement. Payments and other credits are deducted from the Previous Balance before computing the FINANCE CHARGE.

Robert Middleton
198 Sweet Bay Lane
Santee, SC 29142

DATE	PROCEDURE	PATIENT NAME	DOCTOR	CHARGES	CREDITS	BALANCE
1/26/15	Atty J Krell #163598	Robert Middleton			500.00	-500.00
2/2/15	Consult, Exam & Evaluation	Robert Middleton	Peter C. deVito	500.00		0.00
3/2/15	Estab Patient follow up (15)	Robert Middleton	Peter C deVito	30.00		30.00
4/23/18	Estab Patient follow up (15)	Robert Middleton	Peter C. deVito	75.00		105.00

Current	75.00	30 Days	0.00	60 Days	0.00	Please Pay This Amount → 105.00
90 Days	0.00	120 Days	0.00	150+Days	30.00	

Peter C. deVito, M.D.
1050 St. Andrews Boulevard
Charleston, SC 29407

(843)571-2350

THIS IS A STATEMENT OF YOUR ACCOUNT ON THE BELOW DATE. ANY CHARGES OR PAYMENTS MADE AFTER THIS DATE WILL APPEAR ON NEXT MONTH'S STATEMENT

6121-G	2/2/15

A FINANCE CHARGE of ____ % PER MONTH	equal to an	ANNUAL PERCENTAGE RATE of ____ % PER ANNUM

will be added to the unpaid balance of ____ days or more past due as of the billing date appearing on this statement. Payments and other credits are deducted from the Previous Balance before computing the FINANCE CHARGE.

Robert Middleton
198 Sweet Bay Lane
Santee, SC 29142

DATE	PROCEDURE	PATIENT NAME	DOCTOR	CHARGES	CREDITS	BALANCE
1/26/15	Atty J Krell #163598	Robert Middleton			500.00	-500.00
2/2/15	Consult, Exam & Evaluation	Robert Middleton	Peter C. deVito	500.00		0.00

Current	0.00	30 Days	0.00	60 Days	0.00
90 Days	0.00	120 Days	0.00	150+Days	0.00

Please Pay This Amount → 0.00

STATE FO SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF ORANGEBURG) FIRST JUDICIAL CIRCUIT
) CASE NUMBER: 2015-CP-38-01334

TEKAYAH HAMILTON, INDIVIVUALLY AND AS PARENT AND GUARDIAN AD LITEM FOR ROBERT LEE M., JR. A MINOR CHILD UNDER THE AGE OF EIGHTEEN,
Plaintiffs,
v.
REGIONAL MEDICAL CENTER AND JAMIE DOWNING, RN,
Defendants.

AFFIDAVIT OF MONICA STOBBS, RN, BSN

PERSONALLY, appeared before me, the undersigned, who being duly sworn, under the penalties of perjury, says as follows:

1. I am a licensed registered nurse in the state of South Carolina.
2. My education, training and experience are set forth in the attached curriculum vitae (attached hereto as Exhibit 1).
3. My education, training and experience qualify me to render expert opinions regarding the care rendered to Robert Lee M., Jr.
4. I am familiar with the standard of care for what a reasonable, prudent nurse would do or not do in administering IV medication, including but not limited to the intravenous administration of antibiotics including similar situations to that of Robert Lee M., Jr.
5. I reviewed the medical records of Robert Lee M., Jr., which consist, in part, of records from Regional Medical Center located at 3000 St. Matthews Rd., Orangeburg, SC 29118. These are the types of records and documents which I normally consider in rendering an expert medical opinion.

6. After review of the afore mentioned medical records, it is my opinion to reasonable degree of medical certainty that Regional Medical Center and the nursing staff while in the course and scope of its employment at Regional Medical Center committed negligent acts or omissions in its care of Robert Lee M., Jr.

7. On October 25, 2014 Robert Lee M., Jr., was admitted to Regional Medical Center for the treatment of neo-natal fever. During the course of treatment at Regional Medical Center, the nursing staff administered intravenous antibiotic medication to Robert Lee M., Jr. Without intending to limit the scope of my opinions, below are some of the breaches of the standard of care for the administration of IV medication to Robert Lee M., Jr.:

   a. Failing and neglecting to properly inspect the IV site on October 28, 2014 at approximately 4:27 a.m. prior to the administration of antibiotic medication.

   b. Failing and neglecting to properly monitor the IV site after the administration of the antibiotic medication.

8. Further, it is my opinion, to a reasonable degree of medical certainty that the actions or inactions of the defendants most probably caused and/or contributed to the injuries and damages suffered by Robert Lee M., Jr.

9. This Affidavit is given in compliance with the South Carolina Code of Laws which do not require me to state all negligent acts or omissions by any defendant. Additionally, I reserve the right to supplement or amend this Affidavit or any testimony by me after receiving additional medical records, documents, depositions and/or information.

Signature Page to Follow

MONICA STOBBS, RN,BSN

SWORN TO AND SUBRSCIRBED BEFORE ME
This 12th day of March, 2015

SEAL
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISION EXPIRES: 08/15/2024

Monica Stobbs, RN, BSN

164 Market Street, Suite 295
Charleston, SC 29401
TEL: (857) 334-5310 EMAIL: monicastobbs@gmail.com

PROFESSIONAL BACKGROUND

2012 – Present **MEDICAL UNIVERSITY OF SOUTH CAROLINA,** Charleston, SC

Per Diem Nurse at this Level One Trauma Center

- Clinical areas of practice include Adult General Medicine & Surgery

1990 – 2012 **MASSACHUSETTS GENERAL HOSPITAL,** Boston, MA

Per Diem Nurse at this Harvard affiliated hospital

- Clinical areas of expertise include Trauma Surgery, Orthopaedics, Neurosurgery, General Surgery, Acute Medical & Cardiac Units
- Interface daily with nationally recognized physicians in collaborative patient care
- Provide advanced in-patient care using state of the art equipment (including ventilator & cardiac monitoring)
- *Certified* IV Therapy Instructor; BCLS; EKG interpretation

1994 - 1996 **MA DEPARTMENT OF PUBLIC HEALTH,** Boston, MA
Nurse Consultant

- Monitored seven (7) Long-Term Health Care facilities in MA for Quality Assurance, Regulatory Compliance and Standards of Clinical Practice
- Identified substandard areas of health care delivery
- Assisted facilities in developing plans of correction for substandard areas of practice
- Reported directly to MA's top three (3) Health Care officials
- One (1) of two (2) nurses in the country to perform this role

1986 - 1990 **NEW YORK HOSPITAL-CORNELL MEDICAL CENTER,**
New York, NY

1989 - 1990 Acting Head Nurse on an Open Heart Surgery Critical Care Unit
1986 - 1989 Senior Staff Nurse in this 1,000 Bed Metropolitan Hospital

1988 - 1989 **WASHINGTON UNIVERSITY MEDICAL CENTER,** St. Louis, MO

Per Diem Nurse (General Medical/Surgical Units Organ Transplant & Critical Care Units)

- Performed basic & advanced nursing skills in a variety of settings including Critical Care & Organ Transplant Units

1983 - 1985 ST. LOUIS UNIVERSITY HOSPITAL, St. Louis, MO

Charge Nurse/Staff Nurse (Cardiology & Head/Neck Surgical Unit)

- Provided direct patient care including EKG recognition, respiratory & intravenous therapy, advanced physical assessments

EDUCATION: BSN - May 1983, Creighton University School of Nursing
Current License in the State of SC

Presentations:

- Evaluating Spine Injury Claims; NCAJ & APITLA Medical Malpractice Seminar; Raleigh, NC; Nov 2011. CLE credited.
- Evaluating Spine Injury Claims; South Carolina Bar Association; Columbia, SC; October 2012. CLE credited.
- Evaluating Spine Injury Claims; United States Attorney Office, Southern District of Illinois; October 2013. CLE credited.
- Evaluating Spine Injury Claims; United States Attorney Office, Southern District of Florida; February 2014. CLE credited.

Publications:

- D.C. Trial Lawyers Association (DCTLA) Quarterly Journal; "Evaluating Spine Injury Claims". January 2012
- The Nurse's Note
  - "Spine Arthritis & Back Injury Claims; Jan 2010
  - "Spine Surgery: Complications of Spinal Fusion Surgery"; Feb 2010
  - "Evaluating Breast Cancer Cases"; March 2010
  - "Orthopaedic Emergencies: Acute Compartment Syndrome"; April 2010
  - "Case Report: Plaintiff Wins 1.1 Million in ACS Case"; May 2010
  - "Medical Chronology A Critical Tool for Winning Your Case"; June 2010
  - "Evaluating Brain Injury Cases"; July 2010
  - "Sleep Deprivation"; August 2010
  - "Spinal Disc Replacement Surgery"; Sept 2010
  - "Evaluating Cancer Claims"; Oct 2010
  - "Emergency Room Practice: Imaging Protocols for Abdominal Pain"; Nov 2010.

Q. Was that certification thru the institution or to the state?
A. Through, through Massachusetts General Hospital.
Q. So that was a facility certification?
A. Yes.
Q. How long was that program?
A. It was so many years ago. Maybe it was, it was maybe over a week.
Q. And again, since you haven't had any clinical pediatric nursing experience I presume you've never started a pediatric IV?
A. No.
Q. Never cared for a pediatric patient with a peripheral IV?
A. Taking care of an IV is an IV whether it's a baby or an adult. It's the same principle in terms of management of the actual IV and giving administration of medication through it.
Q. All right. I appreciate the answer, but if you can say yes or no and then you're free to say whatever you want. So, my question was, I presume that you have not taken care of a patient with a peripheral IV that's pediatric?
A. I have not.
Q. Thank you. What is your hourly rate for your

Q. When we're talking about Ms. Hamilton and her child, the medication that was administered was what?
A. Ampicillin.
Q. All right. Is ampicillin a vesicant or non-vesicant?
A. It's a vesicant.
Q. Okay. So for the purposes of your deposition in, in, in the broad sense, when I ask you questions do you want me to use extravasation or infiltration to describe those events that occurred?
A. Either would work for this.
Q. Okay. So you think they are synonymous?
A. Yes.
Q. Have you done any literature research to come to any of your thoughts in this case?
A. No, this is basically Nursing 101. There are many articles that talk about policies and procedures for giving IV medication or managing an IV site, it's basic nursing 101 as well.
Q. So you are not relying on any literature in coming to any of your thoughts; is that fair?
A. That's fair. There will be literature that supports my opinions.
Q. But you haven't done a search, any sort of research

that there was any redness to the IV site?
A. No.
Q. Did you see at 4:04 that there was any documentation of any signs and symptoms of Phlebitis?
A. No.
Q. Did you see at 4:04 that there's any documentation of any signs and symptoms of swelling?
A. No. I didn't see the 4:27 either.
Q. All right. How many times have you given a peripheral IV to, with a 24 gauge needle to a pediatric patient?
A. I've administered no medications IV to a pediatric patient. I've administered thousands to adults.
Q. So the answer then would be none?
A. None to pediatric patients. Thousands to adult patients.
Q. So, as you sit here today you can't tell me that you could get blood return on an IV administered to a pediatric patient with a 24 gauge needle --
A. A vein is --
Q. Let me finish. Because you have no experience in doing that?
A. No. I'm not saying that period of vein is a vein. You should get blood return from a vein whether

it's a baby or whether it's an adult. A vein is a vein.

Q. Are you familiar with articles in the literature that say it is difficult to impossible to get blood return on the 24 gauge needle?

A. No. I have managed 24 gauge needles in adults and you can get a blood return.

Q. Well you would agree with me to the care, the management of an adult patient is different from a pediatric patient wouldn't you?

A. The management of a vein is the management of the vein whether it's an adult or whether it's a baby, it's the same. The management of a vein is a vein.

Q. What is your definition of a vesicant?

A. It would be a medication or fluid that can cause a burn like injury to the skin.

Q. Would you agree with me that signs and symptoms of infiltration or extravasation, however you want to, and for this question I'm using those terms synonymously, often do not occur and are not always obvious until a few hours after the patients IV device has failed?

A. I disagree.

Q. All right. Tell me why?

A. Because when theres an infiltration of the vein and

STATE OF SOUTH CAROLINA)) COUNTY OF ORANGEBURG)	IN THE CIRCUIT COURT FIRST JUDICIAL CIRCUIT
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen, Plaintiff, -vs- Regional Medical Center Defendant.	C/A No.: 2015-CP-38-01234 **NOTICE OF MOTION AND MOTION IN LIMINE TO EXCLUDE MONICA STOBBS TESTIMONY**

Defendant, The Regional Medical Center, (hereinafter TRMC), by and through the undersigned, hereby states the following for TRMC's Motion in Limine:

1. The Plaintiff commenced this action alleging Medical Malpractice against the Defendant, TRMC. The matter is scheduled for a date certain trial on May 7, 2018. Defendant TRMCis moving pursuant to this Motion in Limine to exclude Monica Stobbs, RN from testifying as a medical expert in administering/managing pediatric IV therapy.

2. Monica Stobbs is not qualified to testify as to IV Therapy for pediatric patients. There is a clear distinction between treatment of adults and pediatric patients, particularly neonates and infants. Monica Stobbs testified to the fact she never cared for and managed any pediatric patient with a peripheral IV and did not research any treaties or other journals regarding the treatment of pediatric peripheral IV treatment. Her contention that IV management for

pediatric patients is the same for adults is simply not accurate and contrary to modern medicine and the literature. Monica Stobbs has never started an IV on a pediatric patient.

3. In order to qualify an expert they must have the "knowledge, skill, experience, training or education" in order to testify. SCRE 702. "To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter.'"*Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 253, 487 S.E.2d 596, 598 (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995); *see also Botehlo v. Bycura*, 282 S.C. 578, 587, 320 S.E.2d 59, 65 (1984) (orthopedic surgeon was not qualified to testify on the standard of care for podatrist where orthopedic surgeon had no training in podiatry, was not familiar with any journals or periodicals in podiatry, and was not familier with the surgical procedure performed).

4. Ms. Stobb's expert opinion is premised on her belief that the standard of care for IV management is the same for pediatric patients as it is for adults. Stobbs Depo. pg. 13 ll. 13-18 (Exhibit 1). There is a clear distinction between IV management in adults than pediatric patients.[1] Veins in infants are "*obviously* smaller" and they can be "threadlike".[2] In Ms. Stobb's deposition she testified to the fact she never treated a pediatric patient with IV therapy indicating

[1] The Infusion Nurses Society: In fusion Therapy in Clinical Practice, 2nd. eds Hankins J, Lonsway RA, Hedrick C and Perdue MB. Saunders, St. Louis, MO 2001, 561 "Children present a wide variety of physical characteristics different from those in adults. In addition, premature infants and newborns vary greatly from older children in their anatomy and physiology. These characteristics affect the ability of neonates and infants to cope with environmental stress and to manage the metabolism, absorption, distribution, and excretion of medications and solutions. Although body systems in infants and children are different from those in adults, for the purpose of this text, only those related to infusion therapy are addressed in detail." (Exhibit 5).

[2] *Id.* at 562 "The size of venous and arterial vessels in the infant and child are obviously smaller than those in the adult. Although the vessels are anatomically positioned in the same locations throughout life, their sometimes-threadlike characteristics and tendency to hide make them difficult to locate in the young patient." (Exhibit 6).

her lack of skill and experience in the subject matter. Stobbs Depo. pg. 13 ll. 9-24. She further testified she did not read any literature regarding the management of IV's in pediatric patients in preparing for this matter showing she lacks both knowledge and education. Stobbs Depo. pg. 26 ll. 15-24. (Exhibit 2). Her entire expert opinion is based on her speculative belief that pediatric patients are simply little adults. She stated "[t]aking care of an IV is an IV whether it's a baby or an adult." Stobbs Depo. pg. 13 ll. 15-16. And that the standard of care is the same, it is simply "nursing 101." Stobbs Depo. pg 26 ll. 17. She is under the belief that she "should get blood return from a vein whether it's a baby or whether it's an adult." Stobbs Depo. pg. 32 & 33 ll. 24-7 (Exhibits 3 & 4). This is directly contrary to the literature.[3] Because Ms. Stobbs lacks any experience, skill, training, knowledge, or education and her testimony is premised on her experience managing adult patients Ms. Stobbs is not qualified to give an expert opinion on IV therapy in pediatric patients, as she will not assist the jury as she is not qualified on the subject matter.

5. Similar to the facts in *Botehlo,* 282 S.C. 578, Ms. Stobbs, while a nurse, has not administered IV therapy or cared for a pediatric patient with IV therapy, similar to how the orthopedic surgeon was not familiar with the procedure performed by the podiatrist. Likewise, Ms. Stobbs has not reviewed any literature regarding IV therapy in pediatric patients, the same as the orthopedic surgeon not having reviewed any journals or periodicals for podiatry. *Id.* The only distinction is that here Ms. Stobbs is a nurse. Ms. Stobbs has not started or managed an IV on a pediatric patient. Using the requirements of the *Botehlo* case, Ms. Stobbs is not qualified to give an expert opinion on pediatric IV therapy. *Id.*

[3] *Id.* at 422 "Checking for a blood return, or backflow of blood, is not a reliable method for determining the absence of an infiltration. A blood return may not be present when small veins are used because they may not permit blood flow around the cannula; one may think the infusion has infiltrated when it has not." (Exhibit 7).

WHEREFORE, defendant the Regional Medical Center (TRMC) hereby prays this Court issue its Order granting its Motion in Limine excluding Monica Stobb's testimony as an expert.

MICHAEL C. TANNER, L.L.C.

Michael C. Tanner
PO Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Defendants

Bamberg, SC

May 1, 2018

Q. Was that certification thru the institution or to the state?
A. Through, through Massachusetts General Hospital.
Q. So that was a facility certification?
A. Yes.
Q. How long was that program?
A. It was so many years ago. Maybe it was, it was maybe over a week.
Q. And again, since you haven't had any clinical pediatric nursing experience I presume you've never started a pediatric IV?
A. No.
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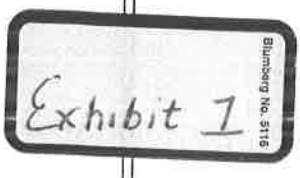

Q. When we're talking about Ms. Hamilton and her child, the medication that was administered was what?
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Q. All right. Is ampicillin a vesicant or non-vesicant?
A. It's a vesicant.
Q. Okay. So for the purposes of your deposition in, in, in the broad sense, when I ask you questions do you want me to use extravasation or infiltration to describe those events that occurred?
A. Either would work for this.
Q. Okay. So you think they are synonymous?
A. Yes.
Q. Have you done any literature research to come to any of your thoughts in this case?
A. No, this is basically Nursing 101. There are many articles that talk about policies and procedures for giving IV medication or managing an IV site, it's basic nursing 101 as well.
Q. So you are not relying on any literature in coming to any of your thoughts; is that fair?
A. That's fair. There will be literature that supports my opinions.
Q. But you haven't done a search, any sort of research

Exhibit 2
Blumberg No. 5116

that there was any redness to the IV site?
A. No.
Q. Did you see at 4:04 that there was any documentation of any signs and symptoms of Phlebitis?
A. No.
Q. Did you see at 4:04 that there's any documentation of any signs and symptoms of swelling?
A. No. I didn't see the 4:27 either.
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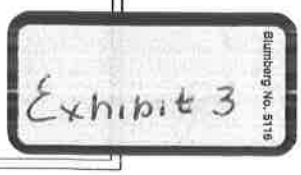

it's a baby or whether it's an adult. A vein is a vein.

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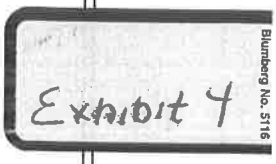

Chapter 30

Intravenous Therapy in Children

Anne Marie Frey, BSN, CRNI*

Starting and maintaining intravenous (IV) therapies in children poses unique challenges to the clinicians responsible for their care. Children are not only very different from adults, but they also display variations among their different age groups. These differences include physical, physiologic, developmental, cognitive, and emotional variables. When any type of infusion therapy is used in a child, a great responsibility is placed on the nurse. Accordingly, the nurse performing IV techniques in children should be highly skilled in the basic IV therapy applications and knowledgeable of the child's developmental stage. Most of the basic principles of safe administration of IV solutions and medications are the same, regardless of the patient's age. However, special considerations are necessary to safeguard the child undergoing these procedures; these measures include the need to calculate small doses and low infusion rates, to choose appropriate venipuncture sites and equipment, and to develop creative measures to distract curious little minds and hands.

This chapter focuses on the needs of children as they relate to infusion therapy and on the unique aspects of caring for children and their families.

Anatomic and Physiologic Differences in Children

Children present a wide variety of physical characteristics different from those in adults. In addition, premature infants and newborns vary greatly from older children in their anatomy and physiology. These characteristics affect the ability of neonates and infants to cope with environmental stresses and to manage the metabolism, absorption, distribution, and excretion of medications and solutions. Although body systems in infants and children are different from those in adults, for the purpose of this text, only those related to infusion therapy are addressed in detail.

The newborn's adjustment to extrauterine life is a complex physiologic process. The first 24 hours of life are the most critical as the newborn makes the respiratory and circulatory transition to extrauterine life. During this period, there is a much higher incidence of death than in the remainder of the neonatal period. All of the body systems undergo change after

*The author and editors wish to acknowledge the contributions made by Corinne Wheeler, an author of this chapter in the first edition of *Intravenous Nursing: Clinical Principles and Practice.*

birth, and most of them remain immature for a while. During infancy (birth to 12 months of age), physical and developmental changes occur more rapidly than during any other period. The infant's head and body grow very rapidly during this period, and major body systems undergo a progressive maturation process. In healthy infants, the birth weight is usually doubled at 6 months and tripled at 1 year. During infancy, certain critical developmental tasks that affect nursing care are mastered. However, each child has his or her own pace of development; no two children of the same age are at the same exact stage of development and maturation.

Biologic development in the toddler period (12 to 36 months) is less dramatic than during infancy. Body systems continue to mature, resulting in many children reaching full maturation by the end of the toddler period. Growth slows during this time. Birth weight is quadrupled by 30 months, and the height at age 3 years is generally about half the adult height. Head circumference growth slows, and chest circumference exceeds the size of both the head and the abdomen. The toddler is able to participate in an increased number of activities as a result of gross and fine motor skill advancement. In toddlers, IV connections must be taped and secured and equipment kept outside of the child's reach.

Early childhood (36 months to 6 years), also referred to as the *preschool period,* is a time of growth stabilization. The average annual weight gain is about 5 pounds (2.3 kg); the increase in height ranges from 2.5 to 3 inches (6.4 to 7.6 cm). Most of the height growth occurs in the legs, leading to a more slender physical appearance. The preschooler's more mature body system enables him or her to tolerate moderate physiologic stress. Skills mastered during the toddler period are refined during this time and include a rapidly developing ability to understand and use language. Expected levels of growth and development must be attained for the child to refine these skills in preparation for the next stage of childhood, school age.

The school-age period (6 to 12 years of age) is a time of gradual growth and development until the end of the period, sometimes referred to as *prepubescence.* The school-age child will grow an average of 2 inches (5 cm) and gain 4.5 to 6.5 pounds (2 to 3 kg) annually. Until prepubescence, there is little difference in size between males and females; toward the end of this stage, however, a growth spurt occurs. Girls first surpass boys in both height and weight. Body proportions approach adult measurements by the end of the school-age period.

Adolescence is the period of transition from childhood to young adulthood. This period is divided into three substages: early adolescence (11 to 13 years), middle adolescence (13 to 15 years), and late adolescence (15 years and older). The changes occurring during adolescence are primarily puberty, growth, and personality. The central nervous system is inundated with hormonal activity, and dramatic and obvious growth changes are noted in both boys and girls. Both sexes develop secondary sexual characteristics and grow larger. Less obvious is the maturation of the reproductive system. This stage is often turbulent for adolescents because they are on a constant emotional roller coaster, attempting to master the developmental tasks for adulthood.

Physiologic system development in children

Thermoregulation. The large surface area in relation volume, thin layer of subcutaneous fat, and unique method producing heat predispose the neonate to excessive heat lo Measures must be taken to protect the newborn from hypoth mia during all aspects of care, including obtaining vascu access and site care. Unlike the adult, the chilled neonate do not shiver but uses the mechanism of nonshivering thern genesis to increase heat production. In response to hyp thermia, norepinephrine is secreted by the sympathetic ne endings. This action stimulates the breakdown of brown to generate heat, allowing distribution of the heated blo through the body.

Increased metabolism as a response to hypothermia resu in higher oxygen and caloric requirements. A healthy infa can usually tolerate increased oxygen consumption; howev a sick infant is predisposed to cold stress and hypoglycem Cold stress begins as the infant requires an increase in oxyg and caloric consumption. The activation of norepinephri stimulates the metabolism, and anaerobic glycolysis resu The lactic acid produced by this process, combined with t acid end products of brown fat metabolism, can lead acidosis.[1]

This process of thermoregulation continues throughout t infant's first several months of life. During infancy, the chil ability to shiver increases. The older infant usually has acquir the benefit of insulation by the gradual growth of adipose tissu By early childhood, the skin is thicker, and the body has a high percentage of fat and a decreased surface area/volume rat these factors enable the preschooler to better cope with enviro mental cold.

The nurse performing such procedures as venipuncture an infant must maintain a neutral thermal environment for t infant to prevent the possibility of cold stress. A neutral thern environment is one that permits the infant to maintain a norm core temperature with minimum oxygen consumption a calorie expenditure. The neutral thermal environment f smaller infants is 35.4° plus or minus 0.5° C (95.7° plus minus 1° F) and for larger infants is 32.5° plus or minus 1.4° (90.5° plus or minus 2.5° F).[2]

To help infants stay warm, nurses can use radiant warmi panels, incubators, cotton blankets, and head coverings (e.g. piece of stockinet knotted at one end) and ensure that only t extremity of the IV insertion site is exposed. Blankets can warmed in warming units or in clean, unoccupied incubators. warming lamp, placed at the recommended safe distance fro the infant, can be used to prevent hypothermia if an infant mu be removed from a neutral thermal environment.

Vessel size. The size of venous and arterial vessels in t infant and child are obviously smaller than those in the adu Although the vessels are anatomically positioned in the sam locations throughout life, their sometimes-threadlike characte istics and tendency to hide make them difficult to locate in th young patient. Applying heat to the extremity before performin venipuncture facilitates venous identification and cathet insertion.

Patient assessment. A complete assessment of the patient, the IV site, the involved extremity, and the infusion system may be necessary to determine the presence of an infiltration. The site around the tip of the cannula and the extremity should be inspected for swelling, blanching, stretched skin, firm tissues, and coolness. It may be helpful to compare the site with the same area on the opposite extremity. If both extremities appear edematous, the patient's medical status should be evaluated. Patients with hemodynamic problems, such as congestive heart failure, toxic conditions, compromised kidney function, hypothermia, and vascular insufficiency, are particularly prone to vascular edema. The immobilized patient or the patient with muscular weakness or paralysis of an extremity may experience edema of the extremity that is totally unrelated to a problem at the IV site.

If an assessment of the involved extremity and the patient's medical status are inconclusive, pressure should be applied to the vein with a finger or tourniquet about 2 inches above the insertion site (it must be above the tip of the cannula). If the cannula is in the vein, this pressure will slow or stop the infusion rate. If the infusion continues despite the venous obstruction, an infiltration has occurred.

Checking for a blood return, or backflow of blood, is not a reliable method for determining the absence of an infiltration. A blood return may not be present when small veins are used because they may not permit blood flow around the cannula; one may think the infusion has infiltrated when it has not. In addition, veins that have had previous punctures or that are very fragile may seep fluid at a site above or below the vein cannula entry point; a blood return may be present, yet an infiltration is occurring. The movement of a cannula, such as in-and-out motions, can also cause the skin and the vein entry site to enlarge, allowing fluid to seep at the vein entry site, causing an infiltration.

Nursing interventions. To prevent or minimize infiltration-associated problems (Box 24-3), it is imperative that the cannula be discontinued once an infiltration has been identified. The type of solution being infused should also be considered. If the solution is isotonic and has a normal pH, the patient may not feel much discomfort unless a large amount of fluid has infiltrated. In these cases, warm compresses, such as warm, moist towels or chemical packs, may help alleviate the discomfort and help absorb the infiltration by increasing circulation to the affected area. Sloughing can occur from the application of warm compresses to an area infiltrated with certain medications, such as potassium chloride. In these instances, the application of cold compresses is preferred.[4] Established policies and procedures should dictate the use of compresses. The involved extremity should be elevated to improve circulation and to help absorb infiltrated fluid.

If weeping of the tissues occurs because of an extensive infiltration or loose thin tissue, as is often present in the elderly, it may be necessary to apply a sterile dressing to the affected area. It is usually better to leave these areas open because the dressing necessitates the use of gauze and possibly tape, which can increase tissue damage. If a dressing is used, it should be applied loosely. Extreme care should be given to prevent infection. The physician should be notified and measures should be carried out as ordered. If an infusion is needed, a cannula is placed in the opposite extremity or in a site above and away from the previous site.

Box 24-3 Effects of an Infiltration

- Deprives the patient of the prescribed rate of medications and solutions essential for successful therapy
- Limits mobility of an extremity
- Limits availability of veins for therapy
- Causes tissue damage
- Causes unnecessary patient discomfort

Preventive measures. Not all infiltrations can be prevented, but adherence to certain measures can minimize their severity. Flexion areas should be avoided if possible. The cannula should be taped securely, and the site should be protected from excessive movement or pressure by use of an armboard and restraints. Restraints must be applied with extreme caution and within the guidelines established by JCAHO.[1] Restraints should be well padded and applied in a manner that will not cause nerve damage, constrict circulation, or cause pressure areas. They should be removed at frequent intervals and range-of-motion exercises performed. Inadequate or improper use of armboards or restraints can cause very serious complications; policies and procedures should be established to guide their use.

Patient education can be a key factor in the prevention and early recognition of the signs and symptoms of an infiltration. Patient knowledge about the care of the IV site and system can prevent activities that may cause an infiltration, such as manipulating the cannula, pulling on the tubing, picking at the dressing, and using the extremity excessively. A patient who knows what to look for can alert the nurse to the early signs of an infiltration, and immediate care can be rendered, thereby preventing the possibility of more-serious complications.

Extravasation. *Extravasation* is the inadvertent administration of a vesicant solution or medication into the surrounding tissues. A vesicant solution is a solution or medication that causes the formation of blisters, with subsequent sloughing of tissues occurring from tissue necrosis (Fig. 24-3).

Patient assessment. It is essential that an extravasation be noted early, before extensive fluid is allowed to infiltrate the interstitial tissues. A complete assessment of the patient, the IV site, the involved extremity, and the infusion system should be performed at regular intervals. The flow rate should never be increased to determine the infiltration of a vesicant, nor should a blood return be used as a reliable method to determine an infiltration. Fluid can seep into the tissues from a previous puncture site or around the vein insertion site and increase the potential for tissue necrosis (refer to Infiltration for the assessment process).

Initial indications that tissue sloughing may occur include pain or burning at the site with progression to erythema and edema. Tissue sloughing is usually apparent within 1 to 4 weeks because of tissue necrosis. Necrosis can involve a small or a large area, including underlying connective tissues, muscles, tendons, and bone, necessitating surgical intervention.

STATE OF SOUTH CAROLINA)) COUNTY OF ORANGEBURG)	IN THE CIRCUIT COURT FIRST JUDICIAL CIRCUIT
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen, Plaintiff, -vs- The Regional Medical Center Defendants.	C/A No.: 2015-CP-38-01234 **NOTICE OF MOTION AND MOTION IN LIMINE TO EXCLUDE PHOTOGRAPHS**

Defendants, The Regional Medical Center, (hereinafter TRMC), by and through the undersigned, hereby states the following for TRMC's Motion in Limine:

1. The Plaintiff commenced this action alleging Medical Negligence against the Defendant, TRMC. The matter is scheduled for a date certain trial on May 7, 2018. Defendants are moving pursuant to this Motion in Limine to exclude photographs of the Plaintiff's injuries;

2. Rule 403 of the SCRE states, "[a]lthough relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." "A trial court has particularly wide discretion in ruling on Rule 403 objections." *Busillo v. City of North Charleston*, 404 S.C. 604, 610, 745 S.E.2d 142 (2013). "To constitute unfair prejudice, the photographs must create 'an undue tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one.'"

State v. Holder, 382 S.C. 278, 290, 676 S.E.2d, 690, 697 (2012) (quoting *State v. Jackson*, 364 S.C. 329, 334, 613 S.E.2d 374 (2005).

3. At trial, Plaintiff intends to introduce photographs of injuries to the Right hand of Plaintiff that were sustained while the plaintiff was a one-month old infant. The images are grotesque, close-up images of the infant's open wounds. These close-up images will create an undue tendency to suggest a decision on an emotional basis and are highly prejudicial to the defendant.

4. There is no scale in the pictures to reflect the actual size of the wound, and the close-up nature of the photos makes the wounds appear substantially larger than they are in reality. The images do not reflect the minor's hand currently, as the plaintiff's hand has healed with some scarring. Further, Plaintiff, Tekayah Hamilton is able to testify to the nature of the wound and have an expert to testify to the injury giving the alternative forms of evidence that are less prejudicial to the defendant. The probative value of these photographs of an open flesh wound are substantially outweighed by the prejudice defendants will face in these are introduced to the jury.

WHEREFORE, defendant The Regional Medical Center (TRMC) hereby prays this Court issue its Order granting its Motion in Limine excluding photographs of the minor's injuries.

MICHAEL C. TANNER, L.L.C.

Michael C. Tanner
PO Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Defendants

Bamberg, SC
May 1, 2018

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG	)	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT
TEKAYAH HAMILTON, Individually and as Parent Guardian Ad Litem for ROBERT LEE M. JR.,	)	CASE NO.: 2015-CP-38-01234
Plaintiff,	)	
vs.	)	**VERDICT FORM**
THE REGIONAL MEDICAL CENTER,	)	
Defendant.	)	

We, the jury, by unanimous consent, have responded to the following questions:

1. Do you find that the Defendant was grossly negligent?
   ✓ YES – Go to Question 2
   _____ NO – Stop deliberations

2. Was the defendant's gross negligence a proximate cause of the Plaintiff's injuries?
   ✓ YES – Go to Question 3
   _____ NO – Stop deliberations

3. Please state the amount of damages, if any, sustained by the minor plaintiff Robert Lee Middleton Jr. [You are to determine only the total amount of the plaintiff's damages and enter that amount below.]

   $ 1,127,280.00 Actual Damages

   Please state the amount of damages, if any, sustained by the Plaintiff Tekayah Hamilton, Individually and as Parent Guardian Ad Litem for Robert Lee Middleton Jr. [You are to determine only the total amount of the plaintiff's damages and enter that amount below.]

   $ 135,477.00 Actual Damages

SIGNED: _____
JURY FOREPERSON

DATED: 5-9-2018, ORANGEBURG, SC.

PLEASE NOTIFY THE BAILIFF WHEN YOU HAVE COMPLETED THE VERDICT FORM.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF ORANGEBURG	)	FIRST JUDICIAL CIRCUIT
TEKAYAH HAMILTON, Individually and as Parent Guardian Ad Litem for ROBERT LEE M. JR.,	)	Case No.: 2015-CP-38-01234
Plaintiff,	)	**NOTICE OF MOTION AND MOTION FOR JNOV OR IN THE ALTERNATIVE MOTION FOR NEW TRIAL**
Vs.	)	
THE REGIONAL MEDICAL CENTER,	)	
Defendant.	)	

TO: JONATHAN F. KRELL, ESQUIRE, AND DAVID WILLIAMS, ESQUIRE, ATTORNEYS FOR PLAINTIFF

YOU WILL PLEASE TAKE NOTICE, Defendant reserves its right to assert the statutory caps in its separate post-trial motion, that as soon as counsel may be heard, the defendant The Regional Medical Center (TRMC), by and through its undersigned attorney, pursuant to Rules 50 and 59 of the South Carolina Rules of Civil Procedure, move the court for (1) judgment notwithstanding the verdict ("JNOV"); (2) a new trial absolute; or (3) a new trial nisi remittitur.

LAW

Rule 50(b) of the South Carolina Rules of Civil Procedure allows that, "a party who has moved for a directed verdict may move to have the verdict and any judgment entered thereon set aside and to have judgment entered in accordance with his motion for a directed verdict." A motion for judgment notwithstanding the verdict and a motion for a new trial may be made in the alternative. Rule 50, SCRCP, at Note 3.

TRMC renews its motion for directed verdict made at the close of Plaintiff's case in chief and renewed at the close of all the evidence. There is no legally sufficient basis for a jury to find that TRMC is liable for damages in this case.

The trial judge may reverse a jury's verdict when a review of the record discloses no evidence which reasonably supports the factual finding necessary to sustain the verdict. *Horry County v. Laychur*, 315 S.C. 364, 434 S.E.2d 259 (1993). While the Court is concerned with the existence of evidence, not its weight, *Curcio v. caterpillar, Inc.*, 355 S.C. 316, 585 S.E.2d 272 (2003), and may not decide credibility issues or to resolve conflicts in the testimony or the evidence, *id.* At 320, 585 S.E.2d at 274, JNOV is warranted when there is no evidence to support the ruling or where the ruling is controlled by an error of law. *Hinkle v. National Cas. Ins. Co.*, 354 S.C. 92, 579 S.E.2d 616 (2003).

The thirteenth juror doctrine "entitles the trial judge to sit, in essence, as the thirteenth juror when he finds 'the evidence does not justify the verdict, and then to grant a new trial based solely 'upon the facts.'"*Norton v. Norfolk S. Ry. Co.*, 350 S.C. 473, 478, 567 S.E.2d 851, 854 (2002) (*quoting Folkens v. Hunt*, 300 S.C. 251, 254, 387 S.E.2d 265, 267 (1990)). As the thirteenth juror, the trial judge hands the jury by refusing to agree with the jury's unanimous verdict and casting his or her vote against it, resulting in a verdict which is no longer unanimous. *Id.*

The Court may grant a new trial, sitting as the thirteenth juror, when it is convinced that a new trial is necessary on the basis of the facts. *Vinson v. Hartley*, 324 S.C. 389, 404, 477 S.E.2d 715, 722 (Ct. App. 1996). Under the thirteenth juror doctrine, a new trial may be granted where the court merely finds that "the verdict is unsupported by

the evidence," that "the verdict is inconsistent and reflects the jury's confusion," or that "justice has not prevailed." *Id.* at 404, 477 S.E.2d at 722-23; *see also Trivelas v. S.C. Dep't of Transp.*, 357 S.C. 545, 552 593 S.E.2d 504, 508 (Ct. App. 2004) (granting new trial where "the evidence does not justify the verdict"); *Norton*, 350 S.C. at 480, 567 S.E.2d 855 (granting new trial when court "disapproves of the verdict on factual grounds"); *McEntire v. Mooregard Exterminating Servs., Inc.*, 353 S.C. 629, 631, 578 S.E.2d 746, 747 (Ct. App. 2003) (characterizing the use of doctrine as "granting a new trial upon the facts").

The Court's discretion in granting or denying a new trial under the thirteenth juror doctrine is "'funded upon the facts, the evidence, the witnesses, the trial circumstances, the verdict and the judge's view of them.'" *Vinson*, 324 S.C. at 404, 477 S.E.2d at 723 (*quoting Fallon v. Rucks*, 217 S.C. 180, 189, 60 S.E.2d 88, 92 (1950)). Consequently, the Court is entitled to "weigh the evidence and rely on his or her view of the circumstances." *Sorin Equip. Co. V. The Firm, Inc.*, 323 S.C. 359, 364, 474 S.E.2d 819, 822 (Ct. App. 1996).

Importantly, this Court need not provide any reasons for its exercise of this thirteenth juror power aside from a finding that the Court disapproves and rejects the verdict based on the facts and evidence. *Howard v. Roberson*, 376 S.C. 143, 654 S.E.2d 877 (Ct. App. 2007). Further, this Court's exercise of its thirteenth juror power will not be disturbed on appeal in the absence of a misuse of the power. *Trivelas*, 357 S.C. 545, 593 S.E.2d 504 (holding that a circuit court's order granting a new trial upon the facts will not be disturbed unless its decision is wholly unsupported by the evidence or the conclusion reached was controlled by an error of law).

As set forth below in the grounds asserted for judgment as a matter of law, the jury's verdict is unsupported by the evidence as set forth herein. First, Plaintiffs presented no evidence that defendant was grossly negligent. Defendant asserts that plaintiff's expert was not properly qualified and as such, no testimony she made should have been offered to the jury. There is no justification for a $1,127,280.00 award of damages in this case to the minor child and $135,477.00 to the mother. Therefore, the verdict should be set aside with a new trial ordered. *See, e.g., Folkens v. Hunt*, 300 S.C. 251, 387 S.E.2d 265 (1990) (upholding the grant of the excise of the trial court's thirteenth juror authority because the verdict was not in accordance with the facts.)

The Defendant asserts it is entitled to an order of JNOV or a new trial absolute on these separate grounds:

I. Monica Stobbs was not qualified to give an opinion on the standard of care of pediatric nursing and pediatric IV administration.

Monica Stobbs should not have been allowed to testify to the standard of care for pediatric nursing IV management. In order to qualify an expert, a witness must have the "knowledge, skill, experience, training or education" in order to testify. SCRE 702. "To be competent to testify as an expert, 'a witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter.'" *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 253, 487 S.E.2d 596, 598 (quoting *O'Tuel v. Villani*, 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995); *see also Botehlo v. Bycura*, 282 S.C. 578, 587, 320 S.E.2d 59, 65 (1984) (orthopedic surgeon was not qualified to testify on the standard of care for podiatrist where orthopedic surgeon had no

training in podiatry, was not familiar with any journals or periodicals in podiatry and was not familiar with the surgical procedure performed).

Similar to the facts in *Botehlo,* 282 S.C. 578, Ms. Stobbs, while a nurse, has not administered IV therapy or cared for a pediatric patient with IV therapy, similar to how the orthopedic surgeon was not familiar with the procedure performed by the podiatrist. Likewise, Ms. Stobbs had not reviewed any literature regarding IV therapy in pediatric patients, the same as the orthopedic surgeon not having reviewed any journals or periodicals for podiatry. *Id.* The only distinction is that here Ms. Stobbs is a nurse. Ms. Stobbs has not started or managed an IV on a pediatric patient. Using the requirements of the *Botehlo* case, Ms. Stobbs was not qualified to give an expert opinion on pediatric IV therapy. *Id.* Therefore defendants are entitled to JNOV or in the alternative a new trial.

II. The Court should have directed a verdict in favor of TRMC as Plaintiff's did not establish Gross Negligence.

Plaintiff's failed to establish the elements of Gross Negligence. The Tort Claims Act "limits government liability regarding the supervision, protection, and control of a patient," and Plaintiffs were required to prove gross negligence. *See Stewart v. Richland Memorial Hosp.* 350 S.C. 589, 592, 567 S.E.2d 510, 511 (2002). "Gross negligence is the intentional conscious failure to do something which it is incumbent upon one to do or the doing of a thing intentionally that one ought not to do. [internal citations omitted] It is the failure to exercise slight care. "*Etheredge v. Richland School Dist. One*, 341 S.C. 307, 311 (2007). "While gross negligence ordinarily is a mixed question of law and fact, when the evidence supports but one reasonable inference, the question becomes a matter of law for the court." Id.

Plaintiff failed to establish Defendant was grossly negligent. Plaintiff's expert testified that she had no opinion as to whether or not Defendant intentionally harmed Plaintiff. Plaintiff's expert was not qualified to give an opinion on the standard of care of pediatric IV administration or monitoring. She also had no experience and did not research the treaties and was therefore not qualified to give an opinion. There was no evidence that TRMC employee Jamie Downing acted with any form of intent to cause harm. Plaintiffs failed to establish a material element of gross negligence, intent.

What the evidence did show was that Jamie Downing inspected the IV site 7 times in the twelve-hour shift, while she was only required to inspect it once a shift. Jamie Downing testified that she flushed the site prior to administering the antibiotics and Cynthia Hurly testified that Jamie Downing exceeded the standard of care. This is evidence that Defendant exercised greater than slight care, and as such, cannot be grossly negligent. *See Etheredge,* 341 S.C. 307.

The evidence presented shows that Defendant exercised greater than slight care and that Plaintiffs have failed to prove the element of intent. The only reasonable inference is that defendant exercised slight care and should have been granted a directed verdict. Therefore, defendants are entitled to JNOV, or to trial *de novo*.

III. Trial Judge erred by not excluding the prejudicial photographs of Robert Middleton, Jr.'s injuries to the Jury.

Rule 403 of the SCRE states, "[a]lthough relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." "To constitute unfair prejudice, the photographs must create 'an undue tendency to suggest a decision on an improper basis,

commonly, though not necessarily, an emotional one." *State v. Holder*, 382 S.C. 278, 290 (2012) (quoting *State v. Jackson*, 364 S.C. 329, 334 (2005)).

The photographs of Robert Middleton, Jr.'s hand should have been excluded from the jury as the prejudicial effect substantially out-weighted the probative value. Due to the excessive jury award, defendant is left to conclude that the photographs substantially prejudiced the defendants. The photographs were grotesque, close-up images of the infants open wound. One of the photographs was quite blurry. There was no scale in the photographs. At no time did defendants argue that the infiltration was not the cause of the wound, and the fact that there was a wound was never disputed.

Due to the excessive jury award, defendant is left to conclude that the jury reached their decision on an emotional basis when they saw the enlarged picture of the infant's open flesh wound. Therefore, defendants are entitled to a new trial absolute.

IV. Cynthia Hurley should have been permitted to testify to whether or not Defendant was grossly negligent or negligent.

"Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." Rule 704, SCRE. "We have held, however that the trial judge has the discretion to permit expert testimony on the ultimate issue before the jury." *Redman v. Ford Motor Co.*, 253 S.C. 266, 278 (1969) (citing *O'Kelley v. Mutual Life Insurance Co.*, 197 S.C. 108 (1941)). "There is no invasion of the province of the jury, for the jury retains its power and duty to judge both the credibility of the witness and the weight to be given to his opinion." *Redman,* 253 S.C. at 278; *but see Dawkins v. Fields,* 354 S.C. 58 (2003) ("In general, expert testimony on issues of law is inadmissible.). "We have heretofore held that the trial judge may in his discretion permit a qualified expert to testify as to his

opinion on the ultimate issue before the jury." *Hughes v. Children's Clinic, P.A.*, 269 S.C. 389, 403 (1977).

Here, TRMC's expert, Ms. Hurley's, testimony was primarily on the standard of care and that Nurse Downing complied with the standard. Unlike the *Dawkins*, 354 S.C. 58, there was no affidavit in the present case, and the testimony was not legal argument. In that case the court was concerned with an expert affidavit that read like legal argument. Additionally, Ms. Hurley was not attempting to usurp the roll of the jury, the proffered testimony was whether or not defendants were grossly negligent. The evidence is not objectionable just because it embraces the ultimate issue. *See* Rule 704, SCRE. The trial court erred by not allowing Cynthia Hurley testify to the ultimate issue as her testimony would not usurp the roll of the jury as they still determined her credibility. Therefore, defendant is entitled to a new trial absolute.

V. The Request to Admit should not have been published to the Jury.

The Request to Admit should not have been published to the Jury and prejudiced the Defendant. "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE. Rule 36 (b) of the South Carolina Rules of Civil Procedure states,

> Any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission. Subject to the provisions of Rue 16 governing amendment of a pre-trial order, the Court may permit withdrawal or amendment when the presentation of the merits of the action will be sub-served thereby and the party who obtained the admission fails to satisfy the court that withdrawal or amendment will prejudice him in maintaining or defense on the merits Any admission made by a party under this rule is for the

purpose of pending action only and is not an admission by him for any other purpose.

RULE 36, SCRCP; *see also Commerce Center of Greenville, Inc. V. W. Powers McElveen*, 347 S.C. 545, 557, 556 S.E.2d 718, 724 (Ct. App. 2001) (" The trial court may allow a party to amend or withdraw its answers to a request to admit when: (1) the presentation of the merits is furthered by the amendment; and (2) the party who obtained the admission cannot demonstrate prejudice because of the amendment."). Defendant asserts that Plaintiff was not prejudiced by withdrawal of these Requests, which was denied by the Court.

Defendant concedes this is an unusual circumstance and the case law addresses issues for withdrawal by the admitting party. The Court should have permitted withdrawal of the RTA because the Plaintiffs could not show that withdrawal would prejudice them in maintaining the merits. Here the Request to Admit (RTA) was highly prejudicial to the defendant and did nothing but confuse the issues. At all times Defendant maintained that they were not negligent. By introducing the RTA to the jury, it had the effect as if Defendant admitted they were negligent. At no time did the Defendant admit negligence. The RTA had the opposite effect because Plaintiffs admitted the amount in controversy was more than $100,000. The RTA request number 1 stated, "Admit the value of the amount in controversy in this action is less than $100,000." The plaintiff denied this. This directly confuses the issues and is highly prejudicial to any probative value it may have.

The purpose of the request to admit was to obtain an Independent Medical Examination, not for Plaintiffs to represent that Defendant admitted the damages were in excess of $100,000.00.

Further, the Request to Admit was not mentioned in Plaintiff's pretrial brief. Plaintiffs intentionally failed to mention it to Defendant's counsel until they were about to publish the RTA to the Jury. This highly prejudiced the defendant, as they had no time to prepare argument and was unable to get rebuttal evidence. Therefore, defendants are entitled to a new trial.

VI. Jury Charges

Defendant contends they are entitled to a new trial as the requested jury charges were not charged to the jury.

> "Ordinarily a trial judge has a duty to give a requested instruction that correctly states the law applicable to the issues and evidence."*Ross v. Paddy*, 340 S.C. 428, 437, 532 S.E.2d 612, 617 (Ct.App.2000). "Where a request to charge is timely made and involves a controlling legal principle, a refusal by the trial judge to charge the request constitutes reversible error." *Id.* "Moreover, when general instructions to the jury are insufficient to enable the jury to understand fully the law of the case and issues involved, a refusal to give a requested charge is reversible error." *Id.*

Fairchild v. South Carolina Dept. Of Transp., 398 S.C. 90, 104, 727 S.E.2d 407, 414 (2012). To warrant reversal, the refusal must be both erroneous and prejudicial. *E..ison v. Parts, Distributors, Inc.*, 302 S.C. 299, 395 S.E.2d 740 (Ct. App. 1990). Defendants should have had the following jury charges.

"I instruct you that the practice of nursing is an art, not a science, and in providing nursing care a nurse is not required to be all knowing and all wise."

"While a Nurses mistake or error in judgment alone would not support a verdict for the plaintiffs in a malpractice lawsuit, if the nurse fails to comply with a recognized

standard of nursing care which would be exercised by a similar nurse under the same or similar circumstances, then liability would attach to the nurse's mistake or error in judgment if it proximately results in injury to the patient."

"I instruct you that the law does not require of a nurse absolute accuracy either in practice or in judgment. Nor does the law hold a nurse to the standard of infallibility. It does not even require of a nurse the utmost degree of care and skill of which the human mind is capable." *see generally Wall v. Suits,* 38 S.C. 377, 383-84 (1995) (discussing physician).

Therefore, defendants should be granted a new trial absolute.

VII. This Court should grant a new trial absolute because the jury verdict is shockingly disproportionate to the evidence admitted at trial.

Defendant is entitled to a new trial on the grounds that the Jury's verdict was grossly excessive and contrary to the evidence.

In addition, a trial judge is required to grant a new trial absolute when the amount of the verdict is "so grossly . . . excessive that it shocks the conscience of the court and clearly indicates the amount was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives." *Waring v. Johnson*, 341 S.C. 248, 257, 533 S.E.2d 906, 911 (Ct. App. 2000); *Vinson v. Hartley*, 324 S.C. 389, 404, 477 S.E.2d 715, 723 (Ct. App. 1996); *Duncan v. Hampton County School Dist. No. 2*, 235 S.C. 535, 517 S.E.2d 449, 455 (Ct. App. 1990) ("The trial court must grant a new trial absolute if the verdict is so grossly excessive that it shocks the conscience of the court and clearly indicates the amount of the verdict was the result of caprice, passion, prejudice, partiality, corruption, or other improper motive."). The term "passion and prejudice" does not "necessarily imply bad faith, wrongful purpose, or moral delinquency," but rather, results

when the award is "against the overwhelming weight of the evidence." *Beasley v. Ford Motor Co.*, 237 S.C. 506, 513, 117 S.E.2d 863, 867.

Importantly, it is an abuse of discretion not to grant a new trial absolute when the verdict is "shockingly disproportionate" to the evidence presented at trial. *Sullivan v. Porter*, 317 S.C. 462, 467, 454 S.E.2d 907, 912 (Ct. App. 1995). "Ordinarily the only means of discovering the existence of passion and prejudice as influencing the verdict is by comparing the amount of the verdict with the evidence before the trial court." *Id.* at 362, 98 S.E.2d at 802. However, in some instances, the "size of the verdict alone may show that it must have been the result of passion or prejudice." Id. (internal citation omitted); *see also Small v. Springs Indus., Inc.* 292 S.C. 481, 486, 357 S.E.2d 452, 455 (1987) ("The size of the jury's verdict alone establishes it is grossly excessive under the facts of this case.").

This case falls squarely within the holding in *Sullivan.* The size of the verdict alone is sufficient to show that the jury must have been moved by passion or prejudice. The evidence presented cannot support a $1,127,280.00 verdict for the claims asserted by the Plaintiffs. The verdict in this case is "without any rational support whatever in the evidence and is so grossly excessive as to show that the jury was actuated by considerations not founded on the evidence and/or the instructions of the court." *Joyner v. St. Mathews Builders*, 263 S.C. 136, 140-41, 208 S.E.2d 48, 50 (1974) (granting a new trial due to the "actual damages being so manifestly and grossly excessive").

Given the complete lack of any cognizable basis to support the damages award, the $1,127,280.00 actual damages award to the minor cannot stand. See *Zorn v. Crawford*, 252 S.C. 127, 138, 165 S.E.2d 640, 646 (1969) (granting a new trial in a

wrongful death action where "a verdict of $250,000.00 for the actual damages sustained by the beneficiaries . . . [was] not supported by the evidence and [could] only be explained upon the basis of sympathy, passion or prejudice on the part of the jury"). Therefore, this Court should vacate the award or order a new trial.

The only evidence of damages was $20,854 in medical bills, some pain and a scar while the jury returned a verdict for $1,127,280.00. The verdict is 54 times the amount of actual damages, this is grossly excessive and shocks the conscience. It is clear that the Jury did not pay attention to the jury instructions. The $135,477.00 jury verdict for Tekeyah Hamilton is further evidence of the jury failing to apply the law as charged. Plaintiff's mother testified she has no plans for the child to undergo any steroid injections or scar revision surgery. Defendant is left to conclude that the jury arrived at its award as a result of passion, caprice, or other improper motives, particularly in light of the excessive verdict compared to the evidence of actual damages. Where a jury renders a verdict in disregard of the charge, it is error for the trial judge not to grant a new trial upon motion. *See, Southeastern Mobile Homes Inc. v. Walicki*, 282 SC. 298, 317 S.E.2d 773 (Ct. App. 1984). Therefore, this Court should vacate the award and order a new trial *de novo*.

VIII. The Court should grant a new trial nisi remittitur because the jury rendered an excessive verdict compared to the evidence offered by plaintiffs.

If the Court denies the JNOV and new trial absolute motions it should next proceed to consider and grant a new trial nisi remittitur because the damages awarded by the jury are clearly excessive compared to the evidence presented at trial. This court "may grant a new trial nisi remittitur when it finds the verdict is merely inadequate or excessive." *Howard v. Roberson,* 376 S.C. 143 (2007). "The consideration of a motion

for a new trial nisi remittitur requires the court to consider the adequacy of the verdict in light of the evidence presented." *Waring v. Johnson*, 341 S.C. 248 (Ct. App. 2000).

"The trial court has wide discretionary power to reduce the amount of a verdict which in his or her judgment is excessive." *See, e.g., Rush v. Blanchard,* 310 S.C. 372 (1993)(affirming trial court's remittitur); *RRR, Inc v. Toggas,* 378 S.C. 174 (Ct. App. 2009 ("[T]he circuit court . . . has the power to grant a new trial nisi when it finds the amount of the verdict to be merely inadequate or excessive"); *Becker v. Walmart Stores, Inc.,* 339 S.C. 629 (Ct. App. 2000) (affirming trial court's granting of motion for remittitur on grounds that amount awarded by jury was "merely excessive").

Here the jury's verdict was grossly excessive. The jury returned a verdict that was 54 times the actual damages. The jury returned a verdict for $1,127,280 for the child and another $135,477 for Tekayah Hamilton, when the actual damages were only $20,854. There is no evidence to support such a verdict. Robert Middleton, Jr still has full use of his hand and he has a scar that will improve with surgery. There's no logical conclusion as to why the jury returned such a verdict and no evidence supports the excessiveness of the verdict. If Defendant's are not granted JNOV or a New Trial Absolute, defendants in the alternative ask for a new trial nisi remittitur.

CONCLUSION

WHEREFORE, defendant TRMC based on all of the foregoing reasons, respectfully request this Court reconsider its decisions and issue and order granting TRMC JNOV or in the alternative, grant Defendant's a new trial absolute, and grant such other and further relief as may be just and proper.

COUNSEL FOR DEFENDANT RESPECTFULLY REQUEST ORAL ARGUMENT.

MICHAEL C. TANNER, L.L.C.

Michael C. Tanner
PO Box 1061
Bamberg, SC 29003
(803)245-9153
Attorney for Defendants

Bamberg, SC

May 17, 2018

STATE OF SOUTH CAROLINA)
)
COUNTY OF BAMBERG)

I, Michael C. Tanner, attorney for defendant, The Regional Medical Center of Orangeburg and Calhoun Counties, in the case of Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen v. Regional Medical Center, case number 15-CP-38-1234 hereby certify that I have served the Notice Of Motion And Motion For JNOV Or In The Alternative Motion For New Trial by mailing a copy of same, with postage prepaid, by United States mail to the person(s) at the address(es) indicated as follows:

Honorable Edgar W. Dickson
Post Office Box 1949
Orangeburg, S.C. 29116

Jonathan F. Krell, Esquire
P.O. Box 399
Charleston, SC 29402

David Williams, Esquire
P.O. Box 1084
Orangeburg, SC 29116

MICHAEL C. TANNER, L.L.C.

By: _____

Michael C. Tanner
P.O. Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Defendant

Bamberg, S.C.

May 17, 2018

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG	)	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT
TEKAYAH HAMILTON, Individually and as Parent Guardian Ad Litem for ROBERT LEE M. JR., Plaintiff, vs. THE REGIONAL MEDICAL CENTER, Defendant.	)	Case No.: 2015-CP-38-01234 POST TRIAL MOTION FOR REDUCTION TO STATUTORY CAP

TO: JONATHAN F. KRELL, ATTORNEY FOR PLAINTIFF

YOU WILL PLEASE TAKE NOTICE, reserving its rights to be heard in the separate post-trial motions, that as soon as counsel may be heard, the defendant The Regional Medical Center (TRMC), by and through its undersigned attorney, will move before this Honorable Court for the following Post-Trial Relief:

1. Defendants are invoking the statutory cap on damages pursuant to the South Carolina Tort Claims Act (§15-78-10, et seq.). Section § 15-78-120(a) provides as follows:

> (a) For any action or claim for damages brought under the provisions of this chapter, the liability shall not exceed the following limits: (1) Except as provided in Section 15-78-120(a)(3), no person shall recover in any action or claim brought hereunder a sum exceeding three hundred thousand dollars because of loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved.

"Provisions establishing limitations upon and exemptions from liability of a governmental entity *must be liberally* construed in favor of limiting liability." *Plyler v. Burns*, 373 S.C. 637, 651 (2007) (citing *Steinke v. South Carolina Dep't of Labor,*

Licensing and Regulation, 336 S.C. 373 (1999)); *see also* S.C. Code Ann. §15-78-20(f) ("The provisions of this chapter establishing limitations on and exemptions to the liability of the State, its political subdivisions, and employees, while acting within the scope of official duty, *must be liberally construed* in favor of limiting the liability of the State.").

2. The Jury returned a verdict for the minor, Robert Lee Middleton Jr., for $1,127,280.00. This amount is excessively higher than the statutory cap and as a matter of law must be reduced to $300,000.00, pursuant to § 15-78-120 (a).

3. Defendant asserts Tekayah Hamilton's jury verdict must be reduced to $20,854.00.

4. A parent is the proper party in interest with respect to past medical expenses and future medical expenses while the child is a minor. *See, Patton v. Miller*, 420 S.C. 471 (2017). Under the Tort Claims Act, a parent may recover medical expenses separately from the parents claim. *See, Wright v. Colleton County School Dist.*, 301 S.C. 282 (1990).

5. The Jury returned a verdict for Tekayah Hamilton for $135,477.00. Pursuant to South Carolina law, Tekayah Hamilton's damages are limited to past and future medical expenses only as set forth above. The only evidence presented to the jury of medical expenses, past and future, were the amount of $20,854.00. Tekayah Hamilton's damages must be reduced to the amount of $20,854.00 for past and future medical expenses for the minor. She is not entitled to any pain and suffering.

WHEREFORE Defendants pray that this Honorable Court reduce the Jury Verdict to $300,000.00 for Robert Middleton Jr. and to $20,854.00 for Tekeyah Hamilton making

the verdict in Compliance with the South Carolina Tort Claims Act and grant such other relief as the Court deems just and proper.

MICHEL C. TANNER, L.L.C.

Michel C. Tanner
Joseph R. Shakibanasab
Post Office Box 1061
Bamberg, S.C., 29003
Attorneys for Defendant

Bamberg, S.C.

May 17, 2018

STATE OF SOUTH CAROLINA)
)
COUNTY OF BAMBERG)

I, Michael C. Tanner, attorney for defendant, The Regional Medical Center of Orangeburg and Calhoun Counties, in the case of Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of eighteen v. Regional Medical Center, case number 15-CP-38-1234 hereby certify that I have served the Post Trial Motion For Reduction To Statutory Cap by mailing a copy of same, with postage prepaid, by United States mail to the person(s) at the address(es) indicated as follows:

Honorable Edgar W. Dickson
Post Office Box 1949
Orangeburg, S.C. 29116

Jonathan F. Krell, Esquire
P.O. Box 399
Charleston, SC 29402

David Williams, Esquire
P.O. Box 1084
Orangeburg, SC 29116

MICHAEL C. TANNER, L.L.C.

By: _____
Michael C. Tanner
P.O. Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Defendant

Bamberg, S.C.

May 17, 2018

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF ORANGEBURG	)	CIVIL ACTION NO. 2015-CP-38-01234
	)	
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18,	)	**PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANT'S MOTION FOR JNOV OR IN THE ALTERNATIVE MOTION FOR NEW TRIAL/NEW TRIAL *NISI REMITTITUR* AND IN OPPOSITION TO DEFENDANT'S MOTION FOR REDUCTION TO STATUTORY CAP**
Plaintiff,	)	
vs.	)	
Regional Medical Center	)	
Defendant.	)	

Plaintiff submits this Memorandum in Opposition to Defendant's ("Defendant") motion for a new trial or, alternatively, for a new trial *nisi remittitur*.

Plaintiff's opposition to Defendant's motion is based on this memorandum of law and any exhibits filed along with this memorandum, the pleadings, and applicable law; all evidence and arguments presented during the trial of this case; as well as any other memorandum of law or arguments that Plaintiff may submit to the Court at or prior to a hearing on the motions. The Court should deny Defendant's motions and withstand the jury's award in the amount of $135,477.00 for Plaintiff Tekayah Hamilton ("Tekayah") and modifying the amount to Plaintiff Robert Lee M. Jr. ("RJ") to $1,065,000.00.

FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of Defendant's failure to implement policies, procedures, and equipment to allow Defendant to properly monitor an IV with ampicillin administered to RJ on or about October 28, 2014, while a patient at Defendant's facility in Orangeburg, South Carolina. Plaintiff's complaint alleges medical negligence, specifically the following:

> The impression of the treating physician was high fever and admission to the hospital was necessary in order to work up CBC, LP, blood and urine cultures. It was decided to begin Ampicillin and Claforan. Pl.'s Complaint par.11
>
> Defendant Regional, by and through its agents and/or employees, and Defendant Downing[1], owed Plaintiff a duty of care to use that degree of care and skill which ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances. Pl.'s Complaint par.33.
>
> Defendants breached that duty of care and were negligent, grossly negligent, careless, willful, wanton, and reckless in the following particulars:
> a) In failing to use reasonable medical care in accordance with the recognized standards of acceptable professional practice in medicine during the care, diagnosis and treatment of Plaintiff;
> b) In failing to act with ordinary and reasonable care in accordance with the recognized standards of acceptable professional practice in medicine;
> c) In failing to follow the Infusion Nurse Society publication on *Policies and Procedures for infusion Nursing of the Pediatric Patient*;
> d) In failing to pursue such appropriate medical modalities and treatments which could have avoided this type of injury and permanent damage;
> e) In failing to act and behave in the same or similar manner that reasonably competent doctors and healthcare facilities and staff would have behaved or acted in the same or similar conditions;
> f) In failing and neglecting to properly inspect the IV site on October 28, 2014, at approximately 4:27 a.m. prior to the administration of antibiotic medication;
> g) In failing and neglecting to properly monitor the IV site after the administration of antibiotic medication;
> h) In failing to adequately train and supervise its medical staff;
> i) In failing to provide the safest care and treatment to Plaintiff; and
> j) For such other acts and omissions that may become more apparent through the discovery of this matter.

Pl.'s Complaint par. 34. Plaintiff attached an affidavit to her complaint by Monica Stobbs, RN, BSN, clarifying and reiterating the breaches in the standard of care by Defendant Regional, by and through its employees, causing harm to RJ and Tekayah. Specifically, Defendant Regional failed to properly monitor RJ's IV site prior to and after administering medication.

At trial Plaintiff offered Monica Stobbs, RN, BSN, as well as Dr. DeVito regarding RJ's future care and Plaintiff herself took the stand. Plaintiff also called nurse Jamie Downing, RN,

[1] Defendant Downing was dismissed as a party after the original summons and complaint was filed.

and published Plaintiff's answers to Defendant's First Set of Requests to Admit to the jury. RJ's medical records and bills were submitted as evidence along with several pictures of his injury and numerous policies and procedures of Defendant Regional.

Defendant called Dr. Davis to dispute RJ's future care, Nurse Jamie Downing, and Cynthia Hurley as their standard of care of expert. Defendant also submitted pictures of RJ's injuries, select medical records and select policies and procedures. Defendant moved for a directed verdict at the end of Plaintiff's case and its own. Defendant has now filed motions for a new trial, new trial nisi remittitur, and reduction to conform to the statutory cap.

STANDARD OF REVIEW

A motion for judgment notwithstanding the verdict may only be granted if no reasonable jury could have reached the challenged verdict. RFT Management Co., LLC v. Tinsley & Adams, LLP, 399 S.C. 322, 332, 732 S.E.2d 166, 171 (2012). A jury's verdict must be upheld unless no evidence reasonably supports the jury's findings. Curcio v. Caterpillar, Inc., 355 S.C.316, 320, 585 S.E.2d 272, 274 (2003). In ruling on a motion for judgment notwithstanding the verdict, the trial court must view the evidence and all inferences reasonably drawn therefrom in the light most favorable to the opposing party. Law v. S.C. Dep't of Corr., 368 S.C. 424, 434, 629 S.E.2d 642, 648 (2006).

The thirteenth juror doctrine is the method used by the trial court to grant a new trial upon a finding that the evidence presented at trial did not support the jury's verdict. Curtis v. Blake, 392 S.C. 494, 505, 709 S.E.2d 79, 85 (Ct. App. 2011). If the amount of the verdict is grossly inadequate or excessive so as to be the result of passion, impulse, prejudice, or some other influence outside the evidence, the trial court must grant anew trial absolute. Id. at 500, 709 S.E.2d at 82. Compelling reasons must be presented to support the trial judge's invasion of the jury's

province, merely highlighting that the verdict is greater than the amount of monetary damages is not enough as such other non-monetary factors must be considered as well. Id. at 501, 709 S.E.2d at 83.

I. The jury's verdict reflects the evidence presented and should only be reduced to a total of $1.2 Million

Ample evidence was presented to the jury to sustain Ms. Hamilton's recovery of $135,477.00, and to sustain RJ's recovery, only reducing it to $1,065,000.00, to bring the total recovery within the statutory cap of $1,200,000.00.

Under South Carolina common law, a parent may recover for her child's medical expenses, loss of services, and other economic losses as a result of incurred medical expenses. *See* Wright v. Colleton County School District, 391 S.E. 2d 564 (1990) and Doe v. Greenville County School District, 375 S.C. 63 (2007). At trial, Plaintiff presented past and potential future medical expenses of approximately $20,824.00. The future expenses include potential surgeries for RJ's scars. Ms. Hamilton also testified to the financial burden on her to take time off of work and travel expenses related to getting RJ to medical treatment appointments. Ms. Hamilton further testified that she has to keep an extra close eye on RJ to prevent reinjury of his hand and to protect his hand from over-exposure. Finally, there was testimony to support the psychological and social affect the scar will have on RJ, which will certainly affect RJ who is currently three years old. She will remain his guardian at least until he is eighteen, fifteen more years. There is evidence to support the award of $135,477.00 for Ms. Hamilton. It is not unreasonable for a jury to make this award in light of the evidence which exists to support it.

Defendant argues RJ's recovery should be reduced to $300,000.00 under section 15-78-120(a). However, Defendant ignores the entirety of the Torts Claims Act and the evidence to trigger the $1.2 Million cap.

The South Carolina Tort Claims Act allows for a maximum recovery out of a single occurrence of one million two hundred thousand dollars when the injury is caused by any licensed physician or dentist. S.C. Code Ann. §15-78-120(a)(4). Subsection (5) reads that subsection (a)(4)

> shall in no way limit or modify the liability of a licensed physician or dentist, acting within the scope of his profession, with respect to any action or claim brought hereunder which involved services for which the physician or dentist was paid, should have been paid, or expected to be paid at the time of the rendering of the services from any source other than the salary appropriated by the governmental entity or fees received from any practice plan.

Id. Defendant argued at trial, and the court agreed, that Plaintiff was required to prove gross negligence of Defendant pursuant to section 15-78-60(25) because the conduct at issue concerned Defendant's "responsibility or duty including but no limited to supervision, protection, control, confinement or custody of any...patient...of any governmental entity." S.C. Code Ann. §15-78-60(25). Indeed, the verdict form asked the jury to find if Defendant, The Regional Medical Center, was grossly negligent[2] in its supervision, protection, etcetera of RJ.

Additionally, under the Tort Claims Act, individual employees cannot be named. S.C. Code Ann. §15-78-70. *See also* S.C. Code Ann. §15-78-20(g) (indicating the inclusion of physicians under the Tort Claims Act and justification for the higher limits thereunder). Thus, the totality of Defendant's conduct is to be considered and is not limited to just the acts of Nurse Downing, but to the entirety of the conduct surrounding the alleged gross negligence and the resulting damages. This position is consistent with Defendant's consistent position that it is not subject to the South Carolina Medical Malpractice Act. *See* Exhibit A. This position is also echoed in the verdict form, which asked for a general verdict. Because there were multiple issues, including the conduct of Defendant's nurses and conduct of Defendant's physicians, the general

[2] Plaintiffs position at trial was that the medical malpractice standard of care applied, not a gross negligence standard as argued by Defendant at trial and charged by the judge. For purposes of Defendant's motions and the law of the case as it stands now, Plaintiffs present arguments based on the gross negligence standard.

verdict form encapsulates all of those issues, sustaining the $1.2 million cap applicable to physicians.

Section 15-78-20(g) explains the importance of including physicians and dentists under the Tort Claims Act stating that patients "deserve accountable and competent health care, regardless of the public or private character of the provider" and the need to "attract qualified physicians and dentists." S.C. Code Ann. §15-78-20(g). In this vain, limitations still exist on what can be recovered in lawsuits involving medical malpractice, but they are "higher limits [as] recognition by the General Assembly of significantly higher damages in cases of medical malpractice." Id. The Nurse Practice Act explains the hierarchy of physicians over advanced practice registered nurses, and then all nurses. S.C. Code Ann. 40-33-20 *et al.* This supervision is particularly emphasized when "administering and delivering medications and treatments as prescribed by an authorized licensed provider" and "providing for the maintenance of safe and effective nursing care rendered directly or indirectly." S.C. Code Ann. §40-33-20(47).

The allegations in Plaintiff's Complaint and expert affidavit certainly address Defendant's conduct in its entirety by and through its healthcare providers, including the conduct of physicians. *See* Factual and Procedural History *supra*. Likewise, the testimony at trial indicated the involvement of physicians. Ms. Stobbs testified proper administration of a saline flush prior to administration of the ampicillin at 4:27 a.m. on October 28, 2014, would have prevented the injury to RJ. She explained the administration of saline is administering medicine. The medical record, as well as Nurse Downing's testimony, indicated that Dr. Boltin, also an employee of Defendant, ordered the administration of the ampicillin, which would include the saline flush, for RJ. Nurse Downing could not have administered the ampicillin and saline flush without a doctor's order. She was subject to the supervision of Dr. Boltin. Through Dr. Boltin's orders Nurse Downing was

responsible for the supervision of RJ, again that conduct falling under section 15-78-60(25). Because of the medical care rendered and the causal connection between the orders from Dr. Boltin, being carried out by Nurse Downing, the $1.2 million cap applies to this case. Thus, after accounting for the $135,477.00 awarded to Ms. Hamilton, RJ's award should be reduced to $1,065,000.00.

Such an award to RJ is supported by the evidence. Testimony provided the basis for RJ's past, present, and future pain and suffering, mental and emotional anguish, anxiety, and loss of enjoyment of life. In its closing, Plaintiff's counsel asked the jury to award RJ a per diem amount for the remainder of his life to compensate him for those damages, suggesting $25.00 or $50.00 per day. RJ's life expectancy is approximately 73.76 years under section 19-1-150, or approximately 26,940 days. The jury's award of $1,127,280.00 divided by 26,940 is approximately $42.00 per day for the rest of his life. Given the severity of the permanent scar, the apparent suffering it has caused and will cause RJ, the jury's verdict is reasonably related to the evidence presented and does not shock the conscience.

Additionally, evidence was produced that the medical recording system did not allow the nurse to follow the policies and procedures. These policies and procedures were promulgated by the MEC, which is a solely physician entity. Therefore, the evidence is that the policies and procedures were implemented in a grossly negligent manner by the physicians. Naming The Regional Medical Center is naming physicians.

There was also evidence presented that Dr. Boltin was in the room close by RJ with the IV at the time the four-hour check was due and when the flush was due but did nothing to require the flush.

Finally, Defendant failed to raise an objection during the trial regarding Plaintiff counsel seeking to incite the jury's emotions, passion, or prejudice. The jury's verdict should be upheld and only modified to fit within the $1.2 million statutory cap.

II. Monica Stobbs, RN, BSN, was qualified to testify regarding the proximate cause of RJ'S injuries

"All expert testimony must satisfy the Rule 702 criteria, and that includes the trial court's gatekeeping function in ensuring the proposed expert testimony meets a reliability threshold for the jury's ultimate consideration." *Austin v. Stokes-Craven Holding Corp.*, 387 S.C. 22, 37, 691 S.E.2d 135, 143 (2010) (internal quotation marks omitted). "[O]nly after the trial court has found that [1] expert testimony is necessary to assist the jury in resolving factual questions, [2] the expert is qualified in the particular area, and [3] the testimony is reliable, may the trial court admit the evidence and permit the jury to assign it such weight as it deems appropriate." *Watson v. Ford Motor Co.*, 389 S.C. 434, 446-47, 699 S.E.2d 169, 175 (2010)."

Plaintiff offered Monica Stobbs as an expert in nursing, particularly regarding the nursing standard of care in monitoring RJ's IV site. The trial judge allowed her to be admitted as a nurse, not a pediatric nurse, indicating Defendant would be able to question her credibility in comparison to Defendant's pediatric nurse expert, but that Ms. Stobbs was indeed qualified to testify regarding the nursing standard of care.

In her testimony, Ms. Stobbs recognized the IV had been placed and medication, including Ampicillin, was administered for over 48 hours without incident. However, leading into the third day, October 27th, Defendant Regional's medical record indicated below standard monitoring of the site, including untimely and incomplete assessments of the IV site, insufficient flushing, and other below the standard care in maintaining and monitoring the IV site which led to the RJ's injuries. She explained that assessment, flushing, and other procedures for monitoring and

inspecting an IV site prior to the administration of medicine and after the administration of medication are the same regardless of the patient's age.

Defendant submitted literature to Ms. Stobbs which conceded the similarities in monitoring an IV site whether the patient was a baby or an adult. Likewise, Defendant's expert agreed and only differentiated that placing the IV and identifying the IV site on an infant could be different from that with an adult. The placing and identification of RJ's site was not the proximate cause of his injuries. Defendant's expert also differed with Ms. Stobbs in that pulling back on the needle to verify proper location of the needle would not be done with a minor. Ms. Stobbs testified that is only one option in assessing an IV site, not the only tool and not the proximate cause of RJ's injuries. As such, any difference in qualifications that may exist between a pediatric nurse and an adult nurse were of no significance in determining the proximate cause of RJ's injuries.

III. There was ample evidence of gross negligence[3] to substantiate the jury's verdict

Plaintiff testified that she was in the room with RJ during the early morning hours of October 28, 2014, when the ampicillin was administered at about 4:27 a.m. by Nurse Downing. The order was to continuously infuse the antibiotic over 20 minutes. Shortly after the ampicillin was started, Plaintiff noticed a visible change in RJ's demeanor, his uncontrollable crying, and apparent discomfort. She repeatedly buzzed for assistance, but to no avail. No one from Defendant responded until approximately 4:50 a.m. when it was documented that RJ was fussy and that the hand was puffy with bruising. The jury could infer from this testimony, and rightly so, that Plaintiff was ignored for over 20 minutes by Defendant, leaving RJ in wretched pain and ultimately a permanent scar. The jury was charged that gross negligence "is the intentional, conscious failure

[3] Again, Plaintiffs position at trial was that the medical malpractice standard of care applied, not a gross negligence standard as argued by Defendant at trial and charged by the judge. For purposes of Defendant's motions and the law of the case as it stands now, Plaintiffs present arguments based on the gross negligence standard.

to do something which is incumbent upon one to do or the doing of a thing intentionally that one ought not to do...the failure to exercise slight care." Ignoring a patient's requests for help for such an extended period of time could certainly be interpreted by the jury as conscious failure to respond.

Additionally, the testimony and evidence revealed that there were multiple, repeated mistakes in the medical records. There were several failures to document the condition of the IV site and several failures to document flushing the site before administering the medication, despite the policies and procedures requiring the same. The jury could have interpreted this as repeated conscious or reckless disregard to do the task incumbent upon Defendant to do.

Finally, Defendant's physicians via the MEC implemented a system of policies and procedures which go with the standard of care, but the nurses, whom the physicians supervise and are responsible for, were not able to fulfill and meet those expectations due to the flawed electronic medical recording system. Furthermore, Dr. Boltin and the nurses ignored the electronic reminder to flush every four hours, intentionally overriding the prompt and not complying with the policies and procedures of the hospital. This conduct could certainly give rise to intentional conduct and/or failure to exercise slight care by the physicians and nurses.

IV. The photographs of RJ's injuries were not prejudicial

The trial judge properly exercised his discretion in allowing the photographs of RJ's injuries. The relevance, materiality, and admissibility of photographs are matters within the sound discretion of the trial court. The trial judge must balance the prejudicial effect of graphic photographs against their probative value. State v. Vang, 353 S.C. 78, 87, 577 S.E.2d *250 225, 229 (Ct.App. 2003). A trial judge's decision regarding the comparative probative value and prejudicial effect of relevant evidence should be reversed only in exceptional circumstances. State

v. Hamilton, 344 S.C. at 357, 543 S.E.2d at 593. Admitting photographs which serve to corroborate testimony is not an abuse of discretion. State v. Rosemond, 335 S.C. 593 at 597, 518 S.E.2d 588 at 590; *see* State v. Tucker, 324 S.C. 155, 478 S.E.2d 260 (1996); State v. Jarrell, 350 S.C. 90, 564 S.E.2d 362 (Ct.App. 2002). However, photographs calculated to arouse the sympathy or prejudice of the jury should be excluded if they are irrelevant or not necessary to substantiate material facts or conditions. State v. Brazell, 325 S.C. 65, 78, 480 S.E.2d 64, 72 (1997). "To constitute unfair prejudice, the photographs must create a `tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one.'" State v. Kelley, 460 S.E.2d 368 at 370-71 (quoting State v. Alexander, 303 S.C. 377, 382, 401 S.E.2d 146, 149 (1991)). A trial judge is not required to exclude relevant evidence merely because it is unpleasant or offensive. Davis v. Traylor, 340 S.C. 150, 530 S.E.2d 385, 387 (Ct.App.2000).

Plaintiff submitted three pictures of the wound and scar at various points in the healing process for the jurors to see from their seats in the jury panel. All three had an object to which the size of the wound and/or scar could be related to: (1) wound – adult thumb, (2) wound – RJ's head, more particularly his ear, and (3) scar – adult thumb. Then, RJ himself presented his hand to the jury for them to see the injury as it is today, giving further reference for the pictures as produced. Defendant also submitted a picture of the injury which was small in size. It was so small that it had to be passed around to the jury, held in each juror's hand, with the ability to analyze up close.

Defendant argues the pictures should have been excluded because they were "grotesque, up-close images of the infants open wound," "one was quite blurry", and "there was no scale in the photographs." Defendant also argues it never disputed the wound existed or that the infiltration caused the wound. However, Defendant did dispute the amount of damages that should be awarded to Plaintiff for that wound, necessitating Plaintiff fully presenting its evidence to that

regard. Also, it is an exercise in speculation and conjecture, at best, whether a more prejudicial effect results from being able to see a picture from a distance versus being able to hold it in your hands and examine it closely. Defendant had no scale to its picture. Plaintiff offered the most definitive scale possible, RJ himself. If one of the pictures was blurry – how does that create a prejudicial affect? The fact is it was a horrible injury which was ugly, unpleasant, and offensive in its nature. Plaintiff did nothing to enhance that reality, merely showed it to the jury. It would have been prejudicial to Plaintiff to NOT show those pictures and misrepresenting to the jury the exact nature of what RJ experienced. The trial judge properly exercised his discretion in permitting the pictures because they accurately reflected the facts of the case.

V. The trial judge properly exercised his discretion in not allowing Cynthia Hurley to testify as to whether or not Defendant was grossly negligent

Defendant properly recognizes the law that it is in the trial judge's discretion "to permit expert testimony on the ultimate issue before the jury." Redman v. Ford Motor Co., 253 S.C. 266, 278. The trial judge did just that in allowing Ms. Hurley to testify as to what could constitute gross negligence, but not the term "gross negligence" itself.

"In general, expert testimony on issues of law is inadmissible." Dawkins v. Fields, 354 S.C. 58 (2003). However, an expert's otherwise admissible opinion is not inadmissible simply because it embraces the ultimate issue to be decided. Id. The distinction between medical malpractice and negligence claims is subtle, with no rigid analytical line separating the two causes of action. Dawkins v. Union Hosp. Dist., 408 S.C. 171, 176, 758 S.E.2d 501, 503–04 (2014). "In medical malpractice actions, expert testimony is required to establish both the duty owed to the patient and the breach of that duty, unless the subject matter of the claim falls within a layman's common knowledge or experience." Id. The requisite expert testimony assists the jury in making a more accurate determination of fault regarding whether a negligence in rendering medical care

proximately caused the patient's injury. Id. Based on this law, the trial judge properly allowed Ms. Hurley to testify as to the appropriate standard of care, which she did. She testified that there was no intentional conduct, which can be gross negligence under South Carolina, and further testified that Nurse Downing met or exceeded the standard of care while caring for RJ. It was very clear for the jury that Ms. Hurley had no critique at all of Nurse Downing's or Defendant's care of RJ. Obviously, the jury chose not to believe her.

VI. The Requests to Admit were properly published to the Jury

The trial judge properly exercised his discretion in accordance with the rules in allowing Plaintiff to publish to the jury the requests to admit submitted by Defendant to Plaintiff. The South Carolina Rules of Civil Procedure plainly state "any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission...the Court *may* permit withdrawal...when the presentation of the merits of the action will be sub-served thereby and the party who obtained (Defendant in this instance) fails to satisfy the court that withdrawal or amendment will prejudice him in maintaining or defense of the merits." SCRCP Rule 36. Defendant argues publishing the requests to admit to the jury had the effect of Defendant admitting they were not negligent, confused the jury, and Plaintiff would not be prejudiced in withdrawing the requests.

If anything, the requests to admit suggested a potential value of the damages to the jury of greater than $100,000.00. The jury's award to Plaintiff individually exceeded that amount by thirty-five thousand dollars and the award to RJ exceeded that amount by more than one million dollars. To suggest the jury's decision hinged on the requests to admit thus seems absurd. Furthermore, for the jury to be confused by the admissions and think that Defendant was admitting negligence, they would have had to ignore Defendant's entire case as well as its attack on all of

Plaintiff's witnesses. There could be no doubt that Defendant disputed liability when its expert testified Nurse Downing exceeded the standard of care. There could be no doubt that Defendant disputed damages when it accused RJ's mother of denying her child car for his scar because he had rickets and because it was expensive to obtain.

Finally, the rule states "the party who obtained the admission" must who that it is not prejudiced in withdrawing the admission. SCRCP Rule 36. Plaintiff did not obtain the admission and thus has nothing to demonstrate. If the court would require Plaintiff to do so in this instance, then the prejudice is clear: although Defendant denies liability, it admits there is value to the damages. Defendant indeed admits in its own post-trial motion briefs that it never denied there was an injury that resulted from the infiltration at their hospital. Allowing the admissions is consistent with Defendant's position, absolutely confirming the merits, Defendant's merits, of the case.

VII. The jury charges sufficiently enabled the jury to understand fully the law of the case and issues involved

The trial judge properly charged the jury with the law applicable to the nursing standard of care even while omitting the exact language requested by Defendant. "The substance of the law is what must be instructed by the jury, not any particular verbiage." State v. Smith, 315 S.C. 547, 554, 446 S.E.2d 411, 415 (1994); *See also* Keaton v. Greenville Hospital System, 334 S.C. 448 (1999). "In reviewing jury charges for error, we must consider the court's jury charge as a whole in light of the evidence and issues presented at trial." Bragg v. Hi-Ranger, Inc., 319 S.C. 531, 462 S.E.2d 321, 330 (Ct. App. 1995) (*citing* Manning v. Dial, 271 S.C. 79, 245 S.E.2d 120 (1978).

In this case, the trial judge charged the jury on standard of care and breach of standard of care, which together echo, if not in the exact verbiage, the specific charge that Defendant requested.

> **Standard of care**
>
> The plaintiff must prove the standard of care the defendant owed in treating the plaintiff.
>
> When a nurse treats a patient, the law *does not require perfection or infallibility*. The law does require that the nurse use that degree of knowledge, care, and skill ordinarily possessed and used by nurses in good standing in the nurse's field of medicine, under the same or similar circumstances and that the nurse follow the generally accepted practices and procedures in the profession.[4]
>
> A nurse *is not an insurer of health and is not required to guarantee results*. A nurse undertakes only to meet the standard of skill possessed generally by others practicing in the field of nursing under same or similar circumstances.
>
> **Breach of the standard of care**
>
> The plaintiff must prove that the defendant negligently departed from the standard of care in treating the plaintiff.
>
> Negligence is the failure to do what an ordinary careful nurse in the nurse's field of medicine would have done under the same or similar circumstances, or the doing of something that an ordinary careful nurse would not have done under the same or similar circumstances.
>
> The mere fact that a treatment does not benefit the patient or that it even hams the patient, is not in and of itself, negligence. A bad result, injury, death, or failure to cure, is not enough, alone, to show that the defendant was negligent. In considering whether the defendant made a reasonable decision, you must

---

[4] Durham v. Vinson, Op. No. 25872 (S.C. Sup. Ct. filed September 13, 2004); Bessinger v. Deloach, 230 S.C. 1, 94 S.E.2d 3 (1956); Jernigan v. King, 312 S.C. 331, 440 S.E.2d 379 (Ct. App. 1993).

> consider the decision in relation to the facts as they existed at the time, and not in light of what hindsight may reveal.

Jury Charges (emphasis added). These charges in essence incorporate the ideas and principles in Defendant's requested charge including "a nurse is not required to be all knowing and all wise" and "the law does not require of a nurse absolute accuracy either in practice or in judgment." Furthermore, Defendant cannot point to any incorrect statement in the judge's charges, only wishes to add some exact verbiage. There is no reversible error. The trial judge accurately stated the substance of the law and there is absolutely no prejudice to Defendant in not including the exact verbiage. Indeed, to add that verbiage would only seem to overemphasize and exaggerate that law to the jury, prejudicing Plaintiff.

CONCLUSION

For the reasons stated above and based on any additional argument at a hearing on this motion, the Court should deny Defendant's motion for JNOV, a new trial or a new trial nisi remittitur, withstand the jury's award in the amount of $135,477.00 for Plaintiff Tekayah Hamilton and modify the amount to Plaintiff Robert Lee M. Jr. to $1,065,000.00.

David R. Williams
Virginia W. Williams
WILLIAMS & WILLIAMS
1281 Russell Street
Post Office Box 1084
Orangeburg, S.C. 29116-1084
Phone: (803) 534-5218
Facsimile: (803) 928-5190
david@williamsattys.com
ginny@williamsattys.com

June 12, 2018

Orangeburg, South Carolina

ATTORNEYS FOR PLAINTIFF

STATE OF SOUTH CAROLINA COUNTY OF ORANGEBURG	)	IN THE COURT OF COMMON PLEAS FIRST JUDICIAL CIRCUIT
TEKAYAH HAMILTON, Individually and as Parent Guardian Ad Litem for ROBERT LEE M. JR., Plaintiff, vs. THE REGIONAL MEDICAL CENTER, Defendant.	)	Case No.: 2015-CP-38-01234 Defendant's Response to Plaintiff's Memorandum in Opposition to Defendant's Motion For JNOV or In the Alternative Motion for New Trial *Nisi Remittur* and in Opposition to Defendant's Reduction to Statutory Cap

TO: JONATHAN F. KRELL, ESQUIRE AND DAVID WILLIAMS, ATTORNEYS FOR PLAINTIFF

NOW COMES DEFENDANT, and states the following in Response to Plaintiff's Memorandum in Opposition to Defendant's Motion For JNOV or in the alternative motion for new trial/new trial Nisi Remittitur and in Opposition to Defendants Motion For Reduction to statutory Cap:

Defendants reiterate and incorporate by reference herein, the arguments contained in Defendant's Post Trial Motion For Reduction To Statutory Cap and Defendant's Notice of Motion And Motion For JNOV or In The Alternative Motion For New Trial.

REPLY ARGUMENT

1: The Statutory Cap is $300,000.00 as this is a Nursing issue and there is no evidence of Physician malpractice and the Plaintiff's never alleged any malpractice by a Physician.

Plaintiffs argue for the first time in the memorandum the $1.2 million-dollar cap for physicians is applicable to this case. However, there were never any allegations in the

Complaint alleging physician malpractice. This case has always been about the pediatric nursing standard of care and whether that standard was breached in a grossly negligent manner. Because this is only a nursing issue, the statutory cap of $300,000.00 applies.

The statutory cap is $300,000.00 according to the S. C. Tort Claims Act. Section § 15-78-120(a) provides as follows:

> (a) For **any** action or claim for damages brought under the provisions of this chapter, the liability shall not exceed the following limits: (1) **Except as provided in Section 15-78-120(a)(3),** no person shall recover in any action or claim brought hereunder a sum exceeding three hundred thousand dollars because of loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved.

SC Code Ann. § 15-78-120(a) (1). Whereas § 15-78-120(a)(3), regarding physicians and dentists, states:

> (3) No person may recover in any action or claim brought hereunder against any **governmental entity** ***and caused by the tort of any licensed physician*** or dentist, employed by a governmental entity and acting within the scope of his profession, a sum exceeding one million two hundred thousand dollars because of loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved.

S.C. Code Ann. § 15-78-120 (a)(3). "Provisions establishing limitations upon and exemptions from liability of a governmental entity *must be liberally* construed in favor of limiting liability." *Plyler v. Burns*, 373 S.C. 637, 651 (2007) (citing *Steinke v. South*

Carolina Dep't of Labor, Licensing and Regulation, 336 S.C. 373 (1999)); *see also* S.C. Code Ann. §15-78-20(f) ("The provisions of this chapter establishing limitations on and exemptions to the liability of the State, its political subdivisions, and employees, while acting within the scope of official duty, *must be liberally construed* in favor of limiting the liability of the State.").

Plaintiff's Complaint does not allege any breaches of the standard of care by a TRMC employed physician. There was no testimony at trial that a TRMC employed physician allegedly violated the standard of practice in treating the child. Monica Stobbs is not a physician and therefore did not testify as to the standard of care for a physician. Further, as defendant asserts, Monica Stobbs was not qualified to testify about pediatric nursing standard of care, it only follows she is even more unqualified to testify to the standard of care for a pediatrician. Plaintiff offered no testimony on physician malpractice, which was also not plead. TRMC was not on notice of any alleged physician malpractice.

The words "and caused by the tort of any licensed physician" in section § 15-78-120 (a)(3) of the S. C. Code, means that the tort *must* have been caused by a licensed physician or dentist in order to trigger the statutory cap of $1.2 million dollars. As such, the words "any" and "except" in the section 15-78-120(a)(1) applies for all other actions not caused by a physician or dentist. The code states, "For *any* action or claim for damages brought under the provisions of this chapter, the liability shall not exceed the following limits: (1) *Except* as provided in Section 15-78-120(a)(3)," (Emphasis added)

A plain reading of the statute is clear. In order to trigger the $1.2 million-dollar cap, the tort must be caused by a licensed physician, if not the $300,000.00 cap applies.

As stated above, there has been no allegations or evidence or testimony that any TRMC physician breached the standard of care. It is abundantly clear the $300,000 cap applies.

In order to allege and prove physician negligence, specifically, plaintiff must present evidence of the generally recognized practice and procedures that would be exercised by competent practitioners in the defendant's field under the same or similar circumstances, and that the defendant departed from the recognized generally accepted standards, practices and procedures in the manner alleged by the plaintiff. Gooding v. Saint Francis Xavier Hospital, 326 S.C. 248, 487 S.E.2d 596 (1997). Plaintiff must use expert testimony to establish both the standard of care and the deviation thereof, and that the said deviation was the proximate cause of plaintiff's injury. Pederson v. Gould, 288 S.C. 141, 341 S.E.2d 633, (1986); Carver v. Medical Society of South Carolina, 286 S.C. 347, 334 S.E.2d 125 (S.C. App. 1985). Plaintiff must also establish the standard of care and deviation therefrom for a nurse. McMillan v. Durant, 312 S.C. 200, 439 S.E.2d 829 (1993). Plaintiff offered no such evidence.

The Plaintiff is also required to establish proximate cause as well as negligence and expert testimony is necessary to establish proximate cause. Bramlette v. Charter-Medical Columbia, 302 S.C. 68, 393 S.E.2d 914 (1990) and Botehlo v. Bycura, 282 S.C. 578, 320 S.E.2d 59 (S.C.Apps. 1984). Proximate cause requires proof of (1) causation in fact and (2) legal cause. Causation in fact is proved by establishing the injury would not have occurred "but for" the defendant's negligence. Legal cause is proved by establishing foreseeability. Bramlette, *supra*. Therefore, only the nursing liability cap of $300,000.00 applies.

II: Tekayah Hamilton's award must be reduced to $20,854.00.

The maximum jury award for Tekayah Hamilton was only to allow her to recover the past and future medical expenses of the minor child and therefore she can only recover $20,854.00.

A parent is the proper party in interest with respect to past medical expenses and future medical expenses while the child is a minor. *See, Patton v. Miller*, 420 S.C. 471 (2017). Under the Tort Claims Act, a parent may recover medical expenses and loss of services separately from the child's claim. *See, Wright v. Colleton County School Dist.*, 301 S.C. 282 (1990). A parent may not recover loss of filial consortium in South Carolina. *See, Doe v. Greenville Cnty. School Dist.*, 375 S.C. 63 (2007).

The jury returned a verdict for Tekayah Hamilton for $135,477.00. Pursuant to South Carolina law, Tekayah Hamilton's damages are limited to past and future medical expenses only as set forth above, as that was the only evidence presented. The only evidence presented to the jury of medical expenses, past and future, was the amount of $20,854.00. Tekayah Hamilton's damages must be reduced to the amount of $20,854.00 for past and future medical expenses for the minor. She is not entitled to any pain and suffering. Doe, supra.

Plaintiff's argued in the memorandum that the financial burden of taking time off work and travel expenses justify the award. There was no evidence presented at trial that Tekayah Hamilton was making or would have made six-figures in the few month period during the incident and recovery. It is even more unreasonable to suggest that travel expenses to and from the Regional Medical Center amounted to $114,623 dollars. Additionally, there was no evidence of travel cost or time off from work submitted to the jury.

There is no evidence of the loss of services presented at trial, and pursuant to South Carolina case law there is no loss for filial consortium, *Doe v. Greenville Cnty. School Dist.*, 375 S.C. 63 (2007). The law is clear Tekeyah's damages are limited to past and future medical expenses only until the child is 18. The only evidence presented to the jury is that of $20,854.00. Therefore, Tekayah Hamilton's verdict must be reduced to the amount of $20,854.00, if defendant's other relief is not granted.

III. The Court Should Grant a New trial absolute because the Jury verdict is shockingly disproportionate to the evidence admitted at trial.

There is no evidence to uphold a jury verdict of $1,127,280 for the child or $135,477 for the mother. The only evidence of damages was $20,854 in medical bills, some pain and a scar. The jury verdict is 54 times the amount of actual damages. Defendant reiterates and realleges herein its argument made in its Motion for JNOV/New Trial as if referenced herein.

A trial Judge is required to grant a new trial absolute when the amount of the verdict is "so grossly . . . excessive that it shocks the conscience of the court and clearly indicates the amount was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives." *Waring v. Johnson*, 341 S.C. 248 (Ct. App. 200). The term "passion and prejudice" does not necessarily imply bad faith, wrongful purpose, or moral delinquency," but rather, results when the award is "against the overwhelming weight of the evidence." *Beasley v. Ford Motor Co.* 237 S.C. 506. (1961).

Here the award is against the overwhelming weight of the evidence. The jury verdict is 54 times the actual damages. Plaintiff's closing argument is not evidence. It is obvious that the jury returned a verdict on the result of passion and prejudice when the

verdict is 54 times the actual damages. Therefore, defendants are entitled to a new trial absolute.

IV. The Court should have directed a verdict in favor of TRC as Plaintiff's did not establish Gross Negligence.

Plaintiffs were required to prove gross negligence. *See generally Stewart v. Richland Memorial Hosp.*, 350 S.C. 589 (2002). "Gross negligence is the intentional conscious failure to do something which it is incumbent upon one to do or the doing of a thing intentionally that one out not to do. [internal citations omitted]. It is the failure to exercise slight care." *Etheridge v. Richland School dist. One*, 341 S.C. 307, 311 (2000).

The evidence shows that the defendants exercised more than slight care. Jamie Downing inspected the IV site 7 times in a twelve-hour shift when the requirement was once every 12 hours. The only pediatric nurse expert, Cynthia Hurly, testified that Jamie Downing exceeded the standard of care. Plaintiff's expert, which defendant denies is an expert, testified that she had no opinion that Jamie Downing intended to harm the minor. There was no evidence of intent, which is required for gross negligence and the evidence shows that Jamie Downing exercised more than slight care.

Further, there were not multiple repeated mistakes in the medical records, plaintiff's expert misinterpreted the records and policies. At no time did plaintiff's present evidence that MEC medical recording system was flawed. Plaintiff's expert was not familiar with the medical recording system and had no experience in operating it. There was also no evidence offered at trial that Dr. Boltin ignored or intentionally override the reminder to flush every four hours. This allegation is raised for the first time in plaintiff's memorandum. Defendant asserts in Section I above this is improper.

There was no evidence of malpractice by Dr. Boltin. Plaintiff's expert testified that after the infiltration she had no criticism to the treatment the child received. She is again, not competent to render opinions as to physician treatment and standard of practice. There were no allegations pled against Dr. Boltin as set forth above and she did not testify to same. There was no evidence of any physician malpractice.

Plaintiffs cannot meet the elements of gross negligence. There was no evidence of intent, and the evidence presented reveals defendants exercised more than slight care. Therefore, defendants should have been granted a directed verdict, as more fully set forth in this Motion for JNOV/New Trial.

V. Monica Stobbs is not qualified to give an opinion as to pediatric IV management.

In order to qualify an expert, a witness must have the "knowledge, skill, experience, training or education" in order to testify. Rule 702, SCRE. "To be competent to testify as an expert, a 'witness must have acquired by reason of study or experience or both such knowledge and skill in a profession or science that he is better qualified than the jury to form an opinion on the particular subject matter." *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 253 487 S.E.2d 596, 598 (1997) *(quoting O'Tuel v. Villani,* 318 S.C. 24, 28, 455 S.E.2d 698, 701 (Ct. App. 1995)).

Monica Stobbs was not qualified to give opinions on the standard of care that would have applied to Jamie Downing. She never managed, monitored, or started a pediatric IV. Ms. Stobbs did not do any research on the literature prior to forming any opinions.

This case is similar to the *Botehlo v. Bycura,* where an orthopedic surgeon was not qualified to testify on the standard of care for podiatrist where the orthopedic surgeon

had no training in podiatry, was not familiar with any journals or periodicals in podiatry and was not familiar with the surgical procedure performed. 282 S.C. 578, 320 S.E.2d 59 (1984).

Ms. Stobbs testified that medical record indicated insufficient monitoring of the site, incomplete assessments and insufficient flushing. Ms. Stobbs never used the Electronic System implemented by TRMC, and she misinterpreted the medical records. Ms. Stobbs was not qualified to testify about any of that, because she never used the system.

Ms. Stobbs testimony cannot be used to establish the standard of care for monitoring a pediatric IV site. She simply, stated Defendants broke the rules. She had no experience or knowledge to explain the rules that were allegedly broken. Her testimony was prejudicial as she had no experience monitoring pediatric IV sites or the medical records. She has never managed or maintained a pediatric IV site.

Monica Stobbs testimony should have been excluded and therefore defendants are entitled to a JNOV or in the alternative a new trial.

VI. The Request to Admit should have not be published to the Jury

Defendants concede that this is an unusual instance. However, the Request to Admit should not have been published to the Jury. Defendant asserts that the probative value of the Request to Admit was substantially outweighed by the prejudicial affect.

Here, Plaintiff's Counsel intentionally failed to even mention to Defendant's counsel that it intended to publish the request to the Jury. Plaintiff's pre-trial brief was silent on the issue. Defendants were unaware, until at the close of plaintiff's case, when plaintiff's counsel suddenly sprung it on defendant's counsel stating it was a stipulation.

There was never any discussion prior about the request to admit. Such tactics are highly prejudicial as defendants had not time to gather rebuttal evidence.

The Request to Admit did nothing but confuse the issues and was highly prejudicial to defendant. It had the effect of admitting negligence, there was no probative value to the Request to Admit. Plaintiff could show no prejudice by the exclusion of the evidence. There was no probative value to the request to admit. The purpose of the request was to obtain an independent medical examination.

The request to admit should not have been published to the Jury and therefore defendants are entitled to a new trial.

The Request to Admit should not have been published to the Jury and prejudiced the defendant. "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Rule 403, SCRE. Rule 36 (b) of the South Carolina Rules of Civil Procedure states,

> Any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission. Subject to the provisions of Rue 16 governing amendment of a pre-trial order, the Court may permit withdrawal or amendment when the presentation of the merits of the action will be sub-served thereby and the party who obtained the admission fails to satisfy the court that withdrawal or amendment will prejudice him in maintaining or defense on the merits Any admission made by a party under this rule is for the purpose of pending action only and is not an admission by him for any other purpose.

RULE 36, SCRCP; *see also Commerce Center of Greenville, Inc. V. W. Powers McElveen*, 347 S.C. 545, 557, 556 S.E.2d 718, 724 (Ct. App. 2001) (" The trial court may allow a party to amend or withdraw its answers to a request to admit when: (1) the

presentation of the merits is furthered by the amendment; and (2) the party who obtained the admission cannot demonstrate prejudice because of the amendment."). Defendant asserts that plaintiff was not prejudiced by withdrawal of these Requests, which was denied by the Court.

South Carolina's case law addresses issues for withdrawal by the admitting party. The Court should have permitted withdrawal of the RTA because the plaintiffs could not show that withdrawal would prejudice them in maintaining the merits. Here the Request to Admit (RTA) was highly prejudicial to the defendant and did nothing but confuse the issues. At all times defendant maintained that they were not negligent. By introducing the RTA to the jury, it had the effect as if defendant admitted they were negligent. At no time did the defendant admit negligence. The RTA had the opposite effect because plaintiffs admitted the amount in controversy was more than $100,000. The RTA request number 1 stated, "Admit the value of the amount in controversy in this action is less than $100,000." The plaintiff denied this. This directly confuses the issues and is highly prejudicial to any probative value it may have.

The purpose of the request to admit was to obtain an Independent Medical Examination, not for plaintiffs to represent that defendant admitted the damages were in excess of $100,000.00. Therefore, defendants are entitled to a new trial.

VII: The probative value of the photographs was substantially outweighed by unfair prejudice.

Rule 403 of the SCRE states, "[a]lthough relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." "To constitute unfair prejudice, the

photographs must create 'an undue tendency to suggest a decision on an improper basis, commonly, though not necessarily, an emotional one." *State v. Holder*, 382 S.C. 278, 290(2012) (quoting state v. Jackson, 364 S.C. 329, 334 (2005)).

The Court should have excluded the photographs from the jury. In plaintiff's memorandum it states "the fact is it was a horrible injury which was ugly, unpleasant, and offensive in its nature." Pl. Memo. In Opposition pg 12. That is indicative of how prejudicial the photographs were to defendant. As shown at trial, there was ample evidence to prove an injury occurred. No witness disputed the injury had occurred. Plaintiff argues that the photograph that defendant introduced was small and had to be passed around and further that plaintiffs did nothing to enhance the photo. However, the plaintiff's photographs were enhanced, they were blown up, completely out of proportion to its relative size on top of the fact all of the photos were originally close-ups. As to the photograph that Defendant passed around, it was not the photograph of the open flesh wound, it was a photograph of the scar.

Given the excessive jury verdict it is evident that the jury returned a verdict on a result of passion and prejudice. Therefore, defendants should be granted a new trial absolute.

CONCLUSION

WHEREFORE, defendant TRMC asserts that based on all of the foregoing reasons contained in this Response, as well as those in the prior two filed Motions, the defendant respectfully requests this Court reconsider its decisions and issue and order granting TRMC JNOV or in the alternative, grant dDefendant's a new trial absolute, and

grant such other and further relief as contained herein and such other relief as may be just and proper.

MICHEL C. TANNER, L.L.C.

Michel C. Tanner
Joseph R. Shakibanasab
Post Office Box 1061
Bamberg, S.C., 29003
Attorneys for Defendant

Bamberg, S.C.

June 22, 2018

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY
Court of Common Pleas

Edgar W. Dickson, Circuit Court Judge

CASE NO.: 2015-CP-38-01234

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee Middleton, Jr., a minor child under the age of eighteen,

..... Respondent,

v.

The Regional Medical Center

.....Defendant.

NOTICE OF APPEAL

Appellant, The Regional Medical Center appeals the attached Order of the Honorable Edgar W. Dickson dated October 25, 2019, and filed October 25, 2019. Appellant received written notice of entry of this Order on October 25, 2019.

Michael C. Tanner
Post Office Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for The Regional Medical Center

Other Counsel of Record:

Jonathan F. Krell, Esquire
Post Office Box 399
Charleston, SC 29402

David R. Williams, Esquire
P.O. Box 1084
Orangeburg, SC 29115

Attorneys for Respondent

November 19, 2019

Orangeburg Common Pleas

Case Caption:	Tekayah Hamilton , plaintiff, et al VS Regional Medical Center , defendant, et al
Case Number:	2015CP3801234
Type:	Order/Other

So Ordered

s/ Edgar W. Dickson #2153

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF ORANGEBURG	)	CIVIL ACTION NO. 2015-CP-38-01234
	)	
Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M. Jr., a minor child under the age of 18,	)	ORDER GRANTING DEFENDANT'S MOTION FOR REDUCTION TO STATUTORY CAP AND DENYING DEFENDANT'S MOTION FOR JNOV OR IN THE ALTERNATIVE FOR A NEW TRIAL
Plaintiff,	)	
vs.	)	
Regional Medical Center	)	
Defendant.	)	

This case was tried before a jury in this Court on or about May 9, 2018. The jury returned a verdict finding Defendant was grossly negligent and awarded $1,127,280.00 to the minor plaintiff Robert Lee M. Jr., and $135,477.00 to Plaintiff Tekayah Hamilton. Defendant filed two, separate post-trial motions, one to reduce the award to the statutory cap and a JNOV or in the alternative for a new trial. After review of the motions, memoranda of counsel and supporting documents, I grant in part Defendant's Motion for Reduction to Statutory Cap and deny Defendant's Motion for JNOV or in the Alternative for New Trial.

FACTUAL AND PROCEDURAL BACKGROUND

This case arises out of Defendant's alleged failure to implement policies, procedures, and equipment to allow Defendant to properly monitor an IV with ampicillin administered to RJ on or about October 28, 2014, while a patient at Defendant's facility in Orangeburg, South Carolina. Plaintiff's complaint alleges medical negligence, specifically the following:

> The impression of the treating physician was high fever and admission to the hospital was necessary in order to work up CBC, LP, blood and urine cultures. It was decided to begin Ampicillin and Claforan. Pl.'s Complaint par.11

> Defendant Regional, by and through its agents and/or employees, and Defendant Downing[1], owed Plaintiff a duty of care to use that degree of care and skill which ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances. Pl.'s Complaint par.33.
>
> Plaintiff asserts Defendants breached that duty of care and were negligent, grossly negligent, careless, willful, wanton, and reckless in the following particulars:
> a) In failing to use reasonable medical care in accordance with the recognized standards of acceptable professional practice in medicine during the care, diagnosis and treatment of Plaintiff;
> b) In failing to act with ordinary and reasonable care in accordance with the recognized standards of acceptable professional practice in medicine;
> c) In failing to follow the Infusion Nurse Society publication on *Policies and Procedures for infusion Nursing of the Pediatric Patient*;
> d) In failing to pursue such appropriate medical modalities and treatments which could have avoided this type of injury and permanent damage;
> e) In failing to act and behave in the same or similar manner that reasonably competent doctors and healthcare facilities and staff would have behaved or acted in the same or similar conditions;
> f) In failing and neglecting to properly inspect the IV site on October 28, 2014, at approximately 4:27 a.m. prior to the administration of antibiotic medication;
> g) In failing and neglecting to properly monitor the IV site after the administration of antibiotic medication;
> h) In failing to adequately train and supervise its medical staff;
> i) In failing to provide the safest care and treatment to Plaintiff; and
> j) For such other acts and omissions that may become more apparent through the discovery of this matter.

Pl.'s Complaint par. 34. Plaintiff attached an affidavit to her complaint by Monica Stobbs, RN, BSN, clarifying and reiterating the breaches in the standard of care by Defendant TRMC, by and through its employees, causing harm to RJ and Tekayah. Specifically, Plaintiff alleged Defendant Regional failed to properly monitor RJ's IV site prior to and after administering medication. Plaintiff did not offer any testimony at trial as to any alleged physician malpractice.

This matter was filed pursuant to South Carolina Tort Claims Act, S.C. Code Ann. §15-78-10, et. Seq. I find that defendant TRMC is a governmental healthcare facility and is afforded the protections of the South Carolina Tort Claims Act, as defined by the Act.

[1] Defendant Downing, a registered nurse, was dismissed as a party after the original Summons and Complaint was filed.

At trial, Plaintiff offered Monica Stobbs, RN, BSN, as well as Dr. DeVito regarding RJ's future care and Plaintiff herself took the stand. Plaintiff also called nurse Jamie Downing, RN, and published Plaintiff's answers to Defendant's First Set of Requests to Admit to the jury. RJ's medical records and bills were submitted as evidence along with several pictures of his injury and numerous policies and procedures of Defendant Regional.

Defendant called Dr. Davis to dispute RJ's future care. Nurse Jamie Downing, testified along with Cynthia Hurley as to standard of care and expert issues. Defendant also submitted pictures of RJ's injuries, select medical records and select policies and procedures. Defendant moved for a directed verdict at the end of Plaintiff's case and its own. The Court denied both motions for directed verdict.

Defendant TRMC filed two separate post trial motions. The first post trial motion was a reduction of the damage caps to reduce the child's award to $300,000.00 and the second was to reduce the mother's jury award to $20,854.00 pursuant to the Tort Claims Act §15-78-120(a) (1). I find that Defendant TRMC's motion for JNOV/New Trial contained the following grounds: Defendant asserted plaintiff's witness, Monica Stobbs, was not qualified to render pediatric nursing opinions; Defendant TRMC asserted that Plaintiff did not establish gross negligence as required by the Tort Claims Act; Defendant TRMC asserts it was prejudiced by photographs submitted to the jury; Defendant TRMC asserts it was error to not allow its expert to testify to an opinion on gross negligence when Plaintiff's expert was allowed to render such opinion; Defendant TRMC asserts it was an error to publish its answers to Request to Admit to the jury; Defendant TRMC alleges it should be granted a new trial as certain jury charges were not given and finally Defendant's motion stated that the verdict was excessive. In ruling on all of these motions, the court has reviewed the motions submitted by Defendant TRMC, the memoranda of

both parties and a review of the applicable law. The Court incorporates all of Defendant's arguments raised in Defendant's motions and memoranda herein, as if repeated verbatim.

STANDARD OF REVIEW

A motion for judgment notwithstanding the verdict may only be granted if no reasonable jury could have reached the challenged verdict. RFT Management Co., LLC v. Tinsley & Adams, LLP, 399 S.C. 322, 332, 732 S.E.2d 166, 171 (2012). A jury's verdict must be upheld unless no evidence reasonably supports the jury's findings. Curcio v. Caterpillar, Inc., 355 S.C.316, 320, 585 S.E.2d 272, 274 (2003). In ruling on a motion for judgment notwithstanding the verdict, the trial court must view the evidence and all inferences reasonably drawn therefrom in the light most favorable to the opposing party. Law v. S.C. Dep't of Corr., 368 S.C. 424, 434, 629 S.E.2d 642, 648 (2006).

The thirteenth juror doctrine is the method used by the trial court to grant a new trial upon a finding that the evidence presented at trial did not support the jury's verdict. Curtis v. Blake, 392 S.C. 494, 505, 709 S.E.2d 79, 85 (Ct. App. 2011). If the amount of the verdict is grossly inadequate or excessive so as to be the result of passion, impulse, prejudice, or some other influence outside the evidence, the trial court must grant a new trial absolute. Id. at 500, 709 S.E.2d at 82. Compelling reasons must be presented to support the trial judge's invasion of the jury's province, merely highlighting that the verdict is greater than the amount of monetary damages is not enough as such other non-monetary factors must be considered as well. Id. at 501, 709 S.E.2d at 83.

ANALYSIS

First, this Court finds that the statutory cap on damages pursuant to the South Carolina Tort Claims Act (§ 15-78-10, et seq.) is applicable to this case. This action against TRMC is

subject to the Tort Claims Act, §15-78-10, et. seq. Specifically, the Act provides that no person shall recover a sum exceeding three hundred thousand dollars because of a loss arising from a single occurrence regardless of the number of agencies or political subdivisions involved unless otherwise provided. S.C. Code Ann. § 15-78-120(a)(1).

In this case, the Jury returned a verdict for the minor, Robert Lee Middleton Jr. ("RJ"), in the amount of $1,127,280.00 and separately for his mother, Tekayah Hamilton, in the amount of $135,477.00. Defendant believes that the award to RJ should be reduced to the statutory cap of $300,000 and further argues that the award to Tekayah Hamilton should be reduced to $20,854. In response, Plaintiff's posits that since this single occurrence involved the totality of Defendant's conduct, which encompasses the alleged conduct of Defendant's physicians, then the applicable recovery cap of $1,200,000.00 contained in section 15-78-120(a)(3) applies.

Plaintiff's Complaint did not contain any allegations of physician malpractice and I do not find that Plaintiff offered any testimony that a physician breached the standard of care and alleged deviation of same. Plaintiff offered no expert testimony as to this issue at trial.

This Court agrees that the $1,127,280.00 award to RJ should be reduced to $300,000.00 pursuant to section 15-78-120(a)(1). As set forth above, the jury verdict for RJ must be reduced pursuant to the Tort Claims Act. Although a doctor ordered the medication and its administration, the crux of Plaintiff's case and the evidence presented at trial was that a nurse breached the applicable standard of care. I find that Plaintiff offered no evidence showing a physician was involved in any of the allegations in this matter. Furthermore, Defendant is correct that the evidence at trial showed RJ's mother incurred $20,854.00 in past medical expenses. However, the jury was presented evidence that Ms. Hamilton would be required to bear the financial burden to take time off of work and travel for any future expenses. Because she

will remain his guardian for at least fifteen more years, this court finds the award reasonable. Therefore, this Court finds that the award of $1,127,280.00 to RJ should be reduced to $300,000.00. Further, the award of $135,477.00 to Ms. Hamilton should remain without alteration. The Court denies Defendant's motion to reduce Ms. Hamilton's verdict to $20,854.00 pursuant to the Tort Claims Act.

Next, Defendant asserts that Monica Stobbs was not qualified to give an opinion on the standard of care of pediatric nursing and pediatric IV administration. Nurse Stobbs testified she never managed, maintained or started Pediatric IV's, nor did she review any literature on these issues. She did testify she did these tasks on adult patients. Once qualified, she testified that the assessment, flushing, and other procedures for monitoring and inspecting an IV site prior to the administration of medicine and after the administration of medication are the same regardless of the patient's age. Therefore, this Court sees no reason to depart from its earlier ruling that Monica Stobbs was properly qualified as an expert in nursing, but not as a pediatric nurse. The Court denies the Defendant's motion raised on this ground.

Similarly, Defendant argues that this Court should have directed a verdict in its' favor because Gross Negligence was not established. The determination of gross negligence is a mixed question of law and fact and should be presented to the jury when evidence supports it. Staubes v. City of Folly Beach, 331 S.C. 192, 205, 500 S.E.2d 160, 168 (Ct. App. 1998), aff'd, 339 S.C. 406, 529 S.E.2d 543 (2000). In this case, an inference that Ms. Downing failed to flush the child's IV is an inference that she failed to use slight care. Further, Plaintiff presented evidence that at least 20 minutes passed between RJ's reaction to the ampicillin and the time Defendant's employees responded to Ms. Hamilton's requests for assistance.

Additionally, witnesses testified that in the medical field, it isn't written down (documented), then it did not happen. Evidence of several failures to document the condition of the IV in question was presented at trial. Because the evidence presented could give rise to intentional conduct and/or a failure to exercise slight care, this Court finds that the evidence presented supported the Jury's finding of Gross Negligence. Defendant's Motion on this ground is denied.

Defendant next argues that the probative value of the photographs of RJ's injuries was substantially outweighed by unfair prejudice. Photographs may be admitted corroborating testimony, however, photographs calculated to arouse the sympathy or prejudice of the jury should be excluded if they are irrelevant or not necessary to substantiate material facts or conditions. State v. Jackson, 364 S.C. 329, 613 S.E.2d 374 (2005). This Court reviewed the photographs prior to their publication.

Although, given the nature of the injury and the child's age, they are hard to look at, there is little doubt the photographs are relevant to corroborate the injury. The photographs were admitted for the purpose of proving the injury and this Court sees no reason to depart from its earlier ruling permitting the pictures because they accurately reflected the facts of the case. Defendant's Motion is denied as to this ground.

Defendant also argues that Defendant's expert, Cynthia Hurley, should have been permitted to testify as to whether or not she believed its' employees were grossly negligent or negligent. Defendant asserts this evidence was proper under Rule 704, SCRE. In general, an expert's testimony on issues of law is inadmissible but not because it simply embraces the ultimate issue. Dawkins v. Fields, 354 S.C. 58 (2003). The Court declines to grant the Defendant's motion on this ground.

The Defendant raised in its motion for JNOV/New Trial the argument that it has been prejudiced by the publication of Request to Produce pursuant to Rule 36, SCRCP. The Court having considered this motion, declines to order a new trial on this ground.

Defendant moved for a new trial as to certain jury charges set forth in its motion of JNOV/New Trial, which are incorporated herein by reference, were not charged to the jury. The Court declines to grant Defendant's motion on this ground, which is denied.

The Defendant requested a new trial based upon the view that the jury verdict was grossly excessive and contrary to the evidence. Defendant asserts in its memoranda that the verdict was 54 times the amount of the actual damages and was a result of passion, caprice, or prejudice. The Court has considered the argument of the Defendant in its memoranda as set forth above, which is incorporated by reference. The Court denies Defendant's motion for a new trial based upon this ground.

Defendant additionally raised that if the Court denied its JNOV or new trial absolute motions it should grant a new trial nisi remittitur as it asserted the damages for excessive compared to the evidence presented at trial. After considering this argument, the court denies to grant the Motion on this ground.

The Court has considered all the issues raised by the Defendant in its post trial motions and denies the motion for JNOV/New Trial as set forth above and partially grants Defendant's motion to reduce the verdict to the Tort Claims Act liability cap. Accordingly, and for these reasons.

IT IS THERFORE ORDERED, that Defendant's Motion for post-trial relief of 1.) JNOV and 2.) a new trial absolute are DENIED. The Defendant's motion of reduction of damages to the

$300,000.00 statutory cap is GRANTED as to the verdict for the minor child, RJ. 3) Defendants motion to reduce the mothers verdict is denied.

AND IT IS SO ORDERED.

Resident Judge Edgar W. Dickson
The First Judicial Circuit

August ____, 2019
Orangeburg, South Carolina

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY
Court of Common Pleas

Edgar W. Dickson, Circuit Court Judge

CASE NO.: 2015-CP-38-01234

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee Middleton, Jr., a minor child under the age of eighteen, ... Respondent,

v.

The Regional Medical Center .....Defendant.

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on Tekayah Hamilton, by depositing a copy of it in the United States Mail, postage prepaid, on November 19, 2019, addressed to her attorneys of record, Jonathan F. Krell, Esquire, Post Office Box 299, Charleston, S.C., and David R. Williams, Esquire, Post Office Box 1084, Orangeburg, S.C., 29116

Michael C. Tanner
Post Office Box 1061
Bamberg, SC 29003
(803) 245-9153
Attorney for Appellant The
Regional Medical Center

November 19, 2019

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM ORANGEBURG COUNTY COURT OF COMMON PLEAS

Honorable Edgar W. Dickson, Circuit Court Judge

Appellate Case No. 2019-001921

Tekayah Hamilton, individually and as parent and guardian ad litem for Robert Lee M., Jr., a minor child under the age of 18, Respondent,

v.

Regional Medical Center, Appellant.

CERTIFICATE OF COUNSEL

The undersigned certifies that this Record of Appeal complies with Rule 210(g), SCACR.

Michael C. Tanner
Morgan R. Long
Post Office Box 1061
Bamberg, South Carolina 29003
(803) 245-9153
Attorney for Appellant

April 30, 2021